160th HOUSE OF DELEGATES

October 18-19, 2014

CALLAWAY GARDENS
PINE MOUNTAIN, GEORGIA
Speakers’ Letter
Medical Association of Georgia
House of Delegates
October 18-19, 2014
The Lodge and Spa at Callaway Gardens, Pine Mountain

MAG Delegates and Alternate Delegates:

Please review the following information to prepare for the Medical Association of Georgia’s (MAG) House of Delegates (HOD) meeting that will take place at The Lodge and Spa at Callaway Gardens in Pine Mountain on October 18-19.

MAG HOD delegates and alternate delegates are encouraged to contact their county medical society to see if it has already reserved a room for them at The Lodge and Spa at Callaway Gardens. MAG’s block of rooms at the Lodge is sold out, though attendees can still call 800.225.5292 and mention the “Medical Association of Georgia” to reserve a one-bedroom cottage at the Southern Pine Cottages at Callaway Gardens for $175 per night. The majority of the cottages are within a quarter-mile of the Lodge. MAG meeting attendees that would like to be placed on a waiting list for a room at the Lodge or need any other assistance with HOD lodging should contact Anita Amin at anita@jlh-consulting.com.

We encourage you to monitor www.mag.org/about-us/house-of-delegates for the latest information on this year’s HOD meeting. You can also download MAG’s HOD app by entering m.mag.org into your smart phone or tablet’s browser address window. Please contact Daphaney Willis at 678.303.9267 or dwillis@mag.org with questions.

John S. Harvey, M.D., Speaker of the House
E. Frank McDonald Jr., M.D., Vice Speaker of the House

Handbook

The HOD handbooks will be emailed to delegates and alternate delegates as a PDF. The handbook also will be posted on the aforementioned webpage. Handbooks will not be printed in 2014. Amendments to the handbook will be posted on the HOD webpage and emailed to delegates and alternate delegates on a regular basis.

Registration Desk

The HOD meeting registration desk will be located at the Lodge registration desk that is just outside the Longleaf Ballroom prefunction area at The Lodge and Spa at Callaway Gardens. A
temporary registration desk will be set up in the Lodge and Spa lobby from 1 p.m. to 3 p.m. on Friday, October 17. The permanent registration desk will be open at 6:30 a.m. on Saturday, October 18 and at 6:45 a.m. on Sunday, October 19. Please note that delegate substitutions can only be made by the applicable society president or executive director at the registration desk.

**Wireless Internet**

Delegates can simply open their web browser to get free wireless internet service at the Lodge and Spa.

**Meeting Schedule**

The HOD will convene in the Longleaf Ballroom at 8:30 a.m. sharp on Saturday, October 18. The opening session is scheduled to conclude by 10 a.m. The second session of the HOD will begin at 8 a.m. on Sunday, October 19.

Although subject to change, the reference committees are scheduled to convene at 11:30 a.m. on Saturday, October 18 as follows…

Reference Committee A – Health Care Policy  
Reference Committee C – Legislation  
Reference Committee F – Finance and Administration  
Reference Committee HC – Certificate of Need

The HOD will adjourn once its business is complete on Sunday, October 19.

**Elections**

Delegates who wish to nominate a MAG member for an elected office will have one minute to make a nominating speech during Saturday’s opening session. In the event that there is just one candidate nominated for an office, the election for that office will be uncontested and no second will be necessary. Elections for uncontested positions will be held on Saturday, October 18. The election of officers for any contested races will take place at about 9 a.m. on Sunday, October 19.

The elections will be conducted under the supervision of the chief teller, the assistant election tellers, and the Constitution and Bylaws Committee. For contested elections, voting will take place using an electronic audience response system. For any runoff elections, electronic handheld devices or paper ballots will only be distributed to the delegates who are seated in the House. Only duly credentialed delegates are permitted to cast a ballot. Alternate delegates who are seated for delegates must report to the registration desk to be properly credentialed and to receive a delegate’s ribbon. Alternate delegates may not vote on any matter unless they are properly credentialed as a delegate. Delegate substitutions can only be made by the applicable society president or executive director at the registration desk.

**Installation**

The ceremony to install Manoj H. Shah, M.D., as MAG’s president will take place in the Cypress Conference Room at 6 p.m. on Saturday, October 18. A reception will take place in the Ironwood Courtyard/Loblolly Prefunction area at 7:00 p.m., while the awards dinner will take
place in the Loblolly Ballroom beginning at 7:30 p.m. The cost to purchase tickets for the reception and dinner in advance is $50; two drink coupons will be included with each awards dinner ticket. Additional drinks may be purchased on a cash basis. Dinner tickets can be obtained by completing the online registration form, which should be returned to MAG by Wednesday, October 1. A limited number of dinner tickets will be available at the HOD registration desk for $100 per person.

Policy Compendium

The most current draft of the policy compendium is available at www.mag.org/about-us/house-of-delegates. The final version of the policy compendium will be included with the delegates’ handbook that will be emailed to delegates and posted on www.mag.org. The policy compendium will be updated after the HOD meeting to account for any actions that are taken by the HOD.

Dress Code

The dress code for the meeting is business casual. The individuals who are seated on a reference committee or on the dais are asked to wear business professional attire (coat and tie). The dress code for the installation ceremony and the awards dinner is black tie or business professional.

GAMPAC

GAMPAC will kick off its 2015 membership drive during the HOD meeting. GAMPAC is MAG’s non-partisan political action committee that elects pro-medicine candidates at the state level. GAMPAC membership levels include the Chairman’s Circle at $2,500, the Capitol Club at $1,000, and GAMPAC membership at $250. GAMPAC members are invited to attend an exclusive lunch that will take place in the Loblolly Ballroom A-C at 12:30 p.m. on Sunday, October 19. The lunch is free for GAMPAC members. U.S. Sen. John Barasso, M.D., will speak at the event. Contact Marcus Downs at 678.303.9280 or mdowns@mag.org for additional information.

MAG Foundation

MAG HOD delegates and alternate delegates are encouraged to support the MAG Foundation's 'Think About It' campaign to reduce prescription drug abuse in the state and/or the Georgia Physician's Leadership Academy. The MAG Foundation's sponsorship levels include the "1849 Club" ($100-$1,000), the "Leadership Society" ($2,500-$10,000), and the "Vanguard Society" ($25,000-$100,000). Contact Lori Cassity Murphy at 678.303.9282 or lmurphy@mag.org for additional information. Also go to www.mag.org/organizations/mag-foundation to make a donation.

Education Sessions
Leadership in Medicine CME – 1.0 AMA PRA Category 1 Credit™

MAG members are encouraged to attend the “Leadership in Medicine” educational session that will take place in the Loblolly Ballroom at The Lodge and Spa at Callaway Gardens from 11:45 a.m. to 12:45 p.m. on Friday, October 17 – right after the MAG Board of Directors meeting. Lt. Col. Thomas R. Hustead, M.D., Medical Corps Recruiting LNO and Recruiting Brigade for the Army Medical
Department, will discuss some of the key challenges that today’s physicians face and the role of leadership in medicine.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the Physicians’ Institute for Excellence in Medicine and the Medical Association of Georgia (MAG). The Physicians’ Institute for Excellence in Medicine is accredited by MAG to provide continuing medical education for physicians.

The Physicians’ Institute for Excellence in Medicine designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

International Medical Graduate Section

MAG’s International Medical Graduates (IMG) section will meet in the Sourwood Boardroom from 4 p.m. to 4:30 p.m. on Saturday, October 18. Contact Kate Boyenga at kboyenga@mag.org for more information.

Medical Student Section

MAG’s Medical Student Section (MSS) will meet in the Sourwood Boardroom from 4:30 p.m. to 5 p.m. on Saturday, October 18. Contact Kate Boyenga at kboyenga@mag.org for more information. It is also worth noting that this year’s HOD meeting will feature a MAG medical student abstract showcase. We encourage you to visit this exhibit, which will be set up in the main hallway.

County Medical Society Caucuses

The county medical society caucuses will begin at 6:45 a.m. on Sunday, October 19. Refer to the pocket program or download MAG’s HOD app at m.mag.org for specific information on the society caucus breakfast meetings.

Special Events

Golf Tournament

A golf tournament will begin with a shotgun start at the Lakeview Golf Course at 1:30 p.m. on Friday, October 17. The cost is $55 per person. HOD attendees may click here to register for the event.
MAG Past Presidents’ Dinner

The MAG Past Presidents’ Reception and Dinner will be held on Friday, October 17. It will take place from 7 p.m. to 9 p.m. at the Carriage & Horses Restaurant located at 607 Butts Mill Road in Pine Mountain. This is an invitation-only, black tie affair.

Cocktail Reception and Welcome Dinner

There will be a cocktail reception and dinner for all HOD attendees and their families at the the Longleaf Terrace and Lawn from 7 p.m. to 9 p.m. on Friday, October 17. Dress is business casual. Click here to register for the reception/dinner.

Georgia Physicians Leadership Academy Dinner

The Georgia Physicians Leadership Academy (GPLA) Steering Committee is inviting GPLA scholars, alumni and spouses to attend a reception in the Cypress Conference Room from 5:30 – 7 p.m. on Friday, October 17.

Exhibitors and Grand Prize Drawing

Exhibitions will be located in the Longleaf Ballroom Prefunction area which is adjacent to the HOD meeting room. MAG and MAG Mutual Insurance Company will conduct a special contest for delegates. Each delegate registration packet will contain a gold-colored ticket, and delegates who have every exhibitor punch their ticket will qualify for a chance to win the grand prize – a $500 American Express gift card. Delegates must be present for the drawing at the end of the meeting on Sunday to qualify.

Airports

Atlanta Hartsfield-Jackson International Airport – www.atlanta-airport.com

The Lodge and Spa at Callaway Gardens

4500 Southern Pine Drive
Pine Mountain, Georgia 31822
www.callawaylodgeandspa.com
706.489.3300

Parking

The parking at The Lodge and Spa at Callaway Gardens is free.
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Room</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Thursday, October 16, 2014</strong></td>
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<tr>
<td>24hr hold</td>
<td>Staff Office</td>
<td>Sourwood Boardroom</td>
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<tr>
<td>1:00PM</td>
<td>Pre-Conference</td>
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<tr>
<td>4:00 p.m. – 6:00 p.m.</td>
<td>MAG Foundation Meeting</td>
<td>Cypress Conference Room B</td>
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<tr>
<td>6:00 p.m.-9:00 p.m.</td>
<td>MAG Foundation Reception and Dinner</td>
<td>Cypress Conference Room A</td>
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<tr>
<td><strong>Friday, October 17, 2014</strong></td>
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<tr>
<td>24hr hold</td>
<td>Staff Office</td>
<td>Sourwood Boardroom</td>
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<tr>
<td>8:00 a.m. – 9:00 a.m.</td>
<td>MAG BOD Breakfast</td>
<td>Loblolly Ballroom Prefunction</td>
</tr>
<tr>
<td>9:00 a.m. – 11:30 a.m.</td>
<td>MAG Board of Directors Meeting</td>
<td>Loblolly Ballroom</td>
</tr>
<tr>
<td>11:45 a.m. – 12:45 p.m.</td>
<td>MAG BOD Lunch and CME</td>
<td>Loblolly Ballroom Prefunction</td>
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<tr>
<td>1:30 p.m. - Until</td>
<td>Golf</td>
<td>Lake View Golf Course</td>
</tr>
<tr>
<td>12:00 p.m.- 3:00 p.m.</td>
<td>Set up Registration</td>
<td>Hotel Lobby</td>
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<tr>
<td>3:00 p.m.- 6:00 p.m.</td>
<td>Exhibitor Set-up</td>
<td>Longleaf Ballroom Prefunction</td>
</tr>
<tr>
<td>5:30 p.m. - 7:00 p.m.</td>
<td>GPLA Reception</td>
<td>Cypress Conference Room A</td>
</tr>
<tr>
<td>7:00p.m. - 9:00 p.m.</td>
<td>MAG Dinner</td>
<td>Longleaf Terrace &amp; Lawn</td>
</tr>
<tr>
<td>7:00 p.m. – 9:00 p.m.</td>
<td>Past Presidents' Reception &amp; Dinner</td>
<td>Carriage &amp; Horses Restaurant - 607 Butts Mill Rd</td>
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<tr>
<td><strong>Saturday, October 18, 2014</strong></td>
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<tr>
<td>24hr hold</td>
<td>Staff Office</td>
<td>Sourwood Boardroom</td>
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<tr>
<td>6:30 a.m. – 3:00 p.m.</td>
<td>Registration</td>
<td>Built-In Registration Desk</td>
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<tr>
<td>6:30 a.m. – 8:00 a.m.</td>
<td>HOD Breakfast</td>
<td>Longleaf Ballroom Prefunction</td>
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<tr>
<td>7:00 a.m. - 8:00 a.m.</td>
<td>CME Session</td>
<td>Longleaf Ballroom</td>
</tr>
<tr>
<td>8:30 a.m. – 10:00 a.m.</td>
<td>House of Delegates (First Session)</td>
<td>Longleaf Ballroom</td>
</tr>
<tr>
<td>9:00 a.m. – 3:00 p.m.</td>
<td>Alliance Meeting</td>
<td>Cypress Conference Room B</td>
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<tr>
<td>10:30 a.m. - 11:30 a.m.</td>
<td>CON Forum</td>
<td>Longleaf Ballroom</td>
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<tr>
<td>11:30 a.m. - 12:30 p.m.</td>
<td>Reference Committee A</td>
<td>Cypress Conference Room A</td>
</tr>
<tr>
<td>11:30 a.m. - 12:30 p.m.</td>
<td>Reference Committee C</td>
<td>Bayberry 1 &amp; 2</td>
</tr>
<tr>
<td>11:30 a.m. - 12:30 p.m.</td>
<td>Reference Committee F</td>
<td>Sourwood 2 &amp; 3</td>
</tr>
<tr>
<td>11:30 a.m. - 12:30 p.m.</td>
<td>Reference Committee HC</td>
<td>Longleaf Ballroom</td>
</tr>
<tr>
<td>12:30 p.m. - 1:30 p.m.</td>
<td>Staff Lunch/Office</td>
<td>Sourwood Boardroom</td>
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<tr>
<td>12:30 p.m.-1:45 p.m.</td>
<td>MAG Mutual - Delegates’ Luncheon</td>
<td>Loblolly Ballroom</td>
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<tr>
<td>1:50 p.m. - 2:00 p.m.</td>
<td>HOD Photo</td>
<td>Longleaf Lawn</td>
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<tr>
<td>2:00 p.m. – 4:00 p.m.</td>
<td>Reference Committee A, continued</td>
<td>Cypress Conference Room A</td>
</tr>
<tr>
<td>2:00 p.m. – 4:00 p.m.</td>
<td>Reference Committee C, continued</td>
<td>Bayberry 1 &amp; 2</td>
</tr>
<tr>
<td>2:00 p.m. – 4:00 p.m.</td>
<td>Reference Committee F, continued</td>
<td>Sourwood 2 &amp; 3</td>
</tr>
<tr>
<td>2:00 p.m. – 4:00 p.m.</td>
<td>Reference Committee HC, continued</td>
<td>Longleaf Ballroom</td>
</tr>
<tr>
<td>4:30 p.m.-5:00 p.m.</td>
<td>IMG Section Meeting</td>
<td>Sourwood 2 &amp; 3</td>
</tr>
<tr>
<td>5:00 p.m.-5:30 p.m.</td>
<td>MAG Medical Student Section Meeting</td>
<td>Bayberry 3 &amp; 4</td>
</tr>
<tr>
<td>5:30 p.m. - 5:45 p.m.</td>
<td>Photography – New President's Photos</td>
<td>Sourwood Prefunction or Outside Near the Fountain</td>
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<tr>
<td>6:00 p.m. – 7:00 p.m.</td>
<td>MAG President Installation</td>
<td>Cypress Conference Room</td>
</tr>
<tr>
<td>7:00 p.m.-7:30 p.m.</td>
<td>MAG Awards Reception</td>
<td>Ironwood Courtyard &amp; Loblolly Pre-function</td>
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<tr>
<td>7:30 p.m.-9:30 p.m.</td>
<td>MAG Awards Dinner</td>
<td>Loblolly Ballroom</td>
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**Sunday, October 19, 2014**

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Room</th>
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</thead>
<tbody>
<tr>
<td>24hr hold</td>
<td>Staff Office</td>
<td>Sourwood Boardroom</td>
</tr>
<tr>
<td>6:30 a.m. - 8:00 a.m.</td>
<td>Distribution of Reference Committee Copies</td>
<td>Longleaf Prefunction</td>
</tr>
<tr>
<td>7:00 a.m. - 8:00 a.m.</td>
<td>Amendment Desk Run Through</td>
<td>Longleaf Ballroom</td>
</tr>
<tr>
<td>6:45 a.m. – 1:00 p.m.</td>
<td>Registration</td>
<td>Built-In Registration Desk</td>
</tr>
</tbody>
</table>

**Component Society Caucus Breakfasts**
<table>
<thead>
<tr>
<th>Time</th>
<th>Group</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:45 a.m. - 8 a.m.</td>
<td>AMA</td>
<td>Cypress Conference Room B</td>
</tr>
<tr>
<td>6:45 a.m. – 8:00 a.m.</td>
<td>Cobb</td>
<td>Sourwood 2 &amp; 3</td>
</tr>
<tr>
<td>6:45 a.m. – 8:00 a.m.</td>
<td>DeKalb, Gwinnett &amp; Hall</td>
<td>Cypress Conference Room A</td>
</tr>
<tr>
<td>6:45 a.m. – 8:00 a.m.</td>
<td>MAA</td>
<td>Loblolly A</td>
</tr>
<tr>
<td>6:45 a.m. – 8:00 a.m.</td>
<td>Troup &amp; Muscogee</td>
<td>Sourwood 4 &amp; 5</td>
</tr>
<tr>
<td>6:45 a.m. – 8:00 a.m.</td>
<td>Georgia Medical Society</td>
<td>Piedmont Dining Room</td>
</tr>
<tr>
<td>6:45 a.m. – 8:00 a.m.</td>
<td>Bibb County</td>
<td>Piedmont Dining Room</td>
</tr>
<tr>
<td>6:45 a.m. – 8:00 a.m.</td>
<td>Dougherty County</td>
<td>Piedmont Dining Room</td>
</tr>
<tr>
<td>6:45 a.m. – 8:00 a.m.</td>
<td>HOD Breakfast (non-cacus)</td>
<td>Longleaf Ballroom Prefunction</td>
</tr>
<tr>
<td>8:00 a.m. - 12:15 p.m.</td>
<td>House of Delegates (Second Session)</td>
<td>Longleaf Ballroom</td>
</tr>
<tr>
<td>11:30 a.m. – 12:15 p.m.</td>
<td>Staff Lunch/Office</td>
<td>Sourwood Boardroom</td>
</tr>
<tr>
<td>12:30 p.m. - 1:30 p.m.</td>
<td>GAMPAC lunch</td>
<td>Loblolly Ballroom B-D</td>
</tr>
<tr>
<td>2:00 p.m. - 5:00 p.m.</td>
<td>House of Delegates -2nd Session Cont. if needed</td>
<td>Longleaf Ballroom</td>
</tr>
<tr>
<td>2:00 p.m. - 5:00 p.m.</td>
<td>Exhibits – Tear Down</td>
<td></td>
</tr>
<tr>
<td>2:00 p.m. - 5:00 p.m.</td>
<td>BOD Organizational Meeting</td>
<td>Loblolly A</td>
</tr>
</tbody>
</table>
First-time visitors: This 2,500-acre garden is not designed to be walked exclusively. For your enjoyment, please access the many attractions, trails and recreational opportunities within the world’s largest public, self-guided woodland garden by vehicle, bicycle or Callaway Cruiser – open-air electric carts available for rent in the Mountain Creek® Inn.

**WALKING TRAILS**

- **Callaway Brothers Azalea Bowl Trail**
  - Length: 1.2 miles; Walking Time: 30-90 minutes; Difficulty Level: easy

- **Holly Trail**
  - Length: .8 miles; Walking Time: 40 minutes; Difficulty Level: easy

- **Lady Bird Johnson Wildflower Trail**
  - Length: .6 miles; Walking Time: 25-45 minutes; Difficulty Level: easy

- **Laurel Springs Trail**
  - Length: .5 miles; Walking Time: 45 minutes; Difficulty Level: moderate

- **Mountain Creek Lake Trail**
  - Length: 1.5 miles; Walking Time: 60-90 minutes; Difficulty Level: easy

- **Overlook Azalea Trail**
  - Length: 1.6 miles; Walking Time: 20-90 minutes; Difficulty Level: easy

- **Rhododendron Trail**
  - Length: 6 miles; Walking Time: 40 minutes; Difficulty Level: easy

- **Robin Lake Trail**
  - Length: 1.9 miles; Walking Time: 30-60 minutes; Difficulty Level: easy

- **Whippoorwill Lake Trail**
  - Length: .5 miles; Walking Time: 45 minutes; Difficulty Level: easy
MAG HOUSE OF DELEGATES
CAMPAIGN MATERIALS GUIDELINES

1. No campaign literature or communications (e.g., letters, information sheets, brochures) shall be distributed by any method unless it:
   a. Clearly delineates which candidate the communication is promoting;
   b. What position that candidate is running for; and
   c. Is signed or endorsed by the candidate that the communication is promoting.

2. Only with the approval of MAG’s Executive Director will it be permissible for candidate-signed or candidate-approved materials (in accordance with paragraph 1 above) to be placed at delegate seats prior any session or meeting of the House.

3. Under the direction of MAG’s Executive Director, any materials not in compliance with paragraph 1 and/or 2 above will be removed by MAG staff.

4. Any disputes or violations will be handled by the Credentials Committee.

John S. Harvey, M.D.
Speaker of the House of Delegates

E. Frank McDonald, M.D.
Vice Speaker of the House of Delegates
INTRODUCTION

The Medical Association of Georgia House of Delegates is the legislative body of our Association responsible for setting its policies. With the exception of the time during the War Between the States, our House of Delegates has met every year since 1849.

The House is a democratic institution. All county component medical societies in Georgia are entitled to representation in our House. Small societies (5 to 49 members) are entitled to one delegate. Larger societies (50 members or more) are entitled to one Delegate for every 25 active members. Additional delegates represent our several House Sections and Specialty Societies, so that our House consists of over two hundred voting delegates.

The House has two main functions: (1) to elect the Association’s officers for the coming year; and (2) to debate and vote on the various resolutions, reports and recommendations submitted to it. MAG officers, MAG committees, county societies (either through their officers or their Delegates to the MAG House), and specialties may submit resolutions, reports and recommendations.

Each year, the House of Delegates considers some 50 to 60 items of business. To expedite matters, each resolution or recommendation is assigned by the House Speaker to a REFERENCE COMMITTEE, composed of six to ten delegates. During the House, Reference Committees hold hearings so that any member of MAG (delegate or not) may express his or her opinion on the resolutions and recommendations. After testimony is heard, each Reference Committee evaluates all the opinions given, and drafts a report to the House recommending courses of action on the resolutions and recommendations. In so doing, the House sets MAG’s policy. Therefore, our House of Delegates meeting consists of a mix of representative democracy (through county and specialty society delegates) and direct democracy (through individual member’s right to speak at Reference Committees). As with all democratic bodies, our House depends on the individual’s expression of opinion.

The MAG House of Delegates exists to give you a means to express your ideas and an opportunity to implement those ideas into action by creating policy regarding the practice of medicine in our state.
ABOUT OUR PROCEDURES

Tradition governs a substantial portion of each formal session of the House of Delegates. Addresses by the President and President – Elect, remarks by the Speaker, recognition of distinguished guests, presentation and acceptance of awards, installation of officers, and the like, are done in this way. It is the prerogative of the Speaker to permit many of these niceties as he/she may feel to be appropriate without unduly intruding upon the time necessary for the House to accomplish its assigned business. In general, such items are scheduled in advance and are published in the Order of Business. Unscheduled presentations may be arranged, either with the Speaker, or by a request to hear them by unanimous consent of the House.

The House of Delegates of the Medical Association of Georgia transacts its business according to The Standard Code of Parliamentary Procedures by Alice Sturgis. Parliamentary procedure serves to aid the House in the orderly, expeditious and equitable accomplishment of its desires. The majority opinion of the House, in determining what it wants to do and how it wants to do it, should always remain the ultimate determinant, yet the right of the minority must never be overlooked. It is the obligation of the Speaker to sense this will of the House to preside accordingly, and to hold his/her rulings ever subject to challenge from and reversal by the House.

INTRODUCTION OF BUSINESS

Business resolutions are brought by voting delegates, county societies, specialty societies or five active MAG members, and by recommendations from MAG Officers and Committee Chairman as part of their annual reports.

The essential element of a resolution is expressed in one or more “RESOLVE” clauses setting forth the author’s specific intent for action. The resolution may carry (a) prefatory statement(s) explaining the rationale of the resolution. These are usually written as a series of “WHEREAS” statements that appear before the “RESOLVE” clauses. There may also be included appendices of materials, which attempt to contribute to the understanding of the topic of the resolution.

In adopting a resolution, the House of Delegates formally adopts only the “RESOLVE” section(s) of the resolution. Consequently, the author’s specific intent for action must be stated fully and completely in the “RESOLVE” clauses(s). To say it another way, the “RESOLVE” clause(s) must be able to convey all concepts for action or policy when read alone. It is unnecessary to amend the language of the “WHEREAS” portions of a resolution since the House will only act on the “RESOLVE” portions as the official item of business. The ultimate question before the House is how to dispose of a specific “RESOLVE”.
REFERENCE COMMITTEE HEARINGS

Except under special circumstances, all resolutions and reports containing recommendations are referred to a Reference Committee so that hearings may be on their contents.

Reference Committees are groups of six to ten delegates selected by the Speaker to conduct open hearings on matters of business before the House. The items are usually divided up into groups containing similar topics. For instance, one Reference Committee may hear resolutions and recommendations pertaining to Legislative issues, another will hear resolutions and recommendations pertaining to Public Health issues and so forth. Having heard discussion on the resolutions and recommendations before it, the Reference Committee compiles a report with recommendations to the House for the disposition of its items of business.

Reference Committee hearings are open to all members of the Association and invited guests. Any member of the Association is encouraged to speak on the resolution or recommendation under consideration. Other non-members, upon recognition by the chairman, may also be permitted to speak.

Fair hearings are the responsibility of the Reference Committee Chairman. The committee may establish its own rules on the presentation of testimony with respect to the order of testimony, the order of consideration, limitation of time, repetitive statements, recesses, and the like. Following the open hearing, a Reference Committee will go into Executive Session for deliberation and preparation of its report. It may call into Executive Session anyone whom it may wish to hear from or question further. The Reference Committee submits a unanimous report to the House of Delegates recommending a disposition for each of the items of business assigned to it. Minority reports from a Reference Committee may be issued in circumstances where the Reference Committee cannot come to consensus on the disposition of an item of business.

REFERENCE COMMITTEE REPORTS

Reference Committee reports comprise the bulk of the official business of the House of Delegates.

Reference Committees have wide latitude in their efforts to facilitate expression of the will of the House on matters before them and give credence to the testimony they hear. They may amend resolutions, consolidate similar resolutions by constructing substitutes, and recommend the parliamentary procedure for disposition of the business before them, such as acceptance, rejection, amendment, referral, and the like for specific item of business.
Specifically, the Reference Committee may make the following recommendations to the House of Delegates:

a) adoption;

b) adoption as amended, with amendments drafted and submitted by the Reference Committee;

c) adoption by substitution, with a substitute resolution drafted and submitted by the Reference Committee;

d) not for adoption;

e) to be filed;

f) referral to Board of Directors/Executive Committee or other Committee

Reference Committee reports will be made available to Reference Committee members and delegates as soon as they are completed. The first reports should be available at the MAG Registration desk on the day of the second MAG House Session.

NOTE: During the reading of Reference Committee reports, the Speaker of the House urges delegates to refer to their Handbooks, following the specific resolution or recommendation under discussion. Reference Committee Report recommendations are just that, recommendations only, and do not become MAG policy until acted on by the House of Delegates. A Reference Committee recommendation is to be considered the main motion before the House and must be dealt with as such.

PARLIAMENTARY PROCEDURE ON THE HOUSE

It is imperative in an assembly of over 200 Delegates that each individual speaking to an issue be recognized by the Speaker, be at a microphone, and be properly identified for the information of those who transcribe the proceedings. In the absence of specific provisions to the contrary in the Bylaws of the Association or in this manual of “Procedures of the House of Delegates,” the House shall be governed by The Standard Code of Parliamentary Procedures by Alice Sturgis. The following text is based on Sturgis.
CLASSIFICATION OF MOTIONS

Business is brought before the House, and acted upon, by the motions of Delegates. A motion is the formal statement of a proposal or question to the House for consideration and action.

Motions are classified into five groups: A) main motions; B) restorative main motions; C) subsidiary motions; D) privileged motions; and E) incidental motions.

MAIN MOTIONS

Main motions are the most important and most frequently used. Their purpose is to bring substantive proposals before the House for consideration and action.

A main motion (or “question”) is presented for discussion by the following steps:

1. The Delegate rises and addresses the Speaker;
2. The Delegates is recognized by the Speaker;
3. The Delegates identifies himself/herself and their local society. The delegate then indicates if they are speaking on behalf of their society or as an individual, and identifies any potential conflict of interest he/she may have on the issues at hand.
4. The delegate proposes (“makes”) his/her motion;
5. Another Delegate seconds it;
6. The Speaker states the motion to the House.

Once a main motion has been brought before the House through the steps above, it is usually considered in the following way:

7. Delegates debate the motion;
8. The Speaker puts the question to a vote;
9. The Speaker announces the result of the vote.
RESTORATIVE MAIN MOTIONS

Restorative Main Motions do not present a new proposal but concern actions that were previously taken. The five main motions have specific names:

a) Amend a Previous Action - to amend a main motion that was approved previously.

b) Ratify - to confirm and thereby validate an action that was taken in an emergency, or where a quorum was not present.

c) Reconsider – to enable the House to set aside an earlier vote on a main motion, and to consider it again as though no vote had been taken on it.

d) Rescind – to repeal or nullify a main motion previously passed.

e) Resume Consideration (take from the table) – to enable the House to consider a motion that was laid on the table during the same House meeting.

SUBSIDIARY MOTIONS

Subsidiary motions alter the main motion, or delay or hasten its consideration. They are:

a) Postpone Temporarily (Table) – used to set aside a pending main motion, which can be taken up for further consideration at any time during the same meeting.

b) Close Debate – used to close discussion on the pending question or questions and to the pending question or questions them to an immediate vote.

c) Limit (or Extend) Debate – used to determine the time that will be devoted to the discussion of a pending motion or the time each speaker may discuss the motion or remove limitations already imposed on to its discussion.

d) Postpone for a Certain Time – used to delay further consideration of a pending main motion and to fix a definite time for its consideration.
e) Refer to a Committee – used to transfer to another body of the organization (such as a committee, council, task force, or Board of Directors) the opportunity and responsibility of studying the proposal and reporting back to the House with recommendations. It can also be to conserve the time of the House by delegating the duty of deciding a proposal and sometimes of carrying out the decision to a smaller group.

f) Amend – used to change a motion that is being considered by the House so that it expresses, as closely as possible, exactly the will of the members.

PRIVILEGED MOTIONS

Privileged motions have no direct connection with the main motion before the House. They are motions of such urgency that they are entitled to immediate consideration. They relate to the members and to the organization rather than to particular items of business. Privilege motions would be main motions but for their urgency. Because of their urgency, they are given the privilege of being considered ahead of other motions that are before the House. Therefore, the following are privileged motions:

a) Recess – used to provide an interlude in meeting. The length of the recess or the establishment of a definite time for resuming deliberations should be set.

b) Adjourn – when no other motion is pending, the motion to adjourn is a main motion and is open to discussion and amendment. When a main motion is pending, however, the motion to adjourn becomes a privileged motion and outranks all other motions. If adopted, the privileged motion to adjourn requires that adjournment take place immediately. The privilege motion to adjourn cannot be debated but may be amended to establish the time when the interrupted meeting may continue.

c) Question of Privilege - to enable a member to secure immediate decision and action by the presiding officer on a request that concerns the comfort, convenience, rights or privileges of the assembly or of the member, or permission to present a motion of an urgent nature, even though other business is pending.
INCIDENTAL MOTIONS

Incidental Motions arise incidentally out of the business before the House. They do not relate directly to the main motion, but usually relate to matters incidental to the conduct of the meetings. Incidental motions may be offered whenever they are needed, and have no order of preference. Because of their very nature they may interrupt business and in some cases may interrupt the Speaker, and should be handled as soon as they arise.

Incidental Motions include:

a) Appeal – used to subject the ruling of the Speaker to examination by the House. Any member, suspecting that the Speaker has been mistaken or unfair in the ruling, may appeal that ruling of the House. The Speaker explains the reason for the ruling and allows the member to state his or her reasons for the appeal. After discussion by the members, the vote is taken, not on the appeal, but on sustaining the decision of the Speaker.

b) Suspended Rules – used to allow the House to take an action, which would otherwise be prevented by a procedural rule or by a program already adopted. A suspension of the rules makes temporarily ineffective whatever obstacle which otherwise would prevent the House from achieving its will. The effect of suspending the rules ends when that action is completed.

c) Consider Informally – used to allow the House to discuss an issue without the restrictions of parliamentary rules. It can be used if no motion is pending in the hope that unrestricted discussion will forge a consensus supporting the substance and the language of the motion that evolves. It also can be used even though a motion is under consideration. The pending motion is considered informally until the members decide to vote on it. This vote terminates the informal consideration.

d) Request to Withdraw Motion – used to allow a member to remove from consideration of the House a motion, which, he or she has proposed. If the Speaker has not stated the motion to the House, permission to withdraw is not necessary.
e) Division of Question – used to divide a motion that is composed of two more independent parts into individual motions that may be considered and voted on separately. If the Speaker agrees that the motion contains at least two propositions, each of which can stand alone as a reasonable motion and each suitable for adoption should the other portion fail, he or she may grant this request.

f) Point of Order – used to get the Speaker’s and the House’s attention to the possibility that a violation of the rules, an omission or an error in the proceedings has occurred and to seek a ruling from the Speaker. A point of order must be raised immediately after the possible error or omission occurs. As soon as the Speaker has made a ruling on the point of order, the business of the House resumes at the point at which it was interrupted.

g) Parliamentary Inquiry – used to acquire the Speaker’s opinion on a matter of parliamentary procedures as it relates to the business under discussion. It does not involve a ruling of the chair. Parliamentary inquiry can also be used to ask the Speaker or the maker of a motion a clarifying question about the pending motion. The request for a parliamentary inquiry may interrupt a speaker only when it requires an immediate answer. A parliamentary inquiry should always be addressed to the Speaker and answered by the Speaker. The Speaker may consult with anyone he or she wishes before answering the inquiry. A member who is interrupted by parliamentary inquiry, once the inquiry is resolved, retains the floor and continues his or her debate. The privilege of parliamentary inquiry should never be used or allowed as a means of delaying the proceedings or harassing a member.

h) Call for Division of Assembly – to verify an indecisive voice or hand vote by requiring voters to rise and, if necessary, to be counted. Any member concerned about the vote may call for a decision as soon as the motion is put to a vote and even before the vote has been announced. Just like any other mandatory requests, division of the assembly should not be used to delay the proceedings or to harass a member.
RULES GOVERNING MOTION AND REQUESTS

Many rules affect when a motion may be introduced, whether it must be seconded, whether it is debatable or amendable and what type of vote it requires for passage. Following is a summary of these rules, taken from The Standard Code of Parliamentary Procedures by Alice Sturgis.

###
### Principal Rules Governing Motions

<table>
<thead>
<tr>
<th>Order of Precedence</th>
<th>Can Interrupt?</th>
<th>Requires Second?</th>
<th>Debatable</th>
<th>Amendable</th>
<th>Vote Required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
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</thead>
<tbody>
<tr>
<td><strong>Privileged Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>No³</td>
<td>Yes³</td>
<td>Majority</td>
<td>None</td>
<td>Amend³</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes³</td>
<td>Yes³</td>
<td>Majority</td>
<td>None</td>
<td>Amend³</td>
</tr>
<tr>
<td>3. Question of privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

| **Subsidiary Motions** |                |                  |           |           |                |                               |                                          |
| 4. Postpone temporarily (table) | No           | Yes              | No        | No        | Majority²      | Main motion                   | None                                     |
| 5. Close debate      | No             | Yes              | No        | No        | 2/3            | Debatable motions             | None                                     |
| 6. Limit debate      | No             | Yes              | Yes³      | Yes³      | 2/3            | Debatable motions             | Amend³                                   |
| 7. Postpone to a certain time | No           | Yes              | Yes³      | Yes³      | Majority       | Main motion                   | Amend³, close debate, limit debate        |
| 8. Refer to committee| No             | Yes              | Yes³      | Yes³      | Majority       | Main motion                   | Amend³, close debate, limit debate        |
| 9. Amend             | No             | Yes              | Yes       | Yes       | Majority       | Rendorable motions            | Close debate, limit debate, amend         |

| **Main Motions** |                |                  |           |           |                |                               |                                          |
| 10. a. The main motion | No            | Yes              | Yes       | Yes       | Majority       | None                          | Restorative, subsidiary                  |
| 10. b. Restorative main motions |             |                  |           |           |                |                               |                                          |
| Amend a previous action | No           | Yes              | Yes       | Yes       | Majority       | Main motion                   | Subsidiary, restorative                  |
| Ratify               | No             | Yes              | Yes       | Yes       | Majority       | Previous action               | Subsidiary                               |
| Reconsider           | Yes            | Yes              | Yes³      | No        | Majority       | Main motion                   | Close debate, limit debate               |
| Rescind              | No             | Yes              | Yes       | No        | Majority       | Main motion                   | Close debate, limit debate               |
| Resume consideration  | No             | Yes              | No        | No        | Majority       | Main motion                   | None                                     |

### INCIDENTAL MOTIONS

<table>
<thead>
<tr>
<th>No order of precedence</th>
<th>Can Interrupt?</th>
<th>Requires Second?</th>
<th>Debatable</th>
<th>Amendable</th>
<th>Vote Required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Decision of chair</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Suspend rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main Motion</td>
<td>None</td>
</tr>
</tbody>
</table>

| **Requests**           |                |                  |           |           |                |                               |                                          |
| Point of order         | Yes            | No               | No        | No        | None           | Any error                     | None                                     |
| Parliamentary inquiry  | Yes            | No               | No        | No        | None           | All motions                   | None                                     |
| Withdraw a motion      | Yes            | No               | No        | No        | None           | All motions                   | None                                     |
| Division of question   | No             | No               | No        | No        | None           | Main motion                   | None                                     |
| Division of assembly   | Yes            | No               | No        | No        | None           | Indecisive vote               | None                                     |

1 Motions are in order only if no motion higher on the list is pending. Thus, if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.

2 Requires two-thirds vote when it would suppress a motion without debate.

3 Debatable if no other motion is pending.

4 Withdraw may be applied to all motions.
### 2014 HOUSE OF DELEGATES

**Items of Business**

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</thead>
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<tr>
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<td>Reference Committee HC</td>
<td></td>
</tr>
<tr>
<td>Officer: 04.14 Treasurer</td>
<td>Reference Committee F</td>
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</tr>
<tr>
<td>Officer: 06.14 Chairman, AMA Delegation</td>
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</table>

<table>
<thead>
<tr>
<th>Director</th>
<th>Reports</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director: 01.14 First District Medical Society</td>
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</tr>
<tr>
<td>Director: 02.14 Second District Medical Society</td>
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<tr>
<td>Director: 03.14 Third District Medical Society</td>
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<tr>
<td>Director: 04.14 Fourth District Medical Society (See DeKalb CMS 15.14)</td>
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<tr>
<td>Director: 05.14 Fifth District Medical Society (See MAA 21.14)</td>
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<tr>
<td>Director: 06.14 Sixth District Medical Society</td>
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<tr>
<td>Director: 07.14 Seventh District Medical Society</td>
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<td>Director: 08.14 Eighth District Medical Society</td>
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<td>Director: 09.14 Ninth District Medical Society</td>
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<tr>
<td>Director: 10.14 Tenth District Medical Society</td>
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<tr>
<td>Director: 11.14 Bibb County Medical Society</td>
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<tr>
<td>Director: 12.14 Clayton-Henry-Fayette Medical Society</td>
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<td>Director: 13.14 Cobb County Medical Society</td>
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<td>Director: 14.14 Crawford W. Long Medical Society</td>
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<td>Director: 15.14 DeKalb Medical Society</td>
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<td>Director: 16.14 Dougherty County Medical Society</td>
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<td>Director: 17.14 Floyd-Polk-Chattahoochee County Medical Society</td>
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<td>Director: 18.14 Georgia Medical Society</td>
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<td>Director: 19.14 Gwinnett-Forsyth County Medical Society</td>
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<td>Director: 20.14 Hall County Medical Society</td>
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<td>Director: 21.14 Medical Association of Atlanta</td>
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<td>Director: 22.14 Muscogee County Medical Society</td>
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<td>Director: 23.14 Richmond County Medical Society</td>
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<th>Section</th>
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<td>Section: 02.14 International Medical Graduate Section</td>
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<tr>
<td>Section: 05.14 Medical Student Section</td>
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<table>
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<th>Special</th>
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<td>Special: 02.14 Medical Association of Georgia Foundation</td>
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<td>Special: 03.14 Medical Association of Georgia Alliance</td>
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<td>Special: 04.14 Policy Sunset &amp; Reaffirmation Report</td>
<td>Consent Calendar</td>
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<td>Special: 05.14 Department of Communications</td>
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<td>Special: 06.14 Department of Membership and Marketing</td>
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<td>Special: 07.14 Georgia Physicians Leadership Academy</td>
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<td>Special: 08.14 Physicians’ Institute for Excellence in Medicine</td>
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<tr>
<td>Special: 09.14 The Physicians Foundation</td>
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### Items of Business

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<td>Committee: 04.14 Committee on Council on Legislation</td>
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<td>Committee: 06.14 Committee on Continuing Medical Education</td>
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<td>Committee: 07.14 Committee on Correctional Medicine</td>
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<td>Committee: 08.14 Electronic Health Care Committee</td>
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<td>Committee: 09.14 Committee on Third Party Payers</td>
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<table>
<thead>
<tr>
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<td>109A.14 Normal Saline Limitations</td>
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<td>110A.14 Preservation of Small Medical Practices</td>
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<td>111A.14 Country of Origin for Prescription Medications</td>
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<td>112A.14 Prior Approval Requirements of Insurance Companies</td>
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<td>301C.14 Interstate Medical License Compact</td>
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<td>302C.14 Stabilized Patients on Biologic Medications</td>
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<td>303C.14 Support for Georgia Drug Monitoring Program</td>
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<td>306C.14 Extending the Medicaid Primary Care Pay Parity</td>
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**Officers**

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<thead>
<tr>
<th>Officer</th>
<th>Reference Committee</th>
</tr>
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<tbody>
<tr>
<td>04.14 Treasurer</td>
<td>Reference Committee F</td>
</tr>
<tr>
<td>01.14 President</td>
<td>Reference Committee HC</td>
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# 2014 HOUSE OF DELEGATES

## Reference Committee Referrals

### Reference Committee A

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<th>Resolution</th>
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<td>Transparency and Labeling of Generic Medications</td>
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<td>102A.14</td>
<td>Cancellation of MOC Program for Physicians Certified Before 1990</td>
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<td>Cost of Meaningful Use Passed Onto Patients</td>
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<td>Stabilized Patients on Biologic Medications</td>
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ORDER OF BUSINESS
MEDICAL ASSOCIATION OF GEORGIA  
160TH ANNUAL SESSION  
ORDER OF BUSINESS  
8:30 A.M., SATURDAY, OCTOBER 18, 2014  
THE CALLAWAY GARDENS LODGE & SPA, PINE MOUNTAIN  
FIRST SESSION, HOUSE OF DELEGATES  

CALL TO ORDER  
John S. Harvey, M.D.  
Speaker, House of Delegates  
E. Frank McDonald Jr., M.D.  
Vice Speaker, House of Delegates  

INVOCATION  
Joy A. Maxey, M.D.  

PRESENTATION OF COLORS  
Georgia State Defense Force  

INTRODUCTION OF OFFICERS AND GUESTS  
John S. Harvey, M.D.  

CREDENTIALS REPORT  
Rutledge Forney, M.D.  

STATE OF THE ASSOCIATION ADDRESS  
William E. Silver, M.D.  
President  

EXECUTIVE DIRECTOR’S REPORT  
Donald J. Palmisano Jr.  
Executive Director/CEO  

NEW RESOLUTIONS  

NOMINATIONS OF CANDIDATES FOR OFFICERS AND AMA DELEGATES/ALTERNATE DELEGATES  

REPORT OF ANNUAL SESSIONS COMMITTEE  
(Consent Calendar)
INTRODUCTION OF NEW BUSINESS

ANNOUNCEMENTS

RECESS FOR REFERENCE COMMITTEE MEETINGS
MEDICAL ASSOCIATION OF GEORGIA
160TH ANNUAL SESSION
ORDER OF BUSINESS
6:00 P.M., SATURDAY, OCTOBER 18, 2014
THE CALLAWAY GARDENS LODGE & SPA, PINE MOUNTAIN
PRESIDENT INSTALLATION & AWARDS, HOUSE OF DELEGATES

WELCOME
John S. Harvey, M.D.
Speaker, House of Delegates

CALL TO ORDER
John S. Harvey, M.D.
Speaker, House of Delegates

E. Frank McDonald Jr., M.D.
Vice Speaker, House of Delegates

PRESIDENT’S FAREWELL ADDRESS
William E. Silver, M.D.

INSTALLATION OF NEW PRESIDENT
Manoj H. Shah, M.D.

PRESIDENT’S ADDRESS
Manoj H. Shah, M.D.

RECEPTION
7:00 p.m. - 7:30 p.m.

AWARDS DINNER
7:30 p.m. – 9:30 p.m.

INVOCATION
Dan DeLoach, M.D.

PRESENTATION OF AWARDS
John S. Harvey, M.D.
William E. Silver, M.D.

ADJOURNMENT
CALL TO ORDER
John S. Harvey, M.D.
Speaker, House of Delegates
E. Frank McDonald, M.D.
Vice Speaker, House of Delegates

CREDENTIALS REPORT
Rutledge Forney, M.D.

GAMPAC REPORT
James W. Barber, M.D.

MAG FOUNDATION AND GPLA REPORTS
Jack M. Chapman Jr., M.D.

ALLIANCE REPORT
Eve Tidwell

REFERENCE COMMITTEE REPORTS
(Order determined and announced by the Speaker)

CONTESTED ELECTIONS

SWEARING IN OF NEW OFFICERS

REFERENCE COMMITTEE REPORTS CONTINUED

NEW BUSINESS
(New business for information, emergency, or by unanimous consent of House)

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Alternate Delegates (term to end 2016)

Seat held by John S. Antalis, Dalton

John S. Antalis, Dalton

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Seat held by Michael E. Greene, Macon
(vacant seat -- full term)

Jack M. Chapman, Jr., Gainesville
John A. Goldman, Atlanta

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As election results are not yet in, the results will be released as an addendum to the MAG House of Delegates Handbook.
# 2014 MAG HOD REFERENCE COMMITTEES

## REFERENCE COMMITTEE A – HEALTH CARE POLICY

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Staff: Susan Moore/Trish Yeatts

## REFERENCE COMMITTEE C - LEGISLATION

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Staff: Marcus Downs/Ryan Larosa

## REFERENCE COMMITTEE F – FINANCE AND ADMINISTRATION

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REPORTS OF OFFICERS AND DIRECTORS
The Georgia AMA delegation attends two American Medical Association (AMA) meetings per year. At these meetings, reports and resolutions are discussed and action is taken. A summary of these two meetings is provided to our House of Delegates.

**AMA INTERIM MEETING – November 16-19, 2013**

The Georgia AMA Delegation attended the Interim Meeting of the AMA on November 16-19, 2013 at the National Harbor Resort in National Harbor, Maryland. The meeting was well attended and your elected delegates represented MAG well.

MAG submitted seven resolutions to the AMA for consideration. These resolutions were distributed to members of the AMA House of Delegates on Sunday, November 17 in their “Sunday Totes.” These are items of business that were not in the original handbook or supplement mailing but were accepted for items of business and provided to members of the House on Sunday and sent to the appropriate reference committee for discussion. The following summary includes the final actions that occurred at the Interim Meeting on MAG’s resolutions:

**RESOLUTIONS SUBMITTED TO AMA FOR ACTION**

**Resolution 220 I-13, Delay or Canceling the Implementation of ICD-10**

Resolution 101A.13 called for the AMA to support delaying or cancelling the implementation of ICD-10. After attempts were made to amend Resolution 220 I-13, the House adopted our original resolution. This action becomes AMA policy.

**Resolution 219 I-13, Drug Enforcement Agency Licensure Fees**

Resolution 102A.13 asked that the AMA work with the Drug Enforcement Agency (DEA) to limit licensure fee increases to no more than that of inflation and decrease the disproportionate amount that physicians have to pay for renewal.

Members of the AMA House of Delegates adopted as amended resolution 219 I-13 heard in Reference Committee B as followed:

**RESOLVED, that our AMA work through appropriate channels to freeze DEA licensure fees for physicians. (Directive to take action)**

**Resolution 919 I-13 High Cost of Re-certification**
MAG’s resolution 103A.13 asked the AMA HOD call for an investigation into the high cost of re-certification and, if such investigation warrants reduction of re-certification fees, then the AMA should proceed with the necessary steps to make it happen.

AMA suggested an edit that was accepted by the delegation which read:

RESOLVED, that our American Medical Association request an investigation into the high cost of recertification and, if such investigation warrants reduction of recertification, that our AMA urge/advocate for a reduction by the ABMS of recertification fees.

The final outcome was: Policies D-275.971, D-275.969, H-275-923 and H-275.924 were reaffirmed in lieu of Resolution 919. (See attachment 1)

Resolution 221 I-13, Elimination of Proposed Penalties for Not Obtaining Meaningful Use

MAG’s resolution 105A.13 strongly encouraged AMA to seek the termination of the “meaningful use” standards of the Centers for Medicare & Medicaid Services (CMS) from medical practice and that the proposed penalties beginning in 2015 should be eliminated immediately and an effort made to gradually integrate tomorrow’s technological advances into health care in a safer, more efficient manner.

AMA resolution 221 I-13 was combined with resolutions 214, and 222 and sent to Reference Committee B for discussions and recommendations. The final action of the AMA HOD was that Policy H-478-991 was reaffirmed in lieu of resolutions 214, 221, and 222. Current policy reads:

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; (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; and (3) will work with the Centers for Medicare & Medicaid Services and the Department of Defense to oppose programs that unfairly penalize or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required. (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 725, A-13; Appended: Res. 205, A-13)

Resolution 221 I-13, Safety of EHR Records

Resolution109A.13 called for AMA to advocate for physicians to have the option to choose either electronic health records (EHR) or paper charts without penalty, and to work through appropriate channels, influence national policy to remove the penalties for not using EHR systems.

This resolution (re-numbered 222 I-13) was combined with resolutions 221 (MAG’s resolution on Eliminating Proposed Penalties for Not Achieving Meaningful Use) and 214. Final action of the AMA HOD was that Policy H-478-991 be reaffirmed in lieu of Resolutions 214, 221 and 222. (Same Policy listed above.)
Resolution 920 I-13, Telemedicine Licensure

Resolution 302 called for AMA to support the continuation of telemedicine licensure by states and oppose efforts to change such to federal licensure of telemedicine.

AMA Resolution 920 I-13 was forward to Reference Committee K for discussions and recommendations. There was mixed testimony on the resolution, which raised concern of the evolving issue of telemedicine. AMA examined the issues related to telemedicine heard at the annual meeting in BOT Report 22-A-13, which included a review of extensive existing AMA policy on telemedicine and licensure.

The AMA HOD adopted to reaffirm policies H-480.969 and D-480.999 in lieu of Resolution 920. (See attachment 2)

Resolution 815 I-13, Vulnerable Patient Access and Protection

Resolution 312C.13 (re-numbered 815 I-13) called for AMA to promote access to appropriate care for all patients; promote special access for vulnerable patients if appropriate care cannot be provided within a patient’s insurance provider network and oppose any health care delivery model, public or private, that restricts patient access to physicians adequately experienced in their disease.

There was supportive testimony on the resolution in Reference Committee J, and the need to ensure that patients have access to appropriate care regardless of their source of health care coverage or the health care delivery model, including accountable care organizations, used to provide care to the patient. It was felt that AMA had several policies in place to address the concerns outlined in Resolution 815 I-13.

The final outcome was that the AMA HOD adopted to reaffirm policies H-373.999, H-285.911, D-165.989, D-285.972 and H-160.952 in lieu of Resolution 815. (See attachment 3)

AMA DELEGATION SUPPORTED RESOLUTIONS

Many times other delegations will ask for support and/or a co-sign of others for a particular resolution that they feel warrants special consideration.

The following resolution was submitted to the AMA HOD with several delegations adding their support, including Georgia.

Resolution 223 I-13, Medicare’s Two-Midnight Rule

RESOLVED, That our American Medical Association petition the Centers for Medicare & Medicaid Services to repeal the August 19 rules regarding Hospital Inpatient Admission Order and Certification; and be it further

RESOLVED, That our AMA immediately seek an opinion and guidance from CMS regarding how physicians should demonstrate “medical necessity” to best prevent unnecessary audit recoupment; and be it further

RESOLVED, That our AMA reaffirm Section 5 of Policy D-320.991 Creating a Fair and Balanced Medicare and Medicaid RAC Program, which states: “Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.”
Final AMA Action

Resolution 223 adopted as amended by deleting the second resolve (noted above).

The following resolution was submitted but was not considered at this year’s Interim Meeting.

Resolution 604 I-13, AMA Election Activities

RESOLVED, That AMA Policy G-610.020[6], Election Campaigns, be amended by addition to read as follows: (Modify Current HOD Policy): (6) A coalition or a state or specialty delegation may finance only one big party at the Annual Meeting irrespective of the number of candidates from the society or coalition. This rule limits a candidate to only one big party at the Annual Meeting whether financed by a coalition or a state or specialty delegation. This rule also limits a state or specialty society or coalition to one big party irrespective of the number of candidates from that society or coalition. At these events, alcohol may be served only on a cash or no-host bar basis. A member of a coalition or section council such as an individual state or medical specialty society, may sponsor a separate party for its candidate(s) only if none of their sponsored candidates are also featured at any coalition or section council’s main event, even if the society otherwise participates in other coalition or section council activities. This will not affect candidate endorsements by societies that are not sponsoring the candidate’s campaign.

Finally a resolution submitted by the Organized Medical Staff Section, Resolution 226, Sustainable Growth Rate Repeal, was considered by the delegation to be one of the most important resolution submitted at this year’s Interim meeting.

The resolution and final actions are as follows:

RESOLVED, That our American Medical Association reaffirm Policy D-450.981, Protecting Patients Rights, which states in part that our AMA will “continue to advocate for the repeal of the flawed sustainable growth rate (SGR) formula without compromising our AMA’s principles for pay-for-performance” (Reaffirm Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-450.947, Pay-for-Performance Principles and Guidelines (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA support SGR repeal proposals that are coupled with physician payment reforms consistent with the AMA’s Pay-for-Performance Principles and Guidelines (AMA Policy H-450.947) (Directive to Take Action); and be it further

RESOLVED, That our AMA advise Congress that any repeal or reform of SGR should include an option for private contracting by Medicare patients. (Directive to Take Action)

Final AMA Action

Substitute Resolution 226 adopted as amended

RESOLVED, That our American Medical Association (AMA) reaffirm AMA policy D-450.981, Protecting Patients Rights, and continue to strongly advocate for the repeal of the flawed sustainable growth rate (SGR) formula and for our AMA’s principles for pay-for-performance (Reaffirm Policy); and be it further

RESOLVED, That our American Medical Association (AMA) reaffirm AMA policy D-450.981,
RESOLVED, That our AMA reaffirm AMA policy H-450.947, Pay-for-Performance Principles and Guidelines (Reaffirm Policy); and be it further

RESOLVED, That our AMA support SGR repeal and continue to strongly advocate for the AMA’s Pay-for-Performance Principles and Guidelines (AMA policy H-450.947) (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate with CMS and Congress for alternative payment models, developed in concert with specialty and state medical organizations, including private contracting as an option (Directive to Take Action).

RESOLVED, That our AMA will continue to advocate for future positive updates in the Medicare physician fee schedule.

Reference Committee B heard virtually unanimous testimony in strong support of the language in the amendment to Resolution 226. Testimony highlighted a fervent desire that physicians convey a focused and unified message in the advocacy efforts to seek repeal of the Sustainable Growth Rate (SGR). There were also many positive comments on how the amended resolution demonstrates significant cooperation among diverse physician sections and delegations. In the final vote, members of the AMA HOD adopted Resolution 226 as amended. (See attachment 4)

CONCLUSION

In conclusion, the AMA Interim Meeting was well attended and very successful. Your delegation caucused several times during the week and gave careful consideration on all items of business before the AMA HOD. If you would like to review any of the other reports and resolutions, go to www.ama-assn.org/ams/pub/meeting/index.shtml

Please keep in mind that although AMA policies adopted at each AMA meeting are the will of the members, implementing the actions are dependent upon the Board of Trustees. We must continue to work with the AMA to ensure that the will of the members are carried forth by AMA leadership.

It is worth noting that AMA-MSS elections were held and in Region IV, Georgia student Jonathan Gillig, of Emory University School of Medicine, will assume the position of delegate.

AMA ANNUAL MEETING – June 7-11, 2014

The AMA Annual Meeting was held at the Hyatt Regency in Chicago. The Georgia Delegation had a very good turnout in spite of the fact that we were minus two of our important delegation members. We were fortunate to have Jack M. Chapman, M.D., and Gary C. Richter, M.D., there to assist. Also noteworthy was that MAG welcomed into the fold, Shamie Das, M.D., who represented the Society of Critical Care Medicine. Dr. Das was elected to the Governing Council of the AMA Resident and Fellow Section.

With the assistance of MAG’s legal counsel, Ms. Patricia (Trish) Yeatts, your delegation brought five resolutions as adopted by the MAG House of Delegates to the AMA for consideration. From the beginning we had an uphill battle as four of our resolutions were placed in the Rules and Credentials Committee for reaffirmation of current AMA policy. At the first session of the House, we were successful in extracting these resolutions for reference committee hearings. The following summary is presented on the outcome of your resolutions. The outcome on these are also presented on the status report of the 2013 House of Delegates in your handbook:
Resolution 106A.14, Endorse Medicare Part D Educational Website

Testimony on the resolution was supportive but limited, and based on the testimony indicating concern regarding patients’ use of insurance brokers to enroll in Medicare Part D and Medicare Advantage plans, Reference Committee A developed substitute language and recommended adoption of the substitution in lieu of Resolution 106. The AMA HOD adopted the following:

RESOLVED, that our American Medical Association request that the Centers for Medicare & Medicaid Services educate Medicare beneficiaries on how to access assistance for enrolling in Medicare Part D and Medicare Advantage plans.

Resolution 124A.14, Generic Changes in Medicare (Part D) Plans

Testimony in Reference Committee A was very supportive. The reference committee agreed with the Georgia Delegation that it can be problematic for Medicare patients when a generic drug they are taking is no longer on their plan’s formulary and they are switched to a different generic. The reference committee brought a recommendation to the floor to adopt, which was the final action of the House of Delegates.

Resolution 709A.14, Change in Coumadin Regulation by CMS

There was supportive testimony on the resolution. The reference committee agreed that patients who are unable to reliably self-monitor anti-coagulation should be able to receive testing by a visiting nurse. The committee also agreed with testimony that it is important to specify that the nurse should be working under physician supervision, and recommended additional amendments to clarify the language of the resolution. The AMA HOD adopted the following amended resolution:

RESOLVED, That our American Medical Association request a change in Centers for Medicare & Medicaid Services’ regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions.

Resolution 710A.14, Reimbursement for Audit Requests

There was mixed testimony on the resolution in the reference committee hearing. The committee agreed that health plan audits presented an often frustrating interruption in physicians’ time that would otherwise be spent caring for patients. Ultimately, the committee believed that AMA policies H-285.943, H-335.980, and H-315.992 sufficiently addressed the concerns raised in the resolution and recommended reaffirmation in lieu of Resolution 710. Members of the House of Delegates agreed with the recommendation and reaffirmed the current policies as follows:

H-285.943 Payment for Managed Care Administrative Services

Our AMA: (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities,
formulary review, etc.), to be assessed to the various insurers. (CMS Rep. 13, I-97; Appended: Res. 806, I-99; Reaffirmation A-04; Reaffirmation I-08; Reaffirmation I-09; Reaffirmed in lieu of Res. 912, I-09; Reaffirmation A-10)

H-335.980 Payment For Copying Medical Records
It is the policy of the AMA to seek legislation under which Medicare will be required to reimburse physicians and hospitals for the reasonable cost of copying medical records which are required for the purpose of post payment audit. A reasonable charge will be paid by the patient or requesting entity for each copy (in any form) of the medical record provided. (Res. 161, I-90; Appended by Res.819, A-98; Reaffirmation A-08)

H-315.992 Copying Records for Audits
Our AMA supports taking appropriate action to ensure that the financial responsibility for producing or copying patient records at the request of any regulatory agency having the authority to do so shall be borne entirely by the requesting agency and the request for said records shall be made at least 30 days in advance of any deadline. (Res. 75, A-91; Reaffirmed: Sunset Report, I-13 01; Reaffirmed: CMS Rep. 7, A-11)

Resolution 711A.14, Reimbursement for Prior Approval Requirements
Resolution 711 asked AMA to develop a methodology for physician reimbursement from insurance companies to compensate for the medical practice expenses of completing prior approval requirements. The reference committee believed that existing policy adequately supported the resolution’s intent. It was noted that ongoing AMA efforts to reduce the burden that prior authorization places on physicians continues and created a whitepaper outlining the costs and workflow inefficiencies of the current process. Additionally, the AMA developed model legislation aimed to reduce the administrative burdens and increase insurer transparency in the prior authorization process. Ultimately, the report of Reference Committee G recommended reaffirmation of current policies in lieu of Resolution 711. The House of Delegates agreed with the recommendation and AMA Policies H-385.951, H-285.943, and H-385.948 were reaffirmed in lieu of Resolution 711 as followed:

H-385.951 Remuneration for Physician Services
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols. 2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work. 3. Our AMA urges insurers to adhere to the AMA’s Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly. (Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11)

H-285.943 Payment for Managed Care Administrative Services
Officer: 06.14

Our AMA: (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers. (CMS Rep. 13, I-97; Appended: Res. 806, I-99; Reaffirmation A-04; Reaffirmation I-08; Reaffirmation I-09; Reaffirmed in lieu of Res. 912, I-09; Reaffirmation A-10)

H-385.948 Reasonable Charge for Preauthorization

The AMA strongly supports and advocates fair compensation for a physician’s administrative costs when providing service to managed care patients. (Res. 815, A-97; Reaffirmation A-04; Reaffirmed: CMS Rep. 4, I-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11)

Council on Medical Education Report 8, Guidelines for Students shadowing Physicians

Resolution 310A-13, Medical Faculty Regulations for Students Shadowing Physicians, introduced by the Georgia Delegation, asked the AMA to develop standard criteria for students to shadow physicians in medical facilities. Resolution 913-I-13, Pre-Medical School Shadowing, submitted by Washington, asked that AMA promote the development of programs that assist physicians in providing pre-medical shadowing opportunities; and communicate to the Association of American Medical Colleges that for the medical schools that have the pre-medical shadowing requirement, it is the obligation of the medical school to aid underprivileged students in getting their shadowing.

CME Report 8 recommended that 1) AMA encourage wide dissemination of the Association of American Medical Colleges’ clinical shadowing guidelines to interested parties, including K-12 students, pre-medical students, health professional advisors, hospitals, medical schools and physicians; 2) that AMA encourage all physicians to provide shadowing opportunities to pre-medical students, and 3) that AMA Policy D-295.941, Facilitating Access to Health Care Facilities for Training, be amended by addition to state that the AMA work with the Association of American Medical Colleges and other national organizations to expedite, wherever possible, the standardization of requirements in regards to training on HIPAA, drug screening, and health requirements for pre-medical and medical students, and resident and fellow physicians who are being educated in hospitals and other health care settings. The report focused on areas common to Resolutions 310-A-13 and 913-I-13, namely concerns and strategies around pre-medical students shadowing physicians.

The reference committee recommended referral of CME Report 8 to ensure a more thorough review of physician shadowing and to provide mechanisms to ensure that individuals from underprivileged and under-represented minority groups are afforded the equal opportunity to participate in shadowing.

OTHER MAG SUPPORTED RESOLUTIONS

Resolution 602A-14, AMA Election Activities
This resolution was first submitted to the AMA Interim Meeting. In accordance with the procedures of the AMA House of Delegates, only those items of business that are related to advocacy are discussed and acted on at the Interim Meeting. Therefore, this item of business was returned to the AMA for a hearing at the Annual Meeting. The resolution called for the AMA to amend Policy G-510.020[6], “Election Campaigns,” to clarify campaign activities. The final outcome was adoption of the following Substitute Resolution 602:

6. A state, specialty society, caucus, coalition, etc., may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) standing in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc., with the candidate’s name on them.

Resolution 615A-14, AMA Advocacy Analysis

This resolution was submitted by Florida. It called for AMA to fund an independent committee of the House of Delegates to evaluate all aspects of AMA’s advocacy efforts and present a report back to the 2015 Annual Meeting. Resolution 615 directed that the analysis be coordinated through a professional consulting firm and shall include but not be limited to: 1. Evaluation of the major issues and the factors contributing to their non-passage as well as their potential for future success; 2. Our AMA lobbying team and potential improvements; 3. The potential use and/or expanded use of contract lobbying firms; 4. Evaluation of the structure and function of our AMA’s Council on Legislation and potential opportunities for improvement; 5. Evaluation of the structure and function of AMPAC and potential opportunities for improvement, as well as better methods to involve more physicians in the process; and 6. Evaluate ways for the House of Delegates and other interested physicians to effectively support the legislative and advocacy teams in promoting legislative issues. Furthermore, it proposed an appointment methodology to be used.

The reference committee received extensive testimony in response to the resolution including amended language from the author that attempted to overcome concerns that the resolution stands in conflict with AMA’s current system of checks and balances. Testimony indicated that engaging a consultant was an expensive and time-consuming process resulting in a single snapshot in time and removed fiscal resources from the other AMA priorities. Other testimony indicated AMA needed to be more nimble and must regularly optimize its advocacy efforts with ongoing feedback to the House of Delegates. Therefore, an annual report with opportunities for the House of Delegates to discuss recommendations would better serve the desire to have ongoing review and communication regarding advocacy activities.

After an extensive discussion on the merits of the resolution and the need for AMA to be more responsive to its members, the House adopted the following Substitute Resolution 615:

RESOLVED, that our American Medical Association Board of Trustees report to the House of Delegates at each Interim Meeting highlighting the prior year advocacy activities to include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts, and that the I-14 report include a summary of the review of the Advocacy Group that was performed in 2012.

CONCLUSION

It is important to note that your delegation met at various times during the AMA meeting to discuss each item of business before the AMA House of Delegates. Members participated on interview panels for the Southeastern Delegation of which Georgia is a member. As chairman and vice chairman of the Georgia Delegation S. William Clark III, M.D., and I serve on the Southeastern Delegation Executive Committee
that meets twice during the meeting. There is much to do at these meetings and we are honored that you
support us in these endeavors. To obtain information on the vast number of actions taken at the meeting,
go to www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/meeting-archives/2014-annual-
meeting.page.

It is on a sad note that I, as your chairman, have decided to step down as your elected AMA Delegate. I
have been honored to serve on the delegation since 1995, and do not take lightly my obligations to the
association that has given me so much over the years. However, circumstances in my life concerning my
own health and that of my family have changed and I feel that it is necessary, in spite of my profound
alliance to MAG, that I step down as a delegate to the AMA and chairman of the AMA Delegation.

I want to take this opportunity to thank all those who served with me on the AMA Delegation, and who I
consider not only colleagues but life-long friends that I cherish:

S. William Clark III, M.D., Vice Chairman, Waycross
Joy A. Maxey, M.D., Atlanta
Thomas E. Price, M.D., Roswell
Sandra B. Reed, M.D., Thomasville
John S. Antalis, M.D., Dalton
E. Dan DeLoach, M.D., Savannah
Michael E. Greene, M.D., Macon
Billie Luke Jackson, M.D., Macon
Alan L. Plummer, M.D., Atlanta

# # #
Attachment 1
Policies reaffirmed in lieu of AMA Resolution 919 i11

D-275.971 American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements

1. Our AMA will work with the American Board of Medical Specialties to streamline Maintenance of Certification (MOC) to reduce the cost, inconvenience, and the disruption of practice due to MOC requirements for all of their member boards, including subspecialty requirements.

2. Our AMA will actively work to enforce existing policies to reduce current costs and effort required for the maintenance of certification and to work to control future charges and expenses. (Sub. Res. 313, A-06; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Appended: Res. 319, A-12; Reaffirmed in lieu of Res. 313, A-12)

D-275.969 Specialty Board Certification and Recertification

1. Our AMA will continue to monitor the progress by the ABMS and its member boards on implementation of Maintenance of Certification (MOC) and encourage ABMS to report its research findings on the issues surrounding certification, recertification and MOC on a periodic basis.

2. An update report will be prepared for the AMA House of Delegates no later than 2010.

3. Our AMA will encourage dialogue between the ABMS and its respective specialty societies to work on development, implementation, and monitoring of MOC that meets the needs of practicing physicians and improves patient care.


H-275.923 Maintenance of Certification / Maintenance of Licensure

Our AMA will:

1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards.

2. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.

3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time.

4. Review all AMA policies regarding medical licensure; determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting.
5. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence.

6. Continue to participate in the NAPC forums.

7. Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

8. Continue to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME.


10. Continue to support the AMA Principles of Maintenance of Certification (MOC).

11. Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL.

12. Our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed, and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10; Appended: Res. 322, A-11; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13)

H-275.924 Maintenance of Certification

AMA Principles on Maintenance of Certification (MOC):

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.

2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.

3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by each board for MOC.

4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties.

7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities.

8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.

9. The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician’s Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A)."

10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13)
Attachment 2
Current Policies related to AMA Resolution 920-i11

H-480.969 The Promotion of Quality Telemedicine

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient’s state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation; (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions. (3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13)

D-480.999 State Authority and Flexibility in Medical Licensure for Telemedicine

Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09)
Attachment 3
Current Policies related to AMA Resolution 815-i11

H-373.999 Patient Advocacy/Protection Activities

The AMA will continue to aggressively pursue legislative, regulatory, communications and advocacy opportunities to identify and correct patient care and access problems created by new health care delivery mechanisms. (BOT Rep. 55, A-96; Reaffirmed: Rules and Cred. Cmt., I-97; Renumbered: CMS Rep. 7, I-05)

H-285.911 Health Insurance Safeguards

Our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (CMS Rep. 8, A-10)

D-165.989 Managed Care Organization Reimbursement Formulas

Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions. (CMS Rep. 6, A-00; Reaffirmed: CMS Rep. 6, A-10)

D-285.972 Tiered, Narrow, or Restricted Physician Networks

Our AMA will: (1) seek to have third party payers disclose, in plain language, the criteria by which the carrier creates a tiered, narrow or restricted network; (2) monitor the development of tiered, narrow or restricted networks to ensure that they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on the potential for a limited number of specialists in the resulting network(s); and (3) seek legislation or regulation which prohibits the formation of networks based solely on economic criteria and ensures that, before health plans can establish new panel networks, physicians are informed of the criteria for participating in those networks, with sufficient advance time to permit them to satisfy the criteria. (Res. 806, I-06; Reaffirmed in lieu of Res. 729, A-08; Reaffirmation I-10)

H-160.952 Access to Specialty Care

The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines. (CMS Rep. 1, A-94; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmation A-09)
Attachment 4
Current Policies related to AMA Resolution 226-i11

D-450.981 Protecting Patients Rights

Our AMA will:

(1) continue to advocate for the repeal of the flawed sustainable growth rate formula without compromising our AMA’s principles for pay-for-performance;

(2) 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

(3) provide a report back to the House of Delegates at its 2006 Annual Meeting. (Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-06; Reaffirmation A-07)

H-450.947 Pay-for-Performance Principles and Guidelines

(1) The following Principles for Pay-for-Performance and Guidelines for Pay-for-Performance are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.

2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients’ health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS
Safe, effective, and affordable health care for all Americans is the AMA’s goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA’s “Principles for Pay-for-Performance Programs” and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

**Quality of Care**

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based quality of care measures must be the primary measures used in any program. 1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties. 2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program. 3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession. 4. Performance measures should be scored against both absolute values and relative improvement in those values. 5. Performance measures must be subject to the best-available risk-adjustment for patient demographics, severity of illness, and co-morbidities. 6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years. 7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.

- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.

- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.

- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

**Patient/Physician Relationship**

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

- Programs must not create conditions that limit access to improved care. 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients. 2. Programs must neither directly
nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient de-selection.

- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

**Physician Participation**

- Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT). 1. Programs should provide physicians with tools to facilitate participation. 2. Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

**Physician Data and Reporting**

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner. 1. Programs should use accurate administrative data and data abstracted from medical records. 2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices. 3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting. 1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives. 2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

Programs must be based on rewards and not on penalties.

Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.

Programs must finance bonus payments based on specified performance measures with supplemental funds.

Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.

Programs must not reward physicians based on ranking compared with other physicians in the program.

Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

Programs must not financially penalize physicians based on factors outside of the physician’s control.

Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
(2) Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA’s "Principles and Guidelines for Pay-for-Performance." (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of Res. 808, I-10; Modified: BOT Rep. 8, I-11)
FIRST DISTRICT MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Aaron H. Davidson, M.D., Director
Michelle R. Zeanah, M.D., Alternate Director

REFERRED TO: Not Referred

FIRST DISTRICT MEDICAL SOCIETY

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First District Medical Society met in conjunction with the Ogeechee River Medical Society. Our activities included the Medical Association of Georgia (MAG) Board meetings in Atlanta in January and May, as well as participating at the House of Delegates (HOD) meeting in Buford in October 2013.

The director and alternate director were re-elected.

Ogeechee River Medical Society met regularly at 10 meetings over the past year. We discussed a number of interesting topics as well as had community resource representatives inform our group of what they do for our patients in the area.

Our group made a trip to the Georgia Capitol as well as held a legislative function where local representatives dined with physicians at the home of incoming president Rani Reddy, M.D., in April 2014.

# # #
SECOND DISTRICT MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: G. Ashley Register Jr., M.D., Director
Billy Ray Price, M.D., Alternate Director

REFERRED TO: Not Referred

SECOND DISTRICT MEDICAL SOCIETY

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**The charter for Southwest GA was revoked per Chapter 3, Section 3 of MAG’s bylaws which requires CMS’s to maintain a minimum of five active members. Those physicians are now listed as Members at Large.**

# # #
SUBJECT: Annual Report

SUBMITTED BY: Manoj H. Shah, M.D., Director
W. Steven Wilson, M.D., Alternate Director

REFERRED TO: Not Referred

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**The charter for Randolph-Stewart-Terrell was revoked per Chapter 3, Section 3 of MAG’s bylaws which requires CMS’s to maintain a minimum of five active members. Those physicians are now listed as Members at Large.**

# # #
FOURTH DISTRICT MEDICAL SOCIETY

Director: 04.14

SUBJECT: Annual Report

SUBMITTED BY: Stanley W. Sherman, M.D., Director
William R. Hardcastle, M.D., Director
Andrea P. Juliao, M.D., Alternate Director
Brian A. Levitt, M.D., Alternate Director

REFERRED TO: Not Referred

_______________________________________________________

FOURTH DISTRICT MEDICAL SOCIETY

(See DeKalb Medical Society – Director 15-14)

# # #
FIFTH DISTRICT MEDICAL SOCIETY

Director: 05.14

SUBJECT: Annual Report

SUBMITTED BY: Rutledge Forney, M.D., Director
Michael C. Hilton, M.D., Director
Matthews W. Gwynn, M.D., Director
Lisa Perry-Gilkes, M.D., Director
Thomas E. Bat, M.D., Alternate Director
Quentin R. Pirkle Jr., M.D., Alternate Director
W. Hayes Wilson, M.D., Alternate Director

REFERRED TO: Not Referred

# # #
## SIXTH DISTRICT MEDICAL SOCIETY

**Director:** 06.14

**SUBJECT:** Annual Report

**SUBMITTED BY:** Thomas B. Gore, M.D., Director
Richard A. Freeman, M.D., Alternate Director

**REFERRED TO:** Not Referred

### SIXTH DISTRICT MEDICAL SOCIETY

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# # #
The Seventh District had a good year in 2014. Hugo Ribot, M.D., from Cartersville completed his first year as Alternate Director and said that he has enjoyed his experience on the MAG Board of Directors.

The Walker-Catoosa-Dade Medical Society has continued to hold monthly meetings in Rossville under the capable leadership of David Bosshardt, M.D. and Michael Wilson, M.D. I was able to attend several of their meetings and enjoyed their discussions about the Patient Protection and Affordable Care Act and other pertinent health issues.

I would like to thank Ms. Patricia Yeatts for giving a legislative update from MAG to the Whitfield-Murray and the Walker-Catoosa-Dade Medical Societies in Dalton in April. In January, the Whitfield-Murray Medical Society held a social gathering with Hamilton Medical Center that was well attended.
I also would like to thank Ms. Joanne Thurston, executive director of the Cobb County Medical Society (CCMS), for inviting physicians from Bartow Medical Society and Carrollton Medical Society to CCMS meetings. I was able to attend a couple of the meetings. I greatly appreciate the opportunity to write an article on Telemedicine in CCMS’ journal, *Scripts.*

I want to congratulate Floyd-Polk-Chattooga County Medical Society for significantly increasing its membership to obtain separate representation on the MAG Board of Directors. Data at the end of 2013 showed 108 MAG members from Floyd-Polk-Chattooga, which includes 31 new members.

In other news, John Antalis, M.D., Director of Dalton, and Hugo Ribot, M.D., Alternate Director of Cartersville, were renamed in their respective positions for another term. Finally, I had discussions with our Seventh District Secretary Matthew Mumber, M.D., on options to enhance the presence of the Seventh District Medical Society throughout the region. I am hopeful we can continue to work on this project in 2015.

**Walker–Catoosa-Dade-County Medical Society submitted by**

**Michael E. Wilson, M.D., Secretary-Treasurer**

The Walker-Catoosa-Dade County Medical Society is currently composed of eight to 10 consistently active members who have met on a monthly basis to discuss the ramifications of the Patient Protection and Affordable Care Act and have learned much from the scientific portion of our meetings.

We have continued to monitor the situation at Hutcheson Medical Center in Ft. Oglethorpe, as the hospital attempts to recover financially, with CMS members actively admitting to the hospital, and supporting the community.

We mourn the passing of David O'Neal, M.D., an orthopedic surgeon based in Chattanooga, and a former member of the Tennessee State Medical Board.

Our membership is growing as more physicians see the necessity of organizing for patient benefit and practice survival and growth.

# # #
EIGHTH DISTRICT MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: S. William Clark III, M.D., Director
James W. Barber, M.D., Alternate Director

REFERRED TO: Not Referred

EIGHTH DISTRICT MEDICAL SOCIETY

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# # #
SUBJECT: Annual Report

SUBMITTED BY: Richard A. Wherry, M.D., Director
Stephen Jarrard, M.D., Alternate Director

REFERRED TO: Not Referred

NINTH DISTRICT MEDICAL SOCIETY

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**The charter for Hart was revoked per Chapter 3, Section 3 of MAG’s bylaws which requires CMS’s to maintain a minimum of five active members. Those physicians are now listed as Members at Large.**

# # #
TENTH DISTRICT MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Steven B. Ellison, M.D., Director
Arthur J. Torsiglieri, M.D., Alternate Director

REFERRED TO: Not Referred

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<td>Milledgeville</td>
<td></td>
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<tr>
<td>East Metro</td>
<td></td>
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<tr>
<td>John O. Bowden, M.D.</td>
<td>70</td>
<td>73</td>
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<tr>
<td>Conyers</td>
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<td>Oconee Valley</td>
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<tr>
<td>William H. Rhodes Jr., M.D.</td>
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<td>6</td>
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<tr>
<td>Union Point</td>
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<tr>
<td>Members at Large</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>99</strong></td>
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**The charter for Franklin was revoked per Chapter 3, Section 3 of MAG’s bylaws which requires CMS’s to maintain a minimum of five active members. Those physicians are now listed as Members at Large.**

# # #
BIBB COUNTY MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: William P. Brooks, M.D., Director
              Robert C. Jones, M.D., Alternate Director

REFERRED TO: Not Referred

BIBB COUNTY MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2012 MAG Members</th>
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<tbody>
<tr>
<td>Robert Jonathan Dean, M.D.</td>
<td>333</td>
<td>323</td>
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<tr>
<td>Macon</td>
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<td>Total</td>
<td>333</td>
<td>323</td>
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</tbody>
</table>

From September 2013 through August 2014, Bibb County Medical Society, Inc., (BCMS) held seven meetings for its membership.

In September, we hosted our Annual Membership Picnic, inviting our local, state, and federal legislators and candidates as guests and welcoming new physicians and their families. Our event was a Sunday afternoon family picnic in which the children played on a water slide and combo climber.

At MAG’s House of Delegates, BCMS filled its delegation and had a total of 14 delegates or alternates in attendance. Madalyn N. Davidoff, M.D., served as chair of Reference Committee A, Health Care Policy, with Stella I. Tsai, M.D., Robert C. Jones, M.D., William P. Brooks, M.D., and Malcolm S. Moore Jr., M.D., also serving on reference committees.

At our November 2013 Middle Georgia Educational Foundation lecture, we provided an evening of entertainment, with Pulitzer Prize-winning editorial cartoonist Mike Luckovich presenting “Inside the Mind of a Cartoonist.” He showed previous cartoons and described the context in which he created them and also drew a cartoon of one of our members during the program.

Our December event was the annual President’s Party, with the installation of officers and presentation of awards. Dr. Davidoff was installed as the 2014 President. Harvey Roddenberry, M.D., was named 2013 Physician of the Year. Russ A. Peace, DDS, and James B. Hall, DDS, were named Citizens of the Year for their long-time dedication to caring for children with very serious dental problems.

In February 2014, Mr. Steve Adams presented “Preparing to Implement ICD-10.” We allowed physicians’ office staff to accompany their physician to the meeting. Mr. Adams gave an excellent presentation, and we were happy to have office staff in attendance.
The March society meeting was entitled “Membership Benefits.” Ms. Tracee Sapp discussed Disability Insurance available through Principal Financial Group, and Mr. Ross Simms of Atlanta Capital Group presented information on MAG’s MEP retirement plan.

The April society meeting topic was “The New Oral Anticoagulants,” presented by Paul L. Douglass, M.D., of Metropolitan Atlanta Cardiology Consultants. His presentation was excellent and gave members more confidence in selecting the appropriate anticoagulant for patients.

On May 8, BCMS members and spouses enjoyed “A Tasting of Appetizers and Craft Beers” at the home of Linda Hendricks, M.D. Seven restaurants provided appetizers appropriate for craft beers, and eight different beers were available for tasting. The event was well attended, and members and guests had a very enjoyable evening.

BCMS members held key roles in MAG, including Chair of the Council on Legislation (Dr. Michael E. Greene) and AMA Alternate Delegates (Dr. Michael E. Greene and Dr. Billie L. Jackson).

# # #
CLAYTON-FAYETTE-HENRY MEDICAL SOCIETY

Director: 12.14

SUBJECT: Annual Report

SUBMITTED BY: (Vacant) Director
(Vacant), Alternate Director

REFERRED TO: Not Referred

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CLAYTON-FAYETTE-HENRY MEDICAL SOCIETY

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<th>Secretary</th>
<th>2012 MAG Members</th>
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<tr>
<td>Daniel T. McDevitt, M.D. Stockbridge</td>
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###
Cobb County Medical Society (CCMS) had a very successful and exciting year. President Debi Dalton, M.D. (2014), and President-elect Gerry Parada, M.D. (2015) led the society in achieving its goals. CCMS nominated and helped elect Tom Emerson, M.D., CCMS past president, as second vice president of MAG at the 2013 House of Delegates. Dr. Emerson is also CCMS participant in the Georgia Physicians Leadership Academy.

Membership expansion for specialties is an objective that we have achieved during the past year. CCMS increased its membership by adding several new specialties. Scripts (the medical journal of CCMS) allowed the different specialties to contribute to the society as a whole.

CCMS held four meetings during 2014. The first was our legislative meeting in January. May 7 featured Lori Foley, principal with PYA speaking on “The Future of Revenue Management in the Business of Medicine.” On September 13 we hosted Congressman Andy Harris, M.D. Dr. Harris is the first anesthesiologist elected to Congress and sits on the Appropriations Committee.

CCMS provided two conferences for our members during 2014. “The Business of Medicine: New Realities” was held at Kennesaw State University on January 18 and February 1. This conference provided 12 category 1 CME credits to participants. CCMS’ “Stroke Conference” was held on September 20 at the WellStar Development Center. Our guest speakers for the conference were Michael Frankel, M.D., professor of neurology, Emory University School of Medicine, and chief of neurology and director of the Marcus Stroke and Neuroscience Center at Grady Memorial Hospital, Scott Wottrich, M.D., board certified radiologist with an interest in CT and MRI applications involving the head and neck, brain and spinal cord, and Nydia Bladuell, M.D., board certified in cardiovascular disease and interventional cardiology and a CCMS member.
*Scripts*, the journal of the Cobb County Medical Society, has expanded pages, contributors, advertisers and recipients during 2014.

The Board of Trustees expanded during 2014 with the inclusion of several new physicians. The committees have been working to enhance the physician cohesion and communication of our board meetings and general membership meetings. To make sure we meet this goal each November we have a social gathering at the Gardens of Kennesaw Mountain. This meeting allows members to get to know each other.

Advocating Constructive health policies is another goal that CCMS accomplished this year. The Cobb Healthcare Professionals PAC has created direct one-on-one contact with our legislators. On January 22, 2013 our legislative dinner allow us to meet, greet, and get to know 15 members of the Georgia General Assembly. The legislators were from Cobb, Bartow, Cherokee, and Fulton counties. We used our legislative meeting to conduct a 10th District Congressional Debate with the candidates. The PAC will host a meet and greet for Congressman Andy Harris, M.D., Attorney General Sam Olens, and David Perdue, who is a candidate for the U.S. Senate. Dr. Emerson, Dr. Dalton, and Joanne Thurston attended MAG’s legislative meeting at Jekyll Island in July 2014.

###
CRAWFORD W. LONG MEDICAL SOCIETY

Director: 14.14

SUBJECT: Annual Report

SUBMITTED BY: Andrew H. Herrin, M.D., Director
Robert R. Byrne, M.D., Alternate Director

REFERRED TO: Not Referred

CRAWFORD W. LONG MEDICAL SOCIETY

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<td>R. Patrick Lucas, M.D.</td>
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# # #
DEKALB MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Stanley W. Sherman, M.D., Director
William R. Hardcastle, M.D., Director
Andrea P. Juliao, M.D., Alternate Director
Brian A. Levitt, M.D., Alternate Director

REFERRED TO: Not Referred

DEKALB MEDICAL SOCIETY

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<th>Secretary</th>
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<tr>
<td>Melissa Seely-Morgan, M.D.</td>
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<td>Decatur</td>
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<td>Total</td>
<td>388</td>
<td>332</td>
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The following is a brief summary of our programs and activities.

Volunteer Leadership

The following were elected to serve in 2014

President................................. Andrea Juliao, M.D.
President-elect............................ Katherine Elmore, M.D.
Past President............................ Brian Levitt, M.D.
MAG Director............................. Stanley W. Sherman, M.D.
MAG Alternate Director................... William Hardcastle, M.D.
Director-at-Large........................ Gulshan Harjee, M.D.
Director-at-Large......................... Robin Dretler, M.D.
Chair of the Commission on Advocacy....... Roy W. Vandiver, M.D.
Chair of the Commission on Community Service ....... Gary R. Bostein, M.D.
Chair of the Commission on Legislative Activities .... Joe Weissman, M.D.
Chair of the Commission on Membership Services........... William R. Hardcastle, M.D.

Community Service

The society continues to operate the highly successful Physicians’ Care Clinic, a community outreach program for the medically indigent in our county. This clinic is supported by part-time paid staff and a large cadre of health care professionals, including numerous DeKalb Medical Society (DMS) members who donate their time. The clinic is supported financially by corporate grants and individual donations.

We have an annuity through the DeKalb Medical Hospital Foundation that supports the annual operating expenses of the clinic.
We continue to raise significant support through the physician community and other private foundations. Our goal is to increase the annuity to a level that the clinic will be self-supporting going forward. PCC operates as a charitable foundation that is operated by the society.

Each year we honor one of our members for their community service with the Julius McCurdy Citizenship Award. This year’s co-recipients were Dr. Bill Hutchinson and his wife, Beverly.

Legislative Activities

We attempt to maintain a close relationship with our legislators through individual contacts as well as support of MAG’s legislative team.

Communications

We have moved to an email communication system for urgent issues and meeting notices for financial reasons. We have an active website that is updated regularly.

Programs

We have developed a Physician Education Series that we plan to kick off shortly. This series will focus on issues pertinent to the economics of medical practice.

Our most popular event each year is our annual meeting. This is a fundraiser for PCC. This black tie affair, which recognized the Hutchinsons as our McCurdy Citizenship Award winners, was held in January.

As we prepare for the MAG House of Delegates’ meeting, we are pleased that Stan Sherman, M.D., is a candidate for Vice Speaker and Joy Maxey, M.D., will again run for AMA Delegate.

Membership and Finances

Our MAG membership increased this year but membership in DMS continues to be our biggest challenge. This also impacts our finances as it prevents us from expanding our program of work and services to our members. We are working with DeKalb Medical Center regarding a special incentive for employed physicians.

It has been a pleasure to serve DMS as president. We believe our county medical society remains a critical entity in the federation of medicine that allows us to maintain a grass roots presence and cultivate leaders for our state and national organizations.

# # #
The purpose of Dougherty County Medical Society (DCMS) is to promote the science and art of medicine and the betterment of public health.

**Officers:**

- Harry Vildibill, M.D. (2013-2016). .................................................Vice President
- Buck Davis, M.D. (2012-2015). .......................................................Secretary/Treasurer

**Board of Directors**

- Karen Lovett, M.D.
- Michael Daugherty, M.D.**
- Deborah Trammell, M.D.
- Timothy Trulock, M.D.*
- Jose Tongol, M.D.
- Christopher Smith, M.D.
- Steve Kitchen, M.D.
- Harry Dorsey, M.D.
- John Edward Vance, M.D.
- Buck Davis, M.D.
- Gurinder Doad, M.D.
- *MAG BOD Director
- **MAG BOD Alternate Director
Board of Censors

Jose Tongol, M.D. 2014  
Karen Lovett, M.D. 2016  
Melinda Greenfield, D.O. 2017  
Harry Vildibill, M.D. 2018

2013 Community Service Projects

RiverFront Run – October 5, 2013 - The RiverFront Run is an annual event presented by the Dougherty County Medical Society as a way for physicians to lead by example and share with their patients the importance of incorporating physical activity and exercise into their daily routines. The 5K (3.1 Mile) and One-mile events are both run and walk friendly. DCMS is proud to donate a portion of the race proceeds to the Darton College Foundation, Inc., Allied Health Program. Darton College is one of the leading producers of health care professionals within the SW Georgia area. More than 300 runners participated in the annual event. DCMS donated $2500 to the program in 2013.

- December 2013 – Holiday social at the home of Dr. Buck and Lisa Davis
- April 22, 2014 – “The Realization and Definition of Violent Criminal Organizations in SW Georgia” – Jeffrey Reed – ATF Special Agent
- May 1, 2014 – Special presentation in connection with MCG Southwest Campus – Chris White

State of the Medical Community in DCMS

Southwest Georgia is experiencing a health care shortage. There are various efforts in the works to help relieve this shortage as evidence of our Family Medicine Residency Program.

Southwest Georgia Family Medicine Residency Statistics:
Current number of residents: 18  
2014 Graduating Class: 8  
Number of 2014 graduates staying in Georgia: 5

Medical College of Georgia at Georgia Regents University has a Southwest campus for third and fourth year medical students located in Albany. Granville Simmons, M.D., is the Dean for this campus. He is currently working on a rural track curriculum for third and fourth year students interested in rural medicine.

The Southwest Georgia Family Medicine Residency at Phoebe Putney Memorial Hospital in Albany is currently working with and partnering with Colquitt Regional Medical Center in Moultrie to develop a rural training track for family medicine. The PGY 1 residents would spend their first year of training at
Phoebe Putney Memorial Hospital in Albany. The PGY 2 and PGY 3 years of training would be at Colquitt Regional Medical Center in Moultrie. This partnership is being supported by the Southwest Georgia Graduate Medical and Research Consortium located in Moultrie. The Southwest Georgia Graduate Medical Research Consortium is a consortium of the following hospitals: Phoebe Putney Memorial Hospital (Albany), Colquitt Regional Medical Center (Moultrie), Tift Regional Medical Center (Tifton), and South Georgia Medical Center (Valdosta).

Phoebe Putney Memorial Hospital was recently awarded $1,000,000 from the Mellon Foundation (Pittsburgh, PA) to fund the building of a housing complex for students from the health care professions. Phoebe will need to obtain some additional funding before construction can start on this housing complex.

**Resident Information Submitted by George T. Fredrick, M.D.**

For the 2013-2014 year, Dougherty County welcomed 33 new physicians to our area; however 20 physicians left our area or retired.

# # #
FLOYD-POLK-CHATTOOGA COUNTY MEDICAL SOCIETY

Director: 17.14

SUBJECT: Annual Report

SUBMITTED BY: (Vacant), Director
(Vacant), Alternate Director

REFERRED TO: Not Referred

FLOYD-POLK-CHATTOOGA COUNTY MEDICAL SOCIETY

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<tr>
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##

# # #
The Georgia Medical Society (GMS) meets the second Tuesday in January, April, October and November at 6 p.m. for a social time and dinner is served at 6:30 p.m. Following dinner, the meeting begins at 7 p.m. The meetings are held at Carey Hilliard’s Restaurant. Members’ spouses are invited to join us for the evening.

On October 29, 2013, GMS sponsored its 13th Annual Health Care Heroes Awards. Nominations were accepted from individuals and/or organizations for individuals that deserved an award in any of the categories of Health Care Innovation, Health Care Education, Community Outreach, Institution/Organization, Allied Health Professionals and Physicians Lifetime Achievement. Eighteen awards were presented.

At the November 12, 2013 meeting, the speaker was Joe Buck, president of the Savannah-Chatham Board of Education. Mr. Buck spoke on “Health and Student Achievement.” Also at this meeting, resolutions on the death of our members, Joseph A. Mulherin, M.D., and Amos Timna, M.D., were read.

On January 14, 2014, the following officers were installed for the year 2014: President Mark E. Murphy, M.D.; Vice President Keith A. Dimond, M.D.; Secretary Fred L. Daniel, M.D.; Treasurer Thomas E. Shook, M.D.; President-Elect Michael J. Wilkowski, M.D.; Member-at-Large to the Board of Trustees Roland S. Summers, M.D.; Historian Thomas R. Freeman, M.D.; and Parliamentarian Roland S. Summers, M.D. The 2013 President William A. Darden, M.D., was honored with a program and presented his past president pin and other gifts. Also at this meeting a resolution on the death of our member George D. Clarke, M.D., was read.
On January 19, 2014, the members enjoyed the GMS annual oyster roast and barbecue at the home of Dr. Mark and Daphne Murphy. The members had a great time and delicious food was enjoyed.

In March, members attended a local CME program sponsored by MAG Mutual Insurance Company (MagMutual). CaRita Connor, GMS executive director, attended the Hospice Savannah annual luncheon meeting and Community Education Committee meeting.

In April, an update and revision to the bylaws was presented and accepted. The speaker at the meeting was Richard L. Weil, M.D., chairperson of the Georgia Composite Medical Board. He spoke on “Georgia Composite Medical Board Update 2014.”

On April 29, 2014, GMS sponsored the High School Preceptorship Program, which is a collaborative internship program between the Savannah-Chatham Public School System and GMS. Ten high school seniors from local public high schools were selected by the Board of Education to participate in the program. The students spent the day with physicians in their practice of medicine. The program began with an orientation breakfast at 6 a.m. and a closing banquet at 5 p.m. with a discussion by the students on their activities for the day. Thirty-three physicians participated. This program is chaired by Michael Zoller, M.D.

On May 13, 2014, GMS sponsored a free public forum on the Patient Protection and Affordable Care Act. The Endowment Fund of GMS gave it a grant to help sponsor this forum. The forum was announced in the local newspaper for eight days and on the local TV station WTOC. Other types of communication were distributed such as posters, letters, etc. The forum was a complete success with more than 200 in attendance. The panels of speakers included Donald J. Palmisano Jr., executive director/CEO of MAG; Diane Weems, M.D., director of the Coastal Health District; Maggie Gill, chief executive officer of Memorial University Medical Center; Michael Kleinpeter, chief executive officer, Optim Health; and David Rubnitz, chief executive officer, Ebenconcepts - Savannah. The moderator for the program was GMS President Mark Murphy, M.D.

On May 30, 2014, GMS was saddened by the death of its member Edwin C. Shepherd, M.D.

Dr. Murphy attended the June 25, 2014 orientation for the new Residents at Memorial University Medical Center and invited them to join.

On July 25, 2014, Dr. Murphy attended a reception for the Medical College of Georgia medical students and extended an invitation to them to join.

Dr. Murphy addressed the new Mercer University medical students at their White Coat Ceremony on August 23, 2014.

GMS will hold its Super Meeting at Alee Shriner’s Building on September 9, 2014, which is co-sponsored by Memorial University Medical Center, St. Joseph’s/Candler Health System and MagMutual. The speaker for the meeting will be Curtis J. Foltz, executive director of the Georgia Ports Authority. The topic of his speech will be “Overview of Georgia Ports Authority.”
Local legislators have been invited to speak on legislative issues at the October 14, 2014 meeting.

GMS has welcomed 56 medical students into its membership in 2014.
GWINNETT-FORSYTH COUNTY MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: John Y. Shih, M.D., Director
James L. Smith, M.D., Alternate Director

REFERRED TO: Not Referred

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<td>Scott W. Schorr, M.D.</td>
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# # #
HALL COUNTY MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Andrew B. Reisman, M.D., Director
Michael H. Callahan, M.D., Alternate Director

REFERRED TO: Not Referred

The following is a brief summary of our 2014 program year.

Volunteer Leadership

The following are serving the Hall County Medical Society: (HCMS):

President.......................................................... Karl Schultz, M.D.
Vice President......................................................... Dan Cobb, M.D.
Secretary/Treasurer.................................................. Abhishek Gaur, M.D.
Past President......................................................... Michael Callahan, M.D.
Past President......................................................... Dan Mullis, M.D.
MAG Director....................................................... Andrew B. Reisman, M.D.
MAG Alternate Director.......................................... Michael Callahan, M.D.

Community Service

HCMS continues its involvement in the “Good News at Noon” medical clinic that serves the indigent of our community as well as the Health Access Initiative. We also continued to provide physicals to students at area high schools.

Legislative Activities

We attempt to maintain a close relationship with our legislators and congressmen through individual contacts as well as support of MAG’s legislative team. We invite them to all of our meetings.
Communications

We use an email/fax distribution system and frequent mailings in an effort to communicate with our members quickly and inexpensively. We also maintain a close contact with the practice administrators, particularly those in the larger groups.

Programs

The society presents several programs to the membership each year focusing primarily on issues related to office management, legislation and politics.

Our spring program featured Alicia Miles, Assistant Professor at Mercer University on “Social Media and the Physician: Managing your Online Presence in a Tech Savvy World.”

Our fall program is under development. New members of the hospital medical staff will be honored.

As we prepare for the MAG House of Delegates meeting, we are pleased that Andrew Reisman, M.D., will be a candidate for Secretary, Jack M. Chapman, Jr., M.D., for AMA Alternate Delegate and Frank McDonald Jr., M.D., for Speaker.

Membership and Finances

Membership recruitment and retention and financial stability continue to be pressing issues and threaten the survival of our society. We are striving to add value to our organization through improved programming and involved leadership.

It has been a pleasure to serve as HCMS president this year.

###
The Medical Association of Atlanta (MAA) started the year with its July 25, 2013 board meeting followed by an offsite planning meeting on August 16 – 18, 2013 at the Ridges Resort. Other board meetings were held on the following dates in the 2013-2014 year: November 19, 2013, January 23, 2014, March 18, 2014, and May 15, 2014.

MAA membership had an active year beginning with a joint legislative meeting with the Cobb, DeKalb, and Gwinnett medical societies on August 25, 2013. More than 350 people attended with Ben Carson, M.D., as the guest speaker.

The association hosted a dinner meeting on January 16, 2014, which featured a debate between MAG Executive Director Donald J. Palmisano Jr. and Richard Jackson on whether the “Patients’ Compensation Act” as proposed in S.B. 141 should replace the current “Medical Tort Liability System.” The reception/dinner and debate was held at the Westin Atlanta Perimeter.

The following MAA members attended the April 2014 GAMPAC Fly-In in Washington, D.C.: Thomas Bat, M.D., Randy Rizor, M.D., and William Silver, M.D.

The association held its spring dinner on April 22, 2014 at Maggiano’s in Buckhead. The topic was “ICD-10: What You Need to Know to Get Paid” with Regina Bates, MBA, as our speaker.

The MAA returned to the Bobby Cox Suite on April 12, 2014, to enjoy a game during the opening week of Atlanta Braves baseball. This continues to be the most popular social event hosted each year.
The year ended with our annual meeting on June 26, 2014 at the Capital City Club with a panel discussion on “Performance Improvement to Enhance Quality and Safety” with Mary Gregg, M.D., Kate Kaplan, M.D., MPH, and Steve Walsh, M.D., serving as panelist. The following officers were installed to serve for the 2013 – 2014 year: President Hayes Wilson, M.D.; President-elect Quentin Pirkle, M.D.; Treasurer Thomas Bat, M.D.; Secretary Charles Wilmer, M.D.; and Chairman of the Board Lisa Perry-Gilkes, M.D.

The following members are currently serving on the board of the MAA: Robert J. Albin, M.D., Larry Bartel, M.D., Sara Caceres, M.D., Dimitri Cassimatis, M.D., Lawrence E. Cooper, M.D., Rutledge Forney, M.D., John A. Goldman, M.D., Matthews Gwynn, M.D., John S. Harvey, M.D., Brian Hill, M.D., Michael C. Hilton, M.D., Mark Hutto, M.D., Albert F. Johary, M.D., Paul K. King, M.D., Welborn Cody McClatchey, M.D., Frances D. McMullan, M.D., Deborah A. Martin, M.D., Dorothy Mitchell-Leef, M.D., Elizabeth Morgan, M.D., Ali R. Rahimi, M.D., Alan R. Redding, M.D., Randy F. Rizor, M.D., William E. Silver, M.D., Barry D. Silverman, M.D., Sumayah Taliaferro, M.D., Earl Thurmond, M.D., Shaun Traub, M.D., Steven M. Walsh, M.D., and Martha Wilber, M.D.

# # #
MUSCOGEE COUNTY MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Frederick Flandry, M.D., Director
W. Frank Willett III, M.D., Alternate Director

REFERRED TO: Not Referred

MUSCOGEE COUNTY MEDICAL SOCIETY

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<td><strong>Total</strong></td>
<td><strong>254</strong></td>
<td><strong>241</strong></td>
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Officers:

1. James D. Majors, M.D., President
2. W. Frank Willett III, M.D., President-Elect
3. Glenn E. Fussell, M.D., Secretary/Treasurer

On January 28, 2014, more than 135 members and spouses attended the Muscogee County Medical Society’s (MCMS) Wine Tasting at Epic Restaurant. It is a unique and wonderful opportunity to network with colleagues and meet new members. Chef Jamie Keating provided the wonderful food pairings and Daniel Thomas of Quality Wines provided the wines. MAG Executive Director Donald J. Palmisano Jr. attended, as well as MAG President William Silver, M.D.

On March 13, we hosted MCMS night at the Columbus Cottonmouth’s Hockey Game in a private suite. Physicians, spouses and their children enjoyed hamburgers, hotdogs, beer and lots of plastic snakes. We had more than 70 attendees including the little ones and residents from both Columbus Regional Family Residency Program and Martin Army Family Residency Program.

On May 9, we enjoyed a golf and tennis night at the Columbus Country Club Tennis Pavilion. Some physicians played nine holes of golf while others played tennis. Others enjoyed cool drinks and good food on the porch. About 50 members and spouses attended.

On August 19, we enjoyed noted Civil War historian Steve Davis’ talk on “Columbus in the Civil War” sponsored by MAG Mutual Insurance Co. at the national Infantry Museum. Members and spouses and guests were treated to a tour of the Infantry Museum walk, cocktails, and a buffet dinner before the talk and presentation by Mr. Davis. Guests included State Senators Ed Harbison and Josh McKoon, Alice House, M.D., dean, Mercer School of Medicine and Teresa Robertson from Congressman Westmoreland’s office, as well as Matt Moore, executive vice president, St. Francis Hospital. There were 89 attending this event.
MCMS had a full delegation of 11 members at MAG’s HOD last year and we will have a full delegation of ten members this year.

# # #
The Richmond County Medical Society (RCMS) has continued to enjoy a variety of informative programs – the majority of which have been for CME credit. We have maintained our increased numbers from last year with the addition of members from the Medical College of Georgia at Georgia Regents University. Our Board of Trustees meetings are well attended and are always forums for vigorous discussion.

**Officers**

- President: Peter Buckley, M.D.
- President-elect: Craig Kerins, M.D.
- Vice President: Donnie Dunagan, M.D.
- Secretary: Edgar R. Hensley, M.D.
- Treasurer: Robert Kaminski, M.D.
- Director: Michael Cohen, M.D.
- Director: John Salazar, M.D.
- Vice Director: Donnie Dunagan, M.D.
- Vice Director: Jill Hauenstein, M.D.

**Membership 2014**

- Active: 554
- Life: 50
- Resident: 2
- Students: 192
- Retired: 75
Total 873

Programs

September 2013  “An Evolutionary Taxonomy of Therapeutic Neurostimulation” – Peter Rosenquist, M.D.

October 2013  “Closed Claim Review” – Joseph Griffin, M.D.

November 2013  “Government at the Bedside” and Annual Legislative Program – Jacqueline Fincher, M.D.

December 2013  Holiday Program – Santa Claus

January 2014  “Understanding Legal Tools: The Key to Lawsuit Prevention and Tax Reduction” – Dave Gibbs, Global Physicians Alliance, LLC

February 2014  “The State Medical Board and You” – Vinayak Kamath, M.D., MBBS

March 2014  Sleep Apnea/ Doctor’s Day – Bashir Chaudhary, M.D.

April 2014  Research Presentations by MCG Residents

May 2014  Risk Management Seminar

July 2014  Recent Advances in Echocardiography – Navin Nanda, M.D. (UAB Medical School)

Our ongoing ‘‘Project Access’’ continues to provide care for the medically indigent in Richmond County under the leadership of Terry Cook, M.D. Our Society runs smoothly thanks to the efforts of Dan Walton, Nancy Graham and Stacy McGahee. We all look forward to the monthly newsletter with its outstanding op-ed piece by our resident journalist, Craig Kerins, M.D. We look forward to another productive year!

# # #
SECTION REPORTS
SUBJECT: Annual Report

SUBMITTED BY: Ali A. Shaikh, M.D., Chairman

REFERRED TO: Not Referred

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**IMG Section Purpose**

International Medical Graduates (IMG) are defined as those physicians who received their undergraduate medical education outside of the U.S. and Canada. In 1963, IMGs represented slightly more than 10 percent of the physician workforce in the U.S. Today, they comprise 25 percent of the U.S. physician population, and more than one-quarter of the resident physician population.

The Medical Association of Georgia (MAG) is one of only 11 states in the country with an established IMG section. MAG formed the section to encourage the support and participation of IMGs in MAG and county medical societies. The section provides a forum for IMGs in organized medicine that promotes the purpose, objectives and goals of MAG and promotes the involvement of IMGs in shaping the future of organized medicine.

**Activities of the IMG Section**

The IMG section met on March 8 and April 19 to discuss ways to address issues affecting IMGs in Georgia, as well as how to increase IMG membership and participation in MAG. The section plans to meet again this year on October 18 to elect officers and continue to discuss items of interest.

**IMG Membership**

Nationally, one in four practicing physicians is an IMG. Georgia ranks 13th in the U.S. with approximately 4,438 IMGs practicing. This equates to about 19 percent of the entire physician workforce in Georgia. At this point in the 2014 dues year there are 415 IMG members in MAG, which is an increase of 12 percent from 2013. IMGs currently represent approximately eight percent of active MAG membership. IMG officers and section members will continue to make a concerted effort to recruit new MAG IMG members through various forms of peer-to-peer contact. Communication is key, and the IMG section will collect and disseminate information regarding important issues they face.

The IMG section would particularly like to thank MAG President William Silver, M.D., for his continued outreach to the IMGs during his presidency.

I also would like to thank the following officers for their service to the IMG section this year:

- Santanu Das, M.D., Vice Chairman
- Dilip C. Patel, M.D., MAG HOD Delegate
- Arvind Gupta, M.D., MAG HOD Alternate Delegate
- Kalish Sharma, M.D., Treasurer
- Abhishek Gaur, M.D., Secretary
About the MAG-MSS

The Medical Student Section (MSS) of the Medical Association of Georgia is a growing body of future physicians that provides a forum for conversation and action regarding the medical profession in the state of Georgia. Our MSS fosters an opportunity for students to actively participate in organized medicine by discussing the challenges facing our profession and spearheading advocacy efforts that are particularly applicable to our stage of training. The MSS also serves as a vital educational institution for students to understand the challenges facing healthcare and medical professionals. We constantly strive to increase our membership to provide our colleagues with an understanding of our changing health care system and the ability to actively shape the future of our profession in the state of Georgia.

Medical students are encouraged to join MAG-MSS for all four years of their medical education. The MSS Executive Council is elected each year at the annual MAG House of Delegates. Their main objectives are to set a calendar of events for the upcoming year, provide school chapters with programming and recruitment options, encourage attendance at MAG events, and help local chapters develop community service efforts.

Executive Council Strategic Plan

The Executive Council has built upon the success of previous years and continued to build our membership and reach across the numerous medical campuses in the state of Georgia. This year we had incredible turnout at the American Medical Association (AMA) annual meeting with four of the state’s six medical campuses represented. Our membership has risen to the challenge of taking up leadership positions in the AMA. MAG members hold the office of regional delegate to the AMA HOD and also leadership positions in our MSS region. Meanwhile, our MSS has worked diligently to increase MAG membership through offering MAG recruitment events to the medical students of the state. As the new classes of students enter this fall, our efforts will ramp up to educate the new students on the Medical Association of Georgia and encourage student participation throughout their four years in medical school.

This past year, our MSS has put on a number of fantastic events statewide. This past winter, three of our medical schools decided to form a committee to bid for and eventually win the honor of holding the AMA MSS region IV meeting in Atlanta. Our group of committed students raised $10,000 to put on the weekend conference for more than 150 medical students from across the southeast. We invited the chief medical officer of the American Cancer Society, Otis Brawley, M.D., to give our keynote address and collaborated with the Savannah College of Art and Design to create a theme for our conference, “The Art of Medicine.” We also put on a health fair at the Atlanta Children’s Museum and created health-themed coloring books to distribute to children in attendance. Simultaneously, more than 50 medical students offered basic health screening services to children and their parents. We also had more than 30 hours of educational programming at the meeting that varied from artistic expression to advocacy education to an overview of organized medicine. It was a fantastic weekend that helped to raise the stature of our state
medical society and entice a variety of students to look into Georgia as a place to practice and train in the future. The weekend could not have been a success without the unwavering support of MAG.

This year, our section has also been hard at work to create the first annual MAG – Student Research Showcase at the upcoming House of Delegates meeting at Callaway Gardens. The showcase is open to all students who are pursuing their medical education in the state of Georgia and is an excellent opportunity for students to share their original work and network with physicians from across the state. Submissions from medical students of all class years are encouraged and we hope that this showcase will grow over the years where we are eventually having a competition with prizes awarded to students. We anticipate 30 to 40 pieces of unique research to be presented at this meeting. We hope you take some time to check out what Georgia medical students have been working on.

The next aim as a council was for our section to become more active participants in advocacy efforts. This year in particular we made it a priority for our members to be represented at state and national meetings. Therefore, we strove to send delegates to every national AMA event and MAG statewide event. Our members were present throughout this year at MAG board meetings, MAG’s “Advocacy Day” at the State Capitol, and the HOD meeting at Lake Lanier. We also sent representatives to the AMA Annual and Interim meeting as well as Advocacy Day at the U.S. Capitol where students met with the staff of Georgia Congressmen and Senators.

We will also be building on the success of last year’s meeting where we passed a resolution pertaining to GME funding. This year our members have authored two resolutions that will be presented at the HOD. We find it essential that the MSS not only partake in the discussion of important issues, but that we also bring forward new topics for discussion. We have therefore pushed our members to author original resolutions that directly affect Georgia.

Our success this past year would not have been possible without the dedication of our MSS leadership team. At the annual MAG-MSS meeting in October 2013 at Lake Lanier, the following student officers were elected to the MAG-MSS Executive Council for 2013-2014:

Chair Jonathan Gillig (Emory) jonathangillig@gmail.com
Vice-Chair Kevin Lindsay (MCG-Athens) kevineddielindsay@gmail.com
Delegate Brett Heimlich (MCG-Augusta) brett.heimlich@gmail.com

Most importantly, the MAG-MSS would not be possible without the guidance of the MAG staff, the MAG General Assembly, and the county medical societies that have been steadfast supporters of our section. Their continued support has provided us with the encouragement, expertise, leadership and resources to foster our section’s growth and we are incredibly grateful for their willingness to shape the next generation of Georgia’s physicians.

MSS Chairman’s Note

As my final year of medical school tosses me into the challenges of residency applications and interviews, I have been asked numerous times to describe what sets me apart from my fellow applicants. I have found myself pondering many different ways to answer this question, however I constantly return to my involvement in organized medicine. As a first-year medical student I still remember my first MAG HOD meeting at Callaway Gardens three years ago. I entered the meeting so lost and confused about the process of writing resolutions and passing policy, yet the entire atmosphere was exciting and invigorating. I saw physicians enthusiastic about improving the current medical system and I knew that this was something I had to become a part of.
Over the years my understanding of organized medicine has improved, and I have been able to identify issues that I am passionate about. MAG has also provided me an avenue to meet incredible mentors and friends who have helped to shape my medical school experience and kept my motivation for becoming a doctor grounded in helping others. Lastly, MAG has provided immense opportunities for my personal growth as a leader and as a future physician.

My involvement with MAG is what I constantly return to when I am faced with the question of what sets me apart from other students. The environment that MAG fosters for students to get involved and participate in advocacy efforts at a state level is something that I am immensely proud of. These experiences are what I constantly share with my peers as I encourage their involvement in MAG. On behalf of the entire Medical Student Section, I want to thank each and every one of you for your unwavering support, your mentorship, and your friendship. Continuing to invest in the future of the medical profession through students will ensure MAG’s vibrancy and efficacy in shaping the face of health care in Georgia.

# # #
SPECIAL REPORTS
GEORGIA MEDICAL POLITICAL ACTION COMMITTEE

SUBJECT: Annual Report

SUBMITTED BY: James W. Barber, M.D., Chairman

REFERRED TO: Not Referred

Charge of the Committee

The Georgia Medical Political Action Committee (GAMPAC) is a voluntary, non-profit, unincorporated committee of individual physicians and others and is not affiliated with any political party. The committee is an independent, autonomous organization, and is not a branch or subsidiary of any national or other political action committee.

Purposes of GAMPAC:

• To promote the involvement of physicians and others to take a more active and effective part in governmental affairs;
• To educate physicians and others as to the understanding of how the three branches of government operate;
• To advise physicians and others as to the evaluation of support of public office holders and candidates for election to public office;
• To organize, promote, encourage and assist actions desirable for the purpose of effective political action;
• To receive and accept contributions from individuals and corporations to the extent authorized by law;
• To make contributions to candidates for public office as authorized by law; and
• To do any and all things necessary or desirable for the attainment of the purposes stated above.

GAMPAC Financial Report

As of August 15, GAMPAC has $204,593.17 cash on hand.

GAMPAC Membership Report

As of August 31, there are 439 GAMPAC Members.

Chairman’s Circle Members 2014 ($2,500) 20 Members

John S. Antalis, M.D.
James William Barber, M.D.
Thomas Edward Bat, M.D.
W. Scott Bohlke, M.D.
Jack M. Chapman Jr., M.D.
S. William Clark III, M.D.
Lawrence E. Cooper, M.D.
Madalyn Nicole Davidoff, M.D.
Eugene Stanley Hurwitz, M.D.
Katarina Gabrielle Lequeux-Nalovic, M.D.
Matthews Weber Gwynn, M.D.
Randy Frank Rizor, M.D.
Robert David Schreiner, M.D.
Manoj H. Shah, M.D.
Stanley Sherman, M.D.
William E. Silver, M.D.
James Smith, M.D.
Jules Toraya, M.D.
Steven Michael Walsh, M.D.
Georgia Orthopaedic Society

Capitol Club Members 2014 ($1,000) 18 Members

Benjamin Hugh Cheek, M.D.
Bret Cameron Crumpton, D.O.
Edmund Roche Donoghue, M.D.
Jeffrey Charles Easom, D.O.
Jenny Jo Grossman, M.D.
Billie Luke Jackson, M.D.
Stephen Jarrard, M.D.
Phillip Stephen Kennedy, M.D.
Craig Michael Kubik, D.O.
Sid Moore Jr., M.D.
Elizabeth Morgan, M.D.
Alan L. Plummer, M.D.
Randall Joseph Ruark, M.D.
Michael John Sharkey, M.D.
Glendon William Smalley Jr., M.D.
Arthur Joseph Torsiglieri, M.D.
Roy W. VANDIVER, M.D.
Michelle Reynolds Zeanah, M.D.

GAMPAC has disbursed $54,100 in contributions as of August 15, 2014. Through the outreach efforts of physicians, GAMPAC has increased its support of and strengthened its relationships with Georgia Democrats and Republicans. As a result, this has promoted the practice of medicine for physicians regardless of party affiliation.

Eighty-two percent of candidates who were supported by GAMPAC won their primary election. With the primary elections concluded, there will now be two physicians in the Georgia Senate, Sen. Dean Burke (R-Bainbridge) and Senate candidate Ben Watson (R-Savannah), as both have no opposition in the general election.

This quarter, the GAMPAC Board approved its 2014 General Election budget of $70,900 in contributions to candidates for the General Assembly and statewide office.

With the General Election budget approved, staff will coordinate with GAMPAC members to support pro-physician candidates seeking election to the Georgia General Assembly. In addition, GAMPAC would like to encourage physicians to develop relationships with their own legislators, especially with the
recent high turnover rate in the General Assembly. It is important for the newer legislators to be brought up to speed on the current issues facing both patients and physicians in Georgia.

GAMPAC will continue its tradition of having a photo booth for professional headshots at this year’s HOD as a benefit for all levels of membership. In addition, U.S. Sen. John Barrasso, M.D., (R-WY) will be the keynote speaker at this year’s annual GAMPAC luncheon – all members are invited to attend.

With 100 percent participation of MAG’s Board of Directors at the previous HOD, GAMPAC will be focusing on 100 percent participation amongst all physicians at this HOD.

I want to take this opportunity to thank the physician volunteers who have served on the GAMPAC Board of Directors and ALL of the members of GAMPAC who have contributed so generously.

I also want to thank the following MAG staff:

Marcus W. Downs, Director of GAMPAC
Ryan M. Larosa, GAMPAC Manager
Elizabeth A. Bullock, Administrative Assistant

# # #
The Medical Association of Georgia Foundation (MAG Foundation) is pleased to present its Annual Report for 2014. Over the past year, we have continued striving on your behalf to lead philanthropic efforts to create a healthier Georgia.

Board of Trustees

In January 2014, John D. Watson Jr., M.D. and Joseph P. Bailey Jr., M.D. resigned from the Foundation’s Board of Trustees. Dr. Watson had given 24 years of service to the Foundation, serving as secretary/treasurer in 1992 and as president from 1993 until his resignation. Dr. Bailey had served on the Foundation’s Board of Trustees for 23 years, serving as vice president from 1992 until his resignation.

To complete the terms of Dr. Watson and Dr. Bailey, Todd Williamson, M.D., and Ali Rahimi, M.D., were elected to the Board of Trustees.

‘Think About It’ Campaign

The MAG Foundation recently announced that some of the most trusted and recognized health care system entities are supporting its ‘Think About It’ campaign to reduce prescription drug abuse by distributing more than 350,000 informational leaflets in the state. This includes CVS Health pharmacies, Walgreens pharmacies, Walmart pharmacies, Kaiser Permanente pharmacies, the Georgia Department of Public Health, Children’s Healthcare of Atlanta, the Northeast Georgia Medical Center in Gainesville, the Phoebe Putney Health System (including Phoebe Physicians Group) in southwest Georgia, and the Georgia Charitable Care Network – which includes about 100 independent non-profit clinics in the state. Other entities that are expected to support the effort going forward include the West Georgia Health System, Emory Healthcare, Northside Hospital Forsyth and the Mayo Clinic in Waycross. The “Help Stop Rx Drug Abuse in Georgia” leaflets encourage Georgians to 1) only take their medicine as prescribed and 2) not share their medicine and 3) store their medicine in a safe and secure place and 4) properly dispose of any unused medicine.

‘Think About It’ co-chairs Dallas Gay and P. Tennent Slack, M.D., and MAG Foundation Director of Program Development Lori Cassity Murphy made a number of presentations in 2014. This included Okfesokee Medical Society (via the Telehealth network), the Troup County Prevention Coalition, the Georgia Society of Interventional Pain Physicians (GSIPP), the National Rx Drug Abuse Summit, the Chattahoochee Study Club, Gainesville First United Methodist Church, Lakeview Academy (Gainesville), Riverside Academy (Gainesville), Parkview High School (Lilburn), Howard High School (Macon), Walton High School (Marietta), the Georgia Physicians Leadership Academy (GPLA) Class VII, the Phoebe Physicians Group, the Troup County Medical Society, the Forsyth County Drug Summit, and the West Georgia Health System.
‘Think About It’ campaign Co-Chair Dr. Slack gave a presentation from Gainesville to members of the Okefenokee Medical Society (OMS) using a live video link on March 27 as part of an effort to explore ways to expand the campaign to reduce prescription abuse in the state to Waycross. The OMS group watched Dr. Slack’s presentation on a video monitor at the Southeastern Telehealth Resource Center in Waycross.

The Medical Association of Atlanta (MAA) has announced that it will support the MAG Foundation as a Gold Level Sponsor ($10,000). Moreover, MAA is challenging other county medical societies in the state to support the campaign with a donation to the MAG Foundation.

The MAG Alliance has agreed to support the MAG Foundation and its ‘Think About It’ campaign with fundraising and outreach support.

The MAG Foundation took an active role in the National Rx Drug Abuse Summit in 2014. The event is billed as “the largest national collaboration of professionals impacted by prescription drug abuse.” It featured MAG Foundation ‘Think About It’ campaign co-chairs Dr. Slack and Mr. Gay. Dr. Slack served on a panel that addressed ways to improve communications between physicians and pharmacists. Mr. Gay, meanwhile, gave a talk on ways the ‘Think About It’ campaign has effected change in Hall County.

In an effort to help prevent prescription drug abuse on college campuses, the MAG Foundation’s ‘Think About It’ campaign donated prescription drug drop boxes to the University of Georgia in Athens and Kennesaw State University.

In May, the Apple Mountain Golf Course in Clarkesville hosted a golf tournament that raised nearly $22,000 for the ‘Think About It’ campaign. The event also served as a memorial tribute to Jeffrey Gay – the grandson of ‘Think About It’ campaign co-chair – who lost his life to prescription drug abuse in 2012.

MAG Foundation ‘Think About It’ campaign leaders Jack M. Chapman Jr., M.D., Dr. Slack and Mr. Gay received the Greater Hall County Chamber of Commerce “Community Service Award” for 2014 for their efforts to reduce prescription drug abuse.

Georgia Attorney General Sam Olens recently launched a “We’re Not Gonna Take It” video contest for Georgia high school students to raise awareness to reduce prescription drug abuse. A Georgia Department of Law press release said that, “Georgia high school students are being challenged to create a 30-second video explaining why they have chosen to live a healthy lifestyle and reject prescription drug abuse. The contest will take place from September 15, 2014 to October 31, 2014. Prizes will be awarded to the winner, runner-up and a people’s choice winner.” Mr. Gay is expected to speak at “We’re Not Gonna Take It” campaign events. Contact Lauren Kane at 404.463.7540 or lkane@law.ga.gov for additional information.

The MAG Foundation has sponsored a number of ‘Think About It’ campaign presentations across the state in 2014. The events address important issues like non-opioid treatment options for chronic pain, screening and monitoring for opioid misuse, diversion and addiction, rules and laws that govern opioid prescribing, and the mechanics of prescribing and prescription monitoring in Georgia. Contact Lori Cassity Murphy at 678.303.9282 or lmurphy@mag.org to schedule a presentation or with questions and for additional information. Go to www.rxdrugabuse.org to make a donation to the ‘Think About It’ campaign.
Georgia Physicians Leadership Academy

The Georgia Physicians Leadership Academy (GPLA) continues to be a dynamic and enterprising program of the MAG Foundation. The update on GPLA is found in the report written by GPLA Steering Committee Chair S. William Clark III, M.D.

W.R. Dancy Student Loan Fund

The MAG Foundation has supported the William R. Dancy, M.D., Student Loan Fund for medical school students for 44 years. The Dancy Fund helps Georgia residents realize their dreams of attending medical school by granting them affordable loans. To date, the Foundation has supported 53 medical students in their pursuit of becoming a physician. Currently, the Fund assists Georgia residents to complete their medical education at an accredited medical school located in Georgia.

Since last year’s report, the Foundation received one (1) new loan application, which was approved and funded.

As of now, the Dancy Fund has three (3) outstanding loans in repayment phase with total balances of $24,000. Funds available for new loans are currently $218,000.

Distressed Physicians Fund

The Distressed Physicians Fund was created to assist physicians and their spouses who experience financial hardship caused by natural disasters or other circumstances beyond their control. Current funds available are $48,000.

Charitable Gift Annuity Plan

The Foundation continues to work with PG Calc, an industry leader in administration of charitable gift annuity plans and with investment advisors Capital Group Private Client Services, to maximize earnings, within acceptable risk margins, on the plan’s assets.

Thank you for taking the time to read this report and learn about your Foundation.

The Board of Trustees would like to especially thank our staff for their dedication and service:

Donald J. Palmisano Jr., MAG Executive Director/CEO and MAG Foundation Executive Director/CEO
Fred Jones, MAG Foundation Director
Lori Cassity Murphy, MAG Foundation Program Development Director

MAG Foundation Board of Trustees:

Jack M. Chapman Jr., M.D., President
John S. Antalis, M.D., Vice President
Stephen M. Walsh, M.D., Secretary/Treasurer
E. Dan DeLoach, M.D.
Ali R. Rahimi, M.D.
M. Todd Williamson, M.D.

# # #
Once a valuable resource for the Medical Association of Georgia (MAG), the Alliance is looking to reinvent itself!

After 70 years of partnering with MAG, the MAG Alliance has fewer than 400 members and a shrinking voice statewide. As we kick-off the new year in January 2015, the Alliance is offering a free membership to every spouse of a MAG physician. We hope to develop friendships through new physician spouses, as well as hospital administrators and physician recruiters. Plans include gathering physician spouses to share MAG’s news and how we can help raise awareness for the MAG Foundation’s ‘Think About It’ program. Please join us as we move forward as the collective voice of medicine and act together as a united front to ensure Georgia physician families are supported and nurtured.

We look forward to a new era through our Collect, “Grant that we may realize it is in the little things that create differences; but in the big things of life we are one.”
The Medical Association of Georgia (MAG) received four awards for its www.mag.org website since the House of Delegates (HOD) met in 2013, including an Association of Marketing and Communication Professionals’ “Hermes Gold Creative Award,” a Horizon Interactive Awards “Bronze Award,” a Web Health “Bronze” Award, and an Academy of Interactive and Visual Arts “Communicator Award.” MAG has won six awards for its website over the past two years.

Between January 1 and August 27, mag.org was visited some 26,000 times – which translates into 112 visits a day. The website had more than 18,500 unique visitors during the first eight months of 2014, and more than 68 percent of those were considered “new” (i.e., first time) visitors. During the same eight-month period, the website’s “Find a Physician” feature was viewed more than 300 times by more than 260 unique users. MAG also redesigned a number of website pages in 2014, including the legal resources, government relations, third party payer, and public health pages.

MAG is now being followed by nearly 3,000 accounts on Twitter (www.twitter.com/MAG1849), which includes a number of state and specialty medical societies. MAG has also increased its presence on Facebook – with 330 ‘likes.’ MAG Executive Director Donald J. Palmisano Jr. can be followed on Facebook, LinkedIn, or on Twitter with the handle @DPalmisanoMAG.

MAG updated its mobile “app” with the information for the 2014 HOD meeting. The app contains an abbreviated version of the HOD pocket program – including details on meeting times and locations, directions to the hotel, and a list of exhibitors and sponsors. It also features a member physician search function. MAG members can download the app to their handheld device or tablet by going to m.mag.org.

The 1Q edition of the MAG Journal focused on national health care issues, including a feature article on the Medicare SGR. The 2Q edition of Journal was focused on practice management issues and included a feature article on the ICD-10 codes that are scheduled to go into effect in 2015. And the 3Q Journal focused on technology, and it included a feature article on the new technologies that are being used by hospitals in the state. MAG members are encouraged to contact Tom Kornegay at tkornegay@mag.org with advertising prospects for the Journal.

MAG continues to distribute its e-News from MAG newsletter to more than 4,400 members 11 times a year. The editorial content addresses a variety of legislative/regulatory, third party payer, practice management, and other issues.

MAG distributed its e-News from the Capitol report on a weekly basis during the legislative session. It also posted updates on its @MAG1849 Twitter account on a daily basis throughout the session.

MAG is now distributing the Georgia Pulse media highlights report to more than 11,000 subscribers on a weekly basis.
Since the HOD met in 2013, MAG distributed a press release that recognized Georgia Speaker David Ralston for receiving MAG’s “Friend of Medicine Award.” MAG also distributed a press release to publicize a report that confirmed that physicians/medical practices are an essential part of Georgia’s economy (e.g., accounting for nearly $30 billion in economic output in 2012). And MAG distributed a press release to express the organization’s conditional support for a bill to repeal or replace the Medicare SGR, as well as a press release to express MAG’s support for state legislation to expand Georgia’s medical marijuana law.

MAG has hosted a series of town hall conference calls in the last year, including ones addressing the Medicare SGR (with Sidney Welch), employed physician arrangements (with the Physicians Advocacy Institute), a POLST and other end-of-life issues, Blue Cross and Blue Shield of Georgia recoupment issues, workers’ compensation, and HIPAA-compliant risk assessments. MAG has leveraged this program by promoting the availability of recordings of the town halls on its website and in its e-News from MAG newsletter. The town halls are offered to MAG members at no cost with a grant from Health Care Research, a subsidiary of Alliant Health Solutions.

MAG distributed a number of alerts during 2014, including one that promoted the creation of a MAG-sponsored VA physician registry in Georgia, one that addressed the State Health Benefits Plan, one that addressed UnitedHealthcare’s physician network, and several that addressed Blue Cross and Blue Shield of Georgia’s policies and procedures for claims. MAG also has distributed alerts addressing the primary election in the state, federal legislation (i.e., Medicare SGR), and state legislation (S.B. 134, S.B. 85, H.B. 885 and medical marijuana) during 2014.

MAG also distributed several surveys in 2014, including one on telemedicine, one on the aforementioned VA registry, one on physicians’ issues that was sent on behalf of the Physicians Foundation, one to rate health insurers in Georgia, and one that addressed MAG’s legislative priorities.

MAG’s Communications Department worked with MAG’s Membership Department to develop a one-page MAG overview/accomplishments fact sheet that’s being used for recruiting purposes, as well as new MAG membership renewal postcards and a new brochure to encourage physicians to join MAG or renew their membership.

MAG assisted the MAG Foundation with several communications resources, including its newsletters, alerts, and several press releases promoting its ‘Think About It’ campaign to reduce prescription drug abuse in the state. MAG also helped the MAG Foundation develop an informational leaflet that is being distributed by more than 600 pharmacies and clinics in the state. And MAG worked with the MAG Foundation to update its www.mag.org/organizations/mag-foundation website page.


# # #
The Department of Membership and Marketing is responsible for providing direct support and services to Medical Association of Georgia members, and developing recruitment and retention programs to attract physicians and medical students into the federation of organized medicine.

I am very pleased to present this report to the House of Delegates (HOD). As you will see, the department has been extremely active this year in promoting membership as a top priority of the Association. As a result, MAG membership is now at its highest level in 17 years. This equals more than a 27 percent increase in membership since 2010.

The 2014 membership year began October 15, 2013 with the first mailing of the dues statement. This mailing was sent to more than 14,000 member and non-member physicians in Georgia. Additional mailings were sent in November, January, March, and April. Email reminders were sent frequently to all renewing physicians. A chart listing completed marketing tactics is below.
The membership department also utilized several different recruitment and retention methods including, but not limited to:

- **Redesign of MAG Materials:** For the first time in many years, the membership department did a complete overhaul of the envelopes and dues statements sent to renewing physicians. The new envelopes increase MAG brand awareness. They are half the size of last year’s envelope, which reduces costs on both printing and postage. MAG also included an insert card briefly describing the benefits of membership and encouraging them to visit the MAG website for more information.

- **Staff Phone Calls:** Instead of using Comnet telemarketing service, MAG’s membership coordinator, Lesley Kent made phone calls to 125 physicians’ offices reminding them that their memberships needed to be renewed. These phone calls were received well with 186 renewals. She spoke directly with the office managers who were very appreciative of the reminder call. Several of the office managers explained that they had forgotten to pay or were planning on paying the dues soon. Some office managers requested group invoices versus individual invoices because they are easier to keep track of. Overall, this membership renewal phone call tactic was much more effective than using Comnet in years past.

- **Postcard Campaign:** MAG’s 2014 marketing campaign features member testimonials on why their membership is important. A series of six postcards, each featuring a different MAG member, were sent to non-renewed physicians. Each postcard featured a QR code that physicians may scan that takes them directly to MAG’s online renewal page.

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<td>9/2/2013</td>
<td>February postcard</td>
<td>2/3/2014</td>
</tr>
<tr>
<td>October postcard</td>
<td>10/3/2013</td>
<td>Renew before expire email</td>
<td>2/19/2014</td>
</tr>
<tr>
<td>Dues billing - 1</td>
<td>Before HOD</td>
<td>Dues billing - 4</td>
<td>3/4/2014</td>
</tr>
<tr>
<td>Ways to renew email</td>
<td>10/25/2013</td>
<td>March postcard</td>
<td>3/3/2014</td>
</tr>
<tr>
<td>Ways to renew email</td>
<td>11/14/2013</td>
<td>Your membership has expired email</td>
<td>3/21/2014</td>
</tr>
<tr>
<td>Dues billing - 2</td>
<td>11/15/2013</td>
<td>Dues billing - 5</td>
<td>4/9/2014</td>
</tr>
<tr>
<td>December postcard</td>
<td>12/2/2013</td>
<td>Email from Donald to expired delegates</td>
<td>4/10/2014</td>
</tr>
<tr>
<td>Dr. Shah letter to IMGs</td>
<td>12/11/2013</td>
<td>Email from Donald to new members</td>
<td>4/10/2014</td>
</tr>
<tr>
<td>Ways to renew email</td>
<td>12/12/2013</td>
<td>Renewal phone calls</td>
<td>March - April</td>
</tr>
<tr>
<td>Renew for tax deduction email</td>
<td>12/26/2013</td>
<td>Renewal reminder with key accomplishments</td>
<td>6/10/2014</td>
</tr>
<tr>
<td>January postcard</td>
<td>1/6/2014</td>
<td>Emory resident event</td>
<td>6/26-6/27/2014</td>
</tr>
<tr>
<td>Dues billing - 3</td>
<td>1/14/2014</td>
<td>Exit Survey</td>
<td>7/2/2014</td>
</tr>
<tr>
<td>Renew before delinquent email</td>
<td>1/22/2014</td>
<td>Exit survey reminder</td>
<td>7/14/2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MCG student recruitment</td>
<td>8/15/14</td>
</tr>
</tbody>
</table>
• **Expansion of MAG’s Group Membership Program:** Throughout the year, Donald Palmisano and membership staff visited several large groups across the state to promote MAG membership. In a recent survey by the Georgia Board of Physician Workforce, 77 percent of GME graduates reported their confirmed practice setting was in a group practice or hospital. Given the fact that Georgia’s new physicians are choosing group/employed settings for their practice at an increasing rate, we’ve found that offering MAG member group discounts serves as the top source for recruiting new members and retention of existing members while simultaneously increasing our market share.

**2014 Membership Statistics**

The membership department had two simple goals for the year. The first was to achieve $1,875,000 in dues revenue for the year. The second was to increase active membership over 2014 totals. I am happy to report that we achieved our budget goal. While we have not yet achieved an increase over 2013 Actives, we remain hopeful that in this final month of 2014 membership, we will see an increase. Charts detailing our progress are below. Please note that all 2014 data reflects membership figures as of August 31, and do not represent year end totals.

**Dues Revenue:** The membership department budgeted 2014 dues revenue at $1,875,000. To date we have collected $2,003,883.50, which is $128,883.50 more than our goal.
Collected Dues Revenue: Below is 2014 year-to-date dues revenue versus previous years. To date, MAG has collected $49,074 less than 2013.

New Members: During 2009 and 2010 we experienced a significant decrease in the number of new members. Due to the fact that our core members are aging and often retiring at an earlier age, it became crucial that we find a way to increase the number of new members. We have been successful in changing this trend by adding 763 new members in the 2014 dues year. This brings us to a new member increase of 3,142 physicians in the last four years.
**Second Year Members:** As we continue to increase the number of new members each year, the second year member category becomes an important one to watch. It is essential that once we get new members, that we retain them. For the 2014 dues year we have 736 second year members.

![Second Year Members as of August 31, 2009-2014](chart)

**Third Year and Plus Members:** This category is quite possibly the most important. We have found that by the time a physician has been a member for at least three years, they will most likely be a member for quite some time. This category is also pivotal as membership dues increase to $500. We currently have 3,792 third year or more members, which is an increase of 168 members over 2013.

![Third Year+ Members as of August 31, 2009-2014](chart)
Total Membership: While we often stress the importance of our Active membership base, MAG has several other categories of membership that are combined to form our total membership number. Our increased focus during 2014 on these other categories such as students and first year free has paid off by bringing the 2014 total membership number to 7,526, which is an increase of 114 over 2013.
**Membership Figures:** Below is a chart comparing all aspects of MAG’s membership in 2014 versus previous years. Please note that the figures below are year-to-date membership comparisons through August 31 whereas the above charts compare 2014 year-to-date versus final end-of-year figures for previous years.

### 2014 Membership Figures
As of August 31, 2014

<table>
<thead>
<tr>
<th>TOTAL ALL CATEGORIES</th>
<th>2011 YTD</th>
<th>2012 YTD</th>
<th>2013 YTD</th>
<th>2014 YTD</th>
<th>+/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Members</td>
<td>248</td>
<td>193</td>
<td>637</td>
<td>858</td>
<td>884</td>
</tr>
<tr>
<td>2nd Year</td>
<td>456</td>
<td>257</td>
<td>222</td>
<td>667</td>
<td>794</td>
</tr>
<tr>
<td>Actives</td>
<td>3449</td>
<td>3471</td>
<td>3408</td>
<td>3360</td>
<td>3624</td>
</tr>
<tr>
<td>Total Active Dues Paying Members</td>
<td>4153</td>
<td>3921</td>
<td>4267</td>
<td>4885</td>
<td>5302</td>
</tr>
</tbody>
</table>

### ACTIVE MEMBERSHIP COMPARISON

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Members</td>
<td>637</td>
<td>858</td>
<td>884</td>
<td>763</td>
</tr>
<tr>
<td>Other Actives</td>
<td>3630</td>
<td>4027</td>
<td>4418</td>
<td>4528</td>
</tr>
<tr>
<td>Total Dues Revenue (all categories)</td>
<td>$1,832,121</td>
<td>$1,943,169</td>
<td>$2,052,957.50</td>
<td>$2,003,883.50</td>
</tr>
</tbody>
</table>
### Membership Categories Retention Rates

<table>
<thead>
<tr>
<th></th>
<th>2013 Total</th>
<th>2014 YTD</th>
<th>% Retained</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014A2s</strong></td>
<td>884</td>
<td>736</td>
<td><strong>83.25</strong></td>
</tr>
<tr>
<td><strong>2014ACT</strong></td>
<td>4426</td>
<td>3782</td>
<td><strong>85.45</strong></td>
</tr>
</tbody>
</table>

### Other Categories of Membership

<table>
<thead>
<tr>
<th></th>
<th>2009 Total</th>
<th>2010 Total</th>
<th>2011 Total</th>
<th>2012 Total</th>
<th>2013 YTD</th>
<th>2014 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Free</strong></td>
<td>832</td>
<td>1069</td>
<td>1350</td>
<td>1131</td>
<td>1060</td>
<td>1311</td>
</tr>
<tr>
<td><strong>Exempt</strong></td>
<td>9</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Affiliate</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Int/Res</strong></td>
<td>101</td>
<td>11</td>
<td>12</td>
<td>5</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td><strong>Associate</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Honorary</strong></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td><strong>Life</strong></td>
<td>370</td>
<td>438</td>
<td>389</td>
<td>379</td>
<td>357</td>
<td>358</td>
</tr>
<tr>
<td><strong>Retired</strong></td>
<td>167</td>
<td>151</td>
<td>151</td>
<td>149</td>
<td>141</td>
<td>140</td>
</tr>
<tr>
<td><strong>Service</strong></td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>20</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td><strong>Students</strong></td>
<td>448</td>
<td>178</td>
<td>310</td>
<td>470</td>
<td>464</td>
<td>393</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1950</strong></td>
<td><strong>1877</strong></td>
<td><strong>2235</strong></td>
<td><strong>2162</strong></td>
<td><strong>2055</strong></td>
<td><strong>2235</strong></td>
</tr>
</tbody>
</table>
CMS Relations

The path to positive and effective relationships with component societies is paved with frequent communication and promotion of membership on a two-way level. In an effort to provide more detailed information on the activities of MAG headquarters to county medical societies (CMS), the executive director holds conference calls with the CMS executives to share information between MAG and CMSs and to provide a forum for CMS executives to discuss issues among themselves.

We’ve heard from several small CMSs over the previous years about the difficulties they have in maintaining a functioning CMS. As a result, MAG recently hired Daphaney Willis to be a resource to help CMSs in the state prosper and grow and, in some instances, become rejuvenated. With that in mind, MAG – with input from physician leaders from across the state – developed a list of services that it is making available to CMSs in Georgia. These optional services include…

- Listing CMS dues on MAG’s billing statements and collecting those dues
- Producing monthly CMS and MAG member rosters and expired membership lists
- Providing CMS member/non-member demographic information
- Creating CMS-branded marketing resources (e.g., letterhead) and email accounts and membership applications
- Providing meeting planning assistance, including location selection, sponsorship acquisition, RSVP tracking, budgeting, and logistics (e.g., A/V, meals)
- Promoting CMS events and meetings with mailings
- Securing speakers for CMS meetings
- Assisting CMS with elections

For years, MAG staff has attended virtually every meeting to which they have been invited, and some to which they affirmatively sought an invitation. The department sends out a list of scheduled CMS and specialty society meetings monthly and asks MAG leaders to schedule attendance.

2015 Membership Year

The 2015 membership year will begin this October with the mailing of the first dues statement. Be on the lookout for your statement! To pay your 2015 MAG dues, contact Lesley Kent at 678.303.6261.

# # #
GEORGIA PHYSICIANS LEADERSHIP ACADEMY

SUBJECT: Annual Report

SUBMITTED BY: S. William Clark III, M.D.

REFERRED TO: Not Referred

2014 Report to the MAG House of Delegates

It is a pleasure to submit this report on the status of the Georgia Physicians Leadership Academy (GPLA). The GPLA is a vigorous program of the MAG Foundation, funded primarily by designated contributions from GPLA alumni and MAG leaders with institutional support from the Physicians’ Institute for Excellence in Medicine and MAG.

The mission of the academy is to provide rising and future physician leaders with enhanced leadership skills. Our curriculum focuses on: 1) mastering communication skills, 2) improving advocacy expertise and 3) developing strategies for negotiating conflict resolution. An important element of the academy is fostering personal relationships with other colleagues who will lead Georgia medical organizations in the future.

The GPLA’s seventh class first met in conjunction with the MAG BOD in May 2014. With its graduation next spring, the academy will have trained 88 MAG physician members from across our state.

Nominations for each class are accepted beginning in November. Candidates must be MAG members who are nominated by their specialty or county medical society. The nominating organization is asked to pay the $1,000 tuition fee that is used to partially underwrite lodging, meals, speakers, and class materials. Transportation costs are the responsibility of attendees.

The GPLA is dependent upon and grateful for continuing financial support from our alumni and MAG leadership. In spring 2012, the GPLA applied for a leadership grant from The Physicians Foundation’s Medical Practice Support Needs grants program and that proposal was denied. We applied again in the next grant cycle and in January 2013 the GPLA was awarded a grant of $75,000 to support the next two GPLA classes, to enhance the curriculum and to develop a fundraising campaign that will ensure and endow the future of the academy. As the result, the Steering Committee has recently approved the launch of an aggressive endowment campaign, which will be initiated at the 2014 MAG HOD.

Dean Robert L. Addleton, EdD, continues as lead faculty and the GPLA curriculum was approved for 26 CME credits with joint sponsorship of the Physicians’ Institute for Excellence in Medicine.

This in-depth, interactive, year-long program stretches over six sessions. The current curriculum is outlined below:

• Session 1. May 3-4, 2014: “Orientation and Self Assessment and Leadership Strategies”
• Session 2. August 16-17, 2014: “Media, Communication and Collaboration in the Medical Environment” St. Simons Island, GA
• Annual GPLA Reception: October 17, 2014: GPLA Alumni Reception dinner at MAG House of Delegates
Leadership Project

All academy class members commit to completing a personal leadership project to benefit their patients, communities, and/or sponsoring medical societies during their class year. Project examples include: planning a membership drive, presenting a health awareness and/or patient education program for the local community. As they progress, physicians may request support from mentors and GPLA faculty and staff as needed.

GPLA Inaugural Class

Scott Bohlke, M.D., Family Physician, Brooklet
Jacqueline Fincher, M.D., Internal Medicine, Thomson
Pan Gallup, M.D., OB/GYN, Savannah
Jeffrey Grossman, M.D., PM & R, Pain Management, Atlanta
Mark Hanly, M.D., Pathologist, Brunswick
Joel Higgins, M.D., OB/GYN, Wyoming
Craig Kubik, D.O., Gastroenterology, Waycross
Howard Maziar, M.D., Psychiatry, Atlanta
Howard McMahan, M.D., Family Physician, Ocilla
David Oliver, M.D., Otolaryngology, Savannah
Andrew Reisman, M.D., Family Physician, Oakwood
Manoj Shah, M.D., OB/GYN, Warner Robins
Marc Wetherington, M.D., Plastic Surgery, Rome

GPLA Class II

James Barber, M.D., Orthopaedics, Douglas
Florence Barnett, M.D., Neurosurgery, Johns Creek
Gloria Campbell-D'Hue, M.D., Dermatology, Atlanta
Bob Jones, M.D., Family Physician, Macon
Sudhakar Jonnalagadda, M.D., Gastroenterology, Douglas
Howard Odom, M.D., Anesthesiology, Canton
Lisa Perry-Gilkes, M.D., Otolaryngology, East Point
John Rogers, M.D., Emergency Medicine, Macon
Angela Shannon, M.D., Psychiatry, Stockbridge
Jules Toraya, M.D., OB/GYN, Savannah
Clyde Watkins, M.D., Internal Medicine, Atlanta

GPLA Class III

Gregorio Abad, M.D., PM&R, Dublin
Santanu Das, M.D., Pediatrics, Warner Robins
Paula Gregory, D.O., Family Physician, Atlanta
Anuj Gupta, M.D., Orthopaedics, Atlanta
Albert Johary, M.D., Internal Medicine, Atlanta
Indran Krishnan, M.D., Gastroenterology, McDonough
Bob Lane, M.D., Anesthesiology, Macon
Cody McClatchey, M.D., Internal Medicine, Atlanta
Charles Moore, M.D., Otolaryngology, Atlanta
Pravinchandra Patel, M.D., Gastroenterology, Columbus
Geoffrey Simon, M.D., Pediatrics, Delaware
Harry Strothers, M.D., Family Physician, Atlanta
Matthew Watson, M.D., Emergency Medicine, Atlanta
Edward Young, M.D., Hospitalist, Macon

GPLA Class IV

David Bogorad, M.D., Ophthalmology, Augusta
Snehal Dalal, M.D., Orthopaedics, Lawrenceville
Madalyn Davidoff, M.D., Cardiology, Warner Robins
Joyce Doyle, M.D., Internal Medicine, Atlanta
Sreeni Gangasani, M.D., Cardiology, Lawrenceville* finishing with Class V
Beulette Hooks, M.D., Family Physician, Midland
Karen Lovett, M.D., Radiology, Albany
Angela Mattke, M.D., Emergency Medicine, Atlanta
Frank McDonald, M.D., Neurology, Gainesville
Margaret Schaufler, M.D., OB/GYN, LaGrange
Sumayah Taliaferro, M.D., Dermatology, Atlanta

GPLA Class V

Victoria Clements, D.O., Pediatrician, Toccoa
Mitch Cook, D.O., Family Medicine, Athens
Edmund Donoghue, M.D., Forensic Pathology, Savannah
Sreeni Gangasani, M.D., Cardiology, Lawrenceville
Michael Groves, M.D., Otolaryngology, Augusta
Stephen Jarrard, M.D., General Surgery, Lakemont
Robert “Bo” Lewis, M.D., Orthopaedics, Columbus
Natrajan Puthugramam, M.D., Reproductive Endocrinology, Augusta
Danny Newman, M.D., Internal Medicine, Augusta
James Velimesis, M.D., Anesthesiology, Milton
Michelle Zeanah, M.D., Pediatrics, Statesboro

GPLA Class VI

Abhishek Gaur, M.D., Cardiology, Gainesville
Keith Johnson, M.D., Anesthesiology, Waycross
Aysha Khoury, M.D., Internal Medicine, Atlanta
McGregor Lott, M.D., Ophthalmology, Waycross
Elizabeth Morgan, M.D., Plastic Surgery, Atlanta
Brian Nadolne, M.D., Family Medicine, Roswell
Henry Patton, M.D., Internal Medicine, Covington
Carla Roberts, M.D., OB/GYN, Atlanta
Randy Ruark, M.D., Orthopaedics, Augusta
Rob Schreiner, M.D., Critical Care, Atlanta
Thekkepat Sekhar, M.D., OB/GYN, Warner Robins
John Sy, D.O., Emergency Medicine, Savannah
Charles Wilmer, M.D., Cardiology, Atlanta

**GPLA Class VII**

Eric Awad, M.D., Neurology, Atlanta
Amanda Brown, M.D., Anesthesiology, Macon
Thomas Emerson, M.D., Urology, Marietta
Rutledge Forney, M.D., Dermatology, Atlanta
Wayne Hoffman, M.D., Family Medicine, Atlanta
Matt Lyon, M.D., Emergency Medicine, Augusta
Adrienne Mims, M.D., Family Medicine, Atlanta
Walt Moore, M.D., Rheumatology, Augusta
Piyush Patel, M.D., Family Medicine, Columbus
Purnima Patel, M.D., Ophthalmology, Atlanta
Ali Rahimi, M.D., Cardiology, Marietta
J Smith, M.D., Emergency Medicine, Atlanta
Vijaya Vella, M.D., OB/GYN, Warner Robins
Steven Walsh, M.D., Anesthesiology, Atlanta

The graphic below shows the specialty and geographic distribution of participants from all GPLA Classes. Please help us accomplish the academy’s mission by making nominations for the missing county medical and specialty societies.
The GPLA Steering Committee expresses particular appreciation to our faculty and staff:

Bob Addleton, EdD, Dean and Lead Faculty
Susan Reichman, BSN, GPLA Administrator
Fred Jones, MAG Foundation Director
Lori Cassity Murphy, Program and Development Director, MAG Foundation
Donald J. Palmisano Jr., MAG Executive Director/CEO
2014 GPLA Steering Committee Members:

- John Antalis, M.D., MAG Foundation Board
- Jim Barber, M.D., Class 2 representative
- Jack Chapman, M.D., MAG Foundation Board
- Madalyn Davidoff, M.D., Class 4 representative
- Jacqueline Fincher, M.D., Class 1 representative
- Mike Greene, M.D., Chair, Council on Legislation
- Stephen Jarrard, M.D., Class 5 representative
- Joy Maxey, M.D., MAG Leadership
- Donald J. Palmisano Jr., MAG Executive Director and CEO
- Manoj Shah, M.D., MAG President-elect
- William Silver, M.D., MAG President
- Johnny Sy, D.O., Class 6 representative
- Eddy Young, M.D., Class 3 representative

# # #
The Physicians’ Institute for Excellence in Medicine (Physicians’ Institute) is a 501(c) 3 subsidiary of the Medical Association of Georgia (MAG). The Physicians’ Institute focuses on outcomes-based education, performance improvement activities, and consulting to support physicians and their teams. The Physicians’ Institute has directed efforts toward meeting its mission of improving patient safety and achieving clinical improvements for physicians and their patients.

Staff for the Physicians’ Institute includes Bob Addleton, Executive Vice President and Adele Cohen, Senior Vice President for Grants and Operations.

**CME Collaborative Educational Grants**

The Physicians’ Institute is a national leader in developing and managing collaborative educational projects that provide managed educational grants and projects to continuing medical education (CME) providers, with a focus on outcomes-based and performance improvement activities. To date, the Physicians’ Institute has developed and managed 38 initiatives and activities located in 25 states focusing on an array of clinical areas.

To support this national development, Bob Addleton continues to be involved in CME leadership activities at the national level. A 2012 research study indicated that Bob was the most networked person in CME, and Bob has been elected VP (President-elect) of the national CME organization for 2015.

Many of the Physicians’ Institute initiatives utilize the Collaborative Grants Model™, which awards secondary grants to CME providers featuring integrated evaluation services, educational design consultation, project management, and aggregate outcome reports. Depending upon the project, standardized curriculum, monographs, video-based content including simulated patients, and audio-visual services may be provided. The Physicians’ Institute has a website that includes educational videos, related resources, and report summaries at [www.physiciansinstitute.org](http://www.physiciansinstitute.org).

During the past year, the Physicians’ Institute completed the following projects:

- **Partnership for Adult Vaccination and Education (PAVE)**
  As a part of national collaborative, PAVE received an educational grant from GlaxoSmithKline to increase the number of eligible persons who receive all of the adult vaccines currently recommended by the U.S. Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP). The Physicians’ Institute supported eight organizations offering CME activities in addition to a subset of physicians participating in the performance improvement component of the project. An array of resources were developed and provided to participants.
• Improving the Primary Care Treatment of Atrial Fibrillation – Block Grants, AHME and AAPA
As part of a national collaborative, the Atrial Fibrillation initiative received three educational grants from the Bristol-Myers Squibb/Pfizer Partnership to focus on three separate audiences. The mission of The Evolution of Anticoagulation Management (TEAM) initiative is to reduce stroke, pulmonary embolism, and other complications associated with thrombus formation through effective continuing education that results in optimal anticoagulation management targeting primary care physicians and their teams. As part of this national initiative, the Physicians’ Institute managed three components with more than 50 educational activities in more than 18 states.

• Patient Centered Medical Home – Phase 2
In Phase 2, the Physicians’ Institute provided consulting services to support the Georgia Academy of Family Physicians’ Patient Centered Medical Home University in support of 10 Georgia physician practices. Services included serving as faculty for educational collaborative and coaching individual practices.

• Opioid Education based on FDA Curriculum – State Medical Societies and AHME
The Physicians’ Institute is one of very few organizations that received support through an FDA educational initiative regarding long acting extended release opioids for prescribers. All pharmaceutical manufacturers of opioids have been required to contribute to a fund to support CME activities that follow a mandated FDA-approved curriculum. The Physicians’ Institute received grant monies to manage two separate programs: 1) 15 State Medical Societies educational activities (including Georgia), and 2) 18 educational activities for hospital systems through the Association for Hospital Medical Education.

Current projects of the Physicians’ Institute include the following:

• Managing Chronic Pain through PCMH – A Pfizer Partnership
In September 2013, the Physicians’ Institute was selected by Pfizer for a partnership project that awarded collaborative grants to five state chapters of primary care specialty societies and primary care associations to manage performance improvement activities for 5-10 practices each related to improving the care of patients who experience chronic pain. The projects are taking place within a Patient Centered Medical Home context. This is the first project of its kind offered by the Physicians’ Institute and only the third partnership entered into by the medical grants office at Pfizer.

• Smoking Cessation Motivational Interviewing/Communications Training – Online Activity
The Physicians’ Institute developed a 10-part online CME activity, which is posted on the Doctors’ Channel with more than 3,000 Learner Completers.

• Adult Vaccinations Communications Training – Online Activity
The Physicians’ Institute developed a four-part online CME activity that includes additional resources for health care providers, which is posted on the Doctors’ Channel.

• Readmission Initiative – Collaboration with MAG
The Physicians’ Institute is working in partnership with MAG on a GHA supported projects focusing on Readmissions in three Georgia hospitals/physician practices.
Patient Centered Medical Home – Phase 3
In Phase 3, the Physicians’ Institute is providing consulting services to support the Georgia Academy of Family Physicians’ Patient Centered Medical Home University in support of Georgia physician practices. Services included providing faculty for educational collaborative and coaching individual practices.

Navicent Health System (formerly Central Georgia Health System)
Consulting on the development and launch for the Center for Learning and Innovation.

Opioid Education based on FDA Curriculum – Phase 2 – State Medical Societies
The Physicians’ Institute will continue this project by supporting and managing educational activities for 10 State Medical Societies.

Rheumatoid Arthritis
The Physicians’ Institute is collaborating with Educational Concepts Group to support educational activities at 10 locations nationwide.

CME Activities
The Institute provides continuing medical education for physicians based on its own activities and through a joint sponsorship program.

2014 CME and Joint Sponsorships include:

- Adult Vaccinations Communications Training – Online Activity
- Smoking Cessation Motivational Interviewing/Communications Training – Online Activity
- Crohn’s & Colitis Foundation
- MAG Foundation
- MAG House of Delegates
- Georgia Physicians Leadership Academy
- Rheumatology Journal Club of Augusta, RSS

Thanks to the members of the Physicians’ Institute Board of Directors for their continuing involvement and support with this endeavor during the past year:

John S. Antalis, M.D.
William A. Bornstein, M.D.
Jack M. Chapman Jr., M.D., Secretary
Madalyn Davidoff, M.D.
Howard M. Maziar, M.D.
Alan L. Plummer, M.D., Vice-President
John Rogers, M.D.
Richard S. Simmons, M.D.
Donald J. Palmisano Jr., MAG Executive Director/CEO, Treasurer

# # #
As always, we are happy to report to you on the progress and activities of the Physicians Foundation (PF).

As you know, we both serve as vice presidents of the PF and are on its five-member executive committee. Since we last reported to you in September 2013, there are many activities since then on which to report.

Our recently completed 2014 survey of physicians yielded an unprecedented 20,100 responses plus an additional 13,000 comments from those responders.

Key findings of the survey include:

- 46 percent of physicians give the Patient Protection and Affordable Care Act (PPACA) a “D or F” grade, while 25 percent give it an “A or B.”
- 81 percent of physicians describe themselves as either overextended or at full capacity, up from 75 percent in 2012 and 76 percent in 2008. Only 19 percent say they have time to see more patients.
- 39 percent of physicians indicate they will accelerate their retirement plans due to changes in the healthcare system.
  - Only 17 percent of physicians indicate they are in solo practice, down from 25 percent in 2012.
  - 72 percent of physicians believe there is a physician shortage; that more physicians should be trained, and the cap on funding for physician graduate medical education should be lifted.
  - Only 35 percent of physicians describe themselves as independent practice owners, down from 49 percent in 2012 and 62 percent in 2008.
  - Seven percent of physicians now practice some form of direct-pay/concierge medicine, while 13 percent indicate they are planning to transition in whole or in part to this type of practice. Seventeen percent of physicians age 45 or younger indicate they will transition into direct pay/concierge practice.

Inasmuch as the PF has not yet released this data to the media, we would appreciate you embargoing this information until October 1, 2014.

A report by Bostrom, commissioned by the PF and entitled “The Medicare Program: An Instrument for Change,” examines the Medicare program as a recent instrument of systemic reform and considers the associated implications for physicians and the broader healthcare system. It is available on the PF website at www.physiciansfoundation.org.
Bostrom will submit a new report in the late first quarter of 2015 outlining the impact of the November 2014 elections on PPACA as well as that of the coming U.S. Supreme Court decisions regarding the challenges to PPACA. This report will also be made available on the PF website at that time.

As Chair of the PF Grants Committee, Dr. Plummer has been deeply involved in a sizable grant awarded to the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill to develop a web-based project model that enables users to estimate physician supply and demand within a set geography and/or specialty.

This “Future Docs Forecasting Tool” estimates the supply of physicians, use of health care services, and capacity of physician supply to meet the health care services need in the U.S. The tool is an important and innovative step forward for health care workforce modeling because it is interactive, web based, and user friendly.

As Chair of the Research Committee, Dr. Ray has spearheaded a PF effort to have Richard “Buz” Cooper write a book entitled, “Healthcare Through the Lens of Poverty.” He is one of the world’s preeminent voices on physician supply and has long suggested that poverty has a very deleterious effect on one’s health and health care costs. We are expecting its publication in early 2015.

Another important activity for the PF has been its Physician Leadership Academy. This year in June, for the first time the Academy was moved to Duke University in Durham, North Carolina. The first few years of the Academy were held in conjunction with Northwestern University’s Kellogg School of Management in Evanston, Illinois. The transition from the Chicago area to North Carolina was very successful, but we did not particularly enjoy the 99 degree temperature for the three-day Academy!

The PF recently concluded some interesting patient/physician focus groups. Information derived will soon appear on our PF website. We both strongly endorsed the idea of doing a comprehensive patient survey in the odd years beginning in 2015 along the same lines as our even year physician surveys. This idea was passed by the PF Board at its recent August meeting.

We both are pleased to have the opportunity to represent MAG on the board of the Physicians Foundation. The work, although time consuming and arduous and intensive, is also rewarding. We are proud that we comprise a significant 40 percent representation on the executive committee of the board. Both of us remain deeply involved in practically all of the PF activities.

If anyone has any questions whatsoever about the Physicians Foundation, please do not hesitate to contact us.

Thank you for the opportunity to serve you, MAG members and the Physicians Foundation.

###
REPORTS OF COMMITTEES
It is an honor and pleasure to serve as Speaker of the House for the Medical Association of Georgia’s House of Delegates.

Your Committee on Annual Session is charged to carry out the approved policies of the association as they relate to the annual meeting as directed by the Board of Directors. It shall study and make recommendations concerning the Annual Session of the association. The committee is composed of officers of the association including Vice Speaker of the House, President, President-elect and Immediate Past President along with me as your Speaker of the House.

Since our last annual session, your committee has been actively involved in planning and organizing the 2014 House of Delegates. As approved last year, the annual session dates and location were determined by the Executive Committee to be Callaway Gardens, October 18-19, 2014.

The budget for HOD 2014 is $110,000. The budget for HOD 2013 was $110,000 with the total expenditures for HOD 2013 being $114,274.

We generated $34,680 in revenue from the sponsors and exhibitors.

The committee met on numerous occasions reviewing several proposals for 2015 and after careful review the Annual Session Committee has voted to hold your 161st Annual House of Delegates at the Hyatt Regency in Savannah on October 16-17, 2015.

Many thanks to the members of the 2013-2014 Annual Session Committee:

E. Frank McDonald Jr., M.D., Vice Speaker of the House
W. Scott Bohlke, M.D., President
William E. Silver, M.D., President-elect
Sandra B. Reed, M.D., Immediate Past President

MAG Staff:

Donald J. Palmisano Jr., Executive Director/CEO
Daphaney Willis, Manager of Membership Outreach & Meeting Planning

# # #
COMMITTEE ON COUNCIL ON LEGISLATION

Committee: 04.14

SUBJECT: Annual Report

SUBMITTED BY: Michael E. Greene, M.D., Chairman

REFERRED TO: Not Referred

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Charge of the Council

The Medical Association of Georgia’s (MAG) Council on Legislation (COL) was established to review legislation and to recommend policy positions to MAG’s policy-making bodies and to communicate MAG’s positions to legislators at the state and federal levels.

Summary of 2014 Regular General Assembly

The highlight of the 2014 legislative session revolves around the relationships that were strengthened and restored within the House of Medicine and with stakeholders on issues affecting health care for Georgians. MAG partnered with several groups on legislative initiatives that were signed into law including a bill that provides coverage for individuals seeking oral chemotherapy and legislation that provides tax incentives to physicians who serve as preceptors in underserved areas. This legislation was groundbreaking and received national attention from several other medical societies.

MAG worked with the specialty societies, the pharmaceutical industry and members of the State Health Benefit Plan to advance legislation that grants the authority to implement a pilot program for bariatric surgery.

While MAG’s landmark bill on transparency (Patient Consumer Protection Act) did not receive a vote in the House Rules Committee, we were able to work with all interested stakeholders (pro and against) to pen a version that was acceptable to most.

MAG tracked more than 400 bills during the biennial – spending a great deal of time working on issues related to Scope of Practice and the potential legal burdens that would fall on physicians’ practices related to referrals and e-discovery.

Legislative Activities

MAG priority: Preserving physician autonomy

Rep. Wendell Willard (R-Sandy Springs) introduced a bill (H.B. 830) that would have codified the definition for surgery in the state. MAG’s House of Delegates addressed this issue in 2013, so MAG and the Georgia Society of Ophthalmology were prepared to develop a definition for surgery had the bill advanced.

MAG position: Supported. Outcome: Did not pass.
Rep. Carl Rogers (R-Gainesville) introduced a “professional transparency” bill (H.B. 971) that would have required every health care professional in the state to wear a badge that includes their credentials and their official role (e.g., physician, PA, nurse) if they are interacting with a patient. MAG was the leading advocate for the bill.

**MAG position:** Supported. **Outcome:** Did not pass.

Sen. Chuck Hufstetler (R-Rome) introduced an “economic credentialing” bill (S.B. 360) that would have allowed individuals who are employed by one facility to have privileges at other medical facilities in order to address some concerns that are related to physician contracts and medical staff bylaws. MAG’s policy is consistent with the bill’s provisions.

**MAG position:** Supported. **Outcome:** Did not pass.

**MAG priority:** Protecting physician confidentiality

Rep. Tom Rice (R-Norcross) introduced a bill (H.B. 721) that would have allowed the Georgia Composite Medical Board to release information about physicians that is related to civil lawsuits.

**MAG position:** Opposed. **Outcome:** Did not pass.

**MAG priority:** Protecting physicians from liabilities

Rep. Ronnie Mabra (D-Atlanta) introduced a bill (H.B. 828) that would make it illegal to receive cash compensation for making referrals to attorneys or health care providers (i.e., “cappers or runners or steerers”) who solicit referrals at the scene of an automobile accident.

**MAG position:** Supported (with MAG-endorsed amendments). **Outcome:** Passed.

Sen. Brandon Beach (R-Alpharetta) introduced the “Patient’s Compensation Act” (S.B. 141) that would have replaced the state’s medical malpractice system with an “administrative compensation system” that would establish independent medical review panels that would evaluate patient injury claims – as well as a board to oversee the system, which would be funded by physicians and other health care providers. MAG opposed the bill because 1) it would increase claims and costs and 2) it would repeal the remaining provisions of the tort reform bill (S.B. 3) that passed in Georgia in 2005 and 3) it would be ruled unconstitutional. MAG’s Board of Directors voted to oppose the bill in 2013 and 2014. An identical version of the bill (H.B. 662) was also introduced by Rep. Mike Cheokas (R-Americus).

**MAG position:** Opposed. **Outcome:** Did not pass.

Sen. Josh McKoon (R-Columbus) and Sen. Willard introduced identical “e-discovery” bills (S.B. 354 and H.B. 643) that called for the state to evaluate new ways to exchange information that is related to lawsuits as parties prepare for litigation. MAG supported amendments that would have 1) reduced the burden of lawsuits on parties that aren’t directly involved in a lawsuit (i.e., when a party is asked to produce a document for the purposes of legal discovery, a printed copy would be acceptable) and 2) required the requesting party to bear the costs associated with producing those documents (e.g., retrieval, production, conversion, formatting).

**MAG position:** Supported. **Outcome:** Did not pass.
Sen. William Ligon (R-Brunswick) introduced a bill (S.B. 186) that would have allowed paramedics to consult with physicians before they transport mentally ill patients to emergency facilities.

**MAG position:** Supported (with MAG-endorsed amendments). **Outcome:** Did not pass.

**MAG priority:** Reinforcing the patient-physician relationship

A bill (S.B. 94) by Sen. Fran Millar (R-Atlanta) would have given advanced practice registered nurses (APRNs) the authority to order radiographic images. MAG worked with the Georgia Radiology Society to oppose this bill given patient safety and cost concerns associated with unnecessary radiographic procedures.

**MAG position:** Opposed. **Outcome:** Did not pass.

Sen. Millar also introduced a bill (S.B. 128) that would allow marriage and family therapists to diagnose. Following an in-depth task force review and a number of stakeholder meetings in 2013, MAG’s Board of Directors voted to oppose this measure during its meeting in January.

**MAG position:** Opposed. **Outcome:** Passed.

Sen. Dean Burke (R-Bainbridge) introduced a bill (S.B. 342) that would have required the Department of Public Health to inform health care providers of a patient’s HIV status.

**MAG position:** Supported. **Outcome:** Passed.

**MAG priority:** Increasing access to care

Rep. Lee Hawkins (R-Gainesville) introduced a bill (H.B. 943) that would allow patients who take oral medications to receive the same kind of health insurance as those who receive chemotherapy drugs on an intravenous basis. The measure was amended to include the provisions of a bill (H.B. 707) that would 1) prohibit state agencies, departments or political subdivisions from using state resources to expand the Medicaid program in the state and 2) prohibit the state from running an insurance exchange and/or accepting federal funds for the purpose of creating or running a state insurance exchange and 3) prohibit the Georgia Commissioner of Insurance from investigating or enforcing any alleged violations related to the federal health insurance requirements that are mandated by the Patient Protection and Affordable Care Act. MAG ended up opposing the bill because of its policy to support legislation that would enable the state to receive federal funds to expand the Medicaid program as long as patients are allowed to use those funds to obtain private health insurance.

**MAG position:** Supported H.B. 943 in its original form but opposed the bill once it was amended with H.B. 707 provisions. **Outcome:** Passed.

Rep. Katie Dempsey (R-Rome) introduced a bill (H.B. 511) that would allow the State Health Benefit Plan to conduct a one-year pilot program for state employees to have bariatric surgery. The pilot would be used to develop the criteria to establish what’s deemed “medically necessary” to determine who should qualify for the surgery. The pilot would be capped at 75 participants. MAG worked with the Georgia
Society of the American College of Surgeons and Johnson & Johnson’s pharmaceutical sector to support this bill.

**MAG position**: Supported. **Outcome**: Passed.

Rep. Allen Peake (R-Macon) introduced a bill (**H.B. 885**) that would have expanded the state’s law permitting the use of cannabidiol extract in strictly controlled research programs for patients who have cancer or glaucoma to patients who suffer from seizures. The bill was 100 percent consistent with MAG policy. MAG stressed that it condemns the use of marijuana (e.g., THC) for general or recreational use throughout the legislative session. H.B. 885 was amended to require health insurance policies that are sold in the state to cover behavioral therapy for children six and under who are diagnosed with autism.

**MAG position**: Supported the original bill. **Outcome**: Did not pass. (Note: *The Atlanta Journal-Constitution* has reported that Gov. Nathan Deal is exploring other options [e.g., an “executive order”] to enable Georgians to have access to the cannabidiol extract.)

Rep. Sharon Cooper (R-Marietta) introduced a bill (**H.B. 965**) that would provide immunity to any person who 1) seeks medical assistance for someone who is experiencing a drug overdose or 2) is experiencing a drug overdose and seeks medical assistance (i.e., they would not be arrested, charged, or prosecuted for a drug violation).

**MAG position**: Supported. **Outcome**: Passed.

Rep. Cooper also introduced the “Therapeutic Cannabidiol Research Act” (**H.B. 1107**) that would have established new standards for clinical trials to care for patients who are under the age of 21 who suffer from severe forms of epilepsy.

**MAG position**: Supported. **Outcome**: Did not pass.

Rep. David Stover (R-Newnan) introduced a bill (**H.B. 853**) that would have provided certificate of need (CON) exemptions for private mental health facilities. MAG policy calls for the repeal of CON.

**MAG position**: Supported. **Outcome**: Did not pass.

Rep. Trey Kelley (R-Cedartown) introduced a bill (**H.B. 910**) that would have allowed the Georgia Department of Community Health (DCH) to approve a “medical-legal partnership” – a program that is conducted or established by a non-profit entity through a collaboration pursuant to a written agreement between one or more medical service providers and one or more legal services programs, including those based within a law school, to provide legal services without charge to assist income-eligible individuals and their families in resolving legal matters or other needs that have an impact on the health of such individuals and families).

**MAG position**: Neutral. **Outcome**: Did not pass.

Rep. Matt Hatchett (R-Dublin) introduced a bill (**H.B. 998**) that would fund medical scholarships and loans for primary care physicians who practice in rural and underserved areas in the state as determined by the Georgia Composite Medical Board. The bill reads that, “For each year of practicing his or her profession in such board approved location, the applicant shall receive credit for the amount of the scholarship received during any one year in medical school.”

**MAG position**: Supported. **Outcome**: Passed.
Sen. McKoon introduced a bill (S.B. 173) that would have established an objective standard to profile and measure physician performance and results – as well as an appeals process for physicians.

**MAG position:** Supported. **Outcome:** Did not pass.

Sen. David Lucas (D-Macon) introduced a bill (S.B. 338) that would have exempted emergency medical facilities from the state’s Certificate of Need (CON) requirements. MAG has policy that supports legislative efforts to repeal the state’s CON requirements.

**MAG position:** Supported. **Outcome:** Did not pass.

Sen. Don Balfour (R-Snellville) introduced a bill (S.B. 391) that would require every medical facility in the state to make a “good faith” effort to become certified by TRICARE (i.e., the U.S. military’s health care program) – though those facilities would not be required to join the TRICARE network. The bill, which does not apply to ambulatory surgery centers, was amended to include the provisions of H.B. 922 – which would provide a tax deduction for certain medical clerkships as a way to get medical faculty in the state to serve as preceptors for young people who have an interest in a career in the health care field (e.g., prospective physicians, PAs, nurse practitioners).

**MAG position:** Supported. **Outcome:** Passed.

MAG priority: Preserving the “Medical Home”

S.B. 85 by Sen. Charlie Bethel (R-Dalton) and H.B 1081 by Rep. Jason Shaw (R-Lakeland) were identical bills that would have allowed pharmacists to administer every vaccine under a blanket protocol (i.e., a patient could get any vaccine from any pharmacist without a physician’s prescription). MAG believes the measures would have given pharmacists too much latitude and would have undermined the patient’s primary care (i.e., their “medical home”). MAG has policy that calls for opposing legislation that contains this provision.

**MAG position:** Opposed. **Outcome:** Did not pass.

**Prescription Drug Monitoring Program**

Sen. Buddy Carter (R-Pooler) introduced a bill (S.B. 134) that would allow information from the Georgia Prescription Drug Monitoring Program to be shared across state lines. MAG opposed amendments to the bill that would have given pharmacists the authority to administer all vaccines to adults under a blanket protocol (i.e., the S.B. 85 provisions); MAG assumed a neutral position on the bill once that language was removed.

**MAG position:** Neutral. **Outcome:** Passed.

**Budget**

State lawmakers passed a $20.8 billion budget (H.B. 744) for the 2015 fiscal year that included several issues that will affect physicians, including…

- A $6.8 million (combined) increase in operating grants for the Mercer University School of Medicine and the Morehouse University School of Medicine;

Committee: 04.14
• $2 million for the Georgia Board of Regents’ “Health Professions Initiative” to fund residencies and address fund graduate medical education;

• Nearly $641,000 for eight additional family medicine residency slots at the Gwinnett Medical Center (five) and the Houston Medical Center (three);

• Nearly $500,000 to increase the amount of “Georgia Physician Workforce Board” residency grants by $333 per resident;

• A $300,000 increase for “Area Health Education Centers” in the state for housing for medical students who are serving in six-week rural, primary care rotations;

• $200,000 for 10 additional loan payment rewards for the Georgia Board of Physician Workforce’s “Physicians for Rural Areas” program;

• Nearly $32,000 for a new medical student capitation contract for five certified Georgia residencies at the Georgia Campus – Philadelphia College of Osteopathic Medicine; and

• A little more than $115,000 for the Georgia Composite Medical Board to implement the pain management licensure program that was created during the legislative session in 2013.

Physicians’ Day at the Capitol

MAG and other specialty societies (including the Georgia Society of Ophthalmology, Georgia Psychiatric Physicians Association, Georgia Orthopaedic Society, Georgia Society of Dermatology, Georgia Society of Anesthesiologists, and Georgia Radiological Society) will host a day at the Capitol on January 28, 2015. Additionally, we will host a luncheon where physicians are encouraged to invite their legislators to attend.

Due to inclement weather, the 2014 Physicians’ Day at the Capitol was cancelled on Wednesday, January 29.

Legislative Study Committees

The Medical Association of Georgia is actively monitoring all of the Legislative Study Committees and has offered itself as a resource to support their efforts. MAG has put a call out to its members to testify at hearings held across the state.

A. Credentialing by Care Maintenance Organizations

Physician/Senator Dean Burke is chairing the Study Committee examining the practice of credentialing by CMOs. The work of this committee is important because it will develop recommendations on developing a more streamlined process to ensure physicians are able to provide services and reduce some of the administrative burden.

B. Violence Against Health Care Workers

Health care providers are often placed in harm’s way when mentally ill and instable individuals come into emergency rooms and other health care facilities under the influence of substances. Chairwoman Katie Dempsey is overseeing the special committee addressing violent acts that have been committed against healthcare workers and the risk involved in their jobs.
C. Medical Education
Chairman Butch Parrish, is leading the study committee exploring options for medical education and physician recruitment and retention in the Georgia. This committee has begun its work by highlighting the need for physicians in underserved areas and within specialties that are essential to the medical community (e.g. several counties in Georgia do not have an OB/GYN).

D. Medical Cannabis
Last year the General Assembly considered legislation that would have allowed families of children with seizure disorders to have access to Cannabidiol oil. MAG has strict policy supporting the use of cannabis for medical disorders provided that it is administered in highly controlled academic settings. MAG vehemently opposes the cannabis use for recreational purposes.

MAG member Matthews Gwynn, M.D. serves as a member on this study committee.

###
The objective of the Committee on Continuing Medical Education has been to make sure that the Medical Association of Georgia’s (MAG) accredited organizations offer quality, meaningful education to Georgia physicians and to ensure that physicians receive the AMA PRA Category 1 Credit™ they need to renew licenses, maintain Board certifications and to retain privileges at hospitals.

Charge of the Committee on Continuing Medical Education

The Committee on Continuing Medical Education (CME) is a special committee of MAG charged with the responsibility of accrediting organizations that desire to provide accredited continuing medical education (CME) activities to Georgia physicians. The CME reviews and approves applications for accreditation and reaccreditation, establishes accreditation policies, provides supervision and guidance to surveyors and holds periodic training sessions for staff of accredited organizations. The CME keeps all accredited organizations updated concerning MAG, Accreditation Council for Continuing Medical Education (ACCME) and American Medical Association (AMA) requirements and policies related to CME.

Accomplishments

During the past year MAG’s Department of Education has continued to build upon the accomplishments of the past with continued focus on distributing information to MAG’s accredited CME providers.

Accomplishments throughout the year have included:

Accreditation Services: There are 39 MAG accredited CME providers. MAG continues to work with accredited CME providers to provide resources that will help them adhere to the ACCME’s Accreditation Criteria. The Criteria lends itself to CME involvement in performance improvement measures, point of care and competency educational endeavors.

CME accreditation surveys continue to be managed by a group of specially trained physician surveyors with the support of one MAG staff member. The primary duties of the MAG Committee on CME are to set policy, make accreditation and reaccreditation decisions and give input to our recognition from ACCME to accredit our state providers.

An extended thank you goes out to the members of the CME. The CME meets a minimum of four times a year. This year our meetings were held on February 19, May 7 and August 6. The final meeting for 2014 is scheduled for November 5.

MAG’s physician surveyors spend a great amount of time reading the applications for accreditation and reaccreditation, reviewing CME activity files and attending the site survey visits of each applicant. Our special thanks go to them for all of their efforts and time given to accomplish these tasks.
Committee on Continuing Medical Education members:

Darrell L. Dean, D.O.
Kimberly W. Megow, M.D.
William E. Silver, M.D.
Wayne S. Mathews Jr., M.D.
Robert L. Addleton, Ed.D.

Physician surveyors:

Darrell L. Dean, D.O., Surveyor
Wayne S. Mathews Jr., M.D., Surveyor
Indran B. Krishnan, M.D., Surveyor

MAG staff:

Andrew J. Baumann, Director of Education

# # #
Committee: 07.14

SUBJECT: Annual Report

SUBMITTED BY: Patton P. Smith, M.D., Chairman

REFERRED TO: Not Referred

During fiscal year 2014, the MAG Committee on Correctional Medicine – under the leadership of Chairman Patton P. Smith, M.D., of Forsyth – met four times. Accreditation fees that were collected were used as the basis for paying consultants and reimbursement for travel expenses to committee members who conduct site visits. All facilities in the accreditation program are billed annually for renewal.

Site visits have been conducted at the following state prisons and county jails during this physical year:
Augusta State Prison, Augusta; Walton County Jail, Monroe; Calhoun State Prison, Morgan; Washington State Prison, Davisboro; Jenkins Correctional Facility, Statesboro; Dodge State Prison, Chester; Coffee Correctional Facility, Nicholls; Chattooga County Jail, Summerville; Wilcox State Prison, Cordele; Dooly State Prison, Perry; Georgia Diagnostic and Classification Prison, Jackson; Rutledge State Prison, Columbus; Autry State Prison, Pelham; Macon State Prison, Macon; and Hays State Prison, Trion.

Georgia Department of Corrections continues a comprehensive intra-state agreement with Georgia Regents University for the provision of health services with an organization specifically created for this purpose, named Georgia Correctional HealthCare, Inc. (GCHC). This agreement includes the responsibility for GCHC paying for the accreditation fees and has been in effect since July 1, 1997. Payments to MAG have been timely. Presently, all state prisons are accredited.

Members continue to be involved on each site visit to jails and prisons. They make recommendations to the Committee regarding accreditation and needed improvements at facilities in the program. The MAG accreditation program is using several consultants regularly; and both committee members and outside consultants conduct accreditation site visits. Since site visits are scheduled intermittently throughout the year, this arrangement continues to work very well and is cost effective.

Annual maintenance reporting has continued since January 1997 and it allows for renewal of all facilities in the MAG program. This allows accredited facilities to renew by reporting and documentation only. On-site visits are scheduled at least every three years. A facility is visited sooner when it is experiencing significant change or if the Committee learns of problems or noncompliance of standards. Twenty-four facilities were renewed by completing annual maintenance reports this fiscal year. These reports require documentation that often identifies problems that are monitored until resolution is obtained.

The National Commission on Correctional Health Care (NCCHC) publishes the Standards for Health Services Prisons/Jails, which this Committee endorses and uses to measure compliance for accreditation purposes. Copies of the current standards are available for purchase directly from the NCCHC. If weaknesses in standards are observed, the Committee on Correctional Medicine makes recommendations it believes will improve the quality of care. After great effort, the Committee has published the MAG Standards for Accreditation in Jails, which is designed to be used primarily in jails with an average daily population of less than 200 people. It is anticipated that the standards, which are user friendly, will be adopted by many jails within the state of Georgia. It is hoped that these same jails will then seek to become accredited.
During this fiscal year, the *Bliven Award for Excellence* was given to Washington State Prison and Riverbend Correctional Facility. These two facilities made perfect scores on their accreditation site visits. In addition, the first *Spivey Award* (presented only to jails) for excellence in the provision of health care was presented to Douglas County Jail.

With the advent of the GRU/GCHC program in prisons, significant changes have been introduced. The regionalization of correctional services has continued. Most infirmaries have been closed with only a few being designated as regional infirmaries. Only a few prisons are providing level III and IV mental health services. These few receive referrals from other prisons in their region. Dental services have been significantly reduced. X-ray services have been reduced by about 50 percent, mostly by reducing full-time x-ray technician’s positions to part-time and the use of mobile x-ray service vendors. Efforts to increase telemedicine continue.

This Committee appreciates the continuing support given by MAG and respectfully submits this report as information on progress experienced this year.

###
The MAG Electronic Health Care Committee (EHCC) members include Jack M. Chapman Jr., M.D. an ophthalmologist from Gainesville (chair); Gary R. Botstein, M.D., a rheumatologist from Decatur; Dan DeLoach, M.D., a plastic surgeon from Savannah; Howard Maziar, M.D., a psychiatrist from Atlanta; Jim Morrow, M.D., a family physician from Cumming; Lawrence Sanders, M.D., an internist from Atlanta; and W. Steven Wilson, M.D., a family physician from Warner Robins and new member Michael Burke, M.D., an Atlanta psychiatrist. The committee is staffed by Susan W. Moore, Director of Third Party Payer Advocacy & Health Policy.

The MAG EHCC has convened on four occasions since January 2014. The EHCC has had an opportunity for discussion and education on a series of topics related to the health care landscape and the impact of technology on the clinical and business practices of physicians.

Over the course of the first two meeting this year, the EHCC reviewed its charge and agreed that since its inception, the purpose had in fact changed. Thus, the EHCC proposed a new charter that more closely aligns with what is realistic and advantageous to MAG members.

**Recommended EHCC Revision:** The EHCC is charged with evaluating and making recommendations regarding the strategic use of information technology to positively impact the delivery of health care. The Committee is a resource for policy evaluation and policy making at the state and national level and is a catalyst for facilitating MAG membership engagement with health care technology through opportunities in education, networking and collaboration with MAG members, community leaders and industry stakeholders.

**Current EHCC Committee:** The Committee is charged with developing a base of knowledge and expertise within MAG to identify, track and positively impact the rapidly changing field in which technology intersects with the delivery of health care. The Committee will use this knowledge and expertise to make recommendations on policy, to participate in and represent the Association on various committees and workgroups related to e-health technology, to develop relationships with vendors of e-health technology and to vet vendors for possible business and partnership relationships.

The EHCC identified the following Objective for its work in 2014, including:

1. Sponsor an education session on the Georgia Health Information Network (GA HIN) at the January MAG BOD. *Complete*

2. Offer a session on GA HIN for EHCC members at the February meeting/conference call. *Complete*

3. Sponsor a Fall MAG member educational session GA HIN to orient MAG members to the Georgia Health Information Exchange and to provide a status of the network’s progress.
4. Sponsor an educational opportunity for EHCC addressing health informatics for physician practitioners. Complete

5. Offer MAG members an educational and training opportunity to increase knowledge and competencies related to health informatics. In process

6. Host a CME Day at the 5th Annual Spring Conference of the Georgia Partnership for TeleHealth. Complete

7. Sponsor a MAG physician panel event at the 5th Annual Spring Conference of the Georgia Partnership for TeleHealth: Finding the Balance – Access, Safety and Quality in Telemedicine. Complete

8. Sponsor a Town Hall Forum on HIPAA and Risk Assessment Compliance for MAG’s membership. Complete

9. Represent the voice of the practicing physician on e-health focused AMA Advisory Committee (Gary Botstein, M.D.) and submit report to BOD. Ongoing.


11. Post timely and relevant e-health information on the MAG website. Complete

12. Recruit three sponsors for the 2014 MAG HOD’s session. In process

EHCC continues to play an active role in the development of the new health information exchange in Georgia. Jim Morrow, M.D., an EHCC member, serves on the Georgia Health Information Network Board of Directors http://gahin.org/. Susan Moore represents MAG on the Georgia Hi Tech Advisory Committee

Objectives


Finally, MAG staff continues to seek opportunities to become knowledgeable about current and proposed electronic health initiatives in order to better advocate for MAG members from a service standpoint and for the purpose of representing the Association’s policies. 2015 will be a busy year as Meaningful Use Stage 2, health information exchange, quality reporting, the implementation of ICD-10 and other program initiatives continue to assume increased space in the world of physician practices. The MAG EHCC will establish its 2015 platform and as has been the case in 2014, it will be successful in meeting its objectives on behalf of MAG leadership and members.

###
The Medical Association of Georgia’s (MAG) Committee on Third Party Payers oversees the relationships of the Association and health insurers – both private and public. When necessary the Committee provides a forum for discussion of issues between and among the Association and the payers. The Committee also reviews federal and state health programs and initiatives and makes its findings available to the Association members through various outlets, such as the MAG website that promotes breaking news and serves as a repository for relevant content and resources.

Third Party Payer Committee members include: John A. Goldman, M.D., chairman, and a rheumatologist from Atlanta; Joel L. Fine, M.D., an internist from Snellville, vice chairman; Mohammed Y. Abubaker, M.D., a rheumatologist from Marietta, Magdi Hanafi, M.D., an OB/GYN from Atlanta; Albert F. Johary, M.D., an internist from Dunwoody; J. Leonard Lichtenfeld, M.D., an oncologist and Deputy Chief Medical Officer with the American Cancer Society from Atlanta and Thomasville; Daniel Thomas McDevitt, M.D., a vascular surgeon from Riverdale; Steven A. Muller, M.D., an orthopedic surgeon from Jonesboro; Alvin R. Sermons, M.D., an OB/GYN from Atlanta; Richard Wherry, M.D., a family practice physician from Dahlonega and ex-officio member, Marilyn Smolinski, Georgia Medical Group Management Association/Marietta OB-GYN Affiliates, PA, Marietta. The Committee is staffed by Susan W. Moore.

The MAG Third Party Payers Committee met this year on February 7 and June 27. The TPP Committee also supported the content and facilitation of a panel at the July Legislative Session. The topic of focus for the panel was Network Adequacy.

MAG’s Third Party Payer activities have aligned its short and long range strategies in that we have:

1. Participated on special state committees and initiatives to influence how health reform is implemented in Georgia (i.e., CMS Hospital Engagement Network, Care Transitions Coalition, Atlanta Regional Collaborative on Health Improvement, GA HITECH Advisory Committee, Health Literacy Project).

2. Collaborated with specialty societies and other stakeholders to issue a formal letter of complaint to BCBSGA regarding the negative impact of SHBP changes and other poor faith payer practices that adversely impact MAG members.

3. Disseminated timely and relevant information on Medicare, Medicaid, and commercial health insurance to MAG’s Department of Communications to publish for physician members.

4. Acted as a direct informational resource for MAG members on Third Party Payer issues (i.e., consulted with some 250 physicians and 50 cases requiring research and intervention).

5. Tracked the progress of 2013 HOD actions that were forwarded to the AMA.
6. Members agreed to initiate a review the committee’s purpose and to revise it as needed to accommodate the current health care landscape in view of PPACA.

7. In view of concerns over poor meeting attendance, feedback was solicited from members to inform the chair about the need to consider adjustments or modifications to the Committee.

8. The MAG TPP Committee hosted representatives from Amgen and J&J to present information related to the topic of Biologics, Biosimilars and Interchangeables, reinforcing the current emphasis on physician education in preparation for 2015 legislative activity in Georgia. The presentation covered the background, the science and current national efforts on the part of state legislatures, pharma, medical societies, the FDA and impacted providers and patients.

9. MAG received an educational grant from Alliant/GMCF, which has supported a series of Town Hall Forums in 2014 on relevant payer matters. On two occasions, these forums provided a venue for BCBSGA and UHC to discuss plans and trends for 2014 and 2015. HIPAA and Risk Assessments also were topics.

10. MAG is represented by staff at a number of routine meetings and new groups where it is important for the physician voice to be present. The newest of these opportunities for MAG is as a member on the ICD-10 Transition Forum, a loosely constructed group of stakeholders who aim to facilitate a repository for related ICD-10 activities and education that is occurring across companies, organizations, agencies and sectors. MAG staff also represents TPP positions at educational forums including practice manager groups, etc.

11. The TPP Committee also completed the five-year policy review in preparation for the October 2014 HOD meeting.

I would like to take this opportunity to thank the committee and its staff for the steady and outstanding efforts in addressing the many third party payer issues that are so important to physicians and their practices.

# # #
SUMMARY OF
HOUSE ACTIONS
## 2013 HOUSE OF DELEGATES

### Reference Committee A

**Chairman:** Madalyn Davidoff, MD  
**Staff:** Susan Moore and Kate Boyenga

<table>
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<tr>
<th>Title/Action</th>
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<tr>
<td>Resolution 101A.13 (Delay or Canceling the Implementation of ICD-10)</td>
<td>AMA Delegation (Donald Palmisano)</td>
<td>Submitted to the AMA for consideration at its i13 meeting. AMA HOD adopted resolution 220 I-13. Due to organized medicine's efforts, ICD-10 has now been delayed until October 2015. MAG will continue its opposition to ICD-10.</td>
<td>✓</td>
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<tr>
<td>Resolution 102A.13 (Drug Enforcement Agency Licensure Fees)</td>
<td>AMA Delegation (Donald Palmisano)</td>
<td>Submitted to the AMA for consideration at its i13 meeting. Resolution 219 I-13 was adopted as amended: That our AMA work through appropriate channels to freeze DEA licensure fees for physicians.</td>
<td>✓</td>
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<tr>
<td>Resolution 103A.13 (High Cost of Re-Certification)</td>
<td>AMA Delegation (Donald Palmisano)</td>
<td>Submitted to the AMA for consideration at its i13 meeting. AMA HOD reaffirmed policies D-275.971, D-275.969; H-275.923 and H-275.924 in lieu of Resolution 919.</td>
<td>✓</td>
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<tr>
<td>Resolution 104A.13 (Electronic Health Care Programs)</td>
<td>AMA Delegation (Donald Palmisano)</td>
<td>MAG submitted its EHR Paper to the AMA and all states across the country. Also, Gary R. Botstein, M.D. was appointed to the AMA Leadership Committee on this topic with Jay Crosson, M.D. of the AMA and former Chief Medical Officer for Kaiser Permanente. The AMA Leadership Committee has met a number of times and Dr. Botstein has kept the Electronic Health Care Committee informed of its progress.</td>
<td>✓</td>
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<td>Resolution 105A.13 (Elimination of Proposed Penalties for not Obtaining Meaningful Use)</td>
<td>AMA Delegation (Donald Palmisano)</td>
<td>Submitted to the AMA for consideration at its i13 meeting. Resolution 221 I-13 was combined with resolutions 214 and 222. AMA HOD reaffirmed policy H-478.991 in lieu of resolutions 214, 221 and 222. Also noted is that meaningful use &quot;stage 3&quot; was delayed for one year.</td>
<td>✓</td>
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<tr>
<td>Resolution 106A.13 (Generic Drug Exemption from Prior Approval Process)</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>MAG testified to a Senate subcommittee on December 19 addressing issues of prior approvals. MAG has submitted correspondence to the Georgia Association of Health Plans outlining the issue. GAHP has agreed to a meeting prior to the 2015 General Assembly. MAG has also had discussions with the allied health professions on a comprehensive insurance package for the 2015 Georgia Assembly, which will be brought to the Council on Legislation.</td>
<td>✓</td>
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<tr>
<td>Resolution 107A.13 (State Law for Insurance Coverage Waiver)</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>MAG testified to a Senate subcommittee on December 19 addressing issues regarding real-time benefits; MAG met with the Commissioner of Insurance and discussed the issue. MAG is awaiting a response from the Commissioner of Insurance.</td>
<td>✓</td>
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<td>Resolution 108A.13 (FDA Test Generic Drugs)</td>
<td>Board of Directors (Donald Palmisano)</td>
<td>The Board approved to send a letter to the Federal Drug Administration in support of its programs on drug testing, and additionally a more robust testing of generic drugs. The letter was mailed in June 2014. On July 7, 2014, MAG received a letter from the Director, Janet Woodcock, M.D., reporting that our letter was referred to the Center for Drug Evaluation and Research.</td>
<td>✓</td>
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<tr>
<td>Resolution 109A.13, Resolves 1 and 2 (Safety of EHR Records)</td>
<td>Electronic Health Care Committee (Susan Moore)</td>
<td>MAG submitted its EHR Paper to the AMA and all states across the country. Also, Dr. Botstein was appointed to the AMA Leadership Committee on this topic with Dr. Crosson.</td>
<td>✓</td>
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<td></td>
<td>AMA Delegation (Donald Palmisano)</td>
<td>Submitted to the AMA for consideration at its i13 meeting. Resolution 222 was combined with 214, 221, and 222. The AMA HOD reaffirmed policy H-478-.991 in lieu of resolutions 214, 221 and 222.</td>
<td>✓</td>
</tr>
<tr>
<td>Resolution 110A.13 (Implementation of Stage 3 Meaningful Use)</td>
<td>Electronic Health Care Committee (Susan Moore)</td>
<td>MAG submitted its EHR Paper to the AMA and all states across the country. Also, Dr. Botstein was appointed to the AMA Leadership Committee on this topic with Dr. Crosson. MAG will work with Georgia HITECH to promote system interface expectations with HHS. Also noted is that implementation of “stage 3” meaningful use was delayed one year.</td>
<td>✓</td>
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<td>Resolution 111A.13 (Reimbursement for Audit Requirements)</td>
<td>AMA Delegation (Donald Palmisano) (Patricia Yeatts)</td>
<td>MAG submitted resolution 111A.13 to the AMA in June 2014. The resolution, now reformatted as Resolution 710 was heard in Reference Committee G. The AMA reaffirmed AMA policies H-285.943, H-335.980, and H-315.992 in lieu of Resolution 710 was the outcome. MAG is working on a toolkit with the Physicians Advocacy Institute (PAI) of which Mr. Donald Palmisano is a member</td>
<td>✓</td>
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<tr>
<td>Resolution 112A.13 (Georgia Disaster Response)</td>
<td>Finance Committee (Sally-Anne Jacobs) Administration (Susan Moore)</td>
<td>The MRC Planning group met on December 17, 2013 to discuss actions needed to move the MAG MRC forward. Staff and John Harvey, M.D. are exploring funding options. Once funding is secure, a draft budget will be referred to the Finance Committee.</td>
<td>✓</td>
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<tr>
<td>Resolution 113A.13 (Reimbursement for Prior Approval Requirements)</td>
<td>AMA Delegation (Donald Palmisano) (Patricia Yeatts)</td>
<td>MAG submitted Resolution 113A to the AMA in June 2014. The resolution, now reformatted as Resolution 711 was discussed in Reference Committee G. The AMA reaffirmed AMA policies H-385.951, H-385.943, and H-385.948 in lieu of Resolution 711 was the outcome.</td>
<td>✓</td>
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<td>Resolution 114A.13, Resolves 1-3 (Implementation of the POLST in Georgia)</td>
<td>Administration (Susan Moore)</td>
<td>A revised policy statement was needed to incorporate resolves 2 and 3 of the resolution. The following is a revised policy statement:</td>
<td>✓</td>
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<tr>
<td>Adopted Resolve 1 that the Medical Association of Georgia (MAG) supports the use of Physicians Orders for Life Sustaining Treatment (POLST) in conjunction with advanced directives for appropriate patients.</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>In regards to the Use of Physicians Orders for Life Sustaining Treatment (POLST) MAG supports the following:</td>
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<td>Adopted as amended from the floor of the House Resolve 2 that MAG supports through legislation or other appropriate means the transferability of POLST from facility to facility through the following:</td>
<td></td>
<td>1. the use of Physicians Orders for Life Sustaining Treatment (POLST) in conjunction with advanced directives for appropriate patients;</td>
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<tr>
<td>1. A physician or other medical provider such as a nurse or EMS, or medical institution, shall respect and honor life sustaining treatment orders executed by another physician.</td>
<td></td>
<td>2. through legislation or other appropriate means, the transferability of POLST from facility to facility through the following:</td>
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<td>2. There is a fundamental &quot;duty to comply&quot; with a patient's wishes. Such that in a situation where a physician is treating a patient who has a POLST signed by a physician who does not have admitting privileges at a hospital or health care facility, this does not remove the obligation of the physician or other medical provider, such as EMS to honor the POLST order.</td>
<td></td>
<td>a. a physician or other medical provider such as a nurse or EMS, or medical institution, shall respect and honor life sustaining treatment orders executed by another physician;</td>
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<tr>
<td>3. The patient or patient's authorized surrogate has signed the order and offered the order in full knowledge of the order's contents and a Georgia medical license is on the order.</td>
<td></td>
<td>b. there is a fundamental &quot;duty to comply&quot; with a patient's wishes, such that in a situation where a physician is treating a patient who has a POLST signed by a physician who does not have admitting privileges at a hospital or health care facility, this does not remove the obligation of the physician or other medical provider, such as EMS to honor the POLST order;</td>
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<tr>
<td>4. A physician or other medical provider, such as a nurse or an EMS, or medical institution, shall not be subject to criminal prosecution, civil liability or professional discipline by honoring a POLST order.</td>
<td></td>
<td>c. the patient or patient's authorized surrogate has signed the order and offered the order in full knowledge of the order's contents and a Georgia medical license is on the order;</td>
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<td></td>
<td>d. a physician or other medical provider, such as a nurse or an EMS, or medical institution, shall not be subject to criminal prosecution, civil liability or professional discipline by honoring a POLST order;</td>
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<tr>
<td>Resolution 114A.13, Resolves 1-3 (Implementation of the POLST in Georgia) – Cont.</td>
<td>Continuing Medical Education (Andrew Baumann)</td>
<td>3. the education of all levels of providers regarding POLST (Physician Order for Life Sustaining Treatment) and conveys the importance of this education through supporting CME. (Res. 114A.13) MAG is working with a coalition on this issue. There was a conference sponsored in 2014. MAG held a town hall forum in May advocating for POLST. Also, the recording was posted on all social media outlets. The town hall session resulted in a county medical society meeting presentation.</td>
<td>✓</td>
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<td>Resolution 115A.13 (MAG-GHA Collaboration)</td>
<td>Administration (Susan Moore)</td>
<td>MAG has met with the Georgia Hospital Association (GHA), and submitted, and received, a grant for the Hospital Engagement Network. Three physician practices and hospitals were selected as pilot participants. The project was initiated in April 2014 and will conclude in December 2014.</td>
<td>✓</td>
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<tr>
<td>Resolution 116A.13 (Endorse Medicare D Educational Website)</td>
<td>AMA Delegation (Donald Palmisano) (Patricia Yeatts)</td>
<td>Resolution 116A.13 was submitted to the AMA in June 2014. The resolution now reformatted as AMA Resolution 106 was discussed in Reference Committee A. The AMA adopted the following Substitute Resolution 106: RESOLVED, that our American Medical Association request that the Centers for Medicare &amp; Medicaid Services educate Medicare beneficiaries on how to access assistance for enrolling in Medicare Part D and Medicare Advantage plans.</td>
<td>✓</td>
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<tr>
<td>Resolution 301C.13, Resolves 1-3 (Georgia Medical Student Clerkship Support)</td>
<td>Administration (Susan Moore)</td>
<td>Policy Statement revised 3/11/14: MAG supports efforts to provide tax credits for non-financially compensated community-based physicians providing third-year core clerkships for Georgia medical students.</td>
<td>✓</td>
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<tr>
<td>Adopted Resolve 1 that the Medical Association of Georgia (MAG) and the physicians of Georgia support the efforts of the Georgia Statewide Area Health Education Centers (AHEC) Network’s annual Primary Care Summit and its participant stakeholders in their efforts to provide tax credits for non-financially compensated community-based physicians providing third-year core clerkships for Georgia medical students.</td>
<td>Administration (Susan Moore)</td>
<td>MAG is a sponsor of the 2014 Georgia Statewide Area Health Education Centers (AHEC) Summit.</td>
<td>✓</td>
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<tr>
<td>Adopted Resolve 2 that MAG will work collaboratively with the give Georgia medical schools, the Georgia Statewide AHEC Network, and other key partners to develop guidelines and limits for these tax credits.</td>
<td>Administration (Susan Moore)</td>
<td>MAG supported the language in H.B. 922 addressing these issues. H.B. 922 bill did not pass but the language supported by MAG passed in S.B. 391.</td>
<td>✓</td>
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<tr>
<td>Adopted Resolve 3 that MAG encourage the Governor and the General Assembly to support legislation creating this tax credit and establishing the statutory to govern its utilization.</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Tax credits for physicians was one of MAG's 2014 legislative priorities and MAG has met with various hospitals to discuss the issue.</td>
<td>✓</td>
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<td>Resolution 302C.13, Resolve 1-2 (Telemedicine Licensure)</td>
<td>Administration (Susan Moore)</td>
<td>Policy Statement: MAG supports the telemedicine licensure by individual states and opposes efforts to change such to federal licensure of telemedicine.</td>
<td>✓</td>
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<tr>
<td>Adopted Resolve 1 that the Medical Association of Georgia (MAG) supports the continuation of telemedicine licensure by individual states and opposes efforts to change such to federal licensure of telemedicine.</td>
<td>Administration (Susan Moore)</td>
<td>Submitted to the AMA i13 for consideration. AMA HOD reaffirmed policies H-480.969 and D-480.999 in lieu of Resolution 920.</td>
<td>✓</td>
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<tr>
<td>Adopted Resolve 2 that the Georgia delegation should carry a resolution to the American Medical Association (AMA) opposing efforts to create federal telemedicine licensure.</td>
<td>AMA Delegation (Donald Palmisano)</td>
<td>MAG submitted this policy statement in opposition to H.R. 3507, a bill that would allow national licensure for government programs including telemedicine. MAG actively lobbied against national licensure during the recent GAMPAC Chairmen Circle Fly-In.</td>
<td>✓</td>
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<td>Resolution 303C.13, Resolve 1-3 (Primary Care Physician Workforce in Georgia)</td>
<td>Administration (Susan Moore)</td>
<td>Policy Statement Revised 3/11/14: MAG supports efforts, including those made by the Georgia Statewide Area Health Education Centers (AHEC), to retain more Georgia primary care GME graduates and to recruit more Georgia medical student graduates into Georgia Primary Care GME programs.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Resolve 1 that the Medical Association of Georgia (MAG) and the physicians of Georgia support the efforts of the Georgia Statewide Area Health Education Centers (AHEC) Network Primary Care Summit and its participant stakeholders in their efforts to retain more Georgia Primary Care GME graduates and to recruit more Georgia medical student graduates into Georgia Primary Care GME programs.</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>MAG is a sponsor of the 2014 Georgia Statewide Area Health Education Centers (AHEC) Summit.</td>
<td>✓</td>
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<tr>
<td>Adopted Resolve 2 that MAG encourages the Governor and the General Assembly to provide funds to equalize the available State Loan Repayment Program payments administered by the Georgia Board for Physicians Workforce to be competitive with the National Health Service Corps.</td>
<td>Medical Student Section (Kate Boyenga)</td>
<td>MAG supported the language in H.B. 922 addressing these issues. H.B. 922 bill did not pass but the language supported by MAG passed in S.B. 391</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Resolve 3 that MAG urges physicians to actively recruit and encourage Georgia medical students to select Georgia GME residency programs and to remain in Georgia to practice.</td>
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<td>One of MAG’s legislative priorities was that of tax credits for physicians and MAG has met with various hospitals to discuss the issue.</td>
<td>✓</td>
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<td>Not only does the MAG Medical Student Section encourage medical students to select Georgia GME residency programs and remain in Georgia to practice, but the AMA Delegation discussed this issue with the Georgia students who attended the AMA Annual meeting representing the Georgia medical schools.</td>
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Reference Committee C  
MAG House of Delegates 2013
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<td>Resolution 304C.13, Resolves 1-2 (Interstate Data Sharing)</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>MAG agreed to language with the Georgia Drug &amp; Narcotics Agency, and other relevant stakeholders. MAG supported the language that passed in S.B. 134 in the Georgia General Assembly which was signed by the Governor. Policy 100.996 will be updated in the database to indicate reaffirming in 2013 by MAG HOD.</td>
<td>✓</td>
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<tr>
<td>Adopted Resolve 1 that the Medical Association of Georgia (MAG) recommends that the Georgia Legislature amend O.C.G.A. § 16-13-60, to include language that permits interstate data sharing with eligible users in all states. Reaffirmed current Policy 100.996 in lieu of Resolve 2 which states that MAG supports interstate communications between prescription drug monitoring programs in jurisdictions with privacy protections for patients and physicians.</td>
<td>Administration (Marcus Downs)</td>
<td></td>
<td>✓</td>
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<td>Resolution 305C.13 (Medicaid Expansion Funding with Private Health Insurance Options through the State Health Insurance Exchange)</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>MAG has met and discussed the issue with the Governor's office. Additionally, MAG opposed H.B. 707 which would have prohibited expanding Medicaid. MAG is also working with the Georgia Public Policy Foundation on alternative Medicaid programs that may be used with Medicaid Expansion funds.</td>
<td>✓</td>
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<td>Adopted with floor amendment that the Medical Association of Georgia (MAG) help craft, support and advocate a waiver from the U.S. Department of Health &amp; Human Services (HHS) Secretary allowing Georgia to use the Medicaid expansion funds to buy private insurance in the state health insurance exchange for eligible Georgia citizens at or below 138 percent of the federal poverty level (FPL).</td>
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<td>Resolution 306C.13 (Prescription Drug Monitoring Program)</td>
<td>Board of Directors (Donald Palmisano)</td>
<td>The Board of Directors, on recommendation of the Council on Legislation at its January 2014 meeting, called for MAG to recommend to the Georgia Legislature that it amend O.G.C.A. § 16-13-60 to include language that permits authorized prescribers and dispensers to designate delegates to obtain prescription drug monitoring program reports on their behalf; that such delegates must be licensed, registered, or certified by a state regulatory or administrative agency; and that, for each delegate, the authorized or dispenser be held responsible for their delegates' use of the system.</td>
<td>✓</td>
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<td>Resolution 307C.13 (Limited Preferred Drugs)</td>
<td>Administration (Marcus Downs)</td>
<td>Policy Statement: MAG supports on all drug benefit plans at least one drug in all drug classes be represented in preferred status.</td>
<td>✓</td>
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Referral to the Board of Directors for a decision that the Medical Association of Georgia MAG recommends that the Georgia Legislature amend O.G.C.A. § 16-13-60 to include language that permits authorized prescribers and dispensers to designate delegates to obtain prescription drug monitoring program reports on their behalf; that such delegates must be licensed, registered, or certified by a state regulatory or administrative agency; and that, for each delegate, the authorized or dispenser be held responsible for their delegates' use of the system.

Board of Directors, on recommendation of the Council on Legislation at its January 2014 meeting, called for MAG to recommend to the Georgia Legislature that it amend O.G.C.A. § 16-13-60 to include language that permits authorized prescribers and dispensers to designate delegates to obtain prescription drug monitoring program reports on their behalf; that such delegates must be licensed, registered, or certified by a state regulatory or administrative agency; and that, for each delegate, the authorized prescriber or dispenser be held responsible for their delegates' use of the system, and directed that MAG continue to closely monitor legislation moving forward in the Georgia General Assembly on this subject matter. Unfortunately this language did not pass in the 2014 Georgia General Assembly.

Since the General Assembly concluded, MAG has had discussions with Georgia Drug and Narcotics and the Georgia Department of Public Health on possible legislative solutions.

MAG is also working with stakeholders including the Council on Alcohol and Drug Addiction on the 2015 legislative agenda.

Adopted as amended that the Medical Association of Georgia (MAG) supports that at least one drug in all drug classes must be represented in preferred status on all drug benefit plans.

Policy Statement: MAG supports on all drug benefit plans at least one drug in all drug classes be represented in preferred status.
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<td>Resolution 308C.13 (Support Legislation to Adopt Clinical Algorithms)</td>
<td>No referral necessary</td>
<td>MAG will continue to work with AHEC on issues related to Graduate Medical Education and rural health</td>
<td>✓</td>
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<td>DID NOT ADOPT Resolution 308C.13 calling for MAG to support that clinical algorithms drawn up and agreed upon by the medical staff of a hospital may serve as important evidence of the &quot;standard of care&quot; for physicians of that hospital and support the use of these agreed upon clinical algorithms as an affirmative defense in the event of medical malpractice claims.</td>
<td></td>
<td>MAG supported H.B. 922 which did not pass the Georgia General Assembly. MAG did support the language in H.B. 922 that passed on another bill and now waits the Governor's signature. Also, the Governor signed H.B. 988, a bill advocating for medical school loans to primary care physicians in rural areas.</td>
<td>✓</td>
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<tr>
<td>Resolution 309C.13 (Graduate Medical Education)</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG supports state efforts to increase funding for all residency programs designed to train physicians to practice medicine in Georgia.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Resolve 1 that the Medical Association of Georgia (MAG) work with interested stakeholders to craft a proposal for a sustainable funding source for graduate medical education that will provide for a growth in the number of physicians available to meet the future needs of our state's population.</td>
<td>Administration (Marcus Downs)</td>
<td>MAG will continue to work with AHEC on issues related to Graduate Medical Education and rural health</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Resolve 2 that MAG supports state efforts to increase funding for all residency programs designed to train physicians to practice medicine in Georgia.</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>MAG will continue to work with AHEC on issues related to cover repayment programs.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Resolve 3 that MAG advocates for an increased number of pilot projects that foster an increase in resident training programs in underserved areas through incentives such as offering loan repayment as a means to address the physician workforce shortage.</td>
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<tr>
<td>Resolution 310C.13 (Solving Georgia's Primary Care Crisis -- Medical Student Clerkships)</td>
<td>Board of Directors (Donald Palmisano)</td>
<td>A report will be presented to the Board of Directors in October for discussion. MAG has had various discussions with the Georgia Composite Medical Board and the Georgia Board for Physician Workforce. MAG has connected the sponsor of this resolution with these stakeholders.</td>
<td>✓</td>
</tr>
<tr>
<td>Resolution 311C.13 (Change of Coumadin Regulations by CMS)</td>
<td>AMA Delegation (Donald Palmisano) (Patricia Yeatts)</td>
<td>Resolution 311C.13 was submitted to the 2014 AMA Annual meeting. Resolution, now reformatted as Resolution 709 was sent to Reference Committee G. The HOD adopted the following amended Resolution 709: RESOLVED, the our American Medical Association request a change in Centers for Medicare and Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR with restrictions.</td>
<td>✓</td>
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<td>Title/Action</td>
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<tr>
<td>Resolution 312C.13 (Vulnerable Patient Access and Protection)</td>
<td>Administration (Susan Moore)</td>
<td>Policy Statement: MAG promotes access to appropriate care for all patients; promotes special access for vulnerable</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that the Medical Association of Georgia (MAG) promotes access to</td>
<td>AMA Delegation (Donald Palmisano)</td>
<td>patients if care cannot be provided within a patient's insurance provider; and rejects any model, public or</td>
<td>✓</td>
</tr>
<tr>
<td>appropriate care for all patients; promotes special access for vulnerable</td>
<td></td>
<td>private, that restricts access to providers adequately experienced in their disease; and brings a policy</td>
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<tr>
<td>patients if care cannot be provided within a patient's insurance provider;</td>
<td></td>
<td>resolution to the American Medical Association (AMA) House of Delegates supporting the same.</td>
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<tr>
<td>and rejects any model, public or private, that restricts access to providers</td>
<td></td>
<td>Submitted to the AMA HOD meeting. AMA HOD reaffirmed policies H-373.999, H0285.911, D-165.989, D-285.972, and</td>
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<td>adequately experienced in their disease; and brings a policy resolution to</td>
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<td>H-160.952 in lieu of Resolution 815.</td>
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<td>the American Medical Association (AMA) House of Delegates supporting the</td>
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<td>same.</td>
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<tr>
<td>Resolution 313C.13 (Use of Pharmacy Drug Cards for Part-D Medicare Patients)</td>
<td>No Referral Necessary</td>
<td></td>
<td>✓</td>
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<tr>
<td>DID NOT ADOPT that the Georgia delegation to the American Medical</td>
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<tr>
<td>Association (AMA) House of Delegates presents a resolution at the AMA HOD</td>
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<td>meeting in winter 2013 or spring 2014 requesting that the AMA pursues the</td>
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<td>lifting of the current Medicare Part D prohibition of the use of patient</td>
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<td>assistance cards provided by drug companies.</td>
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<tr>
<td>Resolution 315C.13 (Support for CME and Curriculum on the Business and</td>
<td>Administration</td>
<td>Policy Statement: MAG supports development of more CME in the areas of medical economics and business and</td>
<td>✓</td>
</tr>
<tr>
<td>Economics of Medicine)</td>
<td>(Andrew Baumann/Kate Boyenga)</td>
<td>design curriculum of medical economics and business, skills in medical schools.</td>
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<tr>
<td>Adopted as amended that the Medical Association of Georgia (MAG) supports</td>
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<tr>
<td>development of more CME in the areas of medical economics and business and</td>
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<tr>
<td>design of curriculum on medical economics and business skills in medical</td>
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<td>schools.</td>
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</tbody>
</table>
| Resolution 316C.13 (Cosmetic Energy Device) | Administration (Susan Moore) | Policy Statement: MAG believes that the definition of the practice of medicine should be clarified to include that the use of lasers, pulsed light devices, or any energy source, chemical or other modality that affects living tissue (when referring to the skin, anything below the stratum corneum), for cosmetic purposes, is the practice of medicine.

MAG is working with the Georgia Composite Medical Board on addressing further patient safety protections in the law, as well as the regulations. The Georgia Composite Medical Board has established a committee and is working on the rules. | ✔ |
<table>
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<th>Title/Action</th>
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<tbody>
<tr>
<td>Officer 04.13 (Treasurer)</td>
<td>No Referral Necessary</td>
<td>The Physicians' Institute for Excellence in Medicine is conducting a study of the issue. The sponsor of the resolution is working closely with PIEM to see if it is financially feasible.</td>
<td>✓</td>
</tr>
<tr>
<td>Filed the Treasurer's report for information</td>
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<td>✓</td>
</tr>
<tr>
<td>Resolution 401F.13 (Study the Feasibility to Teach Physicians the implementation of Health Care Delivery Improvement)</td>
<td>Board of Directors (Donald Palmisano)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Referred to the Board of Directors for decision, that the Medical Association of Georgia will study the feasibility of developing a quality institute to teach physician members the principles and tools of implementation like those taught and executed at Intermountain Institute for Health Care Delivery Research focusing on: 1) producing better outcomes for patients; 2) eliminating waste, reducing cost, and increasing available resources for patients; 3) placing our caring profession back in control of care delivery, and 4) serving as the foundation for useful shared electronic data for the benefit of our patients, physician colleagues, nurses, allied health professionals, and health care administrators.</td>
<td>Physicians' Institute for Excellence in Medicine (Bob Addleton)</td>
<td></td>
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</tr>
<tr>
<td>Resolution 402F.13 (Support the Association of American Physicians and Surgeons)</td>
<td>Board of Directors (Donald Palmisano)</td>
<td>At its May 2014 meeting, the Board of Directors approved that MAG should 1) continue to monitor the antitrust lawsuit filed by the Association of American Physicians and Surgeons in the U.S. District Court with the option to file an amicus brief in the future, and 2) that MAG send a letter to component societies soliciting their positions on the American Board of Medical Specialties Maintenance of Certification (ABMS MOC) program with any recommendations for adjustments to MOC.</td>
<td>✓</td>
</tr>
<tr>
<td>Referred to the Board of Directors for decision, that the MAG support the Association of American Physicians and Surgeons (AAPS) in its antitrust lawsuit in the U.S. District Court in New Jersey that seeks to end the MOC program mandated and run by the American Board of Medical Specialties (ABMS) and its 24 affiliated organizations.</td>
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<tr>
<td>Resolution 403F.13 (Honor the Achievements and Service of William Coppedge Collins, M.D.)</td>
<td>Administration (Tom Kornegay)</td>
<td>This memorial resolution will be attached to the HOD Minutes and kept with the historical documents.</td>
<td>✓</td>
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<td><strong>Title/Action</strong></td>
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<tr>
<td>Officer 01.13, Recommendation 1</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG supports current requirement that APRNs work under &quot;supervision&quot; versus a &quot;collaboration and consultation&quot; agreement with physicians.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that MAG supports the current requirement that APRNs work under &quot;supervision&quot; versus a &quot;collaboration and consultation&quot; agreement with physicians.</td>
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<tr>
<td>Officer 01.13, Recommendation 2</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG opposes increasing an APRN's prescriptive authority to order Schedule II narcotics.</td>
<td>✓</td>
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<tr>
<td>Adopted that MAG opposes increasing an APRN's prescriptive authority to order Schedule II narcotics.</td>
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<tr>
<td>Officers 01.13, Recommendation 3</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG opposes increasing the number of APRNs supervised by a physician greater than current law, which is four, pursuant to a protocol agreement.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that MAG opposes increasing the number of APRNs supervised by a physician greater than current law, which is four, pursuant to a protocol agreement.</td>
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<tr>
<td>Officer 01.13, Recommendation 4</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG opposes current legislation that will allow an APRN to order radiographic imaging pursuant to a physician protocol.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted as amended that MAG oppose current legislation that would allow an APRN to order radiographic imaging pursuant to a physician protocol.</td>
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<td>Officer 01.13, Recommendation 5</td>
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<tr>
<td>Adopted as amended that MAG supports the current law that allow a pharmacist to administer an adult vaccine with a patient-specific prescription and does not support pharmacists administering all adult vaccines under a blanket protocol agreement with a physician. Additionally, MAG urges the equitable distribution of vaccines among physicians, hospitals, and county health departments.</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG supports current law that allow a pharmacist to administer an adult vaccine with a patient-specific prescription, MAG opposes pharmacists administering all adult vaccines under a blanket protocol agreement with a physician, and MAG supports the equitable distribution of vaccines among physicians, hospitals, and county health departments.</td>
<td>✓</td>
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<tr>
<td>Officer 01.13, Recommendation 6</td>
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<tr>
<td>Adopted that MAG opposes proposals that would allow a pharmacist the ability to substitute therapeutic drugs.</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG opposes proposals that will allow pharmacists the ability to substitute therapeutic drugs.</td>
<td>✓</td>
</tr>
<tr>
<td>Officer 01.13, Recommendation 7</td>
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<tr>
<td>Adopted that MAG supports pharmacists obtaining a physician's &quot;consent&quot; prior to substituting a biosimilar for a biologic.</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG supports pharmacists obtaining a physician's &quot;consent&quot; prior to substituting a biosimilar for a biologic.</td>
<td>✓</td>
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<tr>
<td>Officer 01.13, Recommendation 8</td>
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<tr>
<td>Adopted that MAG oppose allowing chiropractors to diagnose patients.</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG opposes allowing chiropractors to diagnose patients.</td>
<td>✓</td>
</tr>
<tr>
<td>Officer 01.13, Recommendation 9</td>
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<tr>
<td>Officer 01.13, Recommendation 10</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG opposes allowing physical therapists direct access to patients.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that MAG opposes allowing physical therapists direct access to patients.</td>
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<tr>
<td>Officer 01.13, Recommendation 11</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG opposes allowing marriage and family therapists to diagnose patients.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that MAG oppose allowing marriage and family therapists to diagnose patients.</td>
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<tr>
<td>Adopted new recommendation that MAG opposes any optometric scope of practice expansion</td>
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<tr>
<td>Officer 01.13, New Recommendation 13</td>
<td>Board of Directors (Donald Palmisano)</td>
<td>The Board of Directors on January 25, 2014 authorized MAG to continue working with state specialty societies in developing a definition of surgery.</td>
<td>✓</td>
</tr>
<tr>
<td>Referred new recommendation to the Board of Directors for decision that MAG suggests developing a definition of surgery for Georgia.</td>
<td>Council on Legislation (Marcus Downs)</td>
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<td>Title/Action</td>
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</tr>
<tr>
<td>Resolution 701S.13 (Nurse Practitioner Scope of Practice, Resolve 1 and 2)</td>
<td>No Referral Necessary</td>
<td>MAG discussed the issue with members of the Georgia legislature, as well as with the Composite Medical Board. No movement was available this past year.</td>
<td>✓</td>
</tr>
<tr>
<td>DID NOT ADOPT Resolve 1 that advanced nurse practitioners should continue their collaborative agreements with physicians and not be granted full license authority.</td>
<td>Council on Legislation (Marcus Downs)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Adopted a mended Resolve 2 that in the interest to maintain the highest quality of care and to maintain the highest quality of medical standards to Georgia patients and to ensure the proper and timely discipline of all physician extenders who take care of patients, the Medical Association of Georgia makes it a legislative priority to transfer Advanced Practice Registered Nurses (including Certified Registered Nurse Anesthetists (CRNA), Certified Nurse Midwives (CNM), Clinical Nurse Specialists (CNS), and Nurse Practitioners (NP) to the Georgia Composite Medical Board with an ex-officio member of the Board.</td>
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<tr>
<td>Resolution 702S.13 (Proper Identification of Mid-level Providers and Physicians)</td>
<td>Council on Legislation (Marcus Downs)</td>
<td>Policy Statement: MAG supports that all mid-level providers and health care extenders introduce themselves accurately and give their correct title when delivering care and to accurately identify the supervising physician, including providing contact information and that such health care extenders and the supervising physicians wear an identification badge that clearly and accurately states their correct titles and degrees.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that the Medical Association of Georgia (MAG) supports that all mid-level providers and health care extenders introduce themselves accurately and give their correct titles when delivering care and to accurately identify the supervising physician, including providing contact information and that such health care extenders and the supervising physicians wear an identification badge that clearly and accurately states their correct titles and degrees.</td>
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<td><strong>Title/Action</strong></td>
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<tr>
<td>Resolution 703S.13 (Improving the House of Medicine’s Advocacy in Georgia, Resolves 1 &amp; 2)</td>
<td>Administration (Marcus Downs)</td>
<td>MAG submitted a questionnaire across the country and has received all responses. The Council on Legislation met two times per month during the legislative session. At its May 2014, the Board of Directors received a report on the results of the questionnaire which showed MAG as being in line or better than most states in its efforts to include state specialty societies in the legislative process of the state organization. The Board approved to continue its process to meet every other week during the session and three times following the legislative session, and before end of the each calendar year.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Resolve 1 that the House of Delegates (HOD) asks Medical Association of Georgia (MAG) staff to investigate successful models of how the state medical society and state specialty societies can work together in a more collaborative and timely fashion on legislative issues.</td>
<td>Administration (Marcus Downs)</td>
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<tr>
<td>Adopted Resolve 2 that MAG staff bring back a proposal to the Board of Directors no later than the summer of 2014 with suggested improvements to implement a more effective process no later than December 2014.</td>
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CONSENT CALENDAR
COMMITTEE ON ANNUAL SESSION

SUBJECT: Policy Sunset and Reaffirmation Report

SUBMITTED BY: John S. Harvey, M.D., Speaker of the House of Delegates

REFERRED TO: Consent Calendar

The House of Delegates (HOD) adopted policy that established a sunset mechanism for Medical Association of Georgia (MAG) policy. Under the sunset mechanism, policies adopted are systematically reviewed after adoption to assess their continuing timeliness and relevance. The MAG Board of Directors shall annually submit to the HOD, a list of MAG policy statements, which in the opinion of the Board no longer serve the best interests of the association.

At the October meeting, the Annual Session Committee will present a list of MAG policies five years old that were reviewed by relevant committees and recommendations made for: 1) retention and reaffirmation; 2) rescission and sunset; and 3) sunset with replacement by a new or revised policy.

The sunset mechanism for MAG policy was established to:

- Promote efficiency in HOD deliberations;
- Identify and rescind outmoded, duplicative, or inconsistent policies;
- Update and/or modify policies which are still pertinent but for which change has occurred; and
- Facilitate development and maintenance of a MAG policy information base and policy compendium.

A complete copy of the 2014 MAG Policy Compendium is posted on the MAG website. Of the 135 policies that were reviewed, 116 are being recommended for retention/reaffirmation, six are being recommended for sunset and 13 are being recommended for new language and replacement by a new or revised policy. Policies that have been recommended for sunset will be retained in MAG’s historical records.

The Annual Session Committee expresses its appreciation to the MAG Board, councils, committees and MAG staff for their continued assistance and cooperation in this activity, as well as MAG’s Department of Health Policy, which is in charge of maintaining the MAG Policy Compendium and organizes the five-year reviews. The contributions and collective expertise of the councils and committees have ensured the continued success of this project.

RECOMMENDATIONS:

1. That the policies set forth in Appendix I, be reaffirmed.
2. That the policies set forth in Appendix II, be sunset.
3. That the policies set forth in Appendix III, be sunset and replaced with new policy.

# # #
## MAG HOUSE OF DELEGATES

**Appendix I**

**MAG Policies for Reaffirmation**

<table>
<thead>
<tr>
<th>Policy #</th>
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<tr>
<td>5.999 Abortion</td>
<td>Abortions should be performed by a properly qualified Doctor of Medicine. The procedure should take place in a hospital or clinic that has personnel and facilities which will provide adequate protection against infection, and proper equipment to combat blood loss, shock or respiratory distress. Physicians must have the right to refuse to perform abortions for any reason. (HD 4/1/1983; Reaffirmed 10/2009) Reviewed by the Council on Legislation and determined to be still relevant.</td>
</tr>
<tr>
<td>20.991 Public Health Efforts to Prevent AIDS</td>
<td>MAG urges members to continue to seek information on AIDS relevant to their daily practice to enhance the success of public health efforts to prevent AIDS. When considering the potentially infectious nature of diseases such as HIV and Hepatitis B physicians should consider current evidence and act prudently with the patients' best interest in mind. (HD 10/17/2009) Reviewed by the Council on Legislation and determined to be still relevant.</td>
</tr>
<tr>
<td>20.999 Dignity of the Patient</td>
<td>MAG supports the dignity and self respect of all medical patients, and opposes all forms of prejudice against any medical patient. (HD 4/1/1988; Reaffirmed 05/2000, 10/2009) Reviewed by MAG Legal Counsel who found this policy still relevant.</td>
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<tr>
<th>Code</th>
<th>Description</th>
<th>Text</th>
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<tr>
<td>30.996</td>
<td>Alcohol Treatment Centers and the Disable Doctors Program</td>
<td>MAG supports the creation of sufficient alcoholic treatment centers to meet the need in Georgia. It believes that alcoholics should be taken to such centers and given proper medical treatment instead of being arrested and taken to jail for public drunkenness. Although Georgia no longer has a drug treatment program specifically for physicians, we support the concept and encourage the Georgia medical licensing board to establish one. This has been successfully done in other states. (HD 10/17/2009)</td>
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<td>Reviewed by the Council on Legislation. The Council determined this policy relevant. It believes that physicians who have been held in the public eye deserve discretion just as any other person when they encounter challenges related to substance abuse.</td>
</tr>
<tr>
<td>30.998</td>
<td>Alcohol Awareness Information</td>
<td>MAG recognizes the detrimental effects of alcohol advertising on the public and supports the use of warning labels on alcohol products and in ads. (HD 4/1/1988; Reaffirmed 05/2000, 10/2009)</td>
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<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<tr>
<td>35.980</td>
<td>Chiropractic Spinal Manipulation</td>
<td>MAG opposes the use of chiropractic spinal manipulation with anesthesia, and continues to educate MAG members of MAG’s concerns regarding such practices. (BD 4/18/2009)</td>
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<tr>
<td></td>
<td></td>
<td>Reviewed by the Council on Legislation. Chiropractic manipulation under anesthesia is considered surgery and surgery is not approved under the chiropractic practice act. This is a patient safety issue and should continue to be MAG’s position.</td>
</tr>
<tr>
<td>35.998</td>
<td>Delegation of Medical Acts</td>
<td>MAG affirms the authority of physicians to delegate medical acts to non-licensed individuals for which the physician is both responsible and liable. (HD 9/1/1983; Reaffirmed 05/2000, 10/2009)</td>
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<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<td>Code</td>
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<td>Policy Details</td>
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<tr>
<td>55.999</td>
<td>Cancer Registry</td>
<td>MAG supports the Central Cancer Registry and encourages hospitals to participate in reporting information to the Central Registry; MAG continues to encourage hospitals to develop hospital cancer programs and gain approval of these programs by survey from the Commission on Cancer of the American College of Surgeons. (HD 4/1/1987; Reaffirmed 5/2000, 10/2009)</td>
</tr>
<tr>
<td>85.992</td>
<td>Death - Definition</td>
<td>MAG has accepted the basic tenets of the World Health organization's statement on death: &quot;The point of death of the different cells and organs is not so important as the certainty that the process has become irreversible by whatever techniques of resuscitation that may be employed. This determination will be based on clinical judgment supplemented, if necessary, by a number of diagnostic aids including brain flow scans. However, no single technological criterion is entirely satisfactory in the present state of medicine nor can any technological procedure be substituted for the overall judgment of the physician&quot;. (HD 10/17/2009)</td>
</tr>
<tr>
<td>85.994</td>
<td>Medical Examiners System - Coroners</td>
<td>MAG supports the establishment of an independent permanent Board to direct and oversee the development and operation of the Medical Examiners System. The Board should be composed of members of the legal and medical profession, of law enforcement representatives and of citizens-at-large, all of whom, because of their special knowledge or interest, can provide meaningful contributions to such Board. The Georgia State Crime Laboratory should also be supervised by the Board.  (HD 4/1/1989; Reaffirmed 5/2000, 10/2009)</td>
</tr>
</tbody>
</table>
| Appendix I  
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| 85.997  
Opposition to the Coroners System | MAG supports the concept of a statewide medical examiners system rather than an elected county coroner system. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009)  
Reviewed by the Council on Legislation and determined to be still relevant. |
|---|---|
| 120.998  
Physician Dispensing | MAG affirms the physician's right to dispense medicine along appropriate guidelines. (HD 4/1/1988; Reaffirmed 05/2000, 10/2009)  
Reviewed by MAG Legal Counsel who found this policy still relevant. |
| 125.999  
Prior Approval for Generic Drug Substitution | Generic drug substitution by pharmacists without prior approval by the physician is not in the best interest of the patient because medical determinations concerning the prescription would no longer be made by the physician who has responsibility for the patient's health. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009)  
Reviewed by the Council on Legislation and determined to be still relevant. |
| 140.984  
Capital Punishment (Death Penalty) | The participation of physicians in the implementation of the death penalty, particularly by the method of lethal injection, should not be required by the State of Georgia, inasmuch as a physician's primary responsibility is to sustain and prolong life. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009)  
Reviewed by MAG Legal Counsel who found this policy still relevant. |
| 140.991  
Dignity of Human Life | MAG encourages physicians to affirm the dignity of human life by employing available pain relief, providing human companionship and giving opportunity for spiritual support and counseling in easing the suffering of their patients. (HD 4/1/1993; Reaffirmed 05/2000, 10/2009)  
Reviewed by the Council on Legislation and determined to be still relevant. |
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<tr>
<th>Section</th>
<th>Description</th>
<th>Relevant Information</th>
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<tbody>
<tr>
<td>140.999</td>
<td>Testing for Inherited Diseases</td>
<td>Testing for an inherited disease whose sole or principal means of prevention is control of human reproduction shall not be mandated by the State; Testing for an inherited disease shall not be mandated by the State unless mortality or irreversible morbidity can be prevented by administration of an effective treatment, the need for which is indicated by the test result in the asymptomatic patient; Testing shall not be mandated by the State for the sole purpose of detecting each and every individual who may carry or may have an inherited disease without consideration of the health care resources consumed thereby; Testing for an inherited disease shall be implemented in a way which retains the benefits resulting from the physician-patient relationship. (BD 1/1/1983; Reaffirmed 05/2000, 10/2009)</td>
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<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
</tr>
<tr>
<td>160.980</td>
<td>Indigent Care</td>
<td>MAG affirms its long standing commitment to assure all citizens' access to quality medical care, regardless of their ability to pay. MAG urges physicians to continue to provide medical care for indigent patients in order that no patient be deprived of medical care because of his/her inability to pay for it. MAG supports the expansion of the State Medicaid Program's adequate coverage of the indigent population. MAG encourages the expansion of participation by physicians in public health clinics, food kitchens for the poor, services to street people, to needy refugees, farmers, and other groups who fall between the cracks of government-funded medical assistance programs. (HD 10/17/2009; Special Report, Appendix III)</td>
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<td>Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
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<tr>
<td>160.981</td>
<td>Medical Home</td>
<td>MAG supports the concept of the medical home that is consistent with the AMA's Joint Principles or the patient-centered medical home. (HD 10/17/2009, Officer 1, Rec. 1)</td>
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<td>Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
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<tr>
<td>160.982</td>
<td>Holistic Medicine</td>
<td>Holistic medicine should be regarded as a philosophy rather than a science. MAG does not endorse holistic practices which lack clinical substantiation, but are commercially marketed and objects strongly to the implication that good health will result from employment of a specific ideology or practice. MAG believes that holistic health centers or clinics should have accountability to licensed physicians and licensed or certified health personnel. The public is encouraged to examine each such center or clinic on its own merits, judging its capability to deliver appropriate health care. MAG affirms the principle that the practice of medicine traditionally addresses the physical, mental and spiritual welfare of the patient. Physicians should continue to stress the patient's self-responsibility for health and to advise the patient on the importance of nutritional awareness, physical fitness and stress management. (HD 10/17/2009)</td>
</tr>
<tr>
<td>160.983</td>
<td>Freedom of Choice</td>
<td>MAG recognizes the freedom and right of patients to choose their doctors and the right of doctors to choose their patients, true emergency excepted, should be recognized. MAG also supports the patient's right of freedom of choice of method of payment. MAG is philosophically opposed to federal and state support of any one type of health care delivery system preferentially over another. (HD 10/17/2009; Special Report: Appendix III)</td>
</tr>
<tr>
<td>160.992</td>
<td>Medical Care for the Disadvantaged</td>
<td>MAG encourages its members to continue their commitment to caring for all patients regardless of their ability to pay.  (HD 4/1/1988) (Reaffirmed 05/2000; 10/2009)</td>
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| Appendix I  
Special: 04.14 |
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<tr>
<th>Section</th>
<th>Description</th>
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</table>
| 160.994 | Alternative Delivery System Advantages  
MAG vigorously opposes any legislation that would give alternative health care delivery systems statutory advantage over the traditional private practice of medicine. (HD 4/1/1987; Reaffirmed 05/2000, 10/2009)  
Reviewed by the Council on Legislation and determined to be still relevant. |
| 160.996 | Private Practice of Medicine - Definition  
MAG defines the private practice of medicine as the delivery of medical care which is carried out in a direct personal relationship in which direct responsibility for care and payment exists between the patient and physician. MAG supports an environment which allows the freedom of choice for both the patient and physician in selecting the location of the delivery of care, alternatives of treatment and the methods of payment for services rendered. (HD 4/1/1985; Reaffirmed 05/2000; 10/2009)  
Reviewed by the Third Party Payer Committee and determined to be still relevant. |
| 160.999 | Rural Health Clinics  
MAG supports rural health clinics provided they are under the direct supervision of a physician. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009)  
Reviewed by the Council on Legislation and determined to be still relevant. |
| 165.974 | Health Care Access  
The Medical Association of Georgia, through lobbying activities and through grassroots membership advocacy activities at the local, state and national levels, shall promote health care reform that supports expansion of health care access for our patients. (HD 10/17/2009; Res. 602HSR.09)  
Reviewed by the Council on Legislation and determined to be still relevant. |
<table>
<thead>
<tr>
<th>165.975</th>
<th>Medical Home</th>
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<tbody>
<tr>
<td>The Medical Association of Georgia, through lobbying activities and through grassroots membership advocacy activities at the local, state and national levels, shall promote health care reform that supports patient-centeredness by expansion of pilot projects for the Patient-Centered Medical Home. (HD 10/17/2009; Res. 602HSR.09)</td>
<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<thead>
<tr>
<th>165.976</th>
<th>Payment System Reform</th>
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<tbody>
<tr>
<td>The Medical Association of Georgia, through lobbying activities at the local, state and national levels, shall promote health care reform that supports the revitalization of primary care via payment system reform and workforce augmentations. (HD 10/17/2009; Res. 602HSR.09)</td>
<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<tr>
<th>165.977</th>
<th>Health Care Benefits to Illegals</th>
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</thead>
<tbody>
<tr>
<td>MAG opposes legislation that would allow individuals that are not lawfully in the United States to obtain health care benefits funded in whole or in part by the U.S. government. (HD 10/17/2009; Officer 1, Rec. 13)</td>
<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<tr>
<th>165.978</th>
<th>Individual Health Insurance Mandate</th>
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<tbody>
<tr>
<td>MAG opposes any statutory imposed mandate that individuals secure health insurance. (HD 10/17/2009; Officer 1, Rec 12)</td>
<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<tr>
<th>165.979</th>
<th>Employer Health Insurance Mandate</th>
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</thead>
<tbody>
<tr>
<td>MAG opposes any statutory mandate that employers provide health insurance benefits to their employees. (HD 10/17/2009; Officer 1, Rec. 11)</td>
<td>Reviewed by the Council on Legislation and determined this policy to be still relevant.</td>
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<tr>
<td>165.980</td>
<td>Government-run Health Plan</td>
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<tr>
<td>165.982</td>
<td>Health Insurance Tax Credit</td>
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<tr>
<td>165.983</td>
<td>Right to Privately Contract</td>
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<tr>
<td>165.984</td>
<td>Individual Insurance Ownership</td>
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<tr>
<td>165.985</td>
<td>Patient-/Physician Relations</td>
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<td>Code</td>
<td>Description</td>
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<tr>
<td>180.975</td>
<td>Health Plan Formulary</td>
</tr>
<tr>
<td>180.976</td>
<td>Health - Individual Retirement Accounts (IRAs)</td>
</tr>
<tr>
<td>180.977</td>
<td>Health Insurance Provision</td>
</tr>
<tr>
<td>180.992</td>
<td>Patients' Rights - Health Insurance</td>
</tr>
</tbody>
</table>
| Code       | Description                                      | Details                                                                                                                                                                                                 | Relevance
|------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| 180.993    | Preadmission Certification - Administrative Services | Preadmission requests by third party payers is a service by physicians to third party payers which is unrelated to patient service; consequently, third party payers are obligated to pay separately for these services. (HD 4/1/1986; Reaffirmed 05/2000, 10/2009) | Reviewed by the Third Party Payer Committee and determined to be still relevant.
| 180.996    | Alternative Payment Mechanisms                   | MAG supports the development of alternative mechanisms of payment for care that increase patient awareness and involvement in the reimbursement process. (HD 4/1/1984; Reaffirmed 05/2000, 10/2009) | Reviewed by the Third Party Payer Committee and determined to be still relevant.
| 180.998    | Utilization Review Mechanisms                    | MAG supports the concept that every hospital medical staff should have a viable, active and effective utilization review mechanism, recognizing that specific needs will vary from place to place, and that in some instances, combined or joint efforts by smaller facilities may be necessary in order to provide utilization review of an acceptable quality. MAG agrees strongly that true utilization review by physicians should be done only to determine the appropriateness and quality of care rendered. it should never be performed as fiscal review. MAG does not believe that physicians performing medical services should be required to perform utilization review simply to aid a facility insurer or other third party to reduce their operating costs. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009) | Reviewed by the Third Party Payer Committee and determined to be still relevant.
<p>| 185.978    | Telephone Message Reimbursements                 | MAG supports third party payer reimbursement for physician services provided by electronic means. (HD 10/17/2009; Special Report, Appendix III)                                                                 | Reviewed by the Third Party Payer Committee and determined to be still relevant. |</p>
<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>Policy Statement</th>
<th>Reviewed by the Committee and determined to be still relevant.</th>
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<tbody>
<tr>
<td>185.979</td>
<td>Health Benefits</td>
<td>MAG supports the inclusion of age and gender appropriate primary and preventative health benefits in insurance and other related legislation and supports clearly defined benefits. (BD 1/24/2009)</td>
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<td>reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
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<tr>
<td>190.990</td>
<td>Timely Submission of Claims</td>
<td>MAG supports establishing a requirement that insurance companies may not deny payment of a claim on the basis that the claim is untimely submitted, provided that the claim is submitted within one year of the date of service. (HD 5/1/1998, Res. 205B-98) (Reaffirmed 10/2009)</td>
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<td>reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
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<tr>
<td>190.996</td>
<td>Claims Processing and Claims Denials</td>
<td>MAG should encourage third party payers to improve timely notification regarding any and all denied claims. (HD 4/1/1989; Reaffirmed 05/2000, 10/2009)</td>
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<td>reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
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<tr>
<td>200.998</td>
<td>Physician Placement</td>
<td>MAG supports the recruitment of fully licensed physicians for short-term, general medicine assignments at Indian Health Service and National Service Corps hospitals and clinics. (EC 12/1/1986; Reaffirmed 05/2000; 10/2009)</td>
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<td></td>
<td></td>
<td>The Council on Legislation reviewed this policy statement and found it still relevant.</td>
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</tr>
<tr>
<td>200.999</td>
<td>Physician Placement</td>
<td>MAG supports computerized placement services and the recruitment efforts of the Georgia Board for Physician Workforce. (HD 4/1/1984; Reaffirmed 05/2000, 10/2009)</td>
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<tr>
<td></td>
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<td>This policy statement was reviewed administratively and determined it to be relevant. MAG continues to support physician placement and the Georgia Board of Physician Workforce.</td>
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<tr>
<td>205.989 Certificate of Need - Laws &amp; Regulations</td>
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It is the position of the Medical Association of Georgia that Certificate of Need is anti-competitive, restricts the development of physician-owned and operated ambulatory surgical procedure and imaging centers, laboratories, and ancillary services, and limits the ability of physicians’ to deliver high quality, cost-effective care to Georgia’s patients.

The Medical Association of Georgia opposes Certificate of Need and supports the repeal of Certificate of Need laws in general and specifically as they apply to physician-owned and operated outpatient diagnostic centers, imaging centers, ambulatory surgical centers, laboratories and ancillary services. The Medical Association of Georgia will endeavor to educate legislators and the business community about the policy benefits of eliminating Certificate of Need.

Until Georgia’s Certificate of Need laws are repealed, the Medical Association of Georgia opposes any changes to such laws that would make it more difficult for physicians to establish and operate ambulatory surgical centers, such as making it more difficult to obtain an exemption from Certificate of Need review or decreasing the capital, equipment, single-specialty physician-owned ASC, or joint venture ASC expenditure thresholds.

With respect to exemptions from Certificate of Need review (and obtaining a Letter of Non-Reviewability), the Medical Association of Georgia supports expanding the exemption from Certificate of Need review for single-specialty physician-owned ambulatory surgical centers to multispecialty physician-owned ambulatory surgical centers. In the alternative, the Medical Association of Georgia supports recognition as a “single-specialty”, for purposes of the single-specialty exemption from Certificate of Need review (and obtaining a Letter of Non-Reviewability) for physician-owned ambulatory surgical centers, any specialty or subspecialty recognized by the American Board of Medical Specialties. The Medical Association of Georgia opposes statutory or regulatory provisions that authorize a competitor of an applicant for an exemption from Certificate of Need review (and Letter of Non-Reviewability) to challenge a determination by the Department of Health that the applicant’s proposed project is exempt from Certificate of Need review. The Medical Association of Georgia will support MAG members who seek legal remedies to Certificate of Need provisions that are unfair to physicians.” (HD 10/17/2009; Special Report, Appendix III)

Reviewed by the Council on Legislation and determined to be still relevant.
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<tr>
<th>Code</th>
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<tbody>
<tr>
<td>210.998</td>
<td>Home Health Care - Physician Payment</td>
<td>MAG supports development of a method (such as CPT Codes) identifying services for reimbursement of physicians who are managing the care of home bound patients through a home health care agency. (HD 4/1/1987; Reaffirmed 5/2000, 10/2009)</td>
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<td>Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
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<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<tr>
<td>215.990</td>
<td>Protocols</td>
<td>MAG opposes the use of registered nurse and physician assistant protocols for hospital employees in employee health clinics. (EC 1/23/2009)</td>
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<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<tr>
<td>215.998</td>
<td>Transfusion Products</td>
<td>MAG supports requiring hospitals providing obstetrical services to have blood products for transfusion immediately available. (HD 4/1/1983; Reaffirmed 5/2000; 10/17/2009)</td>
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<td>Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
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<tr>
<td>230.999</td>
<td>Conditions of Medical Staff Privileges</td>
<td>MAG opposes any requirement that physicians accept Medicare assignment as a condition of medical staff membership. (HD 4/1/1984; Reaffirmed 05/2000, 10/2009)</td>
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<td>Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
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</table>
| 265.993 | Expert Witness                                  | MAG supports the following definition of "expert witness" for the purpose of testifying in medical malpractice cases: "An expert is a physician who has completed an Accreditation Council for Graduate Medical Education approved residency training program in the specialty in which her or she is testifying and is engaged in the clinical practice of that specialty at least 75 percent of the time."  
(HD 10/17/2009 Special Report, Appendix III)                                                                                      | MAG Legal Counsel who found this policy still relevant.                                           |
| 270.978 | Scope of Practice - Opposes Expansion            | MAG continues to vigorously oppose legislation and regulatory action that expand the scope of practice for non-physician health care providers.  
| 275.998 | Laser Surgery Training                          | MAG believes that laser surgery and therapy should be performed only by a licensed physician who meets appropriate professional standards as evidenced by training, experience and credentials.  
MAG further encourages and supports state legislation and rule making by state medical boards in support of this policy.  
| 275.999 | Stratified Licensure - Opposition                | MAG opposes any efforts on the part of government to implement or impose any stratified, tiered, or restrictive licensure structure that limits the practice of a duly licensed physician.  
| Code   | Description                                           | Text                                                                 | Applicable
|--------|-------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------
| 280.986| Nursing Home Care Payments                            | MAG supports Medicare and Medicaid payments to nursing homes based on the actual level of care required for each patient. Providers of nursing home care should be required to adopt a process for admissions to skilled nursing home beds that do not discriminate against the more debilitated patient. (HD 10/17/2009; Special Report, Appendix III) | Reviewed by the Third Party Payer Committee and determined to be still relevant.
| 280.996| Improve Long-Term Care                                | MAG will continue to work with all appropriate agencies to develop and implement recommendations to improve long-term care in Georgia. (HD 4/1/1991; Reaffirmed 05/2000; 10/2009) | Reviewed by the Council on Legislation and determined to be still relevant.
| 280.999| Quality of Nursing Home Care                          | MAG believes its position that high-quality medical care should be assured for all nursing home patients. Alliant GMC F is best qualified to do peer review for quality health care for nursing home patients. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009) | Reviewed by the Third Party Payer Committee and determined to be still relevant.
| 285.975| Medicaid - Access to Care                             | The Medical Association of Georgia opposes any managed care of financing reform that will adversely affect the access to care of Georgia's patients or decrease participation of physicians in those plans, especially in rural communities. (HD 10/17/2009; Special Report, Appendix III) | Reviewed by the Third Party Payer Committee and determined to be still relevant.
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<tr>
<th>Code</th>
<th>Issue</th>
<th>Description</th>
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<tbody>
<tr>
<td>285.999</td>
<td>Capitation Reimbursement</td>
<td>While recognizing the rights of a practicing physician to enter into contractual arrangements with any alternate health care system he/she deems desirable and necessary, as a matter of policy, MAG opposes individual capitation reimbursement systems. (HD 4/1/1987; Reaffirmed 05/2000, 10/2009)</td>
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<td>Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
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<tr>
<td>290.973</td>
<td>Medicaid Eligibility Expansions</td>
<td>The Third Party Payer Committee reviewed this policy statement and found it still relevant. MAG supports legislation that would ensure that 90 percent of those individuals under 200 percent of the federal poverty level be enrolled in Medicaid or SCHIP before eligibility in those programs are expanded. (HD 10/17/2009; Officer 1, Rec. 7)</td>
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<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<tr>
<td>290.991</td>
<td>Voucher System</td>
<td>MAG supports the development of programs that allow the Medicaid population to utilize a voucher system to purchase their choice of health insurance including HMO, PPO, indemnity, or acquire a medical savings account. (EC 5/1/1995; Reaffirmed 05/2000, 10/2009)</td>
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<td>Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
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<tr>
<td>290.993</td>
<td>Drug Utilization Review</td>
<td>MAG supports legislation that establishes the confidentiality of physician profiles (i.e., deviations from established standards) that have been formed in the course of Drug Utilization Review by Medicaid agencies or other state agencies. (HD 4/1/1993; Reaffirmed 05/2000, 10/2009)</td>
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<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<tr>
<td>295.989</td>
<td>Primary Care Physicians</td>
<td>MAG recognizes its commitment to the important role of primary care in medicine and believes there should be increased financial incentives for physicians practicing primary care. (HD 10/17/2009; Officer 1, Rec. 3) Reviewed by the Council on Legislation and determined to be still relevant.</td>
</tr>
<tr>
<td>305.999</td>
<td>Primary Care Training</td>
<td>MAG actively supports and encourages expansion of the training in family practice and other primary care practices and encourages the Governor and the Legislature to provide state support for this training. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009) Reviewed by the Council on Legislation and determined to be still relevant.</td>
</tr>
<tr>
<td>310.999</td>
<td>Graduate Medical Education - Funding</td>
<td>MAG opposes cuts in funding of post graduate medical education in the absence of stable alternate funding sources. (HD 4/1/1985; Reaffirmed 05/2000, 10-2009)</td>
</tr>
<tr>
<td>320.998</td>
<td>Utilization Review</td>
<td>MAG supports: (1) a cooperative study with third party payers and utilization reviewers to develop a streamlined UR system; (2) reminding physicians to release confidential information only after securing a patient medical release; and (3) a physician's authority to charge third party payers for responding to certain extensive inquiries. (HD 4/1/1988; Reaffirmed 05/2000, 10/2009) Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
</tr>
<tr>
<td>330.975</td>
<td>Acceptance of Patients</td>
<td>MAG urges physicians to continue to see Medicare patients. (HD 10/17/2009; Special Report, Appendix III)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>330.976</td>
<td>Payment Denial</td>
<td>MAG opposes &quot;medical necessity&quot; definition in CMS rules and regulations and the use of other CMS-developed &quot;standards&quot; as a measure of quality care and as a basis of payment denial. (HD 10/17/2009; Special Report, Attachment III)</td>
</tr>
<tr>
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<td></td>
<td>Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
</tr>
<tr>
<td>330.991</td>
<td>Audit Methods</td>
<td>MAG supports legislative or regulatory relief to eliminate the extrapolation method in physician Medicare audits. (HD 4/1/1992; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
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<td>Reviewed by the Third Party Payer Committee and determined to be still relevant.</td>
</tr>
<tr>
<td>330.998</td>
<td>Pre-certification</td>
<td>MAG supports allowing patients to obtain their own pre-certification authorization number. (HOD 4/1/1989; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
</tr>
<tr>
<td>355.996</td>
<td>National Practitioner Data Bank Reform</td>
<td>MAG objects to the establishment and methodology employed by the National Practitioners Data Bank (NPDB) on the basis that the Department of Health and Human Services exceeded its statutory authority. We support vigorous efforts against broadening the scope of the NPDB) and toward remedial action to correct all operational problems, including data accuracy and completeness. We object to extended peer review reporting in view of the extreme threat this poses to confidentiality of such information and, in fact, recommend a more restrictive definition of “peer review organization” be made. We believe the Secretary should exercise his statutory authority to afford physicians and other practitioners meaningful opportunities to dispute the accuracy of claims reported to the NPDB and to require the removal of inaccurate reports. (HD 10/17/2009; Special Report, Appendix III)</td>
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<td></td>
<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<td>Code</td>
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<tr>
<td>380.999</td>
<td>Balanced Billing</td>
<td>The Medical Association of Georgia opposes any legislative attempts to prohibit the balanced billing of patients by non-contracted physicians. (HD 10/17/2009; Res. 305C.09)</td>
</tr>
<tr>
<td>385.996</td>
<td>Payment System Framework</td>
<td>MAG endorses any payment system that meets the following criteria: 1) Encourages the development of both patient and physician responsibility, trust, and mutual respect; 2) Increases patient awareness in the reimbursement process; 3) Offers freedom for their services, as well as the method of payment they deem acceptable; and 4) Offers freedom of patients to select providers and their means of paying for the services they receive. (HD 10/17/2009; Special Report, Appendix III)</td>
</tr>
<tr>
<td>390.984</td>
<td>Medicare Mandated Assignment</td>
<td>MAG opposes legislation requiring mandatory assignment of Medicare benefits. (HD 10/17/2009; Special Report, Appendix III)</td>
</tr>
<tr>
<td>390.996</td>
<td>Reimbursement Changes</td>
<td>MAG should continue to use its resources to keep physicians informed of the reimbursement changes occurring in Medicare and Medicaid and express strong opposition to those payment system changes that interfere with the efficient and high quality practice of medicine. (HD 4/1/1987; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
<td>406.977</td>
<td>Education</td>
<td>MAG believes that any health care data collection system should be primarily directed toward education, both for consumers and providers; MAG supports a statewide clearinghouse within Georgia's state health programs which are available for website access by the public. (HD 10/17/2009; Special Report, Appendix III)</td>
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<td>Code</td>
<td>Description</td>
<td>Details</td>
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</tr>
<tr>
<td>420.994</td>
<td>Insurance Coverage</td>
<td>MAG supports coverage for newborn sickness, pregnancy complications, or pre-existing conditions. (HD 10/17/2009, Special Report, Appendix III)</td>
</tr>
<tr>
<td>420.997</td>
<td>Funding</td>
<td>MAG supports the funding for care of the indigent and medically indigent mothers and infants in Georgia. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
<td>420.998</td>
<td>High Risk</td>
<td>MAG supports development of care for high-risk mothers and premature newborn infants. This should be accomplished in a manner that follows normal referral patterns which may or may not comply with designated health areas, but protects the well-being of the patient. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
<td>440.976</td>
<td>Tanning Beds</td>
<td>MAG will work through appropriate channels to urge the AMA and the state of Georgia to use the World Health Organization rating that indoor tanning is of the same class of carcinogen as asbestos and tobacco in order to protect the public from the dangers of indoor tanning, specifically supporting the following: a) a ban on use of tanning beds by minors; b) signed consent forms that specify the risk of melanoma and other forms of skin cancer for users of indoor tanning; and c) a ban on calling indoor tanning &quot;safe.&quot; ( HD 10/17/2009; Res, 105A.09)</td>
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<tr>
<td>440.977</td>
<td>Defibrillators for Police</td>
<td>MAG supports all efforts to equip police with Automatic External Defibrillators (AED) and the training of police officers in the proper use of AEDs. (HD 10/17/2009; Resolution 104A.09)</td>
</tr>
<tr>
<td>440.996</td>
<td>Hepatitis B Virus Immunization</td>
<td>MAG believes that physicians, in proposing prophylaxis with either the plasma-derived or the recombinant DNA Hepatitis B vaccine, include in their consideration, persons in susceptible pre-exposure categories, including, but not limited to, health care personnel, homosexual men and women with multiple sex partners and other high-risk groups. (HD 4/1/1987; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
<td>445.998</td>
<td>Clinical Medicine Public Education and Inquiry</td>
<td>Although the Medical Association of Georgia may comment from time to time on various matters relating to the treatment of disease and/or the maintenance of health, the public may best access medical information on the state's public health, CDC and HHS websites. Other more detailed information may be sought on the AMA website or that of other national medical specialty societies. The Medical Association of Georgia publicly endorses and supports this approach as the most appropriate way to serve both the public need for information and the need to maintain the highest possible level of objective scientific integrity. (HD 10/17/2009; Special Report, Appendix III)</td>
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<tr>
<td>470.990</td>
<td>Steroids - Use By High School Athletes</td>
<td>MAG urges all Georgia junior high and high schools to be aware of the dangerous side effects of the use of steroids. Printed materials and/or seminars conducted for athletes, coaches and parents are available at various locations. (HD 10/17/2009; Special Report, Appendix III)</td>
</tr>
<tr>
<td>470.993</td>
<td>Boxing Opposition</td>
<td>MAG supports elimination of both amateur and professional boxing, a sport in which the primary objective is to inflict injury. (HD 1/1/1987; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
<td>470.995</td>
<td>Medical Evaluation</td>
<td>MAG believes that an unconscious athlete must have a medical evaluation by a licensed medical doctor. The athlete should not be allowed to return to the same contest in which he/she was rendered unconscious. (EC 8/1/1985; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
<td>470.997</td>
<td>Horseback Riding Safety</td>
<td>MAG promotes the need for educational programs to be given to parents, riding instructors, show organizers and managers outlining the risks of horseback riding and methods to minimize those risks. MAG recommends that, where appropriate, satisfactory protective headgear should be selected for each type of riding activity and worn when riding or preparing to ride. (HD 8/1/1984; Reaffirmed 05/2000, 10/2009)</td>
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<tr>
<td>490.999</td>
<td>Smoking Opposition</td>
<td>MAG urges physicians to eliminate cigarette smoking as a personal habit, and also urges smoking to be eliminated from all medical and health-related facilities. MAG actively promotes cessation of smoking among patients and staff. MAG should use its influence to enact anti-smoking legislation within local communities and with health related professionals to gain their cooperation in antismoking efforts. MAG opposes any smoking in any MAG meeting and at MAG headquarters. MAG encourages county medical societies to initiate and support efforts to reduce smoking and other substance abuse in local schools. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
<td></td>
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<td>Reviewed by a task force of physician members and determined to be still relevant.</td>
</tr>
<tr>
<td>505.997</td>
<td>Cigarette Excise Tax</td>
<td>MAG supports an increase of the federal excise tax on cigarettes with the provision that income from this additional taxation be earmarked as revenues for Medicare. (HD 4/1/1987; Reaffirmed 05/2000, 10/2009)</td>
</tr>
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<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
</tr>
<tr>
<td>505.999</td>
<td>Tobacco Sale to Minors</td>
<td>MAG supports the prohibition of the sale of tobacco products to minors. (BD 1/1/1987; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
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<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
</tr>
<tr>
<td>515.994</td>
<td>Sexual Assault Guidelines</td>
<td>MAG supports the use of Sexual Assault Guidelines issued by both the American College of Obstetricians &amp; Gynecologists and the American College of Surgeons as modified to conform with Georgia laws for use as a model by hospital emergency rooms and rape crisis centers throughout Georgia (HD 10/17/2009; Special Report, Appendix III)</td>
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<td></td>
<td>Reviewed by the Council on Legislation and determined to be still relevant.</td>
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<tr>
<td>Code</td>
<td>Policy Title</td>
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<tr>
<td>515.998</td>
<td>Battered Women Information</td>
<td>MAG supports disseminating to all members information on the recognition and treatment of battered women, including statewide referral support systems. (BD 6/1/1989; Reaffirmed 05/2000, 10/2009)</td>
</tr>
<tr>
<td>530.885</td>
<td>Investment Policy</td>
<td>The MAG Board of Directors shall adopt an Investment Policy consistent with the goals of accumulation of capital and the preservation of its value for the economic betterment of MAG. (HD10/17/09)</td>
</tr>
<tr>
<td>530.886</td>
<td>Policy Guidelines - Sunset</td>
<td>The Board of Directors shall submit to the House of Delegates annually a list of MAG policy statements, which in the opinion of the Board no longer serve the best interest of the Association. The presence of policy statement on the list shall be a clear indication that such statement is no longer the policy of the Association, unless by action of the House, they are removed from the list. (HD 10/17/2009; Special Report -- appendix III)</td>
</tr>
<tr>
<td>530.887</td>
<td>Balanced Budget</td>
<td>The Board of Directors shall approve a balanced annual operating budget (HD 10/17/09)</td>
</tr>
<tr>
<td>530.888 Specialty Societies Recognition</td>
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</table>

MAG shall adhere to the following guidelines for recognizing state specialty societies: 1) The MAG Board of Directors may, by a majority vote, recognize certain state specialty societies for the purposes of seating in the House of Delegates, the Council on Legislation and other purposes as specified in the Bylaws; 2) A “specialty” should represent a field of medicine that has recognized scientific validity. A clearly defined subspecialty of internal medicine or surgery may be regarded as a distinct specialty. A specialty must be recognized by the American Board of Medical Specialties; 3) It is desirable, but not necessary, that a specialty society have a relationship to a national specialty society; 4) An applying specialty society should not already be represented within MAG by other societies. In those cases in which multiple societies exist in a single specialty field, representation in MAG should be granted to the society that has a relationship with a national specialty society. If more than one society has a relationship with a national specialty society, representation in MAG may be shared by having societies alternate in voting privileges at meetings. Ultimately, the MAG Board of Directors determines which state specialty society will represent the physicians of that specialty. Notwithstanding the foregoing, no specialty society with representation in MAG on January 1, 2009 shall forfeit such representation as it then existed as a result of this paragraph; 5) Physicians should comprise at least 75 percent of the active voting membership of the specialty society; 6) A specialty society should be established and stable. It should have been in existence in Georgia for at least two years, have a formal leadership and membership structure, and conduct at least one meeting per year; 7) A majority of the physician members of the specialty society should be practicing within the field of the specialty; 8) Specialty society representatives must be MAG members. The specialty society representatives shall work diligently to increase its specialty society’s membership in MAG; 9) Specialty society representatives will be accountable for the same attendance and participation requirements as all other MAG members; and 10) Specialty society delegates to the MAG House of Delegates should be elected by their sponsoring societies. (EC 1/23/2009)

Reviewed by Membership Department and determined to be still relevant. MAG works closely with each specialty society to ensure that all physicians, regardless of specialty, are represented at the House of Delegates meeting. Recognized specialties are given an opportunity each year to qualify for delegate entitlement, and if so entitled, to submit delegates to attend the House of Delegates meeting. This also applies to representation on MAG’s Council on Legislation to that all recognized specialty societies in the state have a voice in the legislative process.
| Appendix I  
| Special: 04.14 |
|---|---|
| **530.978**  
**MAG Journal Evaluations** | MAG's Board of Directors should continue to constantly evaluate the Journal and its Editor, but not set a specific term of service for the Editor.  
(HD 4/1/1994; Reaffirmed 05/2000, 10/2009)  
Reviewed by Editorial Board that found this policy still relevant and should continue. |
| **530.992**  
**Contractual Practice** | MAG should monitor corporate and contractual medicine developments in the state. (HD 530.992; Reaffirmed 05/2000, 10/2009)  
Reviewed by the Council on Legislation and determined to be still relevant. |
| **535.981**  
**Executive Committee Reports** | MAG Board of Directors will approve all actions of the Executive Committee since the previous Board meeting. (HD 10/17/2009)  
Reviewed administratively and determined to be still relevant. |
| **535.982**  
**CMS/Specialty Society Liaison** | MAG member leadership and/or staff designated shall make a special effort to visit component medical and specialty societies upon request to relay information and to respond to concerns.  
(HD 10/17/2009)  
Reviewed by Membership Department and determined to be still relevant. MAG staff and leadership are always available and willing to meet with component societies and specialties. In addition, MAG provides quarterly meetings with specialty society and component society executives to relay information and respond to concerns. |
| **535.983**  
**Voting Privileges** | The bylaws of all MAG-related entities should assure that the President and Treasurer of the Medical Association of Georgia are designated as full voting members of each respective Board of Directors and that the Executive Director be seated as a member of each respective entity's Board of Directors with voting privileges to be determined by the respective Boards.  
(HD 10/17/2009)  
Reviewed administratively and determined to be still relevant. |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>540.998</td>
<td>Council on Legislation - Coordination of Efforts</td>
<td>Specialty groups and individual members should discuss proposed legislation with the Council on Legislation and the lobbyists/consultants for specialty societies should be encouraged to work with the MAG legislative staff for better coordination of efforts. (HD 4/1/1988; Reaffirmed 05/2000, 10/2009) Reviewed by the Council on Legislation and determined to be still relevant.</td>
</tr>
<tr>
<td>545.949</td>
<td>Electronic Transmissions</td>
<td>All reports and resolutions submitted to the MAG House of Delegates should be transmitted electronically. (EC 8/22/2004) (Reaffirmed 10/2009) Review by the Annual Session Committee and determined to be still relevant. Electronic transmission of House of Delegates reports is not only environmentally conscious it also ensures an electronic footprint of the information for tracking purposes.</td>
</tr>
<tr>
<td>555.975</td>
<td>Dues &amp; Assessment / Reinstatement</td>
<td>An active member who fails to pay one year of dues may be reinstated by paying the current year's dues. If he/she fails to pay for more than one year, he/she may be reinstated with payment of the current year. (HD 10/17/09) Reviewed by the Finance Committee and determined to be still relevant.</td>
</tr>
<tr>
<td>555.999</td>
<td>Unified Membership - AMA</td>
<td>MAG, in lieu of supporting unified membership with the AMA, shall encourage its members to join the AMA. (HD 4/1/1985; Reaffirmed 05/2000, 10/2009) Reviewed by Membership Department and determined to be still relevant. MAG works closely with the AMA and sends a delegation to its meetings. Also Georgia students and residents attend these meeting through section representations. We encourage our members to join both MAG and the AMA but feel it should be the physicians discretion to decide to which associations they belong.</td>
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<tr>
<td>565.960</td>
<td>Political Activities by Physicians</td>
<td>MAG urges more participation in Georgia's political scene by physicians running for office or by active support of physicians who seek office and are supportive to the issues important to the physicians and patients of Georgia. MAG requests every specialty society in Georgia to become active in the overall objectives of MAG on its legislative programs. MAG recommends that each county medical society urge its membership to know their congressmen and senators and to actively participate in their campaigns. MAG recommends that each county society have several of their members contact their representatives and senators and to actively participate in their campaigns. MAG recommends that each county society have several of their members contact their representatives and senators regarding how specific national legislation affects the physicians of their district. (HD 10/17/2009; Special Report, Appendix III)</td>
</tr>
<tr>
<td>565.969</td>
<td>Political Contributions</td>
<td>MAG encourages physicians to look upon participation (especially financial participation) as a &quot;part of doing business&quot; and recommends that each physician set aside a percentage of practice income for the purpose of GAMPAC membership and for individual political contributions to such local and state candidates as may be recommended. (HD 10/29/2004; Reaffirmed 10/2009)</td>
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### MAG HOUSE OF DELEGATES

#### Appendix II

**MAG Policies for Sunset**

<table>
<thead>
<tr>
<th>Policy #</th>
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<tr>
<td>165.981 Defined Contributions for Health Insurance Sunset</td>
<td>MAG supports the promotion of defined contributions, which allow employers to provide pre-tax monetary contributions to employees for the purchase of private health insurance in lieu of an employer-sponsored health care plan. (HD 10/17/2009, Officer 1, Rec. 9) Reviewed by the Third Party Payer Committee and recommended for sunset. The issues within the statement is no longer possible under the Affordable Care Act and is no longer relevant as a MAG policy statement.</td>
</tr>
<tr>
<td>180.995 Confidentiality-Patients Group Medical Insurance</td>
<td>MAG supports a remedy to the problem of employers violation of employee/patient confidentiality in the area of group medical insurance claim forms. (HD 4/1/1984; Reaffirmed 05/2000, 10/2009) MAG Legal Counsel reviewed this policy statement and concluded that this was originally a directive and not a policy statement and therefore, recommended sunset. This statement began as a 1984 resolution that read: MAG begin immediate steps seeking a remedy to the problem of employers violation of employee/patient confidentiality with group medical insurance claim forms, and that the proper MAG committee report its findings to the MAG Board of Directors.</td>
</tr>
<tr>
<td>185.998 Well Child Care Coverage</td>
<td>MAG strongly supports insurance coverage for well child supervision. (HD 4/1/1988; Reaffirmed 05/2000,10/2009) Reviewed by the Third Party Payer Committee and recommended for sunset. Preventive services have been covered for many years since this original policy and per the Affordable Care Act, preventive care is covered by all payers.</td>
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<td>Code</td>
<td>Description</td>
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<tr>
<td>295.999</td>
<td>Medical Schools - Curriculum</td>
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<tr>
<td>320.997</td>
<td>Patients' Responsibility</td>
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<tr>
<td>385.999</td>
<td>Cognitive Services</td>
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# # #
### Policy # 140.997
**NonScientific Treatment**

Any treatment which has no scientific basis constitutes a hazard to health care, tends to deceive the patient by giving him false hope, and may cause the patient to delay seeking proper care until his condition becomes irreversible. The public should be informed about the nature of any purported treatment program which has no scientific basis, and the medical profession is well qualified and has a professional responsibility to inform the public regarding such programs. Physical examinations, such as school athlete examinations, should not be performed by nonscientific practitioners but should be performed by those practitioners licensed and qualified to identify all possible conditions reasonably related to the activity to be undertaken by the patient. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009)

**New Language Preferred:**

Any treatment which has no scientific basis constitutes a hazard to health care, tends to deceive the patient by giving him false hope, and may cause the patient to delay seeking proper care until his condition becomes irreversible. Medications that have not been FDA approved shall not be considered absent scientific basis if there is conclusive evidence of its ability to improve a health outcome. The public should be informed about the nature of any purported treatment program which has no scientific basis, and the medical profession is well qualified and has a professional responsibility to inform the public regarding such programs. Physical examinations, such as school athlete examinations, should not be performed by nonscientific practitioners but should be performed by those practitioners licensed and qualified to identify all possible conditions reasonably related to the activity to be undertaken by the patient.

Reviewed by the Council on Legislation that recommended language change. Georgia has been considering usage of drugs that are not FDA approved. Cannabidiol is an example of a drug that has not been FDA approved but has demonstrated positive effects to health outcomes.

### Policy # 165.973
**Sustainable Growth Rate Repeal**

MAG supports repeal of the sustainable growth rate (SGR) in a manner that eliminates the accumulated cuts and bases future Medicare payments to the Medicare Economic Index. (HD 10/17/2009, Officer 1, Rec. 8)

**New Language Preferred:**

MAG supports repeal of the sustainable growth rate (SGR).

Reviewed by the Third Party Payer Committee that recommended language change. The Committee offered a change in the language of the statement that eliminated the reference to the Economic Index.
### Appendix III
Special Report:

<table>
<thead>
<tr>
<th>165.999</th>
<th>Opposition to Profits from Withholding Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAG shall not become involved in any medical care system in which the physician profits from withholding necessary care from patients. (HD 4/1/1987) (Reaffirmed 05/2000; 10/2009)</td>
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<tr>
<td>New Language Preferred: MAG shall not become involved in any medical care system in which the withholding of necessary care from a patient will increase the physicians profits.</td>
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<tr>
<td>Reviewed by the Third Party Payer Committee that recommended language change for clarity.</td>
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<thead>
<tr>
<th>185.980</th>
<th>Prior Authorization</th>
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<tbody>
<tr>
<td>MAG principles on prior authorization are that:</td>
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<tr>
<td>1. Health plans, rather than physicians, should be responsible for checking its own data base of information to verify the patient’s eligibility and coverage information during prior authorization; 2. Patient and health plan information that is obtained by a physician from the health plan’s website in conjunction with a request for prior authorization should be considered forever valid by the health plan for claims payment and any other audit process; 3. Health plans should only allow physicians who perform the medical service or procedure to submit the request for prior authorization; 4. Once a prior authorization request for a service or procedures is approved by the health plan, and the health plan validates the patient’s eligibility and coverage, the health plan is obligated to pay for the service that’s billed by the physician; 5. All managed care contracts should include the provisions that are highlighted in these principles; 6. All health plan requests for patient clinical information made in conjunction with a physician’s request for prior authorization should be commensurate with the complexity of the procedure or service that’s requested; 7. Health plans should provide a specific reason when they deny a medical service or procedure in response to a physician’s prior authorization request; 8. Prior authorizations should not be denied for a minor or immaterial mistake on the request form (i.e., change of date of service); 9. If a medical service is urgent, a health plan should not deny payment of that service for failure of a physician to obtain a prior authorization; 10. All health plans should clearly display a complete list, by name, description and CPT code of services or procedures, which require prior authorization, that’s easily obtainable by the attending physicians on its website and/or other normal methods of communication; 11. All health plans should provide a standard of acceptable prior authorization communication including contact by telephone, fax, and website; 12. Health plans should be transparent in their communication with physicians about the basis for their prior authorization program, including: a) the specific criteria used for determining the medical necessity of the service and the accompanying administrative structure who oversees the process, i.e., national advisory boards, b) the basis for placing a service/procedure on the prior authorization list; c) the cost-effectiveness of the process and d) the profits gained through denial of a PA service or procedure; 13. Health plans should eliminate the financial penalties that are levied against physicians for failing to obtain a prior authorization; 14. All health plans should have a central point for submission for all prior authorization requests, with additional options available as needed; 15. Health plans should standardize their response times to prior authorizations to between 24 to 48 hours; 16. Health plans should allow submissions of prior authorization requests</td>
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without deadlines, other than that it occur before the service or procedure; 17. The list of services required for prior authorization by health plans should be reasonable, consistent among plans, and based on scientific literature which substantiates a reasonable need for the service to be questioned; it should not be solely based on the cost of the service. (BD 1/24/2009)

New Language Preferred:
MAG principles on prior authorization are that:
1. Health plans, rather than physicians, should be responsible for checking its own data base of information to verify the patient’s eligibility and coverage information during prior authorization; 2. Patient and health plan information website in conjunction with a request for prior authorization should be considered forever valid by the health plan for claims payment and any other audit process; 3. Health plans should only allow physicians who perform the medical service or procedure to submit the request for prior authorization; 4. Once a prior authorization request for a service or procedures is approved by the health plan, and the health plan validates the patient’s eligibility and coverage, the health plan is obligated to pay for the service that’s billed by the physician; 5. All managed care contracts should include the provisions that are highlighted in these principles; 6. All health plan requests for patient clinical information made in conjunction with a physician’s request for prior authorization should be commensurate with the complexity of the procedure or service that’s requested; 7. Health plans should provide a specific reason when they deny a medical service or procedure in response to a physician’s prior authorization request; 8. Prior authorizations should not be denied for a minor or immaterial mistake on the request form (i.e., change of date of service); 9. If a medical service is urgent, a health plan should not deny payment of that service for failure of a physician to obtain a prior authorization; 10. All health plans should clearly display a complete list, by name, description and CPT code of services or procedures, which require prior authorization, that’s easily obtainable by the attending physicians on its website and/or other normal methods of communication; 11. All health plans should provide a standard of acceptable prior authorization communication including contact by telephone, fax, and website; 12. Health plans should be transparent in their communication with physicians about the basis for their prior authorization program, including: a) the specific criteria used for determining the medical necessity of the service and the accompanying administrative structure who oversees the process, i.e., national advisory boards, b) the basis for placing a service/procedure on the prior authorization list; c) the cost-effectiveness of the process and d) the profits gained through denial of a PA service or procedure; 13. Health plans should eliminate the financial penalties that are levied against physicians for failing to obtain a prior authorization; 14. All health plans should have a central point for submission for all prior authorization requests, with additional options available as needed; 15. Health plans should standardize their response times to prior authorizations to between 24 to 48 hour that is obtained by a physician from the health plan’s; 16. Health plans should provide peer review services 24/7; 17. Peer review should consist of review by like specialty and practice setting; 18. Health plans should allow submissions of prior authorization requests without deadlines, other than that it occur before the service or procedure; 19. The list of services required for prior authorization by health plans should be reasonable, consistent among plans, and based on scientific literature which substantiates a reasonable need for the service to be questioned; it should not be solely based on the cost of the service.
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<tr>
<th>Code</th>
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<th>Text</th>
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| 210.997| Home Health Care             | MAG supports home health care as an alternative to other inpatient care and encourages physicians to take a more active role in home health care services. (HD 4/1/1988; Reaffirmed 5/2000, 10/2009)  
New Language Preferred  
MAG supports home health care and encourages physicians to take a more active role in home health care services.  
This policy statement was reviewed by a task force of physician members. The task force suggested changing the language of the policy statement. |
| 265.999| Treatment of Minors         | MAG believes physicians should be allowed to treat minors for venereal disease or drug abuse, or suspected venereal disease or drug abuse, without being required to have prior parental consent for such treatment. The physician may elect to advise the parents of the treatment given, but should not be required to do so. MAG supports the position that any individual 18 years of age or over may give consent for medical or surgical treatment, and that any female may give such consent regardless of age or marital status when in connection with pregnancy or childbirth. (HD 4/1/1983; Reaffirmed 5/1/2000; 10/17/2009)  
New Language Preferred  
MAG believes physicians should be allowed to treat minors for venereal disease or drug abuse, or suspected venereal disease or drug abuse, should be required to have parental consent without being required to have prior parental consent for such treatment. The physician may elect to advise the parents of the treatment given, but should not be required to do so. MAG supports the position that any individual 18 years of age or over may give consent for medical or surgical treatment, and that any female may give such consent regardless of age or marital status when in connection with pregnancy or childbirth.  
Reviewed by the Council on Legislation that recommended language change. The Council on Legislation recommended a small change in the policy statement. |
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<th>Code</th>
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<tr>
<td>270.976</td>
<td>Health Insurance Tax Credit</td>
<td>MAG supports legislation which provides tax credits and subsidies to individuals who cannot afford to purchase their own health insurance, as a means of promoting individual ownership of private health insurance. (HD 10/17/2009, Officer 1, Rec. 6)</td>
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<td>New Language Preferred</td>
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<td>MAG supports legislation that provides tax credits and deductions to all and subsidies to those who cannot afford to purchase their own health insurance, as a means of promoting individual ownership of private health insurance.</td>
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<td>Reviewed by the Council on Legislation that recommended language change. The Council on Legislation recommended adding language for more inclusion in the tax structure favorable to physicians.</td>
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<tr>
<td>270.977</td>
<td>Impaired Physicians Practice Act</td>
<td>MAG supports legislation, with necessary statutory authority and adequate funding, that includes establishing an impaired physician treatment program which operates efficiently and effectively to assess and treat impaired physicians. (HD 10/17/2009, Resolution 304C.09)</td>
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<td>New Language Preferred:</td>
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<td>MAG supports legislation and policy with adequate funding to establish an impaired physician treatment program which operates efficiently and effectively to assess and treat impaired physicians. MAG further supports policy mandating that medical students be made aware of these programs as a part of their curriculum.</td>
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<td>Reviewed by the Council on Legislation that recommended language change by inserting medical school curriculum for early awareness. The Council on Legislation members also concluded that this regulation should reside in the Composite Medical Board.</td>
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<tr>
<td>290.974</td>
<td>Federal Poverty Level</td>
<td>MAG supports expansion of Medicaid for low-income families up to 185 percent of the federal poverty level (current level as of July 2009 is about 50 percent of the federal poverty level.) (HD 10/17/2009, Special Report: Appendix III)</td>
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<td>New Language Preferred:</td>
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<td>MAG supports expansion of Medicaid for low-income families up to 133 percent of the federal poverty level.</td>
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<td>Reviewed by the Third Party Payer Committee that recommended language change. The committee suggested new language to reflect current percent of federal poverty level.</td>
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<th>Appendix III</th>
<th>Special Report:</th>
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**370.999**  
**Organ Donations and Transplants**

MAG should implement ways and means of increasing public and professional education and awareness of the need for transplantable cadaveric organs and tissues and should encourage interagency cooperation and unified activity in increasing donations of cardiac transplantable organs. The MAG Journal should solicit articles dealing with blood and tissue donations and transplantation at least once a year. (HD 4/1/1983; Reaffirmed 05/2000, 10/2009)

New Language Preferred:  
MAG should implement ways and means of increasing public and professional education and awareness of the need for transplantable cadaveric organs and tissues, and should encourage interagency cooperation and unified activity in increasing donations of cardiac transplantable organs. The MAG Journal should solicit articles dealing with blood and tissue donations and transplantation at least once a year.

This policy statement was reviewed by a task force of physician members. Members of the committee suggested minor changes in the language of the statement.

| 470.996  
**State Boxing Commission Rules**

MAG believes the State Boxing Commission should include the following points in its rules: a) the ringside physician should have the authority to stop a match if, in his/her medical judgment, continuation would result in death or serious injury to either contestant; b) a physician, possessing an unlimited license to practice medicine and surgery in Georgia, should act as a consultant to the Commission as needed; c) the Commission should require that any contestant who is knocked out undergo an appropriate neurological examination; and d) any professional boxer, as a condition of licensure, should be required to disclose to the Commission all medical records relating to treatment of any physical condition which relates to his/her ability to fight. (HD 8/1/1984; Reaffirmed 05/2000, 10/2009)

New Language Preferred:  
MAG believes the State Boxing Commission should include the following points in its rules: a) the ringside physician should have the authority to stop a match if, in his/her medical judgment, continuation would result in death or serious injury to either contestant; b) a physician, possessing an unlimited license to practice medicine and surgery in Georgia, should act as a consultant to the Commission as needed; c) the Commission should require that any contestant who is knocked out undergo an appropriate neurological examination by a licensed medical doctor; and d) any professional boxer, as a condition of licensure, should be required to disclose to the Commission all medical records relating to treatment of any physical condition which relates to his/her ability to fight.

Reviewed by the Council on Legislation that recommended language change. The committee suggested adding a reference in the neurological examination that it be performed by a medical doctor.
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<th>Appendix III</th>
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<td>Special Report:</td>
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<p>| 470.998       |</p>
<table>
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<tr>
<th>Smoking by Coaches</th>
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<tr>
<td>MAG urges coaches, in their roles as leaders, to restrict smoking. (EC 4/1/1984; Reaffirmed 05/2000, 10/2009)</td>
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<td>New Language Preferred:</td>
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<tr>
<td>MAG urges coaches, in their role as leaders, to restrict their own and their team smoking.</td>
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<td>This policy statement was reviewed by a task force of physician members. The committee recommended that the statement be expanded to include team members.</td>
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<p>| 470.999       |</p>
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<tr>
<th>Injury Prevention</th>
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<td>MAG approves the following points to minimize heat injuries in all sports: 1) Players should have unlimited access to water; 2) In hot weather, practices should be held in the &quot;two-a-day&quot; format, once early in the morning and once late in the afternoon; 3) Coaches should take advantage of continuing education opportunities to keep themselves current in recognizing and treating heat injuries; and 4) School systems should make available qualified athletic trainers to coaches and players in the system. (HD 4/1/1984; Reaffirmed 05/2000, 10/2009)</td>
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<tr>
<td>New Language Preferred WITH TITLE CHANGE:</td>
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<tr>
<td>HEAT INJURY PREVENTION</td>
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<tr>
<td>To minimize heat injuries in all sports, the following points should be followed: 1) Players should have unlimited access to water; 2) in hot weather, practices should be held in the &quot;two-a-day&quot; format (once early in the morning and once late in the afternoon); 3) Coaches should take advantage of continuing education opportunities to keep themselves current in recognizing and treating heat injuries; and 4) School systems should make available qualified athletic trainers to coaches and players in the system.</td>
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<tr>
<td>This policy statement was reviewed by a task force of physician members. The committee determined that heat injury was a key element that should be addressed and recommended a title change. Furthermore, the policy as written was not in the form of a policy statement but that of an action and should be change appropriately.</td>
</tr>
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REFERENCE COMMITTEE

A
RESOLUTION

SUBJECT: Transparency and Labeling of Generic Medications

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee A

Whereas, generic drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents that are expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling; and

Whereas, FDA classifies as therapeutically equivalent those products that meet the following general criteria: (1) they are approved as safe and effective; (2) they are pharmaceutical equivalents in that they (a) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (b) meet compendial or other applicable standards of strength, quality, purity, and identity; (3) they are bioequivalent in that (a) they do not present a known or potential bioequivalence problem, and they meet an acceptable in vitro but not in vivo standard, or (b) if they do present such a known or potential problem, they are shown to meet an appropriate bioequivalence standard; (4) they are adequately labeled; (5) they are manufactured in compliance with current good manufacturing practice regulations; and

Whereas, the statistical methodology for analyzing these bioequivalence studies is called the two one-sided test procedure. Based on the opinions of FDA medical experts, a difference of greater than 20 percent for the (Cmax and AUC) tests was determined to be significant, and therefore, undesirable for all drug products; and

Whereas, the FDA evaluation of therapeutic equivalence in no way relieves practitioners of their professional responsibilities in prescribing and dispensing such products with due care and with appropriate information to individual patients and the physician is ultimately responsible for prescribing medication; and

Whereas, professional care and judgment should be exercised in prescribing generic drugs to patients; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) delegation to the American Medical Association (AMA) House of Delegates present a resolution requesting the AMA to pursue the transparency of prescribing generic drugs by ensuring that generic drugs are adequately labeled according to FDA requirements; that each pill or capsule are labeled with the name of the company, the name of the drug, and the dose of the drug; and that generic medication have a package insert, which will be given to every patient, that includes the FDA bioequivalence data.

# # #

1 FDA APPROVED DRUG PRODUCTS WITH THERAPEUTIC EQUIVALENCE EVALUATIONS 34th EDITION
MAG Policy

125.997 Prescription Labeling
HD 4/1/1989
MAG supports labeling on all prescriptions dispensed to non-hospitalized patients which would show the generic name and the brand name when a brand name is substituted with a generic drug as follows:
Generic Name substituted for Trade Name as in "Furosemide substituted for Lasix." (Reaffirmed 05/2000; 10/5/2008; 10/20/2013)

125.993 Principles for Generic Substitution of Drugs
HD 10/4/2008
Principles for Generic Substitution of Drugs
1. MAG reaffirms its previous policy that all physicians be urged to supplement medical considerations with cost considerations when selecting the drug of choice for an individual patient and to become well informed about the quality of prescription drug products available from multiple sources.
2. Until the methodology for approval of bioequivalence and therapeutic equivalence of all drug products is resolved, MAG reaffirms its previous policies:
   a) that the dose of any medication continue to be titrated for optimum efficacy and safety, especially in patients with chronic disorders who require prolonged therapy or patients in special population groups not expected to respond to a drug in the normal manner;
   b) when multiple refills of a drug product for chronic diseases are anticipated, physicians should avoid substitution unless the products have been proven to be bioequivalent, and
   c) when serious or unusual problems develop that may be related to drug substitution, the findings should be documented. A short federal Food and Drug Administration (FDA) reporting form is available on the last page of the FDA Drug Bulletin, which is sent quarterly to all practicing physicians. Physicians are urged to include the manufacturer and lot number of the drug product in the 1639 form.
3. MAG believes that the physician and pharmacist should take necessary steps to eliminate confusion to the patient when labels are changed as a result of any drug substitution, particularly when the color, shape, and taste of drug substitute vary from the originally prescribed product.
4. Pharmacists should not substitute any generic drug product that has a B bioequivalent rating (i.e., potential of documented bioinequivalent problem). All B-related drug products should be required to demonstrate bioequivalence, or their application should be withdrawn by the FDA.
5. Physicians should become familiar with specific laws governing generic drug substitution in their state and, where applicable, they should obtain a copy of the state's current generic substitution drug formulary.
6. The only text currently available for determining equivalence among drug products (i.e., Approved Drug Product With Therapeutic Equivalence Evaluations (the Orange Book or The List) should be revised as follows: Although the FDA is mandated to do so, single-source drugs should be eliminated. The manufacturing source for all multisource drug products should be included, even if it requires a rapid update system, possibly on-line, for the pharmacist. The inclusion of decisional criteria for determining bioequivalence and therapeutic equivalency of selected agents is recommended.
7. The FDA should proceed without undue delay to implement an imprint coding system for all solid oral dosage forms that allows identification of the manufacturing source of the product even if a non-manufacturing distributor is involved.
   This will markedly aid the physician, the pharmacist, and the patient to know when drug substitution has occurred and will help to resolve causality if a drug product failure has occurred.
8. Selected post-marketing surveillance systems (other than spontaneous reporting) of adverse events should be explored by the FDA. Especially meaningful, might be studies that provide data on:
   a. A comparison of elderly patients with associated multiple diseases and/or on multiple drug therapy in whom the drug will be used, but who are not representative of the group in which the drug was tested for bioequivalency;
b. Studies in patients compared with the group in whom the drug was tested when a number of active metabolites of a drug known to be present in different proportions than the test group; and
c. Studies when the therapeutic index of a drug is quite narrow.

9. Congress should support the generic drug review and approval process with adequate personnel and financial resources for the FDA.
(Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013)
RESOLUTION

Resolution: 102A.14

SUBJECT: Cancellation of MOC Program for Physicians Certified Before 1990

SUBMITTED BY: Richmond County Medical Society

REFERRED TO: Reference Committee A

Whereas, on January 1, 2014, the American Board of Internal Medicine (ABIM) (adhering to standards established by the American Board of Medical Specialties) started its new Maintenance of Certification (MOC) program; and

Whereas, physicians certified prior to 1990 (approximate age 52 and older) are expected to participate in the new MOC program; and

Whereas, the MOC program consists of an annual fee for 10 years; earning a total of 100 MOC points by December 31, 2018, with two- and five-year milestones; and passing the MOC examination in your certification area by December 31, 2023; and

Whereas, practicing physicians in this age bracket have maintained their individual state medical licenses and complied with the necessary CME requirements; and

Whereas, practicing physicians in this age bracket are complying with the requirements for electronic medical records (EMR), electronic prescribing, meaningful use, and preparing for ICD-10; and

Whereas, this program puts additional stress on the practicing physicians’ time and finances and the 10-year annual fee would carry through until these physicians reach the customary retirement age of 62; and

Whereas, not completing any MOC requirements results in the “time-unlimited physicians” being listed as “Certified, Not Meeting MOC Requirements” on the ABIM website; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) delegation to the American Medical Association (AMA) House of Delegates strongly encourage the AMA to support canceling the Maintenance of Certification (MOC) program for physicians certified before 1990.

# # #
MAG Policy

275.992 National Licensure
HD 10/16/2011
MAG strongly opposes any implementation of a national licensure for physicians and rejects the Maintenance of Certification as a requirement to maintain state licensure. (Res. 102A.11)

405.989 Specialty Recertification
HD 10/17/2009
The Medical Association of Georgia supports changes in the American Board of Medical Specialties' rules that allow medical specialty board recertification be voluntary.
RESOLUTION

Resolution: 103A.14

SUBJECT: Choosing Wisely Initiative

SUBMITTED BY: Martha M. Wilber, M.D., Delegate

REFERRED TO: Reference Committee A

Whereas, the American Board of Internal Medicine (ABIM), in conjunction with more than 60 medical specialty societies, has developed the Choosing Wisely Initiative to promote conversations between physicians and patients by helping patients choose care that is: (1) supported by evidence; (2) not duplicative of other tests or procedures already received; (3) free from harm; and (4) truly necessary;¹ and

Whereas, the Robert Wood Johnson Foundation (RWJF) survey of physicians’ attitudes regarding the overuse of medical services in the United States in 2014 found that 66 percent of physicians feel they have a great deal of responsibility to make sure their patients avoid unnecessary tests and procedures and 58 percent of physicians say they are in the best position to address the problem;² and

Whereas, The American Medical Association (AMA) “supports the concepts of the American Board of Internal Medicine Foundation’s Choosing Wisely program” (D-155.988)

Whereas, the state of Colorado has the first state medical society to embrace “Choosing Wisely;” and

Whereas, in 2014 the Washington (State) Health Alliance, the Washington State Medical Association, and the Washington State Hospital Association have jointly sponsored the Washington State Choosing Wisely Task Force to address the issues of safe, quality health care for patients in Washington State; and

Whereas, the Medical Association of Georgia (MAG) believes that clinical guidelines are not a substitute for the experience and judgment of the physician; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) support the concepts of the American Board of Internal Medicine Foundation’s “Choosing Wisely” program.

# # #

¹ http://www.choosingwisely.org/about-us/
MAG Policy

450.989 Medical Treatment Guidelines
BD 04/21/2012
MAG supports the following medical treatment guidelines: 1) that clinical guidelines are intended as general clinical information for reference to promote best practice and are not to be construed as rules, nor are they to become proxies for the standard of care. We support the traditional professional perspective of the physician as the sole and final medical decision-maker in medical treatment; 2) Clinical guidelines must be constructed and adopted based on a broad consensus of opinion from actively practicing physicians and relevant physician organizations, free of conflict of interest. Effective mechanisms shall be established to ensure opportunities for input; 3) Clinical guideline adoption is based on an affirmative vote or similar action by the majority of the physicians for whom the guideline is intended; 4) Clinical guidelines shall be adapted at the local/state/regional level, as appropriate to account for various factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information; 5) Clinical guideline adoption by individual physicians will not be used as the sole exclusion criterion for any third party payer unless the physician is employed or under contract with an entity that chooses to comply with guidelines; 6) Physician compensation should not be based upon adherence to clinical guidelines; 7) Clinical guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical guidelines, when appropriate, in the care of individual patients. The physician's rationale for a change in treatment should be appropriately documented; and 8) Published materials on the use of clinical guidelines should be fact-based and accurate concerning their "true effect."

450.991 Clinical Practice Guidelines
HD 10/13/2007
MAG believes that clinical guidelines are not a substitute for the experience and judgment of the physician; MAG recommends to all specialty and subspecialty societies and others that this reaffirmation be included as an addendum to each clinical guideline. (Reaffirmed 10/20/12)
RESOLUTION

Resolution: 104A.14

SUBJECT: Cost of Meaningful Use Passed Onto Patients

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee A

Whereas, meaningful use standards are being implemented over 10 years; and

Whereas, many of the requirements for meaningful use standards are not in the control of physicians and extraordinarily expensive to implement (e-mails from a percentage of patients on an encrypted platform); and

Whereas, other standards require work that is meaningless to physicians and patients (i.e., specialists who have to survey patients about vaccines; patients who smoke being “counseled” by every physician they encounter); and

Whereas, meaningful use standards effectively created a software industry that physicians must work with; and

Whereas, these meaningful use standards and software companies are changing the ways that physicians interact with patients, increasing expenses by requiring “scribes” and other means of meeting regulatory requirements while also meeting insurance company requirements and providing patient care; and

Whereas, overhead costs for physicians are skyrocketing, reimbursements are flat or declining, and patients do not understand the impact on physicians; and

Whereas, these costs are pushing health care to non-physician providers and significantly decreasing the time that a patient spends with a physician; and

Whereas, physicians have been unable to stop extraordinary burdens related to government regulation; and

Whereas, patients and insurance companies do not bear these costs because physicians cannot pass them onto the end-users of their services, unlike utility companies and private industry; and

Whereas, if patients feel the costs of this regulation, government regulators may be forced to acknowledge the poor value of regulations and consider change; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) encourage the Georgia Insurance Commissioner to allow all physicians to charge a “meaningful use surcharge” outside of their contracts with insurance companies that can be used to cover the additional costs of regulation.

# # #
RESOLUTION

Resolution: 105A.14

SUBJECT: Expansion of Practice and Prevention of Coercive Delegation of Medical Acts

SUBMITTED BY: Walker-Catoosa-Dade Medical Society

REFERRED TO: Reference Committee A

Whereas, many legislative initiatives for expansion of scope of practice to be able to perform medical acts are initiated by Advanced Practice Registered Nurses or their organizations; and

Whereas, all medical acts that may be performed by APRNs are medical acts delegated by a physician under a protocol agreement between a specific physician and a specific APRN; and

Whereas, the rapidly increasing trend for the physician is toward direct employment rather than independent practice; and

Whereas, employers such as hospitals, insurance companies, ACOs, and corporations have brought increasing pressure on physicians to supervise mid-level practitioners as a part of their employment agreement; and

Whereas, under OCGA 43-34-25(g) hospitals may have a physician delegate medical acts to an unlimited number of hospital employed APRNs; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) educate members that OCGA 43-34-25(f) does not require a physician or APRN to be party to a nurse protocol agreement in order to receive reimbursement for medical treatment; and be it further

RESOLVED, that MAG will oppose expansion of scope of practice for APRN performance of medical acts outside of physician requested acts that may be delegated.

# # #
MAG Policy

35.998 Delegation of Medical Acts
BD 9/1/1983
MAG affirms the authority of physicians to delegate medical acts to non-licensed individuals for which the physician is both responsible and liable. (Reaffirmed 05/2000, 10/2009)

360.987 APRN Requirements
HD 10/20/2013
MAG supports the current requirement that APRNs work under "supervision" versus a "collaboration and consultation" agreement with physicians. (Officer 01.13, rec. 1)

360.999 Supervision of Nurses Definition
N/A 4/1/1980
Physician supervision of a nurse means that the physician is responsible for the medical acts performed by the nurse, acting in accordance with his prescription or instruction. The supervising physician or his physician designee must be available daily to examine his patient and must regularly and systematically review the medical care. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013)

120.983 Prescribing by Physicians & Supervised Personnel
HD 10/4/2008
MAG supports the following Prescribing Principles:
1. Only physicians, physician assistants (under physician supervision) and advanced practice nurses (under protocol with a supervising physician), dentists, veterinarians or podiatrists are qualified to prescribe drugs under Georgia law, the Georgia Legislature should not authorize unqualified practitioners to prescribe drugs.
2. Physicians should write prescriptions for a specified length of time and pharmacists are urged not to fill prescriptions past the time marked.
3. MAG supports the concept of a 48-hour delay program in the filling of prescriptions for amphetamines and preludin.
4. MAG believes in the education of physicians and pharmacists regarding all phases in the prescription of medications, including prescribing, writing, signing, sampling and distribution of all drugs as covered in the Georgia Pharmacy Act.
5. Advance Practice Nurses should continue to perform medical acts under the direction and direct supervision of physician and not as independent agents.
6. Medical acts performed by advance practice nurses on orders/directions of the physician, should be billed by the physician (medical acts as distinguished from nursing acts)
   (Special Report 05.08, Attachment 3) (Reaffirmed 10/20/2013)

360.986 APRN Prescriptive Authority
HD 10/20/2013
MAG opposes increasing an APRN's prescriptive authority to order Schedule II narcotics. (Office 01.13, Rec. 2)

360.996 Prescriptive Authority for APNs
HD 4/1/1996
MAG fundamentally opposes independent prescriptive authority for advanced practice nurses. Physician supervision and oversight for using "protocols" is essential. (Reaffirmed 05/1999 and 05/2002; 10/13/07; 10/20/12)
RESOLUTION

Resolution: 106A.14

SUBJECT: Electronic Medical Records Waiver Policy

SUBMITTED BY: John A. Goldman, M.D., Delegate

REFERRED TO: Reference Committee A

Whereas, the Patient Protection and Affordable Care Act (PPACA) creates a regulatory process for the practice of medicine in the United States; and

Whereas, this act increases multiple costs to medical practices including the cost of not only purchasing but maintaining medical electronic records including their security, their updating, yet there is little data as to the benefits or safety for patients; and

Whereas, electronic medical records decrease the efficacy of office practices leading to longer encounter times, physicians seeing few patients and having to remain in the office for longer periods of time to complete the day’s record; and

Whereas, the confidentiality of electronic records is not guaranteed; and

Whereas, daily there are reports of the hacking of a variety of computer systems; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) support that physicians who are not comfortable with the use of electronic medical records (EMR) be granted a waiver allowing them to not use EMR with no financial punishment or fine.

# # #
RESOLUTION

SUBJECT: Maintenance of Certification

SUBMITTED BY: Muscogee County Medical Society

REFERRED TO: Reference Committee A

Whereas, granting private nonprofit organizations the equivalent of monopoly power over Board Certification, and thus potentially licensing and medical practice itself, will tend to increase costs, violate federal IRS, antitrust and interstate commerce legislation and hamper innovation; and

Whereas, board certification, once obtained should not have an expiration date and all time-limited board certification should be converted to lifetime status allowing Maintenance of Certification (MOC) to be truly voluntary; and

Whereas, there is no evidence that physicians who have completed the maintenance of board certification provide better care or produce better clinical outcomes; and

Whereas, MOC and Osteopathic Continuous Certification (OCC) add an additional burden to the continuing medical education required by the state of Georgia; and

Whereas, MOC and OCC are inappropriately costly and time consuming and take physicians away from the care of their patients; and

Whereas, MOC and OCC should not be required for insurance reimbursements or network participation; and

Whereas, MOC and OCC should not be required for maintenance of licensure; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) opposes the continuance of the American Board of Medical Specialties Maintenance of Certification and the American Osteopathic Association Osteopathic Continuous Certification programs.

###
MAG Policy

275.992 National Licensure
HD 10/16/2011
MAG strongly opposes any implementation of a national licensure for physicians and rejects the Maintenance of Certification as a requirement to maintain state licensure. (Res. 102A.11)

405.989 Specialty Recertification
HD 10/17/2009
The Medical Association of Georgia supports changes in the American Board of Medical Specialties' rules that allow medical specialty board recertification be voluntary.
RESOLUTION

Resolution: 108A.14

SUBJECT: Maintenance of Licensure

SUBMITTED BY: Muscogee County Medical Society

REFERRED TO: Reference Committee A

Whereas, physicians already engage in the process of lifelong learning and document such through state licensure requirements; and

Whereas, the intent of maintenance of licensure (MOL) to provide a verifiable system in which a physician can demonstrate their commitment to lifelong learning is redundant, excessively costly and potentially intrusive to patient care; and

Whereas, there is no existing Medical Association of Georgia policy calling for support of MOL; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) opposes any effort by the Georgia Composite Medical Board to adopt, use or require the Federation of State Medical Boards Maintenance of Licensure (MOL) program as a condition of licensure on this basis.

# # #

MAG Policy

275.992 National Licensure
HD 10/16/2011
MAG strongly opposes any implementation of a national licensure for physicians and rejects the Maintenance of Certification as a requirement to maintain state licensure. (Res. 102A.11)

405.989 Specialty Recertification
HD 10/17/2009
The Medical Association of Georgia supports changes in the American Board of Medical Specialties' rules that allow medical specialty board recertification be voluntary.
RESOLUTION

Resolution: 109A.14

SUBJECT: Normal Saline Limitations

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee A

Whereas, American manufacturers of normal saline have had manufacturing issues that have seriously decreased the availability of normal saline;¹ and

Whereas, custom prepared normal saline has suffered from contamination; and

Whereas, shortages of normal saline are projected to lead to a rationing of normal saline and dialysis patients are projected to feel the impact first;² now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) delegation to the American Medical Association (AMA) House of Delegates present a resolution urging the AMA to lead a campaign to limit the use of saline for non-essential, elective procedures until supplies are back to normal.

# # #

¹ www.npr.org/blogs/health/2014/06/22/323679204/shortage-of-saline-solution-has-hospitals-on-edge
RESOLUTION

Resolution: 110A.14

SUBJECT: Preservation of Small Medical Practices

SUBMITTED BY: John A. Goldman, M.D., Delegate

REFERRED TO: Reference Committee A

Whereas, The Patient Protection and Affordable Care Act (PPACA) creates increased regulations of the practice of medicine in the United States; and

Whereas, this act increases multiple costs to medical practices including the cost of not only purchasing but maintaining medical electronic records including their security and updating, yet there is little data as to the benefit of patient; and

Whereas, electronic medical records decrease the efficacy of office practice leading to longer encounter time, seeing fewer patients and having to remain in the office longer periods of time to complete the day’s records; and

Whereas, the anticipated institution of ICD-10 and its cost are estimated to be very high per physician and per practice; and

Whereas, the increase in cost of dealing with insurance companies and their adverse impact on patient care, with prior approval restrictions, payment denials, peer-to-peer interaction, specialty tiers which has been shown in 2005 to cost the average physician practice $82,000 to 85,000 a year per physician; and

Whereas, these practice expenses are increasing and physician payment has been decreasing leading physicians to be extorted to join larger groups; and

Whereas, many physicians in small practices are deciding to go out of practice or join the larger entities because of these costs; and

Whereas, some physicians joining large groups have been disenchanted with large groups and wish to return to a small practice; and

Whereas, the state of Georgia has been losing physicians thus creating a physician shortage; and

Whereas, this loss of practices has been leading to less physician availability in rural Georgia and urban Georgia; and

Whereas, Georgia has a need to increase the number of physicians and retain those in practice and needs those who finish their training to stay in Georgia; and

Whereas, Georgia is reviewing ways to retain physicians; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) take positive action to retain small practices in Georgia and across the country; and be it further
RESOLVED, that the MAG Delegation to the American Medical Association (AMA) submit a resolution to the AMA House of Delegates that includes language: (1) encouraging physicians to maintain their small practices; (2) advocating for waivers for small practices to continue to use non-electronic medical records; (3) eliminating non-compete clauses for physicians who join large groups so the physicians may leave the practice and still stay in Georgia; and (4) stopping the conversion to ICD-10 which is increasing cost to medical practices.

###

**MAG Policy**

160.994 Alternative Delivery System Advantages
HD 4/1/1987
MAG vigorously opposes any legislation that would give alternative health care delivery systems statutory advantage over the traditional private practice of medicine. (Reaffirmed 05/2000, 10/2009)

160.996 Private Practice of Medicine - Definition
HD 4/1/1985
MAG defines the private practice of medicine as the delivery of medical care which is carried out in a direct personal relationship in which direct responsibility for care and payment exists between the patient and physician. MAG supports an environment which allows for freedom of choice for both the patient and physician in selecting the location of the delivery of care, alternatives of treatment and the methods of payment for services rendered. (Reaffirmed 05/2000, 10/2009)
RESOLUTION

SUBJECT: Country of Origin for Prescription Medications

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee A

Whereas, adverse reactions to both name brand and generic medications are common; and
Whereas, different manufacturers of the same generic medication may have different non-active ingredients (including dyes); and
Whereas, prescription medications are being manufactured all over the world; and
Whereas, all clothing in the U.S. is labeled as to country of manufacture and clothing has much less potential for adverse reactions; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) urge the American Medical Association (AMA) to support labeling of all prescription medication by country of origin.

# # #
RESOLUTION

Resolution: 112A.14

SUBJECT: Prior Approval Requirements of Insurance Companies

SUBMITTED BY: John A. Goldman, M.D., Delegate

REFERRED TO: Reference Committee A

Whereas, care of medical patients includes the utilization of medications, imaging, diagnostic procedures and surgical intervention; and

Whereas, the ability to care for our patients requires that we facilitate their care and therapy; and

Whereas, insurance companies have required medical offices to complete a variety of documents, prior approval letters, peer-to-peer contacts, completion reviews, telephone calls and other activities to access care for our patients; and

Whereas, the cost of having our offices complete this activity is expensive; and

Whereas, the Medical Association of Georgia (MAG) did a study in 2010 and developed a publication on the “Environment of Care in Georgia” where we looked at health care in Georgia. During the development of that publication there was a study that found each office spent about $82,975 to $85,276 a year per physician dealing with insurance companies. As that was five years ago; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) advocate that: (1) a standardized prior approval process be developed; (2) physician’s offices be compensated for obtaining the prior approval; (3) insurance companies inform the patient of their need for the prior approval; and (4) that the insurance company is required to explain to the patient how it obtains prior approval and that it is required.

# # #
MAG Policy

185.980 Prior Authorization
BD 1/24/2009
MAG principles on prior authorization are that:
1. Health plans, rather than physicians, should be responsible for checking its own data base of information to verify the patient’s eligibility and coverage information during prior authorization.
2. Patient and health plan information that is obtained by a physician from the health plan’s website in conjunction with a request for prior authorization should be considered forever valid by the health plan for claims payment and any other audit process.
3. Health plans should only allow physicians who perform the medical service or procedure to submit the request for prior authorization.
4. Once a prior authorization request for a service or procedures is approved by the health plan, and the health plan validates the patient’s eligibility and coverage, the health plan is obligated to pay for the service that’s billed by the physician.
5. All managed care contracts should include the provisions that are highlighted in these principles.
6. All health plan requests for patient clinical information made in conjunction with a physician’s request for prior authorization should be commensurate with the complexity of the procedure or service that’s requested.
7. Health plans should provide a specific reason when they deny a medical service or procedure in response to a physician’s prior authorization request.
8. Prior authorizations should not be denied for a minor or immaterial mistake on the request form (i.e., change of date of service).
9. If a medical service is urgent, a health plan should not deny payment of that service for failure of a physician to obtain a prior authorization.
10. All health plans should clearly display a complete list, by name, description and CPT code of services or procedures, which require prior authorization, that’s easily obtainable by the attending physicians on its website and/or other normal methods of communication.
11. All health plans should provide a standard of acceptable prior authorization communication including contact by telephone, fax, and website.
12. Health plans should be transparent in their communication with physicians about the basis for their prior authorization program, including: a) the specific criteria used for determining the medical necessity of the service and the accompanying administrative structure who oversees the process, i.e., national advisory boards, b) the basis for placing a service/procedure on the prior authorization list; c) the cost-effectiveness of the process and d) the profits gained through denial of a PA service or procedure.
13. Health plans should eliminate the financial penalties that are levied against physicians for failing to obtain a prior authorization.
14. All health plans should have a central point for submission for all prior authorization requests, with additional options available as needed.
15. Health plans should standardize their response times to prior authorizations to between 24 to 48 hours.
16. Health plans should allow submissions of prior authorization requests without deadlines, other than that it occur before the service or procedure.
17. The list of services required for prior authorization by health plans should be reasonable, consistent among plans, and based on scientific literature which substantiates a reasonable need for the service to be questioned; it should not be solely based on the cost of the service.

285.981 Prior Approval
HD 5/4/2002
MAG opposes the use of prior approval policies that are inappropriately based on economic factors without the support of clinical evidence. MAG urges regulators, insurers, and others, in both the public and private sector, to reduce and eliminate such policies; MAG urges legislative or regulatory action, at
the state level, to prevent the further utilization of inappropriate prior approval of pharmaceuticals. (Res: 300C-02) (Reaffirmed 10/13/07; 10/20/12)

285.980 Prior Approval
HD 10/29/2004
The Medical Association of Georgia opposes prescription prior approval in the state of Georgia. (Resolve 1 of Res. 106AB.04) (Reaffirmed 10/2009)
RESOLUTION

Resolution: 301C.14

SUBJECT: Interstate Medical License Compact

SUBMITTED BY: Whitfield-Murray Medical Society

REFERRED TO: Reference Committee C

Whereas, the use of telecommunications in medicine is ever expanding in its use in providing health care; and

Whereas, this system involves the requirement of physicians to be licensed in multiple states; and

Whereas, the specific criteria for licensure in each individual state may vary per state; and

Whereas, these varying criteria often create burdensome delays for licensure for physicians who have clean records; and

Whereas, in response to this situation the Federation of State Medical Boards (FSMB) has developed an Interstate Medical License Compact (Compact) in an attempt to address this need. This draft of the proposal can be found on the FSMB website; and

Whereas, while we commend the attempt by the FSMB to address this issue, we have major concerns about its structure, its organization, its function, and its future ramifications as it is currently proposed; and

Whereas, these concerns cover a wide range of issues in the draft proposal; and

Whereas, several provisions in the Compact could very conceivably weaken a state board’s authority once the Compact becomes fully functional and it would not take long for this new bureaucracy of licensure, which has Federal implications, to become the norm for the country if enough states and their legislatures approve this proposal; and

Whereas, one major concern is the Compact’s creation of an interstate commission that would have the ability to promulgate rules that state medical boards cannot ratify individually; and

Whereas, the interstate commission can close a meeting to the public for a very broad amount of reasons and has the ability to create an executive committee to carry out the duties of the commission; and

Whereas, the interstate commission can levy on and collect a binding annual assessment from each member state; and

Whereas, the only way to challenge a promulgated rule is to file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices; and
Whereas, a member state cannot withdraw from the Compact without a statute repealing the original legislation entering into the Compact and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state; and

Whereas, the Compact draft language containing these concerns are attached at the end of the resolution; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) supports the Federation of State Medical Boards (FSMB) Interstate Compact allowing for expedited physician licensure if it’s amended to insure complete state autonomy and address the many concerning clauses; including, but not limited to: the state of principle license clause; the broad executive meetings clause; the commission’s ability to promulgate rules that are binding on all member states; the state withdrawal requirements; and the judicial review clause.

REFERENCE SECTIONS:

SECTION 4. DESIGNATION OF STATE OF PRINCIPAL LICENSE

(a) A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the Compact if the physician possesses a full and unrestricted license to practice medicine in that state, and the state is:

1. The state of primary residence for the physician, or
2. The state where at least 25% of the practice of medicine occurs, or
3. The location of the physician's employer, or
4. If no state qualifies under subsection (1), subsection (2), or subsection (3), the state designated as state of residence for purpose of federal income tax.

(b) A physician may redesignate a member state as state of principal license at any time, as long as the state meets the requirements in subsection (a).

(c) The Interstate Commission is authorized to develop rules to facilitate redesignation of another member state as the state of principal license

SECTION 8. COORDINATED INFORMATION SYSTEM

(g) The Interstate Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.

SECTION 9. JOINT INVESTIGATIONS

(c) A subpoena issued by a member state shall be enforceable in other member states.

(e) Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

SECTION 11. INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION

(b) The purpose of the Interstate Commission is the administration of the Interstate Medical Licensure Compact, which is a discretionary state function.
(h) The Interstate Commission shall provide public notice of all meetings and all meetings shall be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the Commissioners present that an open meeting would be likely to:

1. Relate solely to the internal personnel practices and procedures of the Interstate Commission;
2. Discuss matters specifically exempted from disclosure by federal statute;
3. Discuss trade secrets, commercial, or financial information that is privileged or confidential;
4. Involve accusing a person of a crime, or formally censuring a person;
5. Discuss information of a personal nature where disclosure would constitute a Interstate Commission shall provide public notice of all meetings and all clearly unwarranted invasion of personal privacy;
6. Discuss investigative records compiled for law enforcement purposes; or
7. Specifically relate to the participation in a civil action or other legal proceeding

(k) The Interstate Commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the Interstate Commission, with the exception of rulemaking, during periods when the Interstate Commission is not in session. The executive committee shall oversee the administration of the Compact including enforcement and compliance with the provisions of the Compact, its bylaws and rules, and other such duties as necessary.

(l) The Interstate Commission may establish other committees for governance and administration of the Compact.

SECTION 12. POWERS AND DUTIES OF THE INTERSTATE COMMISSION

(e) Establish and appoint committees including, but not limited to, an executive committee as required by Section 11, which shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties;

(f) Pay, or provide for the payment of the expenses related to the establishment, organization, and ongoing activities of the Interstate Commission;

(g) Establish and maintain one or more offices.

SECTION 13. FINANCE POWERS

(a) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated upon a formula to be determined by the Interstate Commission, which shall promulgate a rule binding upon all member states.

SECTION 15. RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION

(c) Not later than thirty (30) days after a rule is promulgated, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices; provided, that the filing of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Interstate
Commission consistent with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 16. OVERSIGHT OF INTERSTATE COMPACT

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the Compact and shall take all actions necessary and appropriate to effectuate the Compact’s purposes and intent. The provisions of the Compact and the rules promulgated hereunder shall have standing as statutory law but shall not override existing state authority to regulate the practice of medicine.

(b) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the Compact which may affect the powers, responsibilities or actions of the Interstate Commission.

(c) The Interstate Commission shall be entitled to receive all service of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render a judgment or order void as to the Interstate Commission, the Compact, or promulgated rules.

SECTION 21. WITHDRAWAL

(b) Withdrawal from the Compact shall be by the enactment of a statute repealing the same, but shall not take effect until one (1) year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

(e) The withdrawing state is responsible for all dues, obligations and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

(g) The Interstate Commission is authorized to develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

SECTION 23. SEVERABILITY AND CONSTRUCTION

(b) The provisions of the Compact shall be liberally construed to effectuate its purposes
RESOLUTION

SUBJECT: Stabilized Patients on Biologic Medications

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee C

Whereas, patients in rheumatology, oncology, gastroenterology, neurology, dermatology, internal medicine and other practices take complex biologic medications; and

Whereas, conventional drugs are synthesized in a series of chemical reactions in a laboratory, biologics are often produced from cells or living organisms; and

Whereas, biologics are typically large proteins that may be 100 to 1,000 times larger than conventional drugs and often have intricate three-dimensional structures that are essential to their therapeutic activity; and

Whereas, to synthesize and formulate these biologics into medications requires a high level of scientific expertise, and the methods used are proprietary (i.e., owned by the manufacturer and not publicly available for duplication by other manufacturers); and

Whereas, even minor differences in the manufacturing processes can affect how biological medications perform in the body of a given patient; and

Whereas, like any treatment, biologics are sometimes associated with unexpected side effects. In such cases, physicians must be able to trace the exact product that caused the problem so that it can be documented and reported to the relevant organizations; and

Whereas, in discussions with the American College of Rheumatology, UnitedHealthcare revealed a plan that could in fact force patients stable on their biologic to switch medications. They expect to implement the policy change in early 2015; and

Whereas, biologics even of the same class and mechanism of action are not interchangeable in the individual patient; and

Whereas, the American College of Rheumatology has made it clear that, while we share the goal of ensuring affordable access to biologic treatments, we are strongly opposed to any policy that forces patients stable on biologics to switch medications. The potential harm to the patient outweighs any financial benefit; and

Whereas, this policy could affect patients in many practices including those in rheumatology, oncology, gastroenterology, neurology, dermatology, internal medicine and other practices; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) oppose any insurance program that requires patients stabilized on biologic therapy to be required to switch to another biologic medication.

###
RESOLUTION

Resolution: 303C.14

SUBJECT: Support for Georgia Drug Monitoring Program

SUBMITTED BY: Whitfield-Murray Medical Society

REFERRED TO: Reference Committee C

Whereas, the Georgia legislature passed the Georgia Drug Monitoring Program (GDMP) on May 15, 2013 with the expressed intent to reduce the abuse of controlled substances; and

Whereas, although the GDMP has become operational, it has a DEA grant of $100,000 that will run out by January 2016; and

Whereas, the GDMP can continue to function if it can qualify for Federal funding. But to obtain Federal funding, Georgia must be willing to allow physicians to share data with physicians from other states; and

Whereas, the states of Tennessee, North Carolina, South Carolina, and Alabama have qualified for Federal funding and continue to have viable PDMP programs; and

Whereas, the GDMP has been shown in the past year to be a very effective tool to prevent narcotic abuse and to stop drug diversion; and

Whereas, the Medical Association of Georgia (MAG) through its MAG Foundation’s “Think About It” campaign has been in the forefront in the efforts to fight prescription drug abuse; and

Whereas, despite the initial positive results, according to the Georgia Drug and Narcotics Agency, the number of physicians using the site is still exceedingly small. The reasons cited appear to be poor marketing efforts and certain restrictions that were originally placed in the initial law that have hampered its usage; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) actively support the legislature securing funding, by fiscal year 2015, to continue the Georgia Drug Monitoring Program (GDMP).

###

MAG Policy

100.996 Prescription Drug Monitoring
HD 10/20/2013
MAG supports interstate communications between prescription drug monitoring programs in jurisdictions with privacy protections for patients and physicians. (Res: 304C.10) (reaffirmed 10/20/2013)
RESOLUTION

Resolution: 304C.14

SUBJECT: Biosimilar Medications

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee C

Whereas, the Patient Protection and Affordable Care Act (PPACA) creates a regulatory pathway for the approval of follow-on biologic products, often called biosimilars; and

Whereas, for many people with arthritis and other chronic diseases, access to biologic therapies is limited or non-existent due to the extremely high cost or limited availability of treatments; and

Whereas, biosimilars may hold the key to improving access to safe, effective and less expensive treatments for many patients who need biologic therapies to control their disease, its symptoms and pain, but who struggle to afford these therapies; and

Whereas, biologic products are complex medicines manufactured from living organisms and minor changes in the manufacturing process can cause variations in the final product that could dramatically change the way a patient responds to the medication; and

Whereas, patient safety must remain the number one priority in any discussion of the introduction of biosimilars to the market; even if a drug is less expensive and more accessible than a brand name alternative, these advantages mean nothing if the drug does not successfully treat the patient – or worse, harms the patient; and

Whereas, physicians and patients should have access to both interchangeable biosimilars and non-interchangeable biosimilars that have obtained Federal Drug Administration (FDA) approval and patients should have access to all FDA-approved products in a class; and

Whereas, a growing number of states are proposing legislation regulating biosimilars and their potential substitutions for biologics; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) promote legislation or regulation addressing prescribing issues for biologics, including: (1) a requirement ensuring that if a brand biologic medication is prescribed to a patient, that patient receives the specific brand medication; (2) notification of both the physician and patient before any biosimilar medication, either interchangeable or non-interchangeable, is substituted for a biologic medication; and (3) a requirement that pharmacists and prescribers retain records of patients who receive biosimilars for a set period of time.

###
MAG Policy

35.977 Biosimilar Substitutions – Pharmacists
HD 10/20/2013
MAG supports pharmacists obtaining a physician's "consent" prior to substituting a biosimilar for a biologic. (Officer 01.13. Rec. 7)

125.999 Prior Approval for Generic Drug Substitution
HD 4/1/1983
Generic drug substitution by pharmacists without prior approval by the physician is not in the best interest of the patient because medical determinations concerning the prescription would no longer be made by the physician who has responsibility for the patient's health. (Reaffirm 05/2000, 10/2009)
RESOLUTION

WHEREAS, Georgia has a significant problem with prescription drug abuse, overdoses and “pill mills” and theft and forgery of opioid prescriptions is an ongoing problem in Georgia; and

WHEREAS, electronic prescribing is a safe and secure method of transmitting prescriptions and federal regulations now allow electronic prescribing of controlled substances; and

WHEREAS, Georgia statutes and Board of Pharmacy rules have been confusing and contradictory on the subject of electronic prescribing in spite of previous efforts to change the statute and rules; and

WHEREAS, state law § 26-4-80 and § 26-4-80.1 state that any prescription with an electronic signature, not including electronically printed prescriptions with a hand signature, must be on security paper and that every hard copy prescription for Schedule II drugs has to be on security paper; and

WHEREAS, inconsistently, Georgia Rule 480-27-.02(4) states that all electronically generated drug orders, regardless of whether the signature is electronic or hand written, must be on security paper, which is slightly broader than the code; and

WHEREAS, some prescriptions for non-controlled substances that have an electronic facsimile of the physician’s signature and are printed and given to the patient are currently not acceptable by some pharmacies because of this rule; and

WHEREAS, written prescriptions have to be manually recorded into the electronic medical records (EMR) and a copy of the prescription scanned in as well; and

WHEREAS, the cost of additional printers to print from security paper for some prescriptions to avoid printing all prescriptions on security paper is another unfunded mandate; and

WHEREAS, three bills have been passed by the Georgia Legislature to address the issue to no avail; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) advocate to the Georgia Board of Pharmacy to amend Georgia Rule 480-27-.02 so that the language is consistent with the language found in O.C.G.A. § 26-4-80 and § 26-4-80.1; and be it further

RESOLVED, that MAG will work with the Legislature and Georgia Board of Pharmacy to allow and streamline the e-prescribing process for physicians.
REFERENCE SECTIONS:

State Law

§ 26-4-80(C) - A hard copy prescription prepared by a practitioner or practitioner’s agent, which bears an electronic visual image of the practitioner’s signature and is not sent by facsimile, must be printed on security paper.

§ 26-4-80.1. Hard copy prescription drug orders; security paper
(a) Effective October 1, 2011, every hard copy prescription drug order for any Schedule II controlled substance written in this state by a practitioner shall be written on security paper.
(b) A pharmacist shall not fill a hard copy prescription drug order for any Schedule II controlled substance from a practitioner unless it is written on security paper, except that a pharmacist may provide emergency supplies in accordance with the board and other insurance contract requirements.

State Rule

480-27-.02(4) - Electronically generated drug orders presented to a patient by a practitioner must be printed on security paper, and must contain either an electronically reproduced visual image signature of the practitioner with the wording that indicates the signature was electronically generated or the original signature of the practitioner.

###
RESOLUTION

Resolution: 306C.14

SUBJECT: Extending the Medicaid Primary Care Pay Parity

SUBMITTED BY: Georgia Chapter, American College of Physicians

REFERRED TO: Reference Committee C

Whereas, the Medicaid Primary Care Pay Parity program was established to encourage primary care physicians to treat Medicaid enrollees and the current federal program will expire on December 31, 2014; and

Whereas, more than 1.82 million Georgians are currently enrolled in the Medicaid program and more primary care physicians and obstetrician/gynecologists are needed to serve them; and

Whereas, for many women of child bearing age on Medicaid, obstetrician/gynecologists are the only physicians that women see; and

Whereas, Medicaid programs in 30 states and the District of Columbia recognize obstetrician/gynecologists as primary care providers; and

Whereas, well-established research has cited low Medicaid payment as a major reason physicians are reluctant to participate in the program; and

Whereas, prior to the Medicaid Pay Parity program implementation, payment for primary care services in Georgia was 70 percent of Medicare rates; and

Whereas, Georgia’s primary care physicians will face a pay cut of 30 cents on the dollar for providing primary care services if the Medicaid Pay Parity Program is not extended; and

Whereas, 43.8 percent of Georgia’s primary care physicians have stated they would not be accepting Medicaid patient in the coming year; and

Whereas, more than 100 studies show that patient access to primary care is positively associated with lower costs and better outcomes, thus health care costs in Georgia will increase and outcomes will be poorer if the Medicaid Pay Parity Program is discontinued; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) support legislation that extends the Medicaid Primary Care Pay Parity Program; and be it further

RESOLVED, that MAG support obstetrician/gynecologists being included in the Medicaid Primary Care Pay Parity Program.

# # #
RESOLUTION

Resolution: 307C.14

SUBJECT: Georgia License for Expert Witnesses

SUBMITTED BY: Bibb County Medical Society

REFERRED TO: Reference Committee C

Whereas, expert witnesses may give false, unscientific, misleading or egregious testimony; and

Whereas, expert witnesses licensed in Georgia who give such testimony are subject to investigation and sanction by the Georgia Composite Medical Board (GCMB); and

Whereas, such action by the GCMB would be reportable, discoverable, and require disclosure; and

Whereas, such consequences put expert witnesses on notice that there are personal consequences if they offer egregious testimony; and

Whereas, the GCMB has no standing to investigate or sanction experts who do not hold a Georgia license; and

Whereas, this inequity in consequences is unfair and allows expert witnesses who do not hold a Georgia license to offer false testimony without consequence; and

Whereas, other states either require a full medical license or a special expert witness license to serve as an expert witness; and

Whereas, such a requirement gives those state medical boards standing to investigate and sanction experts who offer egregious testimony; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) strongly support that all medical expert witnesses be licensed in Georgia.

# # #
MAG Policy

265.993 Expert Witness
HD 10/17/2009
MAG supports the following definition of "expert witness" for the purpose of testifying in medical malpractice cases: "An expert is a physician who has completed an Accreditation Council for Graduate Medical Education approved residency training program in the specialty in which her or she is testifying and is engaged in the clinical practice of that specialty at least 75 percent of the time." (Special Report, Appendix III)

265.994 Expert Witness Guidelines
HD 10/4/2008
MAG adopts the following Expert Witness Guidelines and encourages affiliated specialty societies to request the incorporation of MAG's Expert Witness Guidelines into their respective national specialty organizations. MAG also encourages the Georgia Composite Medical Board to adopt MAG's Expert Witness Guidelines, (Special Report, Appendix III) (Reaffirmed 10/20/2013)

MAG EXPERT WITNESS GUIDELINES

Expert witnesses are expected to be impartial and should not adopt a position of advocacy except as a spokesman for the field of special knowledge that they represent.

The physician serving as an expert witness should testify as to the practice behavior of a prudent physician.

A physician serving as an expert should have actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given as the result of having been regularly engaged in the active practice of such area of specialty for at least three of the last five years immediately preceding such testimony, or the teaching of such area of practice or specialty for at least half of his or her professional time as an employed member of the faculty of an accredited institution of medical education for at least three of the last five years preceding such testimony.

Prior to offering any testimony, the physician serving as an expert witness should become familiar with all pertinent data relating to the particular matter at issue in the case and should review prior and current concepts relating to the pertinent standard medical practice.

The physician serving as an expert witness should present the court with those opinions which represent the broad spectrum of medical thought and practice. The expert should honestly describe where his or her opinions vary from common practice. The expert should not present his or her own views as the only correct ones if they differ from what might be done by other physicians.

The provision of expert testimony by a physician constitutes the practice of medicine.

The physician serving as an expert witness should not concern him or herself with the legal issues of the matter in question. Rather, the physician should champion what he or she believes to be the truth, not the cause of one party or another.

Compensation of the physician serving as an expert witness should be reasonable and commensurate with the time and effort given to preparing for his or her deposition or court appearance. Physicians should not accept contingency fees for serving as an expert witness."
RESOLUTION

Resolution: 308C.14

SUBJECT: New Medical Education Requirements for State Licensure

SUBMITTED BY: Whitfield-Murray Medical Society

REFERRED TO: Reference Committee C

Whereas, the Federation of State Medical Boards (FSMB) adopted two resolutions at its House of Delegates in 2013 concerning undergraduate and graduate medical education; and

Whereas, FSMB resolution 13-2 directed the FSMB, in collaboration with other stakeholders, to examine the benefits as well as potential harms and unintended consequences that could occur requiring applicants for licensure to have completed 36 months of progressive graduate medical education – setting a higher standard for an unrestricted medical license; and

Whereas, FSMB resolution 13-3 directed the FSMB to work in collaboration with the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), American Medical Association (AMA), and the American Osteopathic Association (AOA) to study the value of shortening the duration of undergraduate medical education from four years to three years and its impact on access to care, patient outcomes, patient safety and medical student indebtedness; and

Whereas, the information obtained from the assessments will be reported to the FSMB HOD in 2015; and

Whereas, this discussion has a profound application to the training of physicians in Georgia as well as the quality of the physicians treating Georgia patients in the near future; and

Whereas, the Georgia Composite Medical Board (GCMB) will be part of the FSMB HOD in 2015 and is seeking input from the MAG HOD as to its position on these two issues so it can frame a Georgia position to the FSMB HOD in 2015; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) support FSMB Resolution 13-2 requiring applicants for licensure to have completed 36 months of progressive graduate medical education; and be it further

RESOLVED, that MAG does not support FSMB Resolution 13-3 that recommends shortening the duration of undergraduate medical education from four years to three years.

# # #
RESOLUTION
Resolution: 309C.14

SUBJECT: Ordering a Prescription Drug Under Protocol

SUBMITTED BY: Walker-Catoosa-Dade Medical Society

REFERRED TO: Reference Committee C

Whereas, the disciplines of advanced nurse practitioners and physicians once distinctive are becoming blurred; and

Whereas, in OCGA 43-34-21 and OCGA 43-26-3, the terms physician and nurse are quite clear and distinctive; and

Whereas, according to OCGA 43-34-21, a physician can enter a medical diagnosis. A nurse can enter a nursing diagnosis in OCGA 43-26-3.8B; and

Whereas, physicians can delegate certain medical acts to an APRN, including the ordering of prescription drugs pursuant to a defined protocol approved by the Georgia Composite Medical Board; and

Whereas, in OCGA 43-34-25, the APRN protocol agreement, the physician delegates “the authority to perform certain medical acts...and acts may include, without being limited to the ordering of drugs, medical devices, medical treatments, diagnostic studies, or in life-threatening situations radiographic imaging tests”; and

Whereas, nowhere in the protocol agreement is the authority that APRN’s can determine a medical diagnosis and prescribe treatments based on a medical diagnosis; and

Whereas, the only reference equating the “prescribing of a prescriptive drug under protocol” and “ordering” is 43-34-25 (11); and

Whereas, OCGA 43-34-23(a)(8) clearly states that ordering is not the same thing as prescribing; and

RESOLVED, that the Medical Association of Georgia (MAG) adopt a policy that APRNs cannot prescribe drugs for treatment of an unconfirmed medical diagnosis and that this policy will supersede all other MAG policy; and be it further

RESOLVED, that MAG support correction of present statute to clarify the distinction between prescribing and issuing a drug order or ordering a drug for the treatment of a previously established medical diagnosis; and be it further

RESOLVED, that MAG adopt a policy that APRNs are trained to enter a nursing diagnosis for a patient and cannot enter an unestablished medical diagnosis for a patient; this policy will supersede all other MAG policy; and be it further
RESOLVED, that MAG supports for nurses to be governed by the Georgia Composite Medical Board.

# # #

MAG Policy

35.998 Delegation of Medical Acts
BD 9/1/1983
MAG affirms the authority of physicians to delegate medical acts to non-licensed individuals for which the physician is both responsible and liable. (Reaffirmed 05/2000, 10/2009)

360.987 APRN Requirements
HD 10/20/2013
MAG supports the current requirement that APRNs work under "supervision" versus a "collaboration and consultation" agreement with physicians. (Officer 01.13, rec. 1)

360.999 Supervision of Nurses Definition
N/A 4/1/1980
Physician supervision of a nurse means that the physician is responsible for the medical acts performed by the nurse, acting in accordance with his prescription or instruction. The supervising physician or his physician designee must be available daily to examine his patient and must regularly and systematically review the medical care. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013)

120.983 Prescribing by Physicians & Supervised Personnel
HD 10/4/2008
MAG supports the following Prescribing Principles:
1. Only physicians, physician assistants (under physician supervision) and advanced practice nurses (under protocol with a supervising physician), dentists, veterinarians or podiatrists are qualified to prescribe drugs under Georgia law, the Georgia Legislature should not authorize unqualified practitioners to prescribe drugs.
2. Physicians should write prescriptions for a specified length of time and pharmacists are urged not to fill prescriptions past the time marked.
3. MAG supports the concept of a 48-hour delay program in the filling of prescriptions for amphetamines and preludin.
4. MAG believes in the education of physicians and pharmacists regarding all phases in the prescription of medications, including prescribing, writing, signing, sampling and distribution of all drugs as covered in the Georgia Pharmacy Act.
5. Advance Practice Nurses should continue to perform medical acts under the direction and direct supervision of physician and not as independent agents.
6. Medical acts performed by advance practice nurses on orders/directions of the physician, should be billed by the physician (medical acts as distinguished from nursing acts)
(Special Report 05.08, Attachment 3) (Reaffirmed 10/20/2013)

360.986 APRN Prescriptive Authority
HD 10/20/2013
MAG opposes increasing an APRN's prescriptive authority to order Schedule II narcotics. (Office 01.13, Rec. 2)
360.996 Prescriptive Authority for APNs
HD 4/1/1996
MAG fundamentally opposes independent prescriptive authority for advanced practice nurses. Physician supervision and oversight for using "protocols" is essential. (Reaffirmed 05/1999 and 05/2002; 10/13/07; 10/20/12)
RESOLUTION

Resolution: 310C.14

SUBJECT: Retention of Family Medicine Physicians in Georgia

SUBMITTED BY: Elizabeth Morgan, M.D., Delegate

REFERRED TO: Reference Committee C

Whereas, physicians as a group face many challenges from regulators and insurers and encroachment by other health care providers - all of which threaten the integrity and independence of our field; and

Whereas, excessive pay disparity disrupts physicians’ ability to speak as one group so as to maintain our high standards for ourselves and our patients; and

Whereas, inadequately compensated physicians deserve additional payment funding to increase reimbursement to the level of other specialties; and

Whereas, the disparity of pay within primary care specialties can be significant, depending on practice location and specialty and can be as high as 4:1 when compared to non-primary care specialties; and

Whereas, ideally disparity of pay should not exceed 2:1 since all licensed physicians have pre-residency education of approximately 20 years and residency training of three to seven years; and

Whereas, Georgia, the 9th most populous state, is 44th in primary care physicians per capita and predicted\(^1\) to rank 50th by 2020 for various reasons if we do not increase our primary care physicians\(^2\), and

Whereas, a 2013-2014 survey of Georgia’s Family Medicine Program Directors and others reported underpayment of family medicine physicians to be the reason that they will not stay to work in Georgia; and

Whereas, the Medical Association of Georgia (MAG) already supports many incentives to raise the income of primary care specialties\(^3\) and is actively involved as an important policy concern in supporting pay parity for family medicine; and

Whereas, integrating the pay parity goals of family medicine physicians into MAG benefits all Georgia physicians and our patients by establishing the value of physicians’ work; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) will seek to reduce the pay disparities across medical specialties by working closely with Georgia’s family medicine physicians, including

\(^1\) AAMC 2011 State Physician Workforce Data Book, Section 1, Figure 3.
\(^3\) Tripp Umbach Final Executive Report 2008
\(^4\) (Policy 165.976, 165.996-6, 295.989, 295.995, 305.999,Resolution 301C.13, 303C.13, 309C.3)
academic program directors to significantly increase pay for family medicine physicians to a level that
will attract and retain them in sufficient numbers in the state of Georgia by or before 2019.

###

**MAG Policy**

295.989 Primary Care Physicians
HD 10/17/2009
MAG recognizes its commitment to the important role of primary care in medicine and believes there
should be increased financial incentives for physicians practicing primary care.

295.995 Primary Care Graduates
HD 4/1/1993
MAG supports increasing the total number of medical graduates across the state entering primary care.
(Reaffirmed 05/2000; 10/5/2008; 10/20/2013)

305.999 Primary Care Training
HD 4/1/1983
MAG actively supports and encourages expansion of the training in family practice and other primary
care practices and encourages the Governor and the legislature to provide state support for this training.
(Reaffirmed 05/2000, 10/2009)

310.995 Primary Care GME Graduates
HD 10/20/2013
MAG support the efforts, including those of the Georgia Statewide Area Health Education Centers
(AHEC), to retain more Georgia primary care GME graduates and to recruit more Georgia medical
student graduates into Georgia primary care GME programs. (Res. 303C.13)
RESOLUTION

SUBJECT: Network Adequacy

SUBMITTED BY: Coffee County Medical Society

REFERRED TO: Reference Committee C

Whereas, although the Patient Protection and Affordable Care Act (PPACA) is meant to expand access to health insurance coverage, insurers offering new plans may be limiting patient access to care in some areas by significantly narrowing or dramatically tiering provider networks; and

Whereas, with the promise of increased patient volume, insurers have negotiated lower payment rates with some physicians; and

Whereas, insurers have excluded many physicians due only to the physicians’ higher costs; and

Whereas, regulators may not be prepared to assess and monitor network adequacy to the degree now required, and without meaningful adequacy requirements and effective monitoring programs, patients’ access to care may be at risk; and

Whereas, provider directories may contain inaccurate or misleading provider information, preventing patients from making informed decisions and creating misperceptions of the networks’ adequacy; and

Whereas, patients, attracted to lower premiums, may be unaware that their new provider network is smaller; that their deductibles may be higher than anticipated; and that they may be forced to pay high out-of-pocket costs in addition to the deductibles to access needed out-of-network care (particularly specialty and subspecialty care); and

Whereas, changes to existing insurance products to rely on increasingly narrow and tiered networks are being implemented without adequate or meaningful notice to patients or physicians; and

Whereas, if insurers are using inadequate or misleading data to select network physicians, or evaluating physicians based on cost alone, some of the sickest patients may not have access to quality, affordable care; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) support a requirement that all health insurance plans are regulated to ensure network adequacy by requiring insurers to provide transparency regarding the methodology for physician selection in health insurance networks and sufficient quality patient access to all physician specialties; and be it further

RESOLVED, that MAG will work with the Georgia Insurance Commissioner and insurers on developing a plan to make certain that health insurance networks are regulated properly to govern the adequacy of the networks – ensuring that the networks are vast enough to address the growing patient volume and provide sufficient quality patient access to all physician specialties, and requiring insurers to provide transparency regarding the methodology for physician selection in health insurance networks.

# # #
REFERENCE COMMITTEE
F
The Finance Committee continues to be active in overseeing MAG’s budget and financial resources. The committee met twice since the last meeting of the HOD. The committee reviews MAG’s financials and investments at each meeting.

The Finance Committee is pleased to report that in February 2014 MAG paid off the mortgage on the building at 1849 The Exchange, Atlanta, GA 30339. The building was purchased in 2006 and at that time we had a 20-year mortgage at 6.15 percent. The payoff included a $310,000 prepayment penalty, but even with taking this into account, the early payoff of the building saved MAG more than $400,000 in interest and cash flow over the remaining life of the loan, which was 12 years.

In 2011, the Finance Committee diligently went through a selection process and appointed Mauldin & Jenkins, CPA, as MAG’s new auditors. FY 2013 was the third year that Mauldin and Jenkins, CPA performed the audit and the Finance Committee is very pleased with their services. The Finance Committee reviewed and approved the audit of the FY 2013 financial statements, which were found to be accurate in all material respects.

In 2009, following the significant downturn of the economy, as well as declining membership, the Finance Committee recommended to the Board of Directors that it approve the five-year strategic goal to build $1 million in reserves. 2012 was the third year of this plan and we are pleased to report that in 2012 MAG surpassed this goal. MAG continues to build its reserves and FY 2013 is the fourth year that MAG’s surplus is more than $200,000. Management is to be commended for its successful growth in membership and continued discipline with management of expenses.

In 2013, the Board of Directors approved a budget for 2014, where revenues exceed expenses by $200,000, and we are pleased to report that MAG is again on target to exceed the budgeted surplus of $200,000.

This report provides delegates with a summary of MAG’s audited financial performance for FY 2013 and our projections on how MAG will end FY 2014.

MAG’s FINANCIAL PERFORMANCE IN FY 2013

This section on MAG’s financial performance in 2013 is divided into two parts. The first part compares our performance in 2013 with 2012 using Combined MAG Figures. We refer to these figures as “combined” because, in addition to the operating revenues and expenditures, which are approved by the Board of Directors, they include the revenues and expenditures of our related entities such as the MAG Foundation, the Physicians’ Institute for Excellence in Medicine, GAMPAC and the MAG Alliance, as well as those that are “restricted” to specific purposes other than general operations.
Examples of “restricted” activities include the Tort Reform Fund, the PR Media Fund and the Partnership with Medicine Fund. In contrast, the Budget approved by the Board of Directors is an Operating Budget that does not include revenues and expenditures for these “restricted” activities.

Because we do not formally budget for these restricted activities, the Combined MAG Figures (both revenues and expenditures) are greater than those found in the 2013 Operating Budget. The financial audit performed each year examines all of MAG’s financial activity, and therefore, includes both restricted and unrestricted revenues and expenditures. These figures are included in the Audit Report presented to the Board of Directors each year and are the ones used in this part of the report.

The **second part** of this section is designed to provide delegates with a more focused, strategic picture of our operating performance by using the Operating Budget figures only. The Operating Budget figures, which do not include revenue or expenditures for “restricted” activities or the revenues and expenses of related entities, allow us to compare our operating performance in 2013 with the operating performance of 2012 as well as compare our actual performance in 2013 with the 2013 budget targets approved by the Board of Directors. This part, therefore, provides delegates with a true comparison of how well we managed to the budget adopted by the Board of Directors.


**FINANCIAL HIGHLIGHTS**

<table>
<thead>
<tr>
<th>(Dollars in thousands)</th>
<th>2013</th>
<th>2012</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues – Dues</td>
<td>$ 2,209</td>
<td>$ 2,138</td>
<td>3.3%</td>
</tr>
<tr>
<td>Revenues – Non dues</td>
<td>3,159</td>
<td>2,515</td>
<td>25.6%</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>5,368</td>
<td>4,653</td>
<td>15.4%</td>
</tr>
<tr>
<td>Personnel expenses</td>
<td>2,300</td>
<td>2,007</td>
<td>14.6%</td>
</tr>
<tr>
<td>Other general and administrative expenses</td>
<td>2,594</td>
<td>2,453</td>
<td>5.7%</td>
</tr>
<tr>
<td>Total Operating expenses</td>
<td>4,894</td>
<td>4,460</td>
<td>9.7%</td>
</tr>
<tr>
<td>Operating results</td>
<td>474</td>
<td>193</td>
<td>145.6%</td>
</tr>
<tr>
<td>Non-operating and non-recurring items</td>
<td>16</td>
<td>83</td>
<td>-80.7%</td>
</tr>
</tbody>
</table>

**Change in Equity**

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2012</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in unrestricted equity</td>
<td>498</td>
<td>584</td>
<td>-14.7%</td>
</tr>
<tr>
<td>Change in restricted equity</td>
<td>(8)</td>
<td>(308)</td>
<td>-97.4%</td>
</tr>
<tr>
<td>Change in association equity</td>
<td>$490</td>
<td>$276</td>
<td>77.5%</td>
</tr>
</tbody>
</table>

| Association equity at year end | $3,969 | $3,478 | 14.1% |
| Employees at year end         | 21     | 20     | 5.0% |
FINANCIAL ANALYSIS

**Revenue**: MAG and its related entities generated Total Revenues of $5,367,991 in 2013 or $715,228 (15.4%) more than 2012. This was primarily due to an increase in grants, primarily Physicians’ Institute for Excellence in Medicine (PIEM), of $525,975 (79.1%), an increase in MAG Mutual Insurance Company revenue of $96,309 (12.4%) and an increase in Membership Dues of $70,512 (3.3%).

Membership Dues Revenue for 2013 was $2,208,748 or $70,512 (3.3%) more than 2012. We produced Non-Dues Revenue of $3,159,243 which is $644,716 (25.6%) more than in 2012.

**Expenses**: MAG and its related entities spent $4,893,836 in 2013 or $434,012 (9.7%) more than in 2012 ($4,459,824). This was primarily due to:

1. An increase in Personnel costs of $292,615 (14.6%). In 2013, MAG increased its personnel count by 1 FTE and payment for staff bonus was also a factor.

2. An increase in Education of $198,845 (24.2%). The Physicians’ Institute for Excellence in Medicine (PIEM) expended $1,000,072 or $196,031 (23.4%) more than 2012 for education purposes in performing their duties required under their grant agreements.

**Non-Operating and Non-Recurring Items:**

1. **Net Unrealized Gain on Life Insurance Policies and Annuity Contracts:**
   - The MAG Foundation recognized a net increase of $72,895 in the values of investment deferred annuity contracts and universal life insurance policies due to earnings on investments, reductions in surrender charges, and changes in market value adjustments.

2. **Change in Value of Accrued Annuity Liabilities:**
   - The MAG Foundation recognized an increase in the present value of future annuity liabilities, which resulted in an expense of $312,392.
3. Net Realized and Unrealized Gain on Investments:
   • The MAG Foundation recognized a $255,654 net gain on its investment account with capital group private client services due to dividends received and unrealized gains.

<table>
<thead>
<tr>
<th>Assets:</th>
<th>2012</th>
<th>2011</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cash and investments</td>
<td>6,734</td>
<td>$ 6,111</td>
<td>10.2%</td>
</tr>
<tr>
<td>Operating assets</td>
<td>465</td>
<td>248</td>
<td>87.5%</td>
</tr>
<tr>
<td>Property and equipment</td>
<td>3,131</td>
<td>3,249</td>
<td>-3.6%</td>
</tr>
<tr>
<td>Cash surrender value of annuity and life insurance policies</td>
<td>2,730</td>
<td>2,742</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Grants and Pledges receivable</td>
<td>104</td>
<td>52</td>
<td>100.0%</td>
</tr>
<tr>
<td>Student loans receivable</td>
<td>24</td>
<td>27</td>
<td>-11.1%</td>
</tr>
<tr>
<td>Total</td>
<td>13,188</td>
<td>12,429</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

MAG and its related entities’ Total Assets increased $758,636 (6.1%) in 2013. This was due to:
1. An increase of $623,589 (10.2%) in Cash and Investments. This increase was primarily due to positive operating surplus in 2013.
2. An increase of $215,966 (86.8%) in Operating Assets. Changes in operating assets from year to year are largely due to timing of cash receipts and payments.
3. A decrease in Fixed Assets of $117,453 (3.6%), primarily due to aging of Fixed Assets.
4. A decrease of $12,021 (0.4%) in the MAG Foundations’ Cash Surrender Value of Annuity and Life Insurance Policies.
5. An increase of $52,430 (101.5%) in MAG Foundation and PIEM Grants receivable.
6. A decrease of $3,875 (14.2%) in Student Loans Receivable.

<table>
<thead>
<tr>
<th>Liabilities and equity:</th>
<th>2013</th>
<th>2012</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating liabilities</td>
<td>$ 266</td>
<td>$ 246</td>
<td>8.1%</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>1,623</td>
<td>1,452</td>
<td>11.8%</td>
</tr>
<tr>
<td>Debt on land &amp; building</td>
<td>1,626</td>
<td>1,706</td>
<td>-4.7%</td>
</tr>
<tr>
<td>Accrued annuity liabilities</td>
<td>5,704</td>
<td>5,547</td>
<td>2.8%</td>
</tr>
<tr>
<td>Association Net Assets</td>
<td>3,969</td>
<td>3,478</td>
<td>14.1%</td>
</tr>
<tr>
<td>Total</td>
<td>13,188</td>
<td>12,429</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

MAG and its related entities’ Liabilities increased $268,324 (3.0%) in 2013. This was due to:
1. Operating liabilities increased $19,967 (8.1%) in 2013. Changes in operating liabilities from year to year are largely due to timing of cash receipts and payments.
2. Deferred Revenue increased $170,973 (11.8%) in 2013. Changes in deferred revenue from year to year are largely due to timing of cash receipts and payments.
3. Debt on Land and Building decreased $80,045 (4.7%) in 2013.
4. The MAG Foundation Section 170 Plan Accrued Annuity Liabilities increased $157,429 (2.8%).
Part II: FY 2013 Management of the Operating Budget.

Managing to the Operating Budget: 2013 is the fourth year of our five-year strategic plan. In 2012 we surpassed our goal of $1 million in surplus and combining our surplus for 2010 ($239,436), 2011 (484,084) and 2012 ($528,857), we reached a cumulative surplus of $1,252,377.

We are pleased to report that this is the fourth year that MAG has surpassed its budgeted surplus of $200,000 and ended the year with a surplus of $442,272, or $242,272 (121.1%) above budget. We are continuing to build the financial strength of the association.

Operating Revenues: Total Operating Revenues in 2013 were $3,776,585. This represents an increase of $157,346 (4.3%) over 2012 and $309,772 (8.9%) above the budget target of $3,466,813. The excess primarily resulted from increased revenues from Membership Dues Revenue of $206,838 (11.2%) and increased revenues from Overhead Allocation from the MAG Foundation and Physicians’ Institute for Excellence in Medicine of $85,674 (109.3%) and increased revenues in Correctional Medicine of $19,485 (12.9%).

Dues revenue in 2013 was $2,056,838, up $109,944 (5.6%) from $1,946,894 in 2012, and above budgeted dues revenues by $206,838 (11.2%).

Non-dues revenue was $1,719,747, up $47,402 (2.8%) from $1,672,345 in 2012. This was primarily the result of:
1. Overhead Allocation from the MAG Foundation and Physicians’ Institute for Excellence in Medicine up $85,674 (109.3%).
2. Correctional Medicine Revenue 19,485 (12.9%).
Operating Expenses: Total Operating Expenses in 2013 were $3,334,313, representing an increase of $243,931 (7.9%) from 2012. Total Operating Expenses were $67,500 (2.1%) more than the budget. Personnel Expenses, which account for approximately 61.1% of all expenses, were up $194,199 (10.5%) from $1,842,994 in 2012 and higher than the budget by $173,893 (9.3%). Non-Personnel Expenses were $1,297,120, up $49,732 (4.0%) in 2012 ($1,247,388) and down $106,393 (7.6%) from the budget ($1,403,513).
Net Operating Income: Net Operating Income is the net of Total Operating Revenues minus Total Operating Expenses resulting in a Net Operating Surplus or Net Operating Deficit. We ended FY 2013 with a Net Operating Surplus of $442,272, which is $242,272 (121.1%) better than the surplus of $200,000 approved by the Board of Directors.

PROJECTED RESULTS FOR FY 2014

(Based on month-end July 2014)

Our fiscal year-end projections are derived by extrapolating operating performance figures from July 2014 to the end of the year. These extrapolated figures suggest that we will come in above target, well ahead of the $200,000 operating budget surplus as adopted by the Board of Directors in 2013. It is the intent of the Board of Directors to use this surplus to continue to build reserves.

Total Revenues are projected to be $3,787,948, an increase of $10,170 (0.3%) from 2013 and $173,822 (4.8%) higher than budget. As we near the end of our dues collection cycle, we estimate that Dues Revenues will be $2,005,000, a $51,838 (2.5%) decrease from 2013 and a $130,000 (6.9%) increase against the budget target of $1,875,000. Non-dues revenue is estimated to be $1,782,948, up $62,008 (3.6%) from 2013 and up $43,822 (2.5%) against the budget.

Total expenses are projected to be $3,402,737, an increase of $54,685 (1.6%) from 2013 and $11,389 (0.3%) below budget. Personnel costs, which are projected to be $2,018,400, is a decrease of $18,793 (0.9%) from 2013 and $3,300 (0.2%) higher than budget. Non-personnel costs are projected to be $1,384,337, which is a $73,478 (5.6%) increase over 2013 and $14,689 (1.0%) lower than budgeted.

A surplus of $385,211 is projected which is $44,515 (10.4%) lower than 2013 and $185,211 (92.6%) higher than budget. Achieving this surplus will allow us to continue to build our reserves.

MAG’s INVESTMENT POLICY

A copy of MAG’s Investment Policy is attached hereto for information. (Attachment 1).

THANK YOU

As Treasurer, I am grateful for the opportunity to have worked with the dedicated members of the Finance Committee this year.

William P. Brooks, M.D., Macon
Manoj H. Shah, M.D., Warner Robins
Rutledge Forney, M.D., Atlanta
Thomas E. Emerson, M.D., Marietta
Arthur Torsiglieri, M.D., Conyers
Edmund Donoghue, M.D., Savannah
Lisa Perry-Gilkes, M.D., Savannah
Michelle R. Zeanah, M.D., Statesboro

MAG Staff:
Sally-Anne Jacobs, Director of Administration and Operations

# # #
MEDICAL ASSOCIATION OF GEORGIA

INVESTMENT POLICY

INTRODUCTION

The finances of the Medical Association of Georgia (MAG) are separated into two categories: “Operating Funds” and “Long Term Investments.” This document represents the Investment Policy for operating funds that are invested and for long-term investments.

Operating Funds: Operating Funds are generated from two sources: Dues Revenue and Non-Dues Revenue. These funds are used to finance the day-to-day operations of the association and are maintained in a “Commercial Paper Account” similar to a money market account so that they are available on a day-to-day basis. A majority, but not all, of the funds in the Commercial Paper Account are “swept” into an investment account at the end of the business day and returned to the Commercial Paper Account before the beginning of the next business day. This allows MAG to earn additional interest on these funds. Funds that are generated early in the membership year that are not needed for the day-to-day operation of the association are often invested in other instruments for use later in the year to meet cash flow needs. When cash on hand exceeds anticipated cash flow needs, the Finance Committee shall assess whether such excess funds should be invested in longer term securities to enhance return on investment.

Long Term Investments: Long Term Investments are those funds that are typically invested for the long-term growth of the association. Funds that comprise MAG’s Long Term Investments were generated by the sale of our PPO known as Georgia Health Network. These funds are maintained in a separate account referred to as managed care funds.

Purpose

The purpose of this Investment Policy is to set forth the investment objectives and investment guidelines for the association’s Invested Operating Funds and Long-Term Investments.

Investment objectives have been formulated with attention to:

• Assuring that the association has sufficient cash flow to allow its uninterrupted operation;
• Maximizing return on investment relative to the risk tolerance of the Medical Association of Georgia;

• The need to achieve prudent diversification of assets; and
• The strategic financial goals of the association.

Duties of the Board of Directors

The Board of Directors has the fiduciary obligation to ensure that the assets of the association are invested in a prudent manner. The Board of Directors will receive a report from the Treasurer at each of its meetings and approve (or disapprove) the financial statements of the association. The
Board of Directors approves the budget and submits a report on the budget and management of the association’s finances to the House of Delegates.

**Duties of the Treasurer and Finance Committee**

The Treasurer is elected by the HOD and serves a term of two years. The Treasurer chairs the Committee on Finance, which is comprised of at least seven (7) members of the Board of Directors appointed by the Chairman of the Board.

The Committee on Finance shall cause to be audited at least annually all accounts of the association. The Committee shall propose an annual budget for the fiscal year beginning on January 1 and submit that budget to the Board of Directors at its last meeting in the last quarter of the fiscal year for Board approval.

**Objectives**

(a) All investments shall fall within the legal requirements and regulations governing the association’s legal status as a 501(c)6 corporation.

(b) Investments of current budget year’s revenue should be structured to conserve principal and earn the highest return available on short-term liquid investments.

(c) Monies in excess of amounts needed for short-term obligations should be invested to earn the highest return available on long-term investments within the risk tolerance as set in allowable ranges for asset categories.

**Types of Investment and Quality Ratings**

The following is a list of investment type and quality ratings:

**Cash Equivalents**

- **Treasury Bills (T-Bills):** That are guaranteed by full faith and credit of the U.S. government.

- **Banker’s Acceptances (BAs):** May be purchased from banks or trust companies, subject to approved FDIC guaranteed insurance limitations, organized under the laws of Canada or the United States of America or any province or state thereof, which have combined capital and surplus of at least $1,000,000,000 in U.S. dollars.

- **Repurchase Agreement (Repos):** May be purchased from banks for trust companies, organized under the laws of Canada or the United States of or any province or state thereof, which have combined capital and surplus of at least $1,000,000,000 in U.S. dollars.

- **Commercial Paper** rated “prime” or its equivalent by either the National Credit Office, Inc. or Standard & Poor’s Corporations, or their successors, and unrated commercial paper of similar quality in which the bank is also investing funds held by it in a trust or
trusts subject to the jurisdiction of the Probate Courts of the State of Georgia (including any investment in pools or mutual funds of such commercial paper owned by the bank).

- **Cash** because of their liquidity and short-term to maturity for purposes of this investment policy, treasury bills, repos, commercial paper, and many money market funds are considered cash equivalents.

**Fixed Income**

- **Certificate of Deposit (CD’s):** May be purchased from banks or trust companies, subject to approved FDIC guaranteed insurance limitations, organized under the laws of Canada or the United States of America or any province or state thereof, which have combined capital and surplus of at least $1,000,000,000 in U.S. dollars.

- **Government Bonds** or other obligations of the United States government the principal and interest of which constitute direct obligations of the United States of America.


- **Corporate Bonds** with a quality rating of no less than A. If downgraded after purchase, then the investment manager and treasurer will monitor until it returns to A.

**Equities**

- **Stocks** or equivalent investments in mutual funds upon the advice of MAG’s investment advisor.

**INVESTMENT OF OPERATING FUNDS**

**Purpose of Operating Funds**

Operating funds are used for the day-to-day operations of the association. The primary source of operating funds is Dues Revenue. Because dues are collected in the fall of the year for the next membership year, MAG often has more funds on hand than required for operations early in the year. Surplus membership dues and Non-Dues Revenue should be invested for the primary purpose of assuring that sufficient funds are available later in the year to meet cash flow needs. Operating Funds in excess of those needed for cash flow purposes may be invested for longer terms.

**Time Horizon for Investment of Operating Funds**

Typically, operating funds are needed for cash flow purposes and are invested for one year or less.
Risk Aversion

Since Operating Funds are used to finance the day-to-day operations of the association and preserve cash flow, the association has a low tolerance for risk of loss in value of invested Operating Funds.

Asset Allocation

The portfolio for the invested Operating Funds should be conservative reflecting the primary need for asset preservation and a low tolerance for risk.

Asset allocation guidelines for investment of operating funds will be as follows:

<table>
<thead>
<tr>
<th>ASSET CATEGORY</th>
<th>ALLOWABLE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equities</td>
<td>0% - 30%</td>
</tr>
<tr>
<td>Fixed Income</td>
<td>0% - 50%</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>50% - 100%</td>
</tr>
</tbody>
</table>

INVESTMENT OF LONG-TERM FUNDS

Purpose of Long-Term Investments

Long-Term Investments are not usually needed to fund the day-to-day operations of the association. Rather, these funds are available to pursue strategic goals of the association such as the purchase of a building or financing a new project. They may also be needed to pay an unexpected debt.

Time Horizon for Investment of Operating Funds

Long-term funds are invested for three (3) to five (5) years or longer.

Risk Aversion

We are willing to bear some short-term decline in value of Long Term Investments in an effort to achieve higher long-term returns.

Asset Allocation

The portfolio for the Long-Term Investments should be consistent with the goal of accumulation of capital and the preservation of its value for the economic betterment of MAG.

Asset allocation guidelines for investment of long-term funds will be as follows:

<table>
<thead>
<tr>
<th>ASSET CATEGORY</th>
<th>ALLOWABLE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td>0% - 25%</td>
</tr>
<tr>
<td>Fixed</td>
<td>0% - 50%</td>
</tr>
<tr>
<td>Cash</td>
<td>10% - 100%</td>
</tr>
</tbody>
</table>
INVESTMENT GUIDELINES

Investment Authority

The Treasurer shall have authority to make/approve investment decisions based upon the Investment Policy developed by the Finance Committee and approved by Board of Directors. This authority may be delegated to the Executive Director.

Investment Manager

MAG expects any investment manager to review the specific investments at a frequency that will ensure the highest available return on its investments reflecting changes in the economy, interest rates and other market factors and recommend changes to the Investment Portfolio if such change is indicated by these factors.

The investment manager shall meet quarterly with the Treasurer and/or Executive Director to discuss strategies and review quarterly performance and assess the overall risk of the portfolio relative to the market as a whole. The investment manager must receive approval from the Treasurer prior to making or changing investments.

The Treasurer shall be responsible for the following activities, but may delegate such authority to the Executive Director:

- Making or changing investments recommended by the investment manager;
- Opening accounts with brokers and dealers;
- Setting up safekeeping for securities;
- Signing specific documents.

The Executive Director shall report to the Treasurer any actions taken on delegated activities within 3 business days of taking such action.

Policy Amendments

Any change to this policy shall be given to the fund/investment managers in writing and such amendments shall be signed by at least two MAG officers. The Finance Committee shall review the investment policy annually.
REFERENCE COMMITTEE
HC
It has been my great privilege to represent you and the rest of the physicians of Georgia as MAG’s president during the past year. In 2014, MAG created a task force to examine the Certificate of Need (CON) issue in depth and to solicit a multitude of physician perspectives. In choosing the members of this task force, I considered a number of factors, including specialty, geographic location, and practice setting. I believe that the task force was balanced and represented a wide range of perspectives.

The task force was charged with 1) reviewing MAG’s existing CON policies and 2) developing any new CON policy recommendations that would be debated during this year’s House of Delegates (HOD) meeting.

This has been an important exercise due to the increased attention that the CON issue has received during the last two state legislative sessions in Georgia and because of MAG’s dramatic growth in membership.

As MAG’s president, I served as the task force chairman, which means that I witnessed the deliberations firsthand – and I can assure MAG members that the task force studied the CON issue in great depth and detail.

I would like to thank and commend the members of the CON Task Force for both their time and their significant contributions. This includes Carolyn Meltzer, M.D., and Richard Duszak, M.D., from the Emory Physicians Group; James Lofton Smith Jr., M.D., from the Georgia College of Emergency Physicians; James Scott, M.D., and Christopher Walsh, M.D., from the Georgia Society of Ambulatory Surgery Centers; Justin Scott, M.D., from the Georgia Society of Anesthesiologists; Sid Moore Jr., M.D., from the Georgia Society of Ophthalmology; Charles Wilmer, M.D., from Piedmont Hospital; Robert Jansen, M.D., and Thomas Emerson, M.D., from the WellStar Medical Group; Jeff Reinhardt, M.D., and Karl Schultz Jr., M.D., from The Longstreet Clinic; Randy Rizor, M.D., from The Physicians Hospital; Douglas Lundy, M.D., from Resurgens; Robert P. Jones, M.D., and Jules Toraya, M.D., from Southcoast Medical Group; Michael P. Madaio, M.D., and Norman Thomson III, M.D., from Georgia Regents University; Charles Procter Sr., M.D., from the Georgia Society of the American College of Surgeons; Hugo D. Ribot Jr., M.D., from Cartersville Ob/Gyn Associates; Michael E. Greene, M.D., chairman of MAG’s Council on Legislation; and Manoj Shah, M.D., MAG’s President-elect.

I encourage MAG members to review the attached CON Task Force reports from the meetings that took place on May 15, June 3, July 15, and August 13.

**CON Issue Overview**

During the first task force meeting on May 15, Hall, Booth, Smith, P.C. attorney Trey Reese gave a CON issues overview. He addressed the issue’s history, the legislative developments that have taken place in the state since 2008, and the current CON laws in Georgia. Mr. Reese also discussed the pros and cons associated with CON law in Georgia. His presentation is available upon request.
Independent Physicians

During the task force’s second meeting, Victor Moldovan – who represents The Longstreet Clinic and the Southcoast Medical Group – addressed the CON issue from a multispecialty ASC perspective. He said that reforming Georgia’s CON laws was an “essential” step that needs to take place to ensure that physicians in the state have adequate career options. Mr. Moldovan also stated that hospitals in Georgia use the CON system as a mechanism to consolidate the number of facilities in the state and to eliminate career options for physicians. Mr. Moldovan concluded his remarks by stating that he believes that repealing or amending CON laws in Georgia would “level the playing field” for physicians and it would require hospitals to work with all physicians.

Health Systems Physicians

During its’ meeting on July 15, the task force heard presentations by representatives of hospital system physicians. This included Richard Duszak, M.D., with Emory Hospital, Charles Wilmer, M.D., with Piedmont Hospital, Thomas Emerson, M.D., with the WellStar Health System, and Mr. Jet Toney with the Georgia Society of Anesthesiologists (GSA).

Dr. Duszak discussed ways CON affects academic medical centers. Dr. Wilmer focused on how CON affects patients. Dr. Emerson pointed out that the health care system in Georgia does not operate like a traditional free market, and he stressed that it is imperative for hospitals to remain viable to ensure that the indigent and Medicare and Medicaid patients have access to care. Mr. Toney said that gastroenterologists and other physicians providing outpatient services have begun excluding anesthesiologists from practicing in ambulatory surgery centers (ASC) in Georgia, and, because of this experience, GSA does not believe repeal of CON would create substantial new practice opportunities for physician anesthesiologists. He said that while GSA’s current position is to oppose wholesale repeal of CON, Society leaders will, in the interest of dialogue on public policy, keep an open mind on all proposals to amend CON law.

Ambulatory Surgery Centers

On August 13, the task force heard from the Georgia Society of Ambulatory Surgery Centers (GSASC). GSASC President Andy King stated that GSASC’s primary CON concern is related to placing further limits on physician practices. He added that GSASC will take steps to ensure that physician-owned ASC are able to practice without further interference from the state. Mr. King stressed the importance of ASC in Georgia. GSASC members Sid Moore, M.D., and Jim Scott, M.D., also gave presentations on why ASC are an important part of Georgia’s health care system.

Final Meeting

During its final meeting on September 6, the task force developed its recommendations for MAG’s HOD. The task force reviewed MAG Policy 205.989, “Certificate of Need – Laws & Regulations,” which will undergo a requisite five-year review during this year’s HOD meeting. If the policy is extracted, the HOD will decide whether to reaffirm the policy or sunset the policy or sunset the policy with new language. MAG’s Council on Legislation reviewed this policy and has recommended that the HOD reaffirm the policy. The current policy (205.989) states that...

“It is the position of the Medical Association of Georgia that Certificate of Need is anti-competitive, restricts the development of physician-owned and operated ambulatory surgical procedure and imaging centers, laboratories, and ancillary services, and limits the ability of physicians to deliver high quality, cost-effective care to Georgia’s patients.
The Medical Association of Georgia opposes Certificate of Need and supports the repeal of Certificate of Need laws in general and specifically as they apply to physician-owned and operated outpatient diagnostic centers, imaging centers, ambulatory surgical centers, laboratories and ancillary services. The Medical Association of Georgia will endeavor to educate legislators and the business community about the policy benefits of eliminating Certificate of Need.

Until Georgia’s Certificate of Need laws are repealed, the Medical Association of Georgia opposes any changes to such laws that would make it more difficult for physicians to establish and operate ambulatory surgical centers, such as making it more difficult to obtain an exemption from Certificate of Need review or decreasing the capital, equipment, single-specialty physician-owned ASC, or joint venture ASC expenditure thresholds.

With respect to exemptions from Certificate of Need review (and obtaining a Letter of Non-Reviewability), the Medical Association of Georgia supports expanding the exemption from Certificate of Need review for single-specialty physician-owned ambulatory surgical centers to multi-specialty physician-owned ambulatory surgical centers. In the alternative, the Medical Association of Georgia supports recognition as a “single-specialty”, for purposes of the single-specialty exemption from Certificate of Need review (and obtaining a Letter of Non-Reviewability) for physician-owned ambulatory surgical centers, any specialty or subspecialty recognized by the American Board of Medical Specialties or an equivalent board. The Medical Association of Georgia opposes statutory or regulatory provisions that authorize a competitor of an applicant for an exemption from Certificate of Need review (and Letter of Non-Reviewability) to challenge a determination by the Department of Health that the applicant’s proposed project is exempt from Certificate of Need review.

The Medical Association of Georgia will support MAG members who seek legal remedies to Certificate of Need provisions that are unfair to physicians.”

During this final meeting, task force members broke into small groups for consideration of four questions:

1. Should multispecialty practices be allowed to open ambulatory surgery centers (ASCs) without having to obtain a CON?
2. Should multispecialty practices be allowed to purchase a single specialty practice with a LNR ASC without having to go through the CON process?
3. What would each group be willing to compromise to achieve a YES to the questions above?
4. What should MAG’s position on CON be for the 2015 General Assembly, i.e., support, oppose or neutral?

Each small group discussion lasted approximately two hours. Each group included four to five physicians with a diversity of opinions that were based on the positions of the different groups. Following a small group discussion, the large group convened to discuss solutions.

After a total of five hours of discussion and debate, the CON task force developed two recommendations for the HOD that were passed by the majority of the task force members, though the recommendations were not unanimous.

I sincerely hope that these reports will provide our delegates with the information that they need to engage in a meaningful discussion about the future of CON in Georgia during the HOD meeting that will take place at Callaway Gardens in Pine Mountain on October 18-19.

It has been my honor to serve as your president, and it has been my honor to work with so many physicians who are genuinely dedicated to organized medicine.
**Recommendations:**

1. That the Medical Association of Georgia (MAG) support a pilot/demonstration project lasting five years allowing multispecialty clinics the ability to purchase a single specialty practice with a LNR ASC without having to go through the certificate of need process. Those practices participating in the pilot are allowed to keep functioning as the practices under a permanent exemption did under the pilot if the study results show the pilot/demonstration pilot was detrimental to the community.

2. That MAG aggressively support challenging the legislature to continue to search for ways to improve the health care of Georgia.

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September 17, 2014

William Silver, MD  
Medical Association of Georgia  
1849 The Exchange, Suite 200  
Atlanta, Georgia 30339

Dear Dr. Silver,

We write to urge the Medical Association of Georgia (MAG) to confirm its longstanding position that Georgia’s Certificate of Need (CON) law should be repealed. The groups listed below endorse that position and maintain their own position that the law should be repealed in its entirety.

Further, we urge MAG not to join with others to introduce or support any CON legislation in the 2015 GA Legislative Session. We see no evidence that the political climate is favorable to amending CON statutes. While it is doubtful that any CON legislation could pass the General Assembly, we believe that introducing CON legislation endangers the meaningful reforms enacted in the 2008. If the issue is on the table, the existing statute that grants the option to physicians to apply for a Letter of Non Reviewability (LNR) when developing physician-owned ambulatory surgery centers (ASCs) becomes vulnerable to repeal or amendment.

Most of us were involved in the recent MAG CON Task Force that provided a forum for physicians to state their opinions and the positions of the groups they represent. It is safe to say there was no agreement among the physicians on task force regarding CON legislation. In fact, the general consensus was that MAG should not engage in the matter legislatively in 2015.

The medical specialty societies and groups represented below believe the best course is to preserve the status quo in 2015 and they, therefore will oppose any CON legislation introduced this session. If MAG engages in CON legislation, the house of medicine may appear fractured which could negatively impact our work on other more important patient centered healthcare legislation.

We urge MAG, by withholding their support for any legislation amending Georgia’s CON statutes in 2015, to join us in protecting the provisions currently in place for their members whose practices have invested in 341 physician-owned ASCs in the state.

Sincerely,

Sid Moore, MD  
Legislative Chair  
GA Society of Ophthalmology

Andy King  
President  
GA Society of Ambulatory Surgery Centers

Kay Kirkpatrick, MD  
President  
Resurgens Orthopaedics

Alex Gross, MD  
President  
GA Society of Dermatology and Dermatological Surgery
MEMORANDUM

TO: MAG CON COMMITTEE
FROM: Dr. Jones, Dr. Toraya and Dr. Reinhardt
RE: Draft President’s Report
DATE: September 17, 2014

Thank you for giving us the opportunity to review the draft of the Presidents Report before it is finalized. We have reviewed it and discussed it amongst ourselves and have several concerns as follows:

1. The Committee identified four questions it would address at the end of the process. Those questions are identified in the Report. The members of the Committee agreed that if we could not reach a consensus on the questions the issue would be sent to the House of Delegates (“HOD”) without a recommendation. That is basically what occurred. We were unable to agree on any specific recommendations. The Report suggests that there was a vote to approve the recommendations identified in the Report with a majority vote. That is not correct. We made some progress about a pilot program of some type but no consensus was reached on it and we do not support the Recommendation No. 1 as drafted. We understood that if there was no consensus that the entire matter would go to the HOD as stated in the four questions. The fact that some of the members or even a majority agreed with some version of the recommendation is not what we agreed as a Committee would be reported. There had to be a consensus and there was not. The Report implies that the Recommendations were the product of some formal process and gives greater weight to the Recommendations than there should be. Moreover, Recommendation No. 2 was not discussed at all. As a result, we ask that the Recommendations be deleted in their entirety and the Report simply state that no consensus was reached.

2. The Report does not reflect the vigorous debate regarding the matter amongst the members. As you now, we fully support an exemption for physician group multi-specialty surgery centers and that the multi-specialty groups be allowed to acquire single specialty practices that have an ASC and keep the ASC as a single specialty ASC. The Report does not properly emphasize our position on this matter and glosses over the nature of the debate. We are concerned that those unfamiliar with the issue will assume the Report represents some kind of consensus on the issue (with some minor opposition) and that the Recommendations should be adopted as is. Again, we ask that the Recommendations be deleted in their entirety and that the Report simply say no consensus was reached. Also, the Report should reflect that there was sharp division in the Committee about the issue and as a result should be considered by the HOD without a recommendation.

3. We realize that there are different points of view about this issue and it would be helpful if some consensus could be reached on it. Where a consensus is not reached the matter should go to the HOD for deliberation. That has been the process in the past and we ask that be the process now.

Thank you again for your participation and work on this very important matter and look forward to seeing you at the HOD.