CHARTING THE COURSE
Navigating through Uncertainty in Health Care
It’s remarkable how much happened in health care this year! During these past 12 months, the Society laid the foundation for our advocacy work during the next 10 years.

Many of our innumerable achievements during this historic period are documented in this Annual Report. We shared our voice and point of view in almost every important health care discussion. As a result, the policies and legislation coming out of our state and our nation, while certainly not perfect, largely preserve the principle that “true north” on the health care compass must be delivering excellent care to patients.

The close engagement between the Society’s members and its leaders this year was essential. Our officers made 270 visits to members at district societies, hospitals, and specialty groups. Under the sagacious leadership of Dr. Mario Motta and his team, the MMS brought what our grassroots members said at those many meetings and focus groups to 100-plus gatherings with regulators and policymakers on Beacon Hill and Capitol Hill. And our Publishing Division certainly did its part in keeping members engaged with up-to-the-minute coverage of health reform on NEJM.org.

I thank the Society’s leaders and all its members for their high level of involvement and energy this year. We’ll certainly need more of the same in the coming year to keep reform headed in the right direction.

Corinne Broderick, Executive Vice President
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The death of Massachusetts Sen. Edward Kennedy on August 26, 2009, was a turning point in the health care reform debate in Washington. Just a month prior to that, the House Energy and Commerce Committee approved health care legislation that included $200 billion for Medicare SGR reform.

After Sen. Kennedy’s death, most hopes for a bipartisan dialog on health care seemed to dissipate. The Senate repeatedly refused to consider any long-term SGR fix, and a series of short-term Medicare payment patches ensued, often with House and Senate leaders sniping at one another until — and even past — the eleventh hour. The epitome of polarization and paralysis took place in February, March, and May when Congress recessed three times without voting to halt a 21-percent cut in Medicare payments to physicians.

PIVOTAL POINTS IN FEDERAL REFORM

07/31/09: House Energy and Commerce Committee approves health care legislation that includes a “public option” and $200 billion for Medicare SGR reform.

08/14/09: Senate Finance Committee releases a health care reform bill with no public option and a small one-year increase in physician Medicare payments. MMS criticizes the bill’s failure to repeal the SGR formula and the proposed Independent Payment Advisory Board (IPAB) for Medicare.

08/26/09: SEN. EDWARD KENNEDY DIES.

10/29/09: House releases amended health reform bill and submits a separate bill to repeal SGR.

11/06/09: MMS declares support of House reform bill (HR 3962) and the bill repealing the SGR formula (HR 3961).

11/07/09: HOUSE PASSES $1 TRILLION REFORM BILL (HR 3962).

11/19/09: HOUSE PASSES MEDICARE PAYMENT REFORM BILL (HR 3961), REPEALING THE SGR FORMULA.

12/16/09: With Senate stalled on SGR repeal, House approves a bill delaying the 21 percent Medicare pay cut until March 1, 2010.

12/19/09: Senate passes the House bill passed on December 16.

12/24/09: SENATE PASSES ITS VERSION OF HEALTH CARE REFORM.
Unless further action is taken, Medicare will melt down again on December 1, 2010. With midterm elections a month before that next “D-Day,” it’s unlikely that America’s physicians will see anything more than another band-aid applied to Medicare. This despite organized medicine’s clear and repeated message to Congress: anything less than a long-term SGR solution costs the government more and more as each day goes by. This message was underscored by the Society’s highly engaged members, who helped shape our responses and answered our calls to action by contacting their lawmakers.

Despite the vitriolic political atmosphere, Congress did manage to pass an historic health care reform bill in March. “Even though the bill is far from perfect, our country is much better off with the legislation, than without it,” said MMS President Mario Motta, MD.

Dr. Motta emphasized that the enactment of health reform was only the first step on a long trudge to remake the U.S. health care system. Some provisions of the law have already taken effect, but most are on an implementation timeline from 2011 to 2014.

The MMS will be actively engaged in the implementation process. As we are in Boston, this Society will be seen and heard in Washington as the details of health care reform get hammered out and put into action.
With insurance premiums steadily rising and state and municipal governments struggling to close budget gaps, cost containment was the main theme of health care discussions in Massachusetts this year. Close monitoring and timely, effective advocacy enabled the MMS to thwart several troubling approaches to curbing health care costs.

Contending that the practice of defensive medicine — arising from a broken liability system — is a key driver of excess cost, the Society identified the Health Care Quality and Cost Council’s Roadmap to Cost Containment as the most comprehensive and rational approach. That document recommends liability reform and administrative simplification as two of eleven strategies, and proposes a multifaceted approach to a multifaceted problem.

The notion of regulating rates paid to and by insurance companies was raised by Gov. Patrick, the Division of Insurance, and the attorney general’s office. Testifying at the State House against a bill that would have forced physicians to accept certain reimbursements as a condition of licensure, MMS Senior Medical Advisor
At the 2009 Interim Meeting (left) and the 2010 Annual Meeting (right), proposed state health reforms dominated the conversations.

Jack Evjy, MD, said, “Rate regulation will make Massachusetts an unattractive place to practice.”

Given the continued decline in the MMS Practice Environment Index and a worsening shortage of practicing physicians in the state, especially in primary care, Massachusetts patients would not be well served by any heavy-handed intervention that would dissuade physicians from practicing here. The MMS worked hard to ensure that the bill passed by the Legislature on the final day of the formal session did not include rate regulation, instead turning over that issue to a study commission of which the MMS will be a member.

The year began with a report from the Payment Reform Commission urging a move to global payment. It ended with lawmakers postponing payment-reform legislation until the next session to give it the in-depth consideration it deserves. The MMS is positioned to be a major voice in that dialog this coming year. Our message is clear and consistent: reforms must account for the pluralistic nature of our health care system, they must be implemented gradually and rationally, they must deal with the costs associated with defensive medicine, and they must include built-in milestones to check for efficacy and unintended consequences.

01/29/10: Massachusetts Attorney General Martha Coakley attributes high health care costs largely to market clout of certain hospitals and doctor groups.

02/11/10: Gov. Patrick files H 4490, which would give him rate-setting authority over hospitals, doctors, and insurers.

03/10/10: MMS TESTIFIES AT STATE HOUSE AGAINST RATE-REGULATION PROVISIONS IN H 4490.

03/17/10: RAND Corp. study cites significant inaccuracies in GIC-like physician cost-profiling programs.

05/18/10: Senate passes health care cost-containment bill, but defeats amendments that would have affected physician licensure and imposed a 2.5 percent surcharge on doctors.

07/04/10: Senate President Therese Murray shelves plans for payment reform legislation in 2010, citing its logistical and political complexity.

07/30/10: Massachusetts Legislature passes a health care bill that addresses small-business health care costs without imposing sweeping rate controls on the overall market.
The buzz around health information technology (IT) got a lot louder this year, largely because the American Recovery and Reinvestment Act of 2009 will provide more than $40 billion to promote and accelerate the adoption of health IT systems nationwide.

In addition to direct reimbursement for “meaningful use” of electronic health records (EHRs) from the Centers for Medicare and Medicaid Services (CMS), the Massachusetts eHealth Institute (MeHI), the state’s Regional Extension Center, will offer technology-adoption services. Meaningful users of EHRs can qualify for Medicare/Medicaid reimbursements of up to $65,000.

INITIAL CRITERIA CRITICIZED

When the CMS released its first version of meaningful-use criteria in January, organized medicine, including the MMS and the AMA, felt that the eligibility requirements were too restrictive and the timelines too tight. In a March letter commenting on the draft rules, the Society told CMS that the aggressive plan would leave many physicians, especially those in solo and small practices, at a disadvantage.

We know that many physicians in small-office practices are daunted by the estimated cost of EHRs, only a portion of which would be offset by federal incentives. They are also stymied by the uncertainty regarding whether what they buy today will “talk to” the hospitals to which they admit patients, the multiple vendors with whom they interact, and to the still-to-be-developed information-exchange systems that will allow discrete EHRs to communicate with one another.

Echoing the concerns of the physician community, in April, a bipartisan group of U.S. senators urged CMS to take a slower approach, with a more gradual implementation timeline and relaxed meaningful-use standards.

After collating feedback from stakeholders, CMS issued final standards for meaningful use in July.

To qualify for incentive payments, physicians must employ 15 core requirements (including clinical decision support tools, CPOE, and electronic delivery of health information to patients) and 5 of 10 additional menu items from which providers can choose. The menu items include capability to incorporate lab results into EHRs, automated reminders to patients, and using EHRs to support patient transitions between

Bridgewater pediatrician Fred Kern, MD, credits the infrastructural, financial, and consulting help he received as keys to his practice’s success with electronic health records.
settings and personnel. There are also quality-reporting requirements in the final regulation.

Even with “relaxed” standards, only time will tell how many Massachusetts physicians will be able to meet the meaningful-use criteria. The MMS is committed to helping as many as possible qualify for the federal subsidies.

The MMS understands the challenges of health IT implementation under the best of circumstances. So the Society has responded to the added layer of federal regulation by boosting our already-substantial EHR resources. We’ve developed an internal team to create programs aimed at helping members achieve meaningful use. And we are committed to ongoing coordination with MeHI, the Massachusetts eHealth Collaborative, the Massachusetts Health Data Consortium, Massachusetts Health Quality Partners, and other organizations that are helping physicians succeed with health IT.

In February, the MMS Committee on Information technology and the Society’s technology department launched a biweekly e-newsletter dedicated to helping physicians qualify for the meaningful-use incentives. The ARRA Advisor provides the latest information about the federal stimulus program, EHR adoption, health information exchanges, quality measures, and other related technology subjects.
For a decade, the Publishing Division has been cutting a path to enhance our value to the medical community in both print and digital environments. That’s no small challenge in a world where anyone with a computer or smart phone can become an instant “publisher.”

As we were successfully reorienting our business to meet the future, a deep recession rocked the world. Any illusions of predictability and control vanished. Not surprisingly, this past fiscal year, publishing revenues fluctuated more within a 12-month period than ever before.

Volatility notwithstanding, sound business decisions and successful cost-containment efforts positioned the division for recovery and revenue stabilization. In the process, we refined our ability to address long-term industry trends and respond quickly and sensibly to worldwide economic forces that are largely beyond our control.
Arising from this decade-long journey and the deep recession is the Publishing Division’s forward-looking “Enterprise plan.” It is designed to align and integrate what were once several distinct products and “sub-strategies” into a unified and robust whole that will advance medical knowledge and improve patient care.

GROWTH AREAS

Online revenue continued to fuel the division’s growth, as it has in recent years. Revenues from the online sector have grown an average of 20 percent annually over the last five years.

In reprints and permissions, we instituted new pricing structures and sales plans that bolstered revenue substantially. Our performance this year in both areas exceeded original budget expectations and is higher than in any previous period.

COSTS DOWN, PROFITS UP

Between fiscal year 2008 and FY 2011, the Publishing Division will have reduced expenditures on the production and delivery of print NEJM issues by one-third. These multimillion-dollar savings arose in large part from renegotiated printer contracts, re-engineered international distribution, and improved production efficiencies throughout the division. Our success in this area positioned us to be profitable once advertising dollars began trickling in again during the second half of the fiscal year.

A MULTIMEDIA POWERHOUSE

In July, we launched the new NEJM.org — a project that occupied the time and energy of nearly everyone in publishing. On its surface, the new NEJM.org boasts a visual redesign, enhanced user functionality to make content more accessible and customizable, and new publishing-management tools that will allow us to create additional value for customers and the business.

But the new NEJM.org is a beginning, not an end. It gives us fresh eyes by which to see our enterprise, where the focus is not only on “producing a journal,” but on creating integrated, multifaceted information delivery systems that exceed customer expectations, support our publishing mission, and grow our bottom line.

Underlying all these advancements is a nimble and more powerful technology platform that will support what we’re doing now, planned expansions, and enterprise initiatives that we haven’t even thought of yet.

Notable Number

477,939 — Pages of content available in the online NEJM Archive, 1812–1989. The Archive, which launched at the same time as the new website, contains searchable text and page images back to 1812, and full functionality from 1945 to 1989.
MEMBERSHIP

Groups Gain Strength, Every Physician Matters
As of June 18, 2010, membership in the MMS totaled 23,036. That represents an increase among Massachusetts physicians of 6.4 percent over last year.

Membership growth in three key demographics that are crucial to our Society’s future — young physicians, women physicians, and residents — grew by 5.8 percent, 7.2 percent, and 12 percent, respectively.

Along with our ongoing effort to reach out to all physicians in Massachusetts, the biggest success of MMS membership development efforts was recruiting physician groups, and the growth in group membership is the headline story of the year.

GROWTH IN MEMBERSHIP, INDIVIDUALS AND GROUPS

We have not — and will not — stop serving and supporting the solo and small-group practices that still make up a majority of physicians in the state. But in following the physician workforce closely, we’ve found that the number of medium- and large-group practices is growing steadily. With the imminent introduction of medical homes and accountable care organizations, the number of physician groups is likely to increase.

Physicians in the Society’s group enrollment programs now constitute 28 percent of total members. The number of physician members enrolled in the MMS as part of a group jumped by 55 percent this past year. Much of that increase came from the enrollment of the nearly 800 physicians affiliated with Atrius Health, an alliance of five nonprofit community-based physician groups in eastern Massachusetts.

“We welcome the participation of Atrius Health in medical society activities and look forward to developing a strong partnership with its medical groups and their physicians,” said MMS President Mario Motta, MD.

Increased physician involvement in MMS activities, governance, educational programs, and health policy is just one side of the Atrius story. “We also feel that this will be a way for our organization to assist other physicians around the state on a range of issues such as global payment, electronic medical records, quality incentives, and shared medical appointments,” said Gene Lindsey, MD, Atrius Health president and CEO.

BENEFITS ATTRACT NEW MEMBERS

The gains this year are all the more impressive in light of a fitful, plodding economic recovery, regionally and nationwide. Consequently, membership retention and growth are evidence of support and appreciation for the many benefits of MMS membership — including effective advocacy with state and federal lawmakers and regulators, continuously updated practice management tools, and professional and financial services that take some of the hassle out of practicing medicine.

Number of Physicians Enrolled in Groups (as of May 31, 2010)

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<th>FY09</th>
<th>FY10</th>
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<td>1,782</td>
<td>2,766</td>
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+55%
This year in Continuing Education was marked by strong growth in the number of participants in activities (see table on page 15). Those impressive statistics reflect the relevance of the topics we offered and the flexibility of formats — live, online, and paper-based home study — that we used to meet diverse learner needs.

The MMS Department of Continuing Education and Certification kept its finger on the pulse of the physician practice environment and offered an array of excellent clinical CME programs, including activities on pandemic flu, men’s and women’s health, pain management, depression, and HPV.

This past year’s activities also addressed non-clinical topics that have a daily impact on physicians. Those included offerings on improving the patient experience, changes in HIPAA regulations, electronic health records, social networking, Medicare audits, conflict of interest, apologizing for medical errors, and the use of e-mail with patients. These activities helped physicians meet the challenges they face in an environment where many outside entities — health plans, regulators, and commercial interests, to name a few — add to the ever-changing landscape of medicine.

Relevance is not the only criterion that CME providers must consider when developing activities for the medical community. The Accreditation Council for Continuing Medical Education (ACCME) requires that every program be designed to improve physician
Continuing Medical Education Live and Online, FY10

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<th>DIRECTLY SPONSORED</th>
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<tr>
<td><strong>LIVE CME ACTIVITIES</strong></td>
<td>19 (-24%)</td>
<td>23 (+5%)</td>
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<tr>
<td><strong>TOTAL EVENT ATTENDEES</strong></td>
<td>3,628 (+25%)</td>
<td>1,696 (+3%)</td>
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<td><strong>ONLINE CME ACTIVITIES</strong></td>
<td>26 (+30%)</td>
<td>32 (-11%)</td>
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<tr>
<td><strong>TOTAL EXAMS COMPLETED</strong></td>
<td>1,172 (+88%)</td>
<td>2,061 (+30%)</td>
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Numbers in parentheses show percentage change relative to FY09.

competence, performance, and/or patient outcomes.

In December, the ACCME voted to upgrade accreditation of the MMS continuing medical education programs from a four-year term to a six-year term that will expire in November 2014.

A year ago, the ACCME determined that the Society’s CME program met all but 1 of 22 criteria that would have generated a six-year accreditation status. Given the opportunity to address this issue, the MMS provided sufficient evidence of improvement, and the ACCME voted to recognize us with its highest term of accreditation.

In 2006, the MMS received a similar six-year accreditation for its Recognition Program, which accredits hospitals, specialty societies, and other health-related entities to grant CME credit for their educational activities.
Close collaboration between the MMS and the Massachusetts Department of Public Health (DPH) really paid off this year, as the state faced the unique challenge of both seasonal flu and a novel H1N1 strain of swine flu.

Working with the DPH, the MMS created a Flu Facts Response Kit and mailed it to 25,000 physicians, nurse practitioners, and physician assistants in October 2009. The kit included official guidance on vaccination and the use of antivirals.

Again collaborating with the DPH, the Society provided an innovative and successful campaign to encourage health care workers to get vaccinated against the flu.

When the DPH issued emergency regulations giving certain non-physician health professionals the right to administer seasonal and H1N1 vaccine, quick training of new vaccinators became necessary. The MMS responded by repurposing the DPH’s live vaccinator training program into an online activity. We also updated our online CME course, “Pandemic Flu: Practice Information and Strategies for Preparedness,” to include information about the H1N1 pandemic.

Throughout last fall and winter, the MMS issued weekly electronic updates on the H1N1 and seasonal flu situation in Massachusetts. These alerts informed health care providers and the public about vaccine supplies, procurement and distribution policies, and the pandemic’s evolving epidemiology, such as the relatively high risk of H1N1 complications among children and pregnant women.

Due largely to this coordinated MMS-DPH teamwork, Massachusetts led the nation in vaccinating its residents against both swine flu and seasonal flu this past fall and winter (see “Notable Numbers”).

CLEARING THE AIR

The 2010 Public Health Leadership Forum in April addressed energy practices and human health. Moderated by Paul Biddinger, MD, vice chair of the MMS Committee on Public Health, the forum featured presentations on the health implications of energy policy and how physicians can save energy in their own health care environments.

Earlier, at the Interim Meeting in December 2009, the MMS House of Delegates adopted policy opposing proposed biomass power plants in Massachusetts on the grounds that they pose an “unacceptable health risk.” The policy arose out of a report jointly sponsored by the MMS Committee on Environmental and Occupational Health.

Notable Numbers

36% — Massachusetts residents inoculated against swine flu — the highest percentage in the nation

57% — Massachusetts residents receiving seasonal flu vaccinations — compared with 37% nationally
Far left: In February 2010, the Massachusetts DPH awarded the MMS a “Public Health Hero” award for its work during the 2009–2010 flu pandemic. The award acknowledged the Society’s role in responding to “unpredictable and trying circumstances” with “extraordinary steps… to protect the health of the public.”

Left: In November 2009, the MMS Physician Focus TV program aired a special edition titled “The Flu: What You Should Know.” Another collaboration with the Massachusetts Department of Public Health, the show examined both seasonal and H1N1 flu. It included two public-service announcements focused on flu in pregnant women and flu-related use of emergency departments. Shown here are (left to right) Lauren Smith, MD, DPH medical director; show host Bruce Karlin, MD; Erin Tracy, MD, vice chair of the Massachusetts chapter of the American Congress of Obstetricians and Gynecologists; and Massachusetts Public Health Commissioner John Auerbach.
MMS AND DISTRICT LEADERSHIP

2009–2010

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