# 2018 Annual Meeting Informational Reports

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The Board of Trustees met on three occasions since the 2017 Interim Meeting of the House of Delegates: January 17, 2018, February 7, 2018, and March 7, 2018. The Board took action on the following items:

**January 17, 2018**

**Summary of Votes**

**For Board Action:**
- Approval of the minutes of the October 11, 2017, Board of Trustees meeting.
- Approval of Interim Committee Appointments for the Committees on Environmental & Occupational Health, Men’s Health, Oral Health, Preparedness, Senior Physicians, and Sponsored Programs.
- Approval of Interim 2017 Resolutions and Reports: Committee Referrals and Prioritization.
- Approval that internal labor costs assigned to Extraordinary Items, estimated at $3M, be classified as an FY18 Extraordinary Item (EI).

**For Recommendation to the House of Delegates:**
- That the following individuals be recommended to the House of Delegates at Annual 2018 as Delegates-at-Large:
  - Karen H. Antman, MD, Provost, Medical Campus and Dean, Boston University School of Medicine;
  - Sandro Galea, MD, MPH, DrPH, Dean, Boston University School of Public Health;
  - George Q. Daley, MD, PhD, Dean, Harvard Medical School;
  - Harris A. Berman, MD, Dean, Tufts University School of Medicine; and
  - Terence R. Flotte, MD, Dean, School of Medicine and Provost and Executive Deputy Chancellor, University of Massachusetts Medical School.

**February 7, 2018**

**Summary of Votes**

**For Board Action:**
- Approval of the minutes of the January 17, 2018, Board of Trustees meeting.
- Approval of the following nominees for the respective 2017-2018 awards.

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<td>Lifetime Achievement Award</td>
<td>M. Donna Younger, MD</td>
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<tr>
<td>Special Award for Excellence in Medical Service</td>
<td>Jessie M. Gaeta, MD</td>
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<td>Distinguished Service to the MMS Award</td>
<td>Lynda M. Young, MD</td>
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<td>Henry Ingersoll Bowditch Award</td>
<td>Lynn Black, MD</td>
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<td>Grant V. Rodkey, MD, Award</td>
<td>Scott J. Gilbert, MD</td>
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<tr>
<td>Lesbian, Gay, Bisexual, Transgender (LGBT) Award</td>
<td>Yvonne Gomez-Carrion, MD</td>
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<tr>
<td>Men's Health Award</td>
<td>Curtis L. Cetrulo, Jr., MD</td>
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<td>Dicken S.C. Ko, MD</td>
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<td>Thomas Manning</td>
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<td>Reducing Health Disparities Award</td>
<td>Megan T. Sandel, MD</td>
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<tr>
<td>Senior Volunteer Physician of the Year Award</td>
<td>Richard B. Wolk, MD</td>
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<tr>
<td>The Woman Physician Leadership Award</td>
<td>Luanne E. Thorndyke, MD</td>
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<tr>
<td>The Women's Health Award</td>
<td>Julie A. Johnson, MD</td>
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<tr>
<td>The Women's Health Research Award</td>
<td>None</td>
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<tr>
<td>Medical Student History Essay Award</td>
<td>TBD</td>
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<tr>
<td>Information Technology Awards</td>
<td>Resident winner: Stephanie Rutledge, MD for Neurocog Student winner: Jackson Steinkamp for MySafeRx</td>
</tr>
</tbody>
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| 2018 Community Clinician of the Year          |                                      |
| Barnstable                                    | Theodore A. Calianos, II, MD         |
| Berkshire                                     | Deborah Buccino, MD                  |
| Bristol North                                 | Lorraine M. Schratz, MD              |
| Bristol South                                 | Jay Schachne, MD                     |
| Charles River                                 | Paul R. Satwicz, MD                  |
| Essex North                                   | Michelle Sasmor, MD                  |
| Essex South                                   | TBD                                  |
| Franklin                                      | None                                 |
| Hampden                                       | None                                 |
| Hampshire                                     | Mary Roy, MD                         |
| Middlesex                                     | TBD                                  |
| Middlesex Central                             | Paula Jo Carbone, MD                 |
| Middlesex North                               | Joseph M. Dulac, MD                  |
| Middlesex West                                | Judd L. Kline, MD                    |
| Norfolk                                       | Lynda G. Kabbash, MD                 |
| Norfolk South                                 | Michael Hughes, MD (posthumously)    |
| Plymouth                                      | Richard N. Levrault, D.O. (posthumously) |
| Suffolk                                       | David Harrison, MD                   |
| Worcester                                     | Francisco Gil, MD                    |
| Worcester North                               | Daniel O’Brien, MD                   |
• Approval of the following award renewal applications for a 7-year period (FY19-FY25).
  o Excellence in Medical Service
  o Information Technology in Medicine
  o Grant V. Rodkey, MD, Award for Outstanding Contributions to Medical Education

• Approval of the History of Medicine Essay Award rules as follows:

History of Medicine Essay Award

The Massachusetts Medical Society (MMS) supports the Committee on History in offering an annual award to be presented to a medical student for the best original, independently researched article related to the history of medicine or public health since the initiation of the MMS in 1781 to the present day. Articles relating to Massachusetts are encouraged. Suggested topics include initiatives that have improved the public’s health or access to medical care or a close analysis of particular movements in medical discovery, diagnostics, therapeutics, education, research, or institutional (e.g., hospitals, journals, medical societies) evolution. The article should be tightly argued and well-referenced. The recipient will be determined by the Committee on History.

• Approval of Interim Committee Appointments for the Committee on Member Services and the Task Force on Academic Physicians, with the verbal addition of Danielle Lamas, MD to the task force.

• Approval that the Massachusetts Medical Society not adopt Resolution A-17 B-204 which reads as follows:

That the Massachusetts Medical Society seeks partnerships and dialogue with relevant stakeholders, including academic health policy departments, health insurance companies, self-insured companies, physicians, consumer advocacy groups, and specialty societies, that have developed appropriate use criteria to explore the concept and feasibility of a model of value-based insurance design coupled with medical savings accounts in which consumer’s copayment for specific services would vary inversely with clinical utility. (D)

Fiscal Note: One-Time Expense of $30,000 (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)

• Approval that the Massachusetts Medical Society adopt the following revised, amended recommendations of the Late CQMP Informational Report A-17-31 as policy:

1. That, in the face of any possible changes in federal laws regarding health insurance coverage, the MMS support and advocate for continuation of the
state individual mandate to purchase health insurance, the state’s Minimum Creditable Coverage standards, and the state Connector Care Program. (D)

2. That the MMS support and advocate evaluation of value-based cost sharing measures for high-deductible health plans and patients’ out-of-pocket costs. (D)

3. That the MMS support and advocate that the Commonwealth assess the impact of cost-sharing on access to care, health outcomes, and medical debt for patients;

4. That the MMS support and advocate that the Commonwealth assess the impact of cost sharing on provider’s due to patients’ inability to pay when there is cost-sharing. (D)

5. That the MMS continue to be a strong voice of concern about the adverse effects of cost-sharing on patient health. (HP)

- Approval that the Massachusetts Medical Society not adopt Resolution A-17 A-104 which reads as follows:

That the MMS encourage relevant state agencies and municipalities to monitor the perfluorochemicals (PFC) level in the drinking water sources from the Commonwealth’s towns to ensure the accepted levels of PFCs for the health of the community. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

- Approval that the Massachusetts Medical Society adopt as amended Resolution A-17 B-205 to read as follows:

That the Massachusetts Medical Society will advocate for law, regulation, or guidance providing that doctors and other providers in nursing homes and skilled nursing facilities are exempt from consulting the prescription monitoring program or MassPAT except at the time of discharge from the facility. (D)

- Approval to temporarily recess the meeting of the Board of Trustees and call to order a special meeting of the Stockholders of the Physicians Insurance Agency of Massachusetts (PIAM).

- Approval that following language be added by amendment to the bylaws of the corporation (PIAM):

No Director may be elected to more than three consecutive three-year terms including time served as a Director prior to the term limit effective date. A Director who has served on the Board for three consecutive terms may be re-elected to the Board after being off the Board for at least two years. The term limit for Directors shall be effective on the date of the 2020 annual meeting of stockholders. A Director serving a term of less than three years is eligible to
continue to serve three full consecutive terms. Service as an ex-officio Director shall not count towards the term limit.

- Approval to adjourn the special meeting of the Stockholders of the Physicians Insurance Agency of Massachusetts and resume the meeting of the Board of Trustees.

- Approval of the following policy on rescinding awards:

  The authority to rescind an award rests with the Board of Trustees of the Massachusetts Medical Society ("Board"). The Board may rescind an award if, in its judgment, the recipient of the award has engaged in conduct that: 1) is inconsistent with the mission and/or values of the Massachusetts Medical Society; 2) undermines the accomplishments that were cited as the basis for the award; or 3) is injurious to the reputation or public image of the Massachusetts Medical Society. Such conduct could occur either subsequent to the award being conferred or prior to the award being conferred if the Massachusetts Medical Society was unaware of the conduct at the time the decision to present the award was made.

  Prior to its decision on rescindment, the Board may solicit recommendations from the Committee on Recognition Awards, the Committee on Ethics, Grievances, and Professional Standards, and/or any committee involved in sponsoring, nominating, or selecting the award or award recipient. In making a recommendation to the Board, the committee(s) shall collect and review reasonably available information relating to a recommendation to rescind, and determine if such information provides a substantial basis to support rescindment.

- Approval to rescind the 2016 LGBT Health Award.

For Recommendation to the House of Delegates:

- None

March 7, 2018 (pending approval)

Summary of Votes

For Board Action:

- Approval of the minutes of the February 7, 2018, Board of Trustees meeting.

- Approval of the following nominees for the respective 2017-2018 awards.

  Medical Student History Essay Award: Rajesh Reddy, "Little City Halls": Columbia Point and the Community Health Center Movement in Boston."

  2018 Community Clinician of the Year
  Essex South - Joseph E. August, MD

- Approval of Interim Committee Appointments for the Joint MMS-MHA Task Force on Physician Burnout.
• Approval that the targeted level for the Risk Reserve Fund be $118M.

• Approval of the 2019 fiscal year budget of the Massachusetts Medical Society as approved by the Committee on Finance on February 15, 2018.

• Approval that the MMS continue to sponsor the enrollment of all MMS Medical Student members as members of the American Medical Association each year with the new incoming first year class for an additional three years.

Fiscal Note: FY 2019 $48,000
          Annually  $48,000

• Approval that the policy on Waiver of Program Fees adopted by the Board of Trustees on September 7, 2011, and as amended below be approved for the next two fiscal years 2018 and 2019 (June 2017 – May 2019) as follows:

1. That the Massachusetts Medical Society waive a portion of its sponsored educational program fees in recognition of volunteer service in fiscal years 2018 and 2019 in accordance with the following criteria:
   - House of Delegates - $100 waiver
   - Committee, Section, Task Force members - $100 waiver
   - Board Members – Trustees and Alternates - $200 waiver
   - District Presidents - $400 waiver

2. That each qualified member who meets one or more of these criteria will receive no more than a total of $400 in waived fees for the fiscal year.

3. That volunteer vouchers for MMS-sponsored educational programs be allowed to roll over for two fiscal years.

4. Members will be notified of their volunteer voucher by email. Voucher balances will be tracked electronically in the member database system.

5. That the MMS Committee on Administration and Management reviews criteria and establishes fee waivers every two years in accordance with the budget process.
Code: BOT Informational Report A-18-02
[A-17 B-204; Late CQMP Informational Report A-17-31 [A-16 B-2];
A-17 A-104; A-17 B-205]
Title: Actions Taken on A-17 Items Referred to Board of Trustees for Decision
Sponsor: Board of Trustees
Henry Dorkin, MD, FAAP, Chair
Resolution/Report History: Resolution A-17 B-204
Late CQMP Informational Report A-17-31 [A-16 B-2]
Resolution A-17 A-104
Resolution A-17 B-205

EXECUTIVE SUMMARY

At A-17, items 1-4 in grid below were referred to the Board of Trustees (BOT) for decision. The BOT referred the items to committees for review and a report with recommendations. The BOT took the actions as indicated (please see Appendices A-D).

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<th>BOT Decision</th>
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<td>Health Insurance in Which Copayments Vary with Clinical Utility (Appendix A)</td>
<td>The Quality of Medical Practice (in consultation with) Committee on Interspecialty</td>
<td>Not Adopted</td>
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<td>3.</td>
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<td>Environmental and Occupational Health</td>
<td>Not Adopted</td>
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MEMORANDUM TO THE BOARD OF TRUSTEES

Subj: Resolution A-17 B-204, Health Insurance in Which Copayments Vary with Clinical Utility

Background
At A-17, the House of Delegates (HOD) referred Resolution A-17 B-204, Health Insurance in Which Copayments Vary with Clinical Utility, to the Board of Trustees (BOT) for decision. The BOT referred this report to the Committee on the Quality of Medical Practice in consultation with the Committee on Interspecialty for a report at the February 7, 2018, BOT meeting.

The resolution directs:
That the Massachusetts Medical Society seeks partnerships and dialogue with relevant stakeholders, including academic health policy departments, health insurance companies, self-insured companies, physicians, consumer advocacy groups, and specialty societies, that have developed appropriate use criteria to explore the concept and feasibility of a model of value-based insurance design coupled with medical savings accounts in which consumer’s copayment for specific services would vary inversely with clinical utility. (D)

Fiscal Note: One-Time Expense of $30,000
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

Reference Committee Testimony
At A-17 the reference committee recommended that this resolution be referred to the BOT for decision. The following is the reference committee’s rationale:

Your reference committee received testimony regarding this resolution both in person and online. Testimony reflected general consensus on two points: first, that demand for services (and the concomitant provision of those services) is one of the major driver of health care costs; and second, that high deductibles, and high copayments cause patients to avoid all care, not just unnecessary or ineffective care. This resolution attempts to address these two facts by increasing the cost to patients of care with low clinical utility, but decreasing it for care of proven utility. Testimony, however, reflected a belief that this is a national issue, and is, in fact, one on which the AMA is currently working. Some stated that a study of this issue would cost millions of dollars, that a large body of research is already available on the topic, and that perhaps a meta-analysis of current knowledge and available data would be more useful. Another testifier raised the issue of how to measure the value or clinical utility of a given procedure or service to a specific patient at a particular moment. Your reference committee also noted online testimony that highlighted the recently implemented mental health parity law, but indicated concern that this resolution could result in greatly increased copayments for mental health services, given that there is such great difficulty in defining and measuring successful outcomes for mental health treatment. The sponsor recognized the complexity of this issue and indicated support for referral based on the testimony presented. Because of all these complex issues, your reference committee recommends that this resolution be referred to the Board of Trustees for decision.
Current MMS Policy
See Appendix

Current AMA Policy/Activity
In response to numerous studies surrounding the increasing price of prescription drugs in the United States, the American Medical Association’s (AMA) Council on Medical Service completed a report on Incorporating Value in Pharmaceutical Pricing (Resolution 712-A-16). In November of 2016, based on the results of a report, AMA delegates reaffirmed several existing AMA policies, including H-195.939, which supports the use of value-based insurance design (V-BID) that could determine patient cost-sharing requirements based on the clinical value of treatment. The AMA first instituted their policy on V-BID in 2013 in response to the Council on Medical Service’s Value-Based Insurance Design report (Report 2-A-13).

Additionally, AMA delegates also adopted new policy outlining principles to guide the support of value-based pricing programs, initiatives, and mechanisms for pharmaceuticals (H-110.986). In addition to the guiding principles, delegates directed the AMA to support direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats.

Discussion
The Massachusetts Medical Society’s Committee on the Quality of Medical Practice and the Committee on Interspecialty met on October 17, 2017, to receive background on and discuss Resolution A-17 B-204 including a presentation by Dr. Joel Rubenstein, author of the resolution, and Dr. Niteesh Choudhry, an expert on the topic of V-BID.

Dr. Rubenstein presented his thesis on a V-BID plan of copayments varying inversely with clinical utility in conjunction with a medical savings account. Dr. Rubenstein examined the failure of many provider-directed, cost cutting measures on reducing the total medical expenditures of the United States. Instead, Dr. Rubenstein pointed to alternative, demand-side drivers to explain the continued inflation of total medical expenditures. His proposed V-BID plan would employ appropriate use criteria to decide whether a medical service is appropriate for a given patient, fostering physician-patient advocacy through communication and shared-decision making. This shared-decision making would protect the patient’s health and financial well-being.

While this proposal sounds simplistic and cost-cutting, Dr. Choudhry’s presentation reminded the group that V-BID remains in its infancy and adequate quality evidence is lacking in its effects on reducing overall cost and improving quality. While there is a wealth of quality evidence that low patient cost-sharing for high-value services increases quality, the evidence points to a neutral, and sometimes, negative effect on overall cost. More concerning, there is a lack of quality evidence that high patient-cost sharing for low-value services improves quality or cuts costs and that some patients need these services and are thus penalized.

In general, the committee members echoed the sentiment of the reference committee that the language of the resolution was broad, vague, and costly. While there were no specific recommendations, the committee made suggestions for amending the language of the resolution, such as including more specific information and a clear endpoint. The committee was unsure how seeking conversation and expertise could add up to the line item of $30,000.00.

Additionally, many committee members agreed that this type of insurance design would further complicate insurance literacy and confuse beneficiaries. Committee members were concerned about the idea that a medical service could be valuable for some beneficiaries, but not for others. Committee members voiced that many of their patients do not know how to use their current insurance, especially
medical savings accounts, appropriately or responsibly. Members stated that this endeavor would be something that insurance companies should implement and support.

Finally, many committee members, specifically primary care physicians, agreed that adding 90 seconds per patient to consult appropriate use criteria would add unnecessary length to their visit with the patient. The burden of documentation after the appointment would, in turn, increase as well.

For this multitude of reasons, both the Committee on the Quality of Medical Practice and the Committee on Interspecialty voted to recommend to not adopt the resolution.

After this meeting, Dr. Rubenstein amended the language of his resolution as follows:

That the Massachusetts Medical Society initiate a feasibility study to explore the concept of value-based insurance design which utilizes consumer copayment inversely related to the clinical utility of services for specific clinical conditions. The study seeks input from relevant expert stakeholders, including academic health policy departments, health insurance and self-insured companies, physician and consumer groups, and specialty societies that utilize appropriate use criteria. The study might consider the role of health savings accounts in such a plan. The outcome of this feasibility study would determine potential future investment in such an insurance product by the academic community, the private insurance market, or even organized medicine. (D)

The new language was shared with the Committee on the Quality of Medical Practice on December 11, 2017. The committee appreciated Dr. Rubenstein’s amending the resolution. The committee continued to feel that the lack of clear cut appropriate and evidence-based guidelines for many common tests and imaging, that the added burden to the provider of completing the prior authorization and the added burden of then explaining to the patient the result makes this type of program not viable as a cost saving measure. The committee continued to feel, therefore, that the amended resolution does not change their opinion.

**Conclusion**

In conclusion, the committee voted to recommend to not adopt both the original and the amended resolution.

The Board of Trustees voted to not adopt the resolution, which reads as follows:

That the Massachusetts Medical Society seeks partnerships and dialogue with relevant stakeholders, including academic health policy departments, health insurance companies, self-insured companies, physicians, consumer advocacy groups, and specialty societies, that have developed appropriate use criteria to explore the concept and feasibility of a model of value-based insurance design coupled with medical savings accounts in which consumer’s copayment for specific services would vary inversely with clinical utility. (D)

**Fiscal Note:**
One-Time Expense of $30,000
(Out-of-Pocket Expenses)

FTE:
Existing Staff
(Staff Effort to Complete Project)
Appendix

Value-Based Insurance Design
The MMS will monitor third-party payers who use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. [D]

The MMS supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.

b. Practicing physicians should be actively involved in the development of VBID programs.

c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.

d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.

e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.

f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices. Where feasible and appropriate, VBID should take patient preferences into account.

g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.

h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.

(HP) MMS House of Delegates, 12/7/13

The MMS will advocate that the AMA study value-based insurance design, its impact on the physician workforce and patient access. (D) MMS House of Delegates, 12/3/11
MEMORANDUM TO THE BOARD OF TRUSTEES


Background
At A-17, the House of Delegates (HOD) referred Late CQMP Informational Report A-17-31 and proposed recommendations for action to the Board of Trustees (BOT) for decision. The BOT referred this report to the Committee on the Quality of Medical Practice (items 1-4) in consultation with the Committee on Legislation for item 1 for a report at the February 7, 2018, BOT meeting.

The proposed recommendations direct:
1. That, in the face of any possible changes in federal laws regarding health insurance coverage, the MMS support and advocate for continuation of the state individual mandate to purchase health insurance, the state’s Minimum Creditable Coverage standards, and the state Connector Care Program. (D)
2. That the MMS support and advocate for value-based cost sharing measures for high-deductible health plans and patients’ out-of-pocket costs. (D)
3. That the MMS support and advocate that the Commonwealth assess the impact of cost-sharing on access to care, health outcomes, medical debt, and impact from provider loss of income due to patients’ inability to pay when there is cost-sharing. (D)
4. That the MMS continue to be a strong voice of concern about the adverse effects of cost-sharing on patient health. (HP)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

Reference Committee and HOD Testimony
At A-17 the reference committee recommended that this informational report be filed. The following is the reference committee’s rationale:

Your reference committee heard limited testimony in favor of the proposed recommendations created from the conclusions of the High-Deductible Health Plan informational report. Some of the limited testimony indicated that the lengthy and last-minute nature of the late file unfortunately did not allow for substantial review and discussion. The reference committee discussed the nature of the report and its importance and felt that there unfortunately was not enough of a compelling argument and not enough awareness or understanding about the extraction of the report to justify supporting the proposed recommendations. Therefore, your reference committee recommends filing this informational report as written.

Upon extraction of the report at the HOD second session, the delegate shared that the late file report was excellent and encouraged members to read the full report. The report focuses on the trend by employers
to use high-deductible health plans (HDHPs) to manage health care costs and that these HDHPs have been shown to limit or delay care for patients while also increasing medical debt for patients as well as medical debt and lower-quality scores for physician practices. He further noted that the report provides meaningful and extremely timely conclusions that should be modified as recommendations and be adopted. The delegate noted that since this report was a late file, additional review would be appropriate, but that the recommendations in the report were timely, and therefore should be referred to the Board for Decision. The chair from the Committee on Legislation noted that item one in the recommendations would be consistent with MMS policy and so the House of Delegates voted to refer these recommendations to the Board for Decision.

MMS Policy - See Appendix

Value Based Insurance Design

Discussion

At the December 11, 2017, and January 29, 2018, committee meetings, the CQMP reviewed the HOD proposed recommendations in comparison to the conclusions in the original report, which are listed below. Upon review of the two versions, the CQMP supported the slightly re-worded HOD recommendations and also amended recommendation three. Specifically, the committee sought to clarify that recommendation three was to study the impact of high deductible health plans on patients’ access to care, health outcomes and medical debt. The committee felt an impact analysis of high deductible plans on patients warranted its own recommendation. They also amended new recommendation four to be more broad in scope.

The committee also discussed talking with patients about the cost of care, one component of the original report’s conclusions and deleted from the recommendations proposed at the HOD. While Medscape 2017 data reports that nationally three out of four physicians are talking with their patients about health care costs and more than one-third indicate that they regularly speak to their patients about costs while an additional 40% speak to them about it occasionally, committee members felt that providers already feel strapped for time and felt that adding another component to an already time-limited visit wouldn’t benefit the patient’s care. While the committee supports the necessity for consideration of cost of care in decision making overall, there was concern about making a recommendation to engage in cost of care conversations at the time of care delivery.

Therefore, the CQMP supports the proposed, revised and amended recommendations listed after these recommendations in the report conclusion.

Recommendations in the original report conclusion:

MMS should continue to use its voice and influence at both the state and federal levels to raise concerns about the adverse impact of HDHPs and other significant cost-sharing on patient health and financial security, and to advocate for actions including:

- Support for the continuation of state health reform provisions — including the Massachusetts individual mandate, the state’s minimum creditable coverage standards, and the Connector Care program — in the face of any federal health reform changes
- Encourage development of insurance plan designs that feature more nuanced cost-sharing mechanisms including value based insurance design
- Encourage state government to monitor more closely the growth of HDHPs and other forms of cost-sharing in health plans, and to assess the impact of HDHPs and other forms of cost-sharing on consumer access to care, health outcomes, medical debt, and debt for providers
- Work to lower the burden of health care costs on patients by encouraging and improving conversations between physicians and patients about cost, and by continuing to be a strong voice of concern for the adverse effects of cost-sharing on patient health, particularly for the most
vulnerable, and of the need to find other, more equitable and durable means of controlling increases in medical costs

The HOD Recommendations:

The proposed modified recommendations direct:
1. That, in the face of any possible changes in federal laws regarding health insurance coverage, the MMS support and advocate for continuation of the state individual mandate to purchase health insurance, the state’s Minimum Creditable Coverage standards, and the state Connector Care Program. (D)
2. That the MMS support and advocate for value-based cost sharing measures for high-deductible health plans and patients’ out-of-pocket costs. (D)
3. That the MMS support and advocate that the Commonwealth assess the impact of cost-sharing on access to care, health outcomes, medical debt, and impact from provider loss of income due to patients’ inability to pay when there is cost-sharing. (D)
4. That the MMS continue to be a strong voice of concern about the adverse effects of cost-sharing on patient health. (HP)

The Committee on Legislation reviewed item 1 and voted to recommend support of item 1 to CQMP.

Conclusion
In conclusion, the Committee on the Quality Medical Practice members voted to support the modified proposed and amended recommendations.

The BOT voted to adopt the following new recommendations of the Late CQMP Informational Report A-17-31 [A-16 B-2] as policy:

1. That, in the face of any possible changes in federal laws regarding health insurance coverage, the MMS support and advocate for continuation of the state individual mandate to purchase health insurance, the state’s Minimum Creditable Coverage standards, and the state Connector Care Program. (D)
2. That the MMS support and advocate for value-based cost sharing measures for high-deductible health plans and patients’ out-of-pocket costs. (D)
3. That the MMS support and advocate that the Commonwealth assess the impact of cost-sharing on access to care, health outcomes, medical debt for patients.
4. That the MMS support and advocate that the Commonwealth assess the impact of cost sharing on provider’s due to patients’ inability to pay when there is cost-sharing. (D)
5. That the MMS continue to be a strong voice of concern about the adverse effects of cost-sharing on patient health. (HP)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Appendix

Value-Based Insurance Design
The MMS will monitor third-party payers who use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. (D)

The MMS supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.

b. Practicing physicians should be actively involved in the development of VBID programs.

c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.

d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.

e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.

f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices. Where feasible and appropriate, VBID should take patient preferences into account.

g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeal process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.

h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.

(HP)

MMS House of Delegates, 12/7/13

The MMS will advocate that the AMA study value-based insurance design, its impact on the physician workforce and patient access. (D)

MMS House of Delegates, 12/3/11
MEMORANDUM TO THE BOARD OF TRUSTEES

Subj: Resolution A-17 A-104, Perfluorochemical (PFC) Drinking Water Contamination

Background
At A-17 the House of Delegates (HOD) referred Resolution A-17 A-104, Perfluorochemical (PFC) Drinking Water Contamination, to the Board of Trustees (BOT) for decision. The BOT referred this report to the Committee on Environmental and Occupational Health (CEOH) for a report at the February 7, 2018, BOT meeting.

The resolution directs:

That the MMS encourage relevant state agencies and municipalities to monitor the perfluorochemicals (PFC) level in the drinking water sources from the Commonwealth’s towns to ensure the accepted levels of PFCs for the health of the community. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)
FTE: Existing Staff
(Staff Effort to Complete Project)

Reference Committee and HOD Testimony
At A-17 the reference committee recommended that this resolution be referred to the BOT for decision. The following is the reference committee’s rationale:

Your reference committee heard testimony indicating member interest and concern about this issue. Members testified that more information is needed on potential risks of PFCs on the public’s health, the pervasiveness of the problem in MA, and the overall cost to test and mitigate, in order to recommend policy. Your reference committee recommends that the resolution be referred to the Board of Trustees for decision in order to further investigate these issues.

Current MMS Policy
The MMS has the following policy regarding this issue:

The Massachusetts Medical Society (MMS) strongly supports aggressive watershed protection throughout the Commonwealth.

The MMS strongly supports accelerated rehabilitation of the water distribution system in the Massachusetts Water Resources Authority (MWRA) service area and in the remainder of the Commonwealth.

The MMS strongly advocates for enhanced monitoring and surveillance systems for contaminants and waterborne disease throughout the Commonwealth.

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
That the MMS recognizes the inextricable link between environmental health, animal health, and human health, and the importance of scientific research in informing policies that protect human health from environmental toxins. *(HP)*

That the MMS will initiate a public health campaign to promote public awareness of the potential sources of pollutants and toxins in the environment and their impact on human health. *(D)*

That the MMS will advocate for policies, regulations, and legislation that protect and promote environmental and human health and that are aligned with MMS strategic and public health priorities. *(D)*

*MMS House of Delegates, 4/29/2017*

**Discussion**

The CEOH undertook a review of information on perfluorochemicals, primarily from state and federal government sources, in an attempt to ascertain the relative risk posed by perfluorochemicals in Massachusetts drinking water, the actions that have been undertaken to mitigate that risk, and the potential benefit of any further action MMS might recommend.

Perfluorochemicals (PFCs) are synthetic chemicals typically associated with manufacturing of non-stick coatings, water-proofing and stain-proofing treatments, and certain firefighting foams. Products containing PFCs include carpets, clothing, furniture fabrics, food packaging, paper packaging, non-stick coated cookware, and firefighting materials. The most prevalent PFCs in the United States are perfluorooctane sulfonic acid (PFOS) and perfluorooctanoic acid (PFOA). Most people in the United States and other industrialized countries have measurable amounts of PFCs in their blood.1,2

Studies have shown linkages between PFCs and adverse health outcomes. Animal studies have suggested that PFCs disrupt endocrine activity and liver function, reduce immune function and cause developmental problems.3 Human studies have been less consistent but have shown associations between PFC exposure and reduced fertility, low birth weight, high cholesterol, changes in thyroid hormone levels and increased cancer risk.4,5

Drinking water is only one source of PFC exposure. PFCs have been found in outdoor and indoor air, house dust, animal tissues, human blood serum and human breast milk, and surface and drinking water.6 The primary pathway for PFC exposure is ingestion, including dietary intake and hand-to-mouth transfer from surfaces treated with PFCs.7,8 PFCs are bioaccumulative and may persist in the environment and in humans due to their chemical properties and long half-life, estimated between two and nine years.9 Beginning in 2000, PFC manufacturers began voluntarily phasing out production of the compounds. In 2010, the EPA launched the PFOA Stewardship Program to end production of PFCs by 2015 with the commitment of the eight largest U.S. manufacturers.10,11

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2 https://www.cdc.gov/biomonitoring/PFAS_FactSheet.html
4 https://www.atsdr.cdc.gov/pfc/health_effects_pfcs.html
5 http://www.nceeh.ca/sites/default/files/Health_effects_PFCs_Oct_2010.pdf
7 https://www.epa.gov/sites/production/files/2017-08/documents/ace3_pfc_updates_8-4-17.pdf
11 https://www.epa.gov/sites/production/files/2017-08/documents/ace3_pfc_updates_8-4-17.pdf
PFCs in drinking water are not currently regulated in the United States. However, six perfluorinated compounds, including PFOS and PFOA, were monitored under the EPA’s Third Unregulated Contaminant Monitoring Rule (UCMR). This rule requires the testing of unregulated contaminants every five years; the testing serves as a primary source for EPA to develop its regulatory decisions.12 The most recent round of testing, UCMR3, collected national data on 28 chemicals, including six PFC compounds, from 2012 to 2015.13 The results of this testing, along with peer reviewed health effects assessment, will be used to develop regulation if deemed necessary.14

In May 2016, the EPA released health advisories for PFOA and PFOS, making a lifetime health advisory for each compound, or a sum of the two, of 0.07 parts per trillion. The EPA is currently evaluating the need for a Maximum Contaminant Level (MCL).15 In order to establish a regulation for PFCs, the EPA considers prevalence and peer-reviewed journals to make a determination on whether to initiate the process to develop a national primary drinking water regulation. PFCs are currently considered a priority for Integrated Risk Information System (IRIS) assessment which identifies and characterizes the health hazards of chemicals found in the environment.16 Several members of Congress from states where PFCs pose a concern have introduced federal legislation to monitor PFCs and allow funds for cleanup of water contamination.17

In August 2016, the Massachusetts Water Resource Authority issued a press release stating that PFASs (per- and polyfluoroalkyl substances) “are not a concern for MWRA water and have never been detected.” MWRA tests the water supply each year for over 120 contaminants. MWRA has tested for and did not find Perfluorooctanoic acid (PFOA), Perfluorooctanesulfonic acid (PFOS), Perfluorononanoic acid (PFNA), Perfluorohexanesulfonic acid (PFHxS), Perfluoroheptanoic acid (PFHpA) or Perfluorobutanesulfonic acid (PFBS).18

UCMR3 testing by the Massachusetts Department of Environmental Protection (MassDEP) indicated a few larger public water supplies in Massachusetts had levels above the EPA health advisory guidelines for PFOA and PFOS. In response, MassDEP took action by taking affected wells off-line, blending sources to lower the levels, installing filter systems to remove the chemicals, or through provision of bottled water while other actions are taken.19

PFOA and PFOS are not currently on the list of 80 contaminants regularly monitored by MassDEP or on their emerging contaminant priority list.20, 21 Water sampling costs $350 per sample; multiple samples are necessary to collect reliable data. Testing may be advisable in certain situations, for example, proximity to

16 https://www.epa.gov/iris/iris-agenda
17 https://www.congress.gov/bill/115th-congress/house-bill/1348/text?q=%7B%22search%22%3A%5B%22polyfluoroalkyl%22%5D%7D&r=1
18 http://www.mwra.com/01news/2016/081116-pfas-not-found-water.html
19 E-mail correspondence with Director of Drinking Water Program on October 25, 2017
20 http://www.mass.gov/eea/agencies/massdep/toxics/sources/contaminant-screening-process.html
known sources of contamination, detections in nearby groundwater, surface water or other drinking water supplies. MassDEP, EPA and other states are developing approaches to target and prioritize sampling.

**Conclusion**
PFC contamination does not appear to pose a significant public health risk to Massachusetts water supplies. Both state and federal agencies are attending to the issue of PFCs, through guidance, testing, and educational information for the public. PFC contamination is based on a site’s history; state and federal agencies are currently monitoring select water sources where PFCs may be a concern, and, in cases where PFCs have exceeded federal standards, steps have been taken to mitigate the risks, and are developing approaches to prioritize sampling of water supplies. Because it appears that state and federal governments are taking appropriate steps to examine and address potential risk from PFCs, and MMS action may unnecessarily alarm the public or divert resources from other issues which may pose a greater risk, CEOH recommends not adopting the original resolution.

The Board of Trustees voted to not adopt the resolution, which reads as follows:

That the MMS encourage relevant state agencies and municipalities to monitor the perfluorochemicals (PFC) level in the drinking water sources from the Commonwealth’s towns to ensure the accepted levels of PFCs for the health of the community. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
MEMORANDUM TO THE BOARD OF TRUSTEES

Subj: Resolution A-17 B-205, Nursing Facilities’ Doctors and Other Prescribers Should be Exempt from Consulting MassPAT

Background
At A-17, the House of Delegates (HOD) referred Resolution A-17 B-205, Nursing Facilities’ Doctors and Other Prescribers Should be Exempt from Consulting MassPAT, to the Board of Trustees (BOT) for decision. The BOT referred this report to the Committee on Legislation in consultation with the Committee on Geriatric Medicine and the Task Force on Opioid Therapy and Physician Communication for a report at the February 2018 BOT meeting.

The resolution directs:

RESOLVED, That the Massachusetts Medical Society will advocate for law, regulation, or guidance providing that doctors and other providers in nursing homes and skilled nursing facilities are exempt from consulting the prescription monitoring program or MassPAT. *(D)*

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

Reference Committee Testimony
At A-17, the reference committee recommended that this resolution/report be referred to the BOT for decision. The following is the reference committee’s rationale:

Your committee heard overwhelming support for this resolution but also heard some important concerns voiced about the facilities to which this MassPAT exemption should apply. In discussing these concerns there was overwhelming support for exemptions in nursing homes and there was a general consensus with regard to the fact that Short Term stays in Skilled Nursing Facilities should not be exempt. Your reference committee reviewed and discussed two proposed amendments, one submitted by the sponsor initially and then another submitted later and supported by the sponsor.

The challenge your reference committee faced was how to exactly structure the language to accomplish the specific exemptions in an appropriate manner. It was felt that the term Long Term Care may actually include other facilities that do not align with the intent of the exemption. Your reference committee discussed how the term “Long Term Care” covers nursing homes, assisted living facilities, skilled nursing facilities, etc. and the reference committee felt this term was too broad to accomplish the intended goals. Your committee acknowledges the importance of and the need for exemption to MassPAT in this general area, and desires to preserve the intent of the resolution and the will of those testifying. The reference committee feels that there is an important need for clarified language. As such, your reference committee recommends referral to the BOT for decision.
**Current MMS Policy**
There is no existing policy specifically on this issue.

**Discussion**
The Committee on Legislation reviewed this resolution on January 25, 2018. The Committee was generally in support of the resolution but noted the same type of concerns expressed by the reference committee. An amendment is being offered that should resolve the issue without getting into the nature of various facilities. The Committee is recommending that the resolution be amended such that the MassPAT be queried only at the time of discharge from a nursing home or skilled nursing facility. The Committee on Geriatric Medicine and the Task Force on Opioid Therapy and Physician Communication expressed consensus with this approach.

Proposed amendments:
(Added text shown as “text”)
RESOLVED, That the Massachusetts Medical Society will advocate for law, regulation, or guidance providing that doctors and other providers in nursing homes and skilled nursing facilities are exempt from consulting the prescription monitoring program or MassPAT **except at the time of discharge from the facility.** *(D)*

**Conclusion**
The Committee recommends that the Resolution be amended to indicate that the MassPAT only be queried at the time of discharge.

The BOT voted to adopt the resolution as amended to read as follows:

RESOLVED, That the Massachusetts Medical Society will advocate for law, regulation, or guidance providing that doctors and other providers in nursing homes and skilled nursing facilities are exempt from consulting the prescription monitoring program or MassPAT **except at the time of discharge from the facility.** *(D)*

Fiscal Note:  
(Out-of-Pocket Expenses)  
No Significant Impact

FTE:  
(Staff Effort to Complete Project)  
Existing Staff
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Title: Establishment of a Pilot Medically-Supervised Injection Facility in MA
Sponsors: Committee on Legislation
Theodore Calianos, MD, Chair
Task Force on Opioid Therapy and Physician Communication
Dennis Dimitri, MD, Chair

Report History: BOT Report A-17 A-1
Resolution A-16 A-104

Background
At A-17, the House of Delegates adopted BOT Report A-17 A-1 [A-16 A-104], Establishment of a Pilot Medically-Supervised Injection Facility in MA. The BOT referred this report to the Committee on Legislation & Task Force on Opioid Therapy and Physician Communication for implementation and an informational report at A-18. The report directs:

That the MMS advocate for a pilot supervised injection facility (SIF) program in Massachusetts under the direction and oversight of a state-led task force convened by a state authority, such as the MA Department of Public Health, to discuss the legal considerations and paths forward, and that the task force:

- Advocate for an exemption from federal drug laws for the pilot SIF program as well as pursue state legislation legalizing the pilot SIF program, and consider partnering with other states or entities in seeking such a waiver of the applicable federal laws.
- Include an advisory board of experts, which includes experts from the Vancouver SIF as well as state and federal government officials if possible, under the jurisdiction of the task force, to design the evaluation protocol (including careful design of informed consent protocols regarding research) for the pilot.
- Consider building on a program such as a supportive place for observation and treatment (SPOT), given its expertise providing comprehensive, high-quality, harm-reduction services to populations that would be served by SIFs, and its reputation with government officials and other stakeholders in Boston.
- Consider harm-reduction strategies (counseling, referral, and placement on demand for all types of drug treatment) as a component of the pilot beyond SIFs to ensure comprehensive health care is available to marginalized persons who inject drugs.

(D)

Fiscal Note:
No Significant Impact
(Out-of-Pocket Expenses)

FTE:
Existing Staff
(Staff Effort to Complete Project)

Discussion
At A-17, when the HOD adopted policy to advocate for a pilot supervised injection facility (SIF) program in Massachusetts, the MMS became the first medical society to officially support such
sites. At the annual meeting of the American Medical Association in June 2017, the Massachusetts delegation presented testimony about the MMS SIF policy in support of a similar resolution. The AMA subsequently voted to adopt policy supporting pilot SIF programs in the United States. Across the country SIFs are increasingly gaining attention as a way to reduce the number of people who are dying from opioid misuse and substance use disorders (SUDs), reduce other complications of SUD, and to get more persons who inject drugs into treatment for their SUD. In May 2017, the Massachusetts Health and Hospital Association Board of Trustees voted unanimously to support the MMS proposal for the creation of a pilot SIF program.

State, Local, and Federal Advocacy
In the months since the MMS SIF policy passed, Massachusetts legislators have debated a bill that would allow for SIF programs to operate in Massachusetts and proposed a budget amendment to study the feasibility of SIFs. The Medical Society has been active at the state and local level, testifying before the Joint Committee on Mental Health, Substance Use, and Recover to convey the findings of our study, and the MMS position of advocating for a pilot SIF program through a state-led task force. MMS participated in a discussion of state senators interested in the issue, and has now been engaged with many of those same senators as legislators contemplate amendments to the Governor’s “Opioids 2.0” CARE bill. In fact, MMS raised the idea of SIFs at a high-profile hearing of the Governor’s opioid bill, and has raised the issue in many follow-up meetings with legislators and staff. MMS leadership met with Secretary Marylou Sudders, the Baker administration’s chief of health and human services, who said on WGBH in January 2018 that she is “open to understanding more” about supervised injection sites, while anticipating that “federal law would pose a challenge to launching any in Massachusetts.” In his testimony before the Boston City Council, MMS president Dr. Hank Dorkin stated:

“In closing, it is important to remember that SIFs are not experimental. Research from decades of operation in countries across the world show that SIFs are a proven strategy, one piece of a larger, comprehensive continuum of healthcare to aid those struggling with addiction. Therefore, we urge Massachusetts, as a world leader in pioneering, compassionate healthcare, to establish a state-led task force to consider piloting SIFs in the Commonwealth. The current opioid epidemic represents the greatest public health crisis our state has faced in recent memory. Therefore, it will take a variety of brave and innovative strategies to change its course. SIFs should be one of those strategies.”

Dr. Dennis Dimitri, chair of the Task Force, presented the MMS SIF report to the Worcester Board of Health in June 2007. As other state and federal medical society and medical specialty societies have endorsed or considered endorsing SIFs, MMS continues to be a resource to other states to share both background information and various legislative strategies.

A coalition in support of the establishment of supervised injection faculties has formed in Massachusetts, led by SIFMA NOW, AIDS Action, and others. SIFMA NOW is a volunteer group of physicians, lawyers, harm reductionists, advocates, people in recovery, and active drug users working together to reduce accidental overdose deaths in Massachusetts by increasing

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proven harm reduction strategies like supervised injection. The MMS is active with the coalition on issues which align with the Society’s policies and advance shared goals.

The MMS is also engaged with The Big Cities Health Coalition, a forum for the leaders of America’s largest metropolitan health departments to exchange strategies and jointly address issues to promote and protect the health and safety of the 55 million people they serve. MMS has shared information regarding the organization’s strategy for development of SIF policy, and well as interfaced with state and local government.

Other states have introduced legislation that would affirmatively authorize SIF programs. Advocates and attorneys working toward legalizing SIFs believe they have a strong case, given the authority of states and localities to remove criminal penalties if an action is in the interest of the public’s health.

The MMS has also been active on this issue at the federal level. The MMS policy was shared with all members of the MA Congressional Delegation. The MMS also worked with Senator Warren’s office on questions regarding SIFs for Surgeon General Dr. Jerome Adams during his confirmation hearings. Participants to the 2018 AMA National Advocacy Conference discussed the MMS policy in support of a pilot SIF during their meetings with the Massachusetts Congressional delegation and their staff. On March 26, 2018, the MMS sponsored a briefing to educate Senate staff in Washington, D.C. about the MMS policy on SIFs. The purpose of the briefing was to educate Senate staff about SIFs, what the research reveals, the experience of the physicians at Boston Healthcare for the Homeless who care for patients at The SPOT - Safe Place for Observation and Treatment, legal issues, and why a growing number of physician organizations are supporting pilot SIFs as one resource to keep their patients alive in the war against opioid abuse and substance-use disorder.

Research

The MMS is actively engaged with the research community across the nation. In Philadelphia, Baltimore, New York City, Ithaca, Seattle, and San Francisco, efforts to legalize SIFs have intensified. “Several cities look set to make this happen in the near future,” says Alex Kral, PhD, director of the Behavioral and Urban Health Program at RTI International, a nonprofit research and development institute. Meanwhile, an underground SIF is currently operating at an undisclosed location in the US. Dr. Kral secured a three-year grant to study its outcomes. During its first two years of operation, the facility provided a safe space for 2,500 injections, according to the American Journal of Preventive Medicine (2017). The two on-site overdoses in that (pre-fentanyl) period were successfully treated, and the program averted over 2,300 instances of public injection and 1,725 instances of unsafe syringe disposal.

Education and Outreach

MMS continues to educate and advocate regarding establishment of SIFs as a harm reduction model to address substance use disorder, engage vulnerable individuals in the health care system, transition individuals into treatment and save lives. MMS leadership actively participates in discussion with clinical and non-clinical audiences at the local, state and national level.

Conclusion

The Society’s advocacy for establishment of a pilot supervised injection facility program in Massachusetts under the direction and oversight of a state-led task force is ongoing.
Background

The mission of the Committee on Membership (COM) is to develop and implement strategies for membership recruitment and retention efforts for the MMS. These strategies include the preservation and cultivation of relationships through the wide range of membership constituencies.

One of the most important methods of outreach to physicians in Massachusetts is through Group enrollment. Group engagement continues to be an important area of our membership strategies. The MMS Board of Trustees approved a model to be used within group enrollment outreach and that is the Group-within-a-Group (GwG) pilot project, which we use with enrollment activities and initiatives for larger groups.

The Committee on Membership continues its outreach to mid-to-large size groups and utilizes the BOT guidelines for Group-within-a-Group recruitment efforts. A Group-within-a-Group is currently defined as an opportunity to create a membership group and establish a presence within a larger organization/entity that includes a discount to incentivize additional membership enrollment.

The Group-within-a-Group enrollment option is consistent with the MMS membership goals to:

1. Establish a strategic presence / base within larger physician entities such as hospitals and healthcare organizations.
2. Promote MMS initiatives that focus on larger groups, networks, and organizations, such as ACOs and other institutional models.
3. Seek upper-level management support with, and for the Society’s priorities through, collegial and collaborative group engagement.
4. Enroll new members for long-term commitment and continued growth as well as foster existing relationships with current members.
5. Enhance the MMS’s position nationally of membership innovation with physician groups.

The number of physician groups that are enrolled with the MMS is now 204 and of that number 11 are GwG enrolled groups with close to 1,400 members. The total number of members enrolled as group members is 4,772, which represents 44.1% of regular, in-state, physician members.

New Developments

The committee continues to review the current Group-within-a-Group structure and has determined that there is considerable intrinsic value in not only enrolling but establishing a collaborative and productive relationship with these entities as part of our Group program.
The GwG project has been positive. MMS Officers and senior management have been establishing renewed relationship with our existing GwG groups. Over the past year there have been a number of meetings, teleconferences, and outreach to these groups continuing the dialogue of mutual endeavors and teamwork.

The feedback from the GwG groups has been rewarding as they feel it is a worthy relationship to be included in the House of Medicine and to partner on important health care initiatives. Other positive feedback confirmed that physicians enrolled through their group see it as a true benefit of their affiliation with the group organization.

The group relationship communication plan via the Committee on Membership provides valuable MMS work products to the groups via the group administrators and lead or sponsoring physician.

MMS distributes new information and publications to the group audience and promotes access the documents on the MMS members-only areas of the website. This has led to requests from groups to provide additional information, as well as copies for distribution at educational programs. This is a demonstrated value of the work products developed by various MMS committees and departments.

Because of this feedback, we continue our outreach with several potential organizations presenting the GwG option.

Conclusion
The committee will present its recommendations for the continuation of the GwG program at the Committee on Finance Meeting in April and with for the Board of Trustees at their meeting in June.

A summary of the Group-within-a-Group project exploring the value of enrollment and the collaborative and productive relationships fits perfectly with our overall organizational priorities. Moreover, it demonstrates the Society’s reach with larger institutions, which is valuable when advocating for our physicians and their patients.
Background
At A-17, as a result of TFTL Report: I-16 C-1 [I-15 C-3] Ensure Representative Diversity in MMS Leadership Pathways, the MMS Bylaws were amended to create a Minority Affairs Section. Per the MMS Bylaws, 5.07, “The Minority Affairs Section is composed of Massachusetts Medical Society members who represent the interests of underrepresented groups and communities across the membership.”

Discussion
A planning committee has convened to prepare plans for the formation of the MMS Minority Affairs Section (MAS). The following is an outline of the Minority Affairs Section (MAS) Planning Committee’s activities and newly-created operating guidelines.

MMS members involved in the formation of the MAS include:
- Nidhi K. Lal, MD, Middlesex North, Chair
- Milagros E. Abreu, MD, Middlesex West (chair CoDIM)
- Frederic Baker, MD, Worcester
- Ronald W. Dunlap, MD, Norfolk South
- Pei-Li Huang, MD, Charles River (CoM)
- Vincent C. Smith, MD, Norfolk
- Fatima Cody Stanford, MD, Suffolk
- McKinley Glover, MD, Suffolk, Resident and Fellow Section Member
- David Ma, Worcester, Medical Student Section Member
- Navin Popat, MD
- Emily C. Cleveland, MD (RFS representative)
- Carl Streed, Jr., MD (CoLGBTQ Matters representative)
- Anand Habib (Medical Student representative )
- Aimie Zale, MD (CoWIM representative)
- Rajendra Trivedi, MD (IMG Section chair)
- Janine Rodrigues-Saldanha, MD

The planning committee’s principle activities have involved drafting of the MAS operating guidelines, which articulate the MAS core mission, composition, and governance.

To inform this process, the planning committee consulted the operating guidelines of existing MMS sections (e.g., IMG, OMSS, and RFS), as well as the by-laws of the AMA-MAS.
The planning committee began this process with its first meeting on October 3, 2017, and completed the development of the guidelines over the next several months, including subsequent meetings on November 21, 2017, and January 30, 2018.

Conclusion

At this time, the planning committee submits the MAS operating guidelines (please see appendix) with this informational report, with plans for the appointment of the section’s inaugural executive committee and officers by the MMS president at the 2018 Annual meeting of the House of Delegates.
Appendix

Organizational Guidelines of the
Massachusetts Medical Society Minority Affairs Section
(MMS-MAS)

CHAPTER I – PURPOSE

1. MINORITY AFFAIRS SECTION. There shall be a section of the Massachusetts Medical Society (MMS) known as the Minority Affairs Section (herein referred to as MAS or Section) established by the MMS House of Delegates.

The MAS shall provide a physician and medical student forum dedicated to:
- Addressing minority health and minority physician professional issues;
- Increasing the participation of underrepresented minority physicians and students in the MMS and MMS leadership; and
- Advising the MMS House of Delegates (HOD) on minority policies and programs.

The MAS shall also represent the interests of its members in the MMS-HOD, pursuant to current MMS Bylaws.

2. PARTICIPATION – Participation in the Section’s activities shall be open to all MMS members. Membership shall be:
   1. Initiated upon the request of the individual physician or medical student.
   2. Open to any MMS member physician or medical student who expresses an interest in minority physicians or minority health issues.

CHAPTER II – OFFICERS

1. EXECUTIVE COMMITTEE. There will be an Executive Committee of the MAS to direct the programs and activities of the Section, subject to the approval of the MMS House of Delegates. In addition, The Executive Committee will elect one representative from amongst its members to represent the MMS-MAS at the Interim and Annual Meetings of the American Medical Association Minority Affairs Section.

A. COMPOSITION. The Executive Committee shall consist of at least seven (7) members and shall not exceed a total of fifteen members (15). Members of the Executive Committee shall include a Chair, Vice-Chair, Delegate to the MMS House of Delegates, Representative to the AMA-MAS, up to three at-large members, a medical student representative, a resident representative and representatives from the International Medical Graduate (IMG) Section, Young Physician Section (YPS), Committee on LGBTQ Matters (CoLGBTQ), Committee on Diversity in Medicine (CoDIM), Committee on Women in Medicine (CoWIM) and Committee on Membership (CoM),

The medical student, resident and IMG Section, YPS, CoLGBTQ, CoDIM, CoWIM and CoM representatives will be appointed annually by their respective sections and committees. In addition to the appointed representatives, additional seats on the Executive Committee may be filled by members of the Section through the normal election process. Resident member(s) of the Executive Committee are eligible to hold all offices.
B. ELECTIONS. With the exception of the appointed section and committee representatives, all members of the Executive Committee will initially be appointed by the MMS president. In order to ensure continuity, the Executive Committee shall implement staggered terms. Following an initial election of seven members to serve a two-year term, three members will be elected at each subsequent annual election to serve a three-year term. Nominations will be held annually via email to the MMS-MAS membership and elections conducted in conjunction with the MMS-MAS annual meeting.

1. NOMINATIONS. Any member of the MMS-MAS may be nominated for any of the four elective offices or three at-large positions. Only members of the MMS-MAS may nominate candidates.

2. NOTIFICATION. MMS-MAS members will be notified of nominations received at least 30 days prior to the annual meeting. Nominations may be made after the 30 day deadline but will not be circulated in advance of the annual meeting, and nominations may also be made from the floor.

C. MEETINGS. Regular meetings of the Executive Committee may be held at such times and places as determined by the Executive Committee. Meetings of the Executive Committee may also be called by the Chair or by any two other officers.

D. ATTENDANCE. Executive Committee members are required to attend a minimum of 50% of committee meetings during an MMS administrative year. If an Executive Committee member fails to meet the minimum percentage of meetings during the first year of his/her two-year term, the Executive Committee will discuss the attendance policy with the member and may request his/her resignation. If the member continues to serve on the Executive Committee but fails to attend subsequent meetings, the Executive Committee may terminate the member’s remaining term on the committee. In exercising its discretion under this paragraph D, the Executive Committee shall have regard for reasonable explanation for the member’s non-attendance.

In the event of a vacancy, due to the voluntarily resignation or the termination of a member, the position will be filled as outlined in Chapter II, 4 – VACANCIES.

2. OFFICERS. The Officers of the Executive Committee shall be a Chair, Vice Chair, a Delegate to the MMS House of Delegates and a Representative to the AMA-MAS. The election of officers will be made by the Executive Committee from amongst its members. The election of officers will be held at the Executive Committee’s first meeting of the administrative year. Officers will be elected by a majority vote of the Executive Committee.

The Officers will have the following duties and responsibilities:

A. CHAIR. The Chair will direct the activities of the MMS-MAS. The Chair will preside at any meetings of the MMS-MAS, as well as all meetings of the Executive Committee.

B. VICE CHAIR. The Vice Chair will assist the Chair and preside in the absence of the Chair or at his or her request.
C. **DELEGATE.** The Delegate will represent the members of the MMS-MAS in the MMS House of Delegates.

D. **REPRESENTATIVE** The Representative will be a current member of the AMA and represent the members of the MMS-MAS at the Interim and Annual Meetings of the American Medical Association Minority Affairs Section.

3. **TERMS.** Elected Executive Committee members, with the exception of the Representative to the AMA-MAS, will serve a term of three years, to run concurrently with the MMS administrative year (June 1 to May 31). The elected Representative to the AMA-MAS and the eight Executive Committee members appointed by their sections and committees will serve a term of one year but may be reelected and reappointed to serve additional one-year terms. No member will serve as Chair for more than three consecutive terms. Any officer originally appointed to serve less than a year of an unexpired term will not be regarded as thereby having served a term. Nothing in these guidelines will be construed as forbidding later re-appointment to any office, after an interruption of two administrative years in consecutive service.

4. **VACANCIES.** Any vacancy in the office of Chair will automatically be filled by the Vice-Chair for the duration of the vacated term. Any vacancy occurring in the office of Vice-Chair will be filled for the remainder of the term by a majority vote of the remaining members of the Executive Committee at their next meeting. The MMS President will appoint replacements for any vacancies in the offices of Delegate or members-at-large for the remainder of the term(s), after consultation with the Executive Committee. As part of this consultation, the Executive Committee shall make recommendations to the MMS President for replacements for member-at-large positions, which will include all MMS-MAS Executive Committee candidates who were not elected to the Executive Committee but who received the next highest number of votes in the preceding election. The MMS-RFS will appoint a replacement for any vacancy in the appointed resident position.

**CHAPTER III - MEETINGS OF THE MEMBERSHIP**

1. **GENERAL MEETINGS.** The Section shall hold one meeting of the entire Section membership annually.

2. **SPECIAL MEETINGS.** Special meetings of the membership may be called by the Executive Committee or by a petition of the Section’s membership. Such a petition must be signed by a minimum of 25% or 20 (whichever is fewer) current members of the Section, and Section members must be given a minimum of 15 days notice of any such meeting.

**CHAPTER IV - PARLIAMENTARY AUTHORITY**

1. **PARLIAMENTARY AUTHORITY.** All meetings of the Section and the Executive Committee shall be governed by the parliamentary rules and usage contained in the current edition of American Institute of Parliamentarians Standard Code of Parliamentary Procedure when not in conflict with these guidelines.
CHAPTER V - MMS BYLAWS

1. MMS BYLAWS. These guidelines shall be construed to be consistent with the MMS Bylaws and the Section shall enact no guidelines in conflict with the bylaws of the Society.

CHAPTER VII – AMENDMENTS TO MMS-MAS ORGANIZATIONAL GUIDELINES

1. AMENDMENTS. These guidelines may be amended by either: a majority vote of the MMS-MAS Executive Committee, or by the MMS Board of Trustees.
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Code:           CPL Informational Report A-18-06 [I-17 C-1]
Title:          Strengthening the Medical Malpractice Tribunal
Sponsor:        Committee on Professional Liability
                Stephen Metz, MD, Chair, MD, Chair

Report History: CPL Report I-17 C-1

Background

At I-17, the House of Delegates adopted as amended CPL Report I-17 C-1, Strengthening the Medical Malpractice Tribunal. The Board of Trustees referred this report to the Committee on Professional Liability for implementation and an informational report at A-18. The report directs:

1. That the Massachusetts Medical Society work to promote to its members and other physicians licensed in Massachusetts the value of the Medical Malpractice Tribunal. Such promotion could include, but need not be limited to:
   a. Updating the online video explaining the tribunal and its role
   b. Publishing a brochure about the tribunal to distribute to members and others
   c. Article placement in Vital Signs and Vital Signs This Week
   d. Advertising in Vital Signs

2. That the Massachusetts Medical Society work to recruit physicians licensed in Massachusetts to join a database of physicians willing to serve on a Medical Malpractice Tribunal. Such recruitment efforts could include, but need not be limited to:
   a. Publishing a brochure about the tribunal to distribute to members and others
   b. Article placement in Vital Signs and Vital Signs This Week
   c. Advertising in Vital Signs
   d. Working with the Board of Registration in Medicine to ask that they add a way for physicians to enroll when applying for licensure or relicensure
   e. Working with medical malpractice insurance providers to ask their insureds to enroll

3. That the Massachusetts Medical Society study and report back at A-18:
   a. Incentives for doctors participating in a Medical Malpractice Tribunal including but not limited to CMEs, medical liability insurance discounts, credit for jury duty, and travel expenses
   b. Options to improve the Medical Malpractice Tribunal process

(D)

Fiscal Note: One-Time Expense of $20,000
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Discussion
This report concerns Item 3, directing the Society to study and report back on incentives for doctors participating in a medical malpractice tribunal, and options to improve the medical malpractice tribunal process.

Incentives
The Committee on Professional Liability has examined each of the options described as incentives for participation, and has received feedback and replies as follows:

a. Medical Liability Insurance Discounts. Committee staff and the Society’s Assistant General Counsel will meet with representatives from two of the larger insurers in Massachusetts (COVERYS and CRICO) to discuss this possibility, but research shows that discounts are usually given for low claim-submission rates and risk education, and that medical malpractice insurers are unlikely to implement a discount for participation in a tribunal.

b. Credit for Jury Duty. Discussions with trial court personnel reveal that no mechanism currently exists to give credit for jury duty for anything outside of the jury-duty system, and that the general sense at the court is that the medical malpractice tribunal itself is a significant benefit to the medical profession which is enjoyed by no other profession, and thus physicians should need no additional incentive to participate on a tribunal.

c. Travel Expenses. Discussions with trial court personnel reveal that no mechanism currently exists to reimburse travel expenses for non-court-employees, and that the general sense at the court is that the medical malpractice tribunal itself is a significant benefit to the medical profession which is enjoyed by no other profession, and thus physicians should need no additional incentive to participate on a tribunal. Further, the trial court budget is stretched thin and it is unlikely to be increased to absorb the cost of physician travel for tribunal participation. Separately, the Society does not have a budget that could cover physician travel expenses for tribunal participation either.

d. CME Credits. Research and ongoing discussions with the Director of Accreditation and Recognition, NEJM Group Education (formerly referred to as the Medical Education Department) show that tribunal participation would not be eligible for *AMA PRA Category 1 Credit™*, which requires a series of planning documents, periodic reviews, and reports, but might be eligible for *AMA PRA Category 2 Credit™*. Category 2 credit is self-reported, and can include teaching, unstructured online searching and learning, reading authoritative medical literature, small group discussions, self-assessment activities, medical writing, research, and peer review and quality assurance participation, among others.¹

An online publication of the Board of Registration in Medicine, published in 1989,

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lists some examples of activities eligible for risk management CME credit, and includes “serving as a member of a medical malpractice tribunal (this meets the definition of risk-management because it involved medical-legal issues).” Further, CRICO represents to its insureds that they “may use time participating in medical tribunals for AMA PRA Category 2 Credit™ which is self-claimed. (Keep a copy of the activity and time spent participating for your records).” More recent guidance from the Board of Registration in Medicine states that it will accept for AMA PRA Category 2 Credit™ activities that meet or is the equivalent of the standards set by the AMA. Committee staff have reached out to the Society’s Accreditation and Recognition department, which will, in turn, speak with the AMA’s medical education department to attempt to discern whether medical malpractice tribunal participation might qualify for AMA PRA Category 2 Credit™, and, if so, whether such an activity could be designated for risk management credit. Once the committee receives that answer, it will work to disseminate the information to Society members and other physician tribunal participants.

e. Other Options. As it considered various measures and incentives that might be available, the Committee on Professional Liability realized that the Massachusetts Medical Society might be able to provide a discount code for a Continuing Medical Education activity for a physician who participates in a tribunal. Additionally, the Society could honor tribunal participants with a recognition certificate, publication of a list of participants, a recognition or awards dinner. Staff is exploring all of these options and will implement them as appropriate.

Options to Improve the Tribunal Process

Given the recent implementation (as of January 1, 2018) of a Superior Court rule revising the process by which a tribunal will be convened, and potentially limiting the circumstances in which a tribunal will be needed, it seems process improvements may already have been implemented. The Committee on Professional Liability has studied the use to which the tribunal process has been put, and some defense counsel assert that the most useful portion of the process is the receipt of the plaintiff’s expert witness statement and offer of proof. The new Superior Court Rule requires that the expert witness statement and offer of proof be provided even before a tribunal is convened, which may now obviate the need for a tribunal in many instances.

Historically, some districts of the Superior Court had access to video conferencing equipment, such that the physician member of the tribunal could participate remotely, including from MMS district offices and headquarters. Unfortunately, that capacity no

2 Massachusetts Board of Registration in Medicine Frequently-Asked Questions About Continuing Medical Education, August 1, 1989, p. 8, question 12, accessed on March 2, 2018 at http://archives.lib.state.ma.us/bitstream/handle/2452/49084/ocm31275692.pdf;sequence=1
longer exists, and the courts are not amenable to re-creating it. The trial court budget is stretched thin and it is unlikely to be increased to absorb the cost of videoconferencing for these tribunals.

Conclusion

In sum, the Committee on Professional Liability will continue to study and implement measures to incentivize physicians to participate on medical malpractice tribunals, including allowing the claiming of AMA PRA Category 2™ Risk Management credits, public recognition awards, and others. Fortunately, it is likely that the implementation of the new Superior Court rule regarding the tribunal process will soon lead to improvements. The committee will publicize any changes it implements or of which it becomes aware.
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Title: Stark Law and Physician Compensation
Sponsors: Committee on the Quality of Medical Practice
Barbara Spivak, MD, Chair
Committee on Legislation
Theodore Calianos, MD, Chair

Report History: BOT Informational Report A-17-02
OMSS Report A-16 B-4

Background
At A-16, the House of Delegates referred to the Board of Trustees (BOT) for decision OMSS Report A-16 B-4, Stark Law and Physician Compensation. The BOT referred this report to the Committee on the Quality of Medical Practice for a report at the March 2017 BOT meeting. In lieu-of-OMSS Report A-16 B-4 the BOT adopted the following:

1. That the MMS update its Guide to Physician Employment and its 2005 version of Making Sense of the Stark Law: Compliance for the Medical Practice to include discussion on Compensation with regards to current state and federal laws, safe harbors and waivers. (D)

2. That the MMS hold webinars on Physician Employment and Compensation with regards to current state and federal laws as well as safe harbor and waiver laws to help physicians understand their rights and protections. (D)

3. That MMS encourage physician and physician leaders to actively join physician compensation committees in all types of institutions to effectively advocate for fair and reasonable physician compensation models. (D)

Fiscal Note: $10,000 -$15,000 (Out-of-Pocket Expenses)
FTE: Existing Staff (Staff Effort to Complete Project)

At A-17, the BOT reported this action in BOT Informational Report A-17-02. The informational report was extracted at the HOD first session and sent to reference committee. The report was amended by addition of the following directive was added, which the HOD adopted:

4. That the Massachusetts Medical Society oppose and advocate against the misuse of the Stark Law to cap or control physician compensation. (D)
For implementation, Items 1-3 were referred to the CQMP, item 2 in consultation with the Committee on Medical Education, and item 2 in consultation with the Organized Medical Staff Section. Item 4 was referred to the Committee on Legislation, the Committee on the Quality of Medical Practice, and the MMS Physician Practice Resource Center (PPRC). The following is an update on implementation.

**Item 1:** The Committee on Quality Medical Practice and the Physician Practice Resource Center has engaged with Donoghue & Barrett to create a Stark Law series for educational purpose and an updated physician compensation handbook. These webinars and documents will be completed for use in 2018.

**Item 2:** The Physician Practice Resource Center is creating educational videos for seminars on physician employment, contracting, and payment, and working for CME credit.

**Item 3:** The Massachusetts Medical Society and the Organized Medical Staff will continue to work on webinars on physician employment and Compensation with regards to current state and federal laws as well as safe harbor and waiver laws to help physicians understand their rights and protections.

**Item 4:** The Massachusetts Medical Society will advocate against the misuse of the Stark Law and continue ongoing educational efforts to inform physicians on the misuse of the law to cap or control physician compensation.

**Discussion**

All listed items above are on-going and active. As items 1 and 2 noted above, the PPRC is working with Donoghue and Barret on a Stark Brief Series and to film several webinars to complement the briefs. These will be archived and CME approved. The Committee on Medical Education reviewed these concepts and approved them. The PPRC working with OMSS and the resident section has also created a series of finance programs including on topics of Physician Compensation Models and Effective Negotiation of Employment Agreement. The webinars will be archived and CME credits will be available.

Regarding Item 3: the OMSS is updating its Model by-laws and will include recommendations to actively join physician compensation committees in all types of institutions.

Regarding Item 4: The MMS will continue to monitor the application of the Stark law and oppose any efforts to use it to limit physician compensation. Of note, the MMS strongly supported the extension of Stark Law exception and safe harbor through 2021 permitting physicians to accept electronic health record (EHR) donations and support from hospitals. The MMS has also continuously advocated for changes to the Stark Law which are necessary to allow ACOs, APMs and other new physician hospital organizations to succeed and thrive.

During this Administration, there has been no significant legislative or regulatory activity related to Stark, although CMS Administrator Seema Verma has indicated an interest in addressing the limitations Stark presents with respect to new payment models. An interagency task force is being assembled to look at this issue. The MMS will monitor federal activities with respect to changes to the Stark Law and continue to advocate
Conclusion

Items in this report are being actively pursued and completed. By the end of 2018, items 1, 2, and 3 will be completed.

Item 4 is ongoing.
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<th>Item</th>
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<th>Code</th>
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<td>A-17 A Item 1</td>
<td>Establishment of a Pilot Medically-Supervised Injection Facility in MA</td>
<td>BOT Report A-17 A-1</td>
<td>Adopted</td>
<td>Legislation, Opioid Therapy and Physician Communication</td>
<td>A-18</td>
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**STATUS:**

| A-17 A Item 2 | Improving Naloxone Access | Resolution A-17 A-101 | Adopted as Amended | (1-4) Opioid Therapy and Physician Communication (5) MA AMA Delegation | A-18       | # 2, 3, 5 Completed |

**STATUS:**
Task Force on Opioid Therapy and Physician Communication
Expanding access to naloxone is a strategic focus for the Task Force on Opioid Therapy, and efforts are ongoing. The Society met with the Department of Public Health Bureau of Substance Abuse Services to learn more about access points to naloxone and how to communicate with physicians and patients. In spring 2018 a Physician Focus cable program featured a physician and a pharmacist explaining how naloxone works to reverse an opioid overdose and answering some basic yet critical questions about naloxone, and an accompanying community news article was released to inform the public. In addition, a training video was produced to demonstrate use of naloxone. MMS remains in contact with payers regarding cost sharing for naloxone and most insurers in the state provide coverage of the drug and affordable co-pays. According to the Massachusetts Department of Public Health, Mass Health covers the cost of naloxone for members. For those outside mainstream health care, the state can provide safety-net access to naloxone through the Overdose Education and Naloxone Distribution pilot program.

The March 2018 *Vital Signs* was dedicated to the opioid epidemic, and information regarding access to naloxone and standing orders was a featured article. Emphasis was placed on messaging about how to get and use naloxone. It’s important for all patients prescribed an opioid or with a substance use disorder to be educated about the potential risk of overdose.

**Key Messages for Patients**
- **Go to the pharmacy:** Since 2014, all Massachusetts retail pharmacies licensed by the Board of Pharmacy must obtain a standing order and maintain a continuous supply of naloxone rescue kits, which consist of two medication-filled syringes and instructions on how to administer the drug.
- **Talk to the pharmacist:** Pharmacists at locations that recognize standing orders are required to complete DPH-approved naloxone training, including how to advise customers on when and how to deploy naloxone correctly.
- **Insurance covers it:** MassHealth, and most insurers in the state, cover naloxone with affordable co-pays, according to the Massachusetts Department of Health (MDPH).
- **Other options:** The Overdose Education and Naloxone Distribution (OEND) pilot program, is aimed at those most at risk of experiencing an opioid overdose, and has 21 locations statewide: mass.gov/eohhs/docs/dph/substance-abuse/naloxone-info.pdf
- Educational tools: MDPH has online and print resources for patients, families, communities, providers, and state municipalities and agencies: mass.gov/overdose-prevention-and-naloxone-access.
AMA Delegation
The MA AMA Delegation met on September 5, 2017, and reviewed Item #5 as directed. Following a brief conversation, it was agreed the AMA already had policy on this item and no further action was required. The specific AMA policy is entitled, “Increasing Availability of Naloxone” H-95.932.

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organization, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA urges the Food and Drug Administration to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).

A-17 A Item 3 Access to Medication-Assisted Treatment for Prisoners with Opioid Use Disorders Resolution A-17 A-102 Adopted as Amended (1) Legislation (2) Opioid Therapy and Physician Communication, MA AMA Delegation A-18 Ongoing

STATUS:
Committee on Legislation
MMS has advocated extensively over the past several months to require that all persons incarcerated in Massachusetts have access to the full spectrum of evidence-based recovery services. The primary means by which we have pursued this advocacy is through a comprehensive criminal justice reform bill that is currently pending in the State House. Specifically, the Medical Society supported medication-assisted treatment (MAT)-mandate provisions in both the House and Senate versions of the criminal justice bill, as the legislation was finalized in each chamber. The Medical Society then ramped up its advocacy in support of these provisions as the bill went to conference committee- the process by which a group of three Senators and three Representatives are tasked with negotiating a compromise bill between the two chambers.

As the MMS learned that there were certain constituencies that were pushing the conference committee to strike or dilute the MAT requirement, the Medical Society joined with other stakeholder groups, including the Association for Behavioral Health, to write a letter to the conferees again urging passage of this provision. The letter referenced much of the evidence cited in the MMS resolution, as well as several recent publications on the issue. Lastly, MMS staff has worked with state house staff as they work to support the legislators’ attempts to include this provision in the final bill, including by providing the staff with literature on cost-benefits analyses, and connecting the state house staff with physicians with experience directing MAT programs in houses of correction, both in Rhode Island and at Ricker’s Island in New York City.
Lastly, because of the reference to the MassHealth formulary in this resolution, it is important to note that the Medical Society continues to advocate for a full, robust formulary for medication-assisted treatments in the MassHealth program. The state Executive Office of Health and Human Services proposed narrowing the MassHealth formulary this summer, and the Medical Society provided testimony in opposition to this proposal, citing substance use disorder medications as an example of why open, robust formularies are important, especially for the MassHealth patient population.

Task Force on Opioid Therapy and Physician Communication
Expanding access to medication assisted treatment is a strategic focus for the Task Force on Opioid Therapy. Substance use disorder can be treated, and those efforts can begin in medical practice settings whether in the community or in correctional settings. Access to evidence-based recovery support services, including medication-assisted treatments for inmates with opioid use disorders and transition plans for post-release care is consistent with standards of care in the community.

MMS is in contact with representatives from the correctional system and continues to dialogue about the need to continue medication assisted treatment for individuals being treated upon incarceration, as well as advocating for the initiation of evidence-based treatment while incarcerated and comprehensive transitioning planning. Massachusetts 2016 Chapter 55 data documents that individuals recently released from prisons have a short-term risk of death from opioid overdose that is greater than 50 times the risk for the general public. The effort to educate and advocate regarding substance use disorder treatment for patients with a history of incarceration is ongoing.

In a related discussion, in September 2017 an amicus brief filed in the Massachusetts Supreme Judicial Court by the MMS and other organizations seeks to influence the case of a Massachusetts woman with opioid use disorder who was required to remain substance-free as a condition of her probation and later tested positive for fentanyl. Suboxone was prescribed as part of the woman’s treatment and began just days before she was jailed for testing positive. The case focuses on whether an individual can be incarcerated or otherwise sanctioned because of a recurrence of a symptom; in this instance, relapse, a common symptom many with opioid use disorder experience before attaining complete abstinence. This case illustrates an example of the intersection of substance use disorder history and judicial system policy.

MA AMA Delegation
The MA AMA Delegation met on September 5, 2017 and reviewed Item #2 as directed. Following a brief conversation, it was agreed that the most effective approach would be to send a letter to the AMA Chair of the Board of Trustees, Dr. Patrice Harris, to share the directive:

“that the MMS work with the AMA and any relevant organizations to advocate for access to the full spectrum of evidenced-based recovery support services, including all medication-assisted treatments for federal inmates with opioid use disorders and transition plans for post-release care.”

Dr. Harris responded noting, among other points, that “Medication-assisted treatments for opioid addiction, including but not limited to buprenorphine and methadone, are powerful and cost-effective tools used in the community to fight the opioid epidemic.”

Dr. Harris thanked us for reaching out to them on this important issue and stated that it is one that is taking on increased importance, and one that they welcome the opportunity to work with us and others to identify the many different areas for action—and potential solutions. Dr. Harris agreed that patients with a substance use disorder need access to evidence-based care in prison, including MAT for those with an opioid use disorder, and further, believe that this issue expands beyond those incarcerated, and encompasses the “full spectrum of care from arrest to post-incarceration release.”

Dr. Harris is looking forward to working with MMS on the issue of opioids.
### Status/Implementation Chart for 2017 Annual Meeting Resolutions/Reports

#### Reference Committee A: Public Health

|------|------------|-------------|--------|------|----------|------|------|------|

**STATUS:**

**Committee on Legislation**
MMS has identified a champion for this cause in the State House and has engaged with the House Committee on Ways and Means to explore opportunities to enact legislative language and/or funding to expand needle/syringe disposal and exchange programs. MMS has also reached out to the Boston Public Health Commission and to AHOPE Boston Needle Exchange.

In addition, the Medical Society has closely monitored a law suit between the state and a proposed needle exchange on Cape Cod. The Massachusetts Supreme Judicial Court issued an opinion indicating that needle exchanges not seeking state funding do not need authorization from the Massachusetts Department of Public Health. This decision could remove some regulatory barriers for privately funded needle exchanges.

**Committee on Public Health and Task Force on Opioid Therapy**
MMS has been in communication with leaders in the community, including the Massachusetts League of Community Health Centers, AHOPE Boston Needle Exchange and Boston Public Health Commission. Discussion has centered around education and outreach, securing funding for needle exchange programs, and increased opportunities for community participation in needle exchange through traditional and nontraditional venues. In March 2018 the Medical Society jointly provided a conference, ‘Bridging Syndemics: Treating Infections Complicated by Substance Use Disorder’. This case-based, interdisciplinary program was directed to those involved in the care of patients with difficult-to-treat infections complicated by substance use disorder. It explored the nexus of substance use disorder, and prevention and management of infectious diseases, with the goal of identifying strategies to improve patient outcomes. Improving access to clean needles and safe disposal is central to the health and safety of individuals and communities. The program was jointly provided with the Massachusetts Department of Public Health, Boston Public Health Commission, Massachusetts Infectious Diseases Society, and the Northeast Branch of the American Society for Microbiology.

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<th>A-17 A-3</th>
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<td>Streamlining Human Immunodeficiency Virus Testing of Source Patients Following an Occupational Exposure</td>
<td>Resolution A-17 A-103</td>
<td>Referred to the BOT for Report Back at A-18</td>
<td>(1,2) Public Health (in consultation with) Environmental and Occupational Health, Organized Medical Staff Section (3) Legislation</td>
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<td>Perfluorochemical (PFC) Drinking Water Contamination</td>
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<td>Environmental and Occupational Health</td>
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**STATUS:**
## Status/Implementation Chart for 2017 Annual Meeting Resolutions/Reports

**REFERENCE COMMITTEE A: Public Health**

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<td>A-17 A Item 7</td>
<td>Gasoline-Powered Leaf Blowers</td>
<td>CEOH Report A-17 A-3</td>
<td>Adopted</td>
<td>MMS Policy Compendium</td>
</tr>
<tr>
<td>A-17 A Item 8</td>
<td>Protecting Public Health from Natural Gas Infrastructure in Massachusetts</td>
<td>Resolution A-17 A-105</td>
<td>Adopted as Amended</td>
<td>(1) MMS Policy Compendium (2) Legislation and MMS Policy Compendium</td>
</tr>
<tr>
<td>A-17 A Item 10</td>
<td>Non-Exercise Activity Thermogenesis (NEAT)</td>
<td>CNPA Report A-17 A-5</td>
<td>Adopted</td>
<td>MMS Policy Compendium</td>
</tr>
<tr>
<td>A-17 A Item 11</td>
<td>Support of Reach Out and Read Literacy Program</td>
<td>Resolution A-17 A-106</td>
<td>Adopted</td>
<td>(1) MMS Policy Compendium (2) Legislation and MMS Policy Compendium</td>
</tr>
</tbody>
</table>

### Status:

**A-17 A Item 7**

The Medical Society wrote a letter to the state’s Energy Facilities Siting Board, housed within the Massachusetts Department of Public Utilities, which has authority over decisions regarding the siting of natural gas infrastructure projects. In the letter, the Medical Society referenced the extensive approval process outlined on the Siting Board’s website, including an explicit section requiring various environmental review procedures. The MMS letter then urges the Siting Board to adopt a similar procedure for issues pertaining to human health, specifically requesting that they require ongoing independent Comprehensive Health Impact Assessments to assess the health risks of all existing and proposed new or expanded natural gas infrastructure in Massachusetts.

**A-17 A Item 8**

The Committee on Geriatric Medicine (CGM) has provided Society membership with information on programs and services offered by the Massachusetts Executive Office of Elder Affairs (EOEA) through *Vital Signs, Vital Signs This Week*, and with links on the MMS website. As an example, last June, members were informed of a centralized Elder Abuse Reporting System, staffed 24/7. As mandated reporters, physicians can access one number for the initial intake. Similarly, the CGM is working with the EOEA on providing MMS members with information on its MassOptions service, which connects elders, individuals with disabilities, caregivers, and family members to community services and supports.

**A-17 A Item 10**

The MMS advocated throughout the Fiscal Year 2018 state budget for the inclusion of funding for the Reach Out and Read program. The Medical Society wrote letters to the Ways and Means committees who are primarily responsible for each year’s budgets, as well as the budget conference committee which is tasked with negotiating a final state budget. MMS was pleased to see included the legislature’s final budget an allocation of $1,000,000 for the Reach Out and Read program. MMS was dismayed to see the Governor veto this line item, and again urged the legislature to override this veto. MMS was pleased to see the override of this veto, and a restoration of the funding for the Reach Out and Read program.
### Status/Implementation Chart for 2017 Annual Meeting Resolutions/Reports

**Reference Committee A: Public Health**

<table>
<thead>
<tr>
<th>A-17 A Item 12</th>
<th>Educating Physicians about the Importance of Cervical Screening in Female-to-Male Transgender Patients</th>
<th>Resolution A-17 A-107</th>
<th>Adopted</th>
<th>LGBT Matters (and MMS Policy Compendium)</th>
<th>A-18</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATUS:</strong></td>
<td>In an effort to educate physicians about the importance of cervical screening in female-to-male transgender patients, the Committee on LGBTQ Matters had an informational flyer available at their booth at last year’s Annual Meeting. The committee also invited the original authors of the resolution to author an article about this topic which will be featured in <em>Vital Signs this Week</em>. Information will also be made available on the Committee’s page on the MMS website.</td>
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</table>

<table>
<thead>
<tr>
<th>A-17 A Item 13</th>
<th>Protection of Transgender Individuals’ Right to Use Restroom of Choice</th>
<th>Resolution A-17 A-108</th>
<th>Adopted</th>
<th>(1, 2) MMS Policy Compendium (3) Legislation (and MMS Policy Compendium)</th>
<th>A-18</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATUS:</strong></td>
<td>The MMS has closely monitored legal developments related to the protections to transgender individual’s use of the restroom that accords with their gender identity. MMS was pleased to see the Massachusetts legislature enact legislation to specifically codify gender identity in the list of protected classes covered by Massachusetts anti-discrimination laws. These amendments have now taken affect, prohibiting discrimination in places of public accommodation based on an individual’s gender identity. With complex statutory changes such as those made in Massachusetts—especially those that apply to all places of public accommodation—the Medical Society has closely monitored the resulting guidelines that advise individuals and entities on the implementation of these laws. The Medical Society was pleased to review an extensive guidance authored by the Massachusetts Office of the Attorney General entitled, “Gender Identity Guidance for Public Accommodations.” MMS is in regular contact with the Attorney General’s office and will continue to monitor the implementation of these important protections. At this time, no further state legislative changes have been identified. The MMS will continue to monitor state implementation of the law and will act accordingly should federal action be necessary. On a somewhat related issue, the MMS submitted comments in opposition to the DHHS proposed rule which would in effect expand “conscience protections” to allow health care workers to deny treatment to people based on their gender and other issues.</td>
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<table>
<thead>
<tr>
<th>A-17 A Item 14</th>
<th>Improving Mental Health at Colleges and Universities for Student Populations</th>
<th>OMSS Report A-17 A-6</th>
<th>Adopted</th>
<th>MMS Policy Compendium</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-17 A Item 15</td>
<td>Marketing of Smartphone-Integrated Infant Physiologic Monitors</td>
<td>Resolution A-17 A-109</td>
<td>Adopted as Amended</td>
<td>MMS Policy Compendium</td>
</tr>
<tr>
<td>A-17 A Item 16</td>
<td>CPR as a Requirement to Graduate High School</td>
<td>Resolution A-17 A-110</td>
<td>Adopted</td>
<td>Legislation</td>
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<tr>
<td><strong>STATUS:</strong></td>
<td>The MMS has written a letter to the Joint Committee on Education, in support of their favorable report of a bill that would require CPR as a condition for public high schools in the Commonwealth. While the MMS supports this requirement for all high schools, we feel that passing this legislation would be an important step towards</td>
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that goal. The MMS has offered to assist the Joint Committee on Education in their efforts to pass this legislation moving forward, and we will continue to monitor legislative developments regarding this issue.

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<tbody>
<tr>
<td>A-17 A Item 18</td>
<td>Maximizing Function and Minimizing Disability</td>
<td>Resolution A-17 A-111</td>
<td>Referred to BOT for Report Back at A-18</td>
<td>(1) Public Health (2, 3) Medical Education (in consultation with) Public Health</td>
<td>A-18</td>
</tr>
</tbody>
</table>

**STATUS:**


**STATUS:**  
**The Committee on Environmental and Occupational Health**
The Committee on Environmental and Occupational Health has discussed this three-year directive at length, and is primarily focusing its attention on climate change, and related human health effects, particularly in Massachusetts. MMS has sponsored two conferences this year open to physicians and the public designed to raise awareness of environmental issues and toxins affecting human health, one on climate change and nuclear war held in western Massachusetts; a second on the natural gas infrastructure held at Boston University. The committee has reached out to physicians and organizations engaged in relevant topic areas to assist in the development and promotion of messages to the public through the MMS website, and social media channels. The summer 2018 issue of the MMS newsletter Vital Signs will focus on environmental health issues. A social media presence on this issue will begin in FYI 2019.

**Committee on Legislation**
The Medical Society continues to survey the legislative and regulatory landscape for issues at the intersection environmental protection and public health. This year, for example, MMS provided testimony related to a regulatory proposal by the Massachusetts Department of Energy Resources related to energy policy. Specifically, the Medical Society provided information about biomass consumption, and testified about the potential health effects of combustion-based energy sources.

In addition, MMS continues to be an active advocate in the tobacco policy space, this year, filing legislation to restrict smoking and the harmful effects of second-hand smoke from public areas, such as Faneuil Hall.

MMS will continue to monitor legislative developments to find future areas for legislative and regulatory advocacy.
<table>
<thead>
<tr>
<th>Item</th>
<th>Title</th>
<th>Code</th>
<th>Action</th>
<th>Referred to</th>
<th>Report Due</th>
<th>(If Directive) Completed</th>
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</thead>
<tbody>
<tr>
<td>A-17 B Item 1</td>
<td>Supporting Medicaid as a Federal Entitlement Program</td>
<td>Resolution A-17 B-201</td>
<td>Adopted as Amended</td>
<td>MMS Policy Compendium</td>
<td></td>
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<tr>
<td>A-17 B Item 2</td>
<td>Health Care Is a Basic Human Right</td>
<td>Resolution A-17 B-202</td>
<td>Refer to the BOT for Report Back at A-18</td>
<td>MMS Presidential Officers</td>
<td>A-18</td>
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<tr>
<td>A-17 B Item 3</td>
<td>Effective Health Care Cost Control</td>
<td>Resolution A-17 B-203</td>
<td>Not Adopted</td>
<td>NA</td>
<td></td>
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<tr>
<td>A-17 B Item 4</td>
<td>Health Insurance in which Copayments Vary with Clinical Utility, a Value-Based Insurance Design</td>
<td>Resolution A-17 B-204</td>
<td>Referred to the BOT for Decision (Not Adopted)</td>
<td>Board of Trustees (Feb 2018 BOT Meeting: The Quality of Medical Practice (in consultation with) Interspecialty Committee)</td>
<td>A-18</td>
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<tr>
<td>A-17 B Item 5</td>
<td>Nursing Facilities’ Doctors and Other Prescribers Should Be Exempt from Consulting MassPAT</td>
<td>Resolution A-17 B-205</td>
<td>Referred to the BOT for Decision (Adopted as Amended)</td>
<td>Board of Trustees (Feb 2018 BOT Meeting: Legislation (in consultation with) Geriatric Medicine, Opioid Therapy and Physician Communication)</td>
<td>A-18/A-19</td>
<td>(For implementation)</td>
</tr>
</tbody>
</table>
### Informational Report A-18-08
#### Status/Implementation Chart for 2017 Annual Meeting Resolutions/Reports
#### REFERENCE COMMITTEE B: Health Care Delivery

**STATUS:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Resolution</th>
<th>Status</th>
<th>Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-17 B-206</td>
<td>Resolution A-17 B-206</td>
<td>Adopted</td>
<td>Legislation</td>
</tr>
<tr>
<td>A-18 Ongoing</td>
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<tr>
<td><strong>STATUS:</strong></td>
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<tr>
<td>The MMS has monitored the legislature for policies regarding prescription drug donation, especially as the Massachusetts Senate has taken up the issue of health care costs in the Commonwealth through proposing comprehensive legislation. The MMS has not found an appropriate legislative vehicle for prescription drug donation during the current legislative session. The MMS continues to monitor health care cost containment legislation and state budgets and budget amendments, and if this issue is not addressed in this session, the MMS will consider filing legislation during the next session or identifying the appropriate regulatory agency to with whom to engage on this important issue.</td>
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<td><strong>STATUS:</strong></td>
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<tr>
<th>Item</th>
<th>Resolution</th>
<th>Status</th>
<th>Committee</th>
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</thead>
<tbody>
<tr>
<td>A-17 B-207</td>
<td>Resolution A-17 B-207</td>
<td>Referred to the BOT for Report Back</td>
<td>Geriatric Medicine</td>
</tr>
<tr>
<td>A-18</td>
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<tr>
<td><strong>STATUS:</strong></td>
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<tr>
<td>The Committee on Geriatric Medicine (CGM) has been working with MMS leadership regarding the Society’s commitments to the MA Coalition for Serious Illness Care (MCSIC) including education staff, trustees and physician members on proxy use and completion. The CGM’s 2014 brochure, “Planning Ahead: What are your Choices?” highlighted the need for every person 18 years of age and older to consider, execute, and communicate wishes about healthcare decisions with a proxy form. Additionally, CGM leadership and staff participated in a statewide Massachusetts Coalition for Serious Illness Care workshop and planning meeting regarding development of a statewide registry for healthcare proxies, as well as other advance directives and orders. Vendors provided brief presentations on their secure networks and abilities to conform to electronic health records. CGM continues to monitor and participate in this work.</td>
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<tr>
<td><strong>Committee on Legislation</strong></td>
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<tr>
<td>The MMS has filed legislation in the State House to improve medical decision-making, specifically by creating an additional pathway for incapacitated patients who have not previously designated a Health Care Proxy. MMS has identified this as a priority bill and has engaged with a broad group of stakeholders to build momentum. In our testimony for this bill, we continue to promote the Health Care Proxy as the gold standard for surrogate decision-making, and we also continue to urge the legislature to find ways to promote the appropriate designation and use of Health Care Proxies. We continue to track this legislation and would consider filing similar legislation in future sessions if it does not pass during this session.</td>
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<tr>
<td>The COL will continue to closely monitor conversations of the MA Coalition for Serious Illness Care (MCSIC) regarding the creation of a statewide registry for Health Care Proxies. As such an initiative would require buy-in from a broad range of stakeholders, the MCSIC provides a valuable opportunity for</td>
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</table>
### Conversation regarding this issue. If the MCSIC ultimately recommends pursuing such policy, COL will engage with coalition members in their advocacy strategy. If they do not, COL will consider filing legislation in the 2019 legislative session.

<table>
<thead>
<tr>
<th>A-17 B Item</th>
<th>Resolution</th>
<th>Report</th>
<th>Recommendation</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 9</td>
<td>Living Will as One of the Several Voices of the Patient</td>
<td>COL Report A-17 B-1 [A-16 A-102]</td>
<td>Adopt (COL’ Recommendation to Not Adopt Resolution A-16 A-102)</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Item 10</td>
<td>Physician-Rating Websites</td>
<td>Resolution A-17 B-209</td>
<td>Referred to the BOT for Report Back at I-17 Update: (Adopted as Amended) (Policy in MMS Policy Compendium)</td>
<td>Communications (in consultation with) The Quality of Medical Practice</td>
<td>I-17</td>
</tr>
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**STATUS:**
Please see COC Report I-17 B-6 in I-17 Delegates’ Handbook or www.massmed.org/recentproceedings.

<table>
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<tr>
<th>A-17 B Item</th>
<th>Resolution</th>
<th>Report</th>
<th>Recommendation</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 11</td>
<td>Scope of Practice</td>
<td>Resolution A-17 B-210</td>
<td>Referred to the BOT for Decision Update: (Adopted)</td>
<td>Board of Trustees (Oct. 2017 BOT Meeting: Legislation)</td>
<td>I-17/I-18</td>
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**STATUS:**
Please see BOT Informational Report I-17-02 in I-17 Delegates’ Handbook or www.massmed.org/recentproceedings.

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<tr>
<th>A-17 B Item</th>
<th>Resolution</th>
<th>Report</th>
<th>Recommendation</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
</table>

**STATUS:**
**Informational Report A-18-08**  
Status/Implementation Chart for 2017 Annual Meeting Resolutions/Reports  
REFERENCE COMMITTEE B: Health Care Delivery

(2) MMS Policy Compendium | A-18 | Ongoing |
|----------------|---------------------------------------------------------------|---------------------|---------|---------------------------------------------------------------|---|-------|

**STATUS:**  
The MMS is contacting both CMS and the Massachusetts Commissioner of Insurance to inform them about the problem and to seek their assistance in addressing this problem. The letter in part states, “Another problem caused by these networks is the financial penalties levied against physicians who refer patients out of the network for necessary care. We believe this is a violation of the patients’ right to access care and physician’s responsibility to help patients receive medically necessary care. At a minimum we believe the process and criteria plans and systems use when out of network care is denied should be transparent, and include an open and easily manageable appeals process to question the decision. We also encourage state regulators to be more vigilant about enforcing rules about network adequacy.” The MMS will continue its advocacy on these issues both with private plans and payors, Medicare Advantage plans and now as part of the implementation of Medicare ACOs.

| A-17 B Item 14 | Hospital Discharge Communications | OMSS Report A-17 B-4 | Adopted | (1) Legislation (and MMS Policy Compendium)  
(2, 4, 5-9) MMS Policy Compendium  
(3) The Quality of Medical Practice, Information Technology (and MMS Policy Compendium)  
(11) Organized Medical Staff Section (and MMS Policy Compendium) | A-18 | Ongoing |
|----------------|-----------------------------------|---------------------|---------|---------------------------------------------------------------|---|-------|

**STATUS:**  
Committee on Legislation  
The MMS has continued to engage with state legislative and regulatory stakeholders to promote interoperability, largely through use the Mass HIway, the state’s health information exchange. MMS has testified and met regularly with staff of the Executive Office of Health and Human Services regarding the implementation of its regulation pertaining to a mandate that all provider use interoperable medical records.

While the Medical Society opposed this policy vehemently, the resulting regulatory process has been an opportunity to engage with the staff of the Mass HIway to promote an approach for physicians to achieve interoperability, either through connection to the exchange via their electronic medical record, or via access to the exchange via a web-mail service offered by the state at a nominal fee. In addition, the Medical Society has engaged with the legislature to urge
them to seek statutory change to extend the function "opt-out" consent policy adopted by the Mass HIway to all health information exchanges in the state. Lastly, the Medical Society continues to monitor the budget of the Mass HIway, and was pleased to see a reallocation of funding included in a recent supplemental budget signed by Governor Baker.

The Quality of Medical Practice
Providers are eager to know when and where their patients get care from someone else. The coordination of care across the health care continuum is crucial to implementation, management, and evaluation of a patient's treatment plan. In addition, communication between providers can reduce money lost to readmissions, medical error, or rejected claims. The MMS will continue to advocate for timely and consistent communication with MassHealth and other payors.

The following are new mechanisms that facilitate communication between providers after discharge. For example, Boston-based PatientPing, which went live in UMass Memorial in June 2016, connects providers across the country instantly. PatientPing informs providers when their patient is admitted to an unaffiliated facility with real-time notifications. This allows providers to connect with each other to discuss treatment options and plans. This technology is primarily aimed at Medicare patients (especially ones with multiple chronic conditions) and providers that are part of ACOs. ACOs, and other emerging payment structures, have financial incentives to manage the care of a specific population of patients. Other companies like PatientPing include Diagnotes and PatientSafe.

Additionally, NEHEN is a consortium of New England regional payers and providers who have designed and implemented a secure and innovative health information exchange for reducing administrative costs while improving the quality, safety, and efficiency of care delivery. Through collaboration of major payers and provider organizations, NEHEN facilitates clinical information exchange both within and between healthcare delivery networks, reducing overall health-related costs. For ACOs, NEHEN will allow providers to track real-time data about a patient. For example, if an ACO member is discharged from the ED or inpatient setting, secure reports that include administrative information and real-time clinical data about the discharge will be available to a care team that can proactively ensure the appropriate aftercare for that patient. This allows ACOs to function more efficiently.

Organized Medical Staff Section
The OMSS is working with legal counsel to update its MMS Model Medical Staff Bylaws (MMSB) to incorporate communication strategies between physicians, hospital staff and administration, and patients to improve discharge planning, process and responsibility as detailed in this adopted report.

Discharge summaries are critical to patients and their families and when they are not coordinated or become very complex, they elicit confusion that can lead to readmission.

Incorporating this policy into the MMSB will support and guide medical staffs as they represent and advocate for their physician members. Additionally, this information and the recommended processes will assist the whole health care team as well as hospital administration, in the delivery of a comprehensive and timely discharge summary for the patient. This item is considered ongoing.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>A-17 B Item 15</td>
<td>Stop the Bleed/Save a Life</td>
</tr>
<tr>
<td>Resolution A-17 B-211</td>
<td>Refer to the BOT for Decision</td>
</tr>
<tr>
<td></td>
<td>Update: (Amended and Reaffirmed in-Lieu-of)</td>
</tr>
<tr>
<td>Board of Trustees (Oct. 2017 BOT Meeting: Preparedness)</td>
<td>I-17/I-18</td>
</tr>
</tbody>
</table>
### A-17 B Item 16

**Telemedicine to Improve Access to Care and Reduce Health Care Disparities**

**COL Report A-17 B-5 [A-16 B-203]**

**Adopted**

**(1, 3) Legislation**

**A-18**

**Ongoing**

### Committee on Legislation

The Medical Society has had a strong advocacy presence on bills related to telemedicine. MMS filed bills in both the House and Senate which would ensure both coverage and reimbursement for telemedicine services. One of the primary barriers preventing the expansion to telemedicine in Massachusetts is the up-front capital expenditures on HIPAA compliant telemedicine platforms. This cost-benefit decision or a physician or physician practice is particularly difficult to make without assurance of reimbursement from insurance companies. MMS has therefore focused its efforts to expand access to telemedicine by focusing on creating an environment where physicians can reasonably predict reimbursement and therefore make capital investments in telemedicine technology.

The Medical Society filed legislation in the state house pertaining to telemedicine this session. The MMS bill would first expand health insurance and Medicaid coverage for the provision of medical care via telemedicine for all appropriate services to the same extent they are covered by a policy for in-person care. While many insurers have independently taken the initiative to cover telemedicine, the bill would ensure consistent coverage for patients in Massachusetts.

The legislation would also require adequate reimbursement for services provided via telemedicine. It would require that reimbursement by carriers for telemedicine services be determined on the same basis as reimbursement for the same in-person services. We believe assurances of adequate reimbursement contained in this bill will help promote more physicians to begin offering telemedicine to their patients.

Lastly, the bill provides the important patient protection of limiting co-payments and deductibles for telemedicine services to no more than the cost sharing for in-person care.

In addition to our stand-alone legislation, the Medical Society has weighed in on many other related legislative proposals, including telemedicine policy contained in multiple iterations of the Senate Cost Containment bill. MMS provided comment on early drafts that did not address reimbursement, and is pleased to see some language related to reimbursement in the final Senate bill. MMS will continue to monitor such bills, including a potential health care cost bill in the House, to advocate for telemedicine laws that ensure both coverage and parity in reimbursement.

### Committee on the Quality of Medical Practice

Massachusetts state law defines telemedicine as “the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment.” Massachusetts is one of many states that has been slow to adopt telemedicine. Even though Massachusetts laws and regulations have not addressed the area in depth, many Massachusetts insurers and providers are pursuing their own experiments with telemedicine and are offering telemedicine services to facilitate care delivery. Harvard Pilgrim Health Care’s Doctor on Demand partnership, BCBS’s American Well partnership, Partner’s TeleHealth, and Beth Israel Deaconess’ Teladoc are just a few examples. Harvard Pilgrim and BCBS cover on-demand (urgent) care and behavioral health consultation (psychologists and psychiatrists). MMS through the Department of Practice Solutions and Medical Economics and the PPRC has ongoing conversations with provider organizations and health plans. In those conversations, MMS continues to monitor the telemedicine services and to advocate for efficacy, safety and
Committee on Information Technology

The MA legislature has not yet passed the current law - it has apparently passed the Senate but not the House. Since MMS policy is to support Telemedicine, CIT feels that it should be considered ongoing until we are satisfied that the initiative is complete. CIT will continue to monitor possible legislative changes in the area of technology that would materially affect the initiative.

| A-17 B Item 17 | Fair Process for Employed Physicians | OMSS Report A-17 B-6 | Adopted | (1) MMS Policy Compendium (2, 3) Organized Medical Staff Section (and MMS Policy Compendium) | A-18 | Ongoing |

**STATUS:**

The OMSS is working with legal counsel to update its MMS Model Medical Staff Bylaws (MMSB) to incorporate whistleblower protections as stated in this report, in order to support and guide medical staffs as they represent and advocate for their physician members.

The situation of a physician raising questions concerning quality, safety or the efficacy of health care should not result in adverse treatment of that physician by the hospital or health care institution and this should be codified in each institution’s Medical Staff Bylaws. The MMS MMSB will recommend that such policy be included during the development or review of each institution’s medical staff bylaws.

In addition to the MMS policy for whistleblower protection for physicians, the OMSS will also include in the MMSB recommendations for the establishment of medical staff forums. It is the belief of the OMSS that such forums will provide an open environment for medical staff members and health care institution’s administration to transparently address such issues, which may ultimately avoid the necessity for whistleblowing. These items are considered ongoing.

| A-17 B Item 18 | Outcomes on A-16 and I-16 Items Referred to BOT for Decision [Item: A-16 B-4, Stark Law and Physician Compensation] | BOT Informational Report A-17-02 | Adopted as Amended | Legislation, The Quality of Medical Practice, Physician Practice Resource Center | A-18 | #s 1, 2, 3 will be completed by end of 2018. |

**STATUS:**


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<th>with) Legislation (2-4) The Quality of Medical Practice</th>
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<td>A-17 C 1</td>
<td>MMS Annual and Three-Year Strategic Plans</td>
<td>CSP Report A-17 C-1</td>
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<td>MMS Presidential Officers</td>
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<tr>
<td>A-17 C 2a</td>
<td>Policy Sunset Process (Reaffirmed for 7 Years)</td>
<td>OFFICER Report A-17 C-2 (SECTION A)</td>
<td>Adopted</td>
<td>MMS Policy Compendium</td>
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<td>A-17 C 2b</td>
<td>Policy Sunset Process (Policies Amended)</td>
<td>OFFICER Report A-17 C-2 (SECTION B)</td>
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<td>MMS Policy Compendium</td>
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<td>A-17 C 2c</td>
<td>Policy Sunset Process (Reaffirmed for 1 Year)</td>
<td>OFFICER Report A-17 C-2 (SECTION C)</td>
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<td>3c. Prescription Marketing</td>
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<td>4c. Ethics and Managed Care</td>
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<td>Ethics, Grievances, and Professional Standards, The Quality of Medical Practice</td>
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<td>6c. Principles on Medical Professional Review of Physicians</td>
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<td>Ethics and Grievances, The Quality of Medical Practice</td>
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<td>5c. Physician Call</td>
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<td>7c. Third Party Insurers</td>
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<td>The Quality of Medical Practice, Legislation</td>
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### Status/Implementation Chart for 2017 Annual Meeting Resolutions/Reports

**REFERENCE COMMITTEE C: MMS Administration**

<table>
<thead>
<tr>
<th>A-17 C Item 3</th>
<th>Opioids and Substance Use Disorder Policy</th>
<th>TFOTP Report A-17 C-4</th>
<th>Adopted</th>
<th>Committee on Violence Intervention and Prevention (and MMS Policy Compendium)</th>
<th>Ongoing</th>
</tr>
</thead>
</table>

**STATUS:**

Members of the Committee on Violence Intervention and Prevention have reached out to experts in the area of bullying, including those with special knowledge in social media, trauma informed approaches, workplace harassment, and the overall current state of bullying. Members have also sought out policy statements regarding bullying from other medical specialty societies, including the American Academy of Pediatrics. At the time of this report writing, plans are being solidified for an hour and a half webinar, with plans to submit planning documents to the Committee on Sponsored Programs by the April 24 deadline.

**STATUS:**

The opioid abuse epidemic continues to be the Society’s highest public health priority issue. The Task Force on Opioid Therapy determined three priorities for 2017-2018:

- management of chronic pain
- access to medication assisted treatment
- improved access to naloxone

**Highlights**

**Pain Management**

Physicians seeking other methods of treatment for their patients need the resources to provide care for patients reflecting the best evidence based practice. Incorporating treatments such as acupuncture, physical therapy and cognitive behavior therapy must be made accessible and affordable. MMS leadership participated in meetings with payors to advocate for appropriate coverage for non-opioid treatment of pain. The Task Force met with the Massachusetts Health Quality Partnership regarding initiatives addressing pain and the physician/patient experience.

**Medication Assisted Treatment**

To improve access to medication assisted treatment, accessible professional education and mentoring need to be provided to all physicians in
Informational Report A-18-08
Status/Implementation Chart for 2017 Annual Meeting Resolutions/Reports
REFERENCE COMMITTEE C: MMS Administration

all specialties. MMS is working with DPH and other stakeholders to conduct a needs assessment of physicians to determine barriers to MAT prescribing.

Access to Naloxone
The MMS strongly advocates for affordable access to naloxone, and is working with payers to include naloxone with minimal or no cost sharing. MMS has met with DPH Bureau of Substance Abuse Services to learn more about access points to naloxone and how to communicate with physicians and patients. MMS has focused efforts on educating the public about naloxone, including producing a PSA to demonstrate use.

Supervised Injection Facilities
MMS continues to educate and advocate regarding this harm reduction model to address substance use disorder, engage vulnerable individuals in the health care system, transition individuals into treatment and save lives.

Other
MMS offers comprehensive CME courses at no cost to all physicians nationally. As of the end of February 2018, 1,990 courses have been completed by 881 individual users in 2018. In total since May 2015, 42,953 courses have been completed by 15,806 individual users.

Worked with the Department of Public Health and the Massachusetts Hospital and Hospital Association (MHA) to introduce the core medical school curriculum into residency training.

Worked with the MHA to develop and disseminate a physician and patient fact sheet, tools to use when prescribing opioids. Received a grant from the MetroWest Health Foundation to translate the patient materials into Spanish and Portuguese and further disseminate the materials in specific geographic regions.

Provided MMS opioid prescribing guidelines, and physician and patient fact for a NEJM direct mail marketing campaign to physicians outside of Massachusetts,

Co-sponsored a course on caring for patients with difficult-to-treat infections complicated by substance use disorder.

STATUS:
The Committee on Geriatric Medicine has a long-held interest in collaborating with other appropriate health care organizations, and state and private agencies, to educate, inform, and highlight the importance of completing advance directives, including healthcare proxies, for anyone 18 years of age and older. The MMS has partnered with Honoring Choices Massachusetts in bringing advance directive education and tools (in many languages) to members and patients alike. Similarly, the MMS has engaged with the Massachusetts Coalition for Serious Illness Care, committing to educating our staff, Board members, and physician membership on proxy use and completion.

The Committee on Public Health concurs, noting that it should be the work of the medical community to de-stigmatize end-of-life discussions and decisions. Refinement of end of life tools, along with comprehensive education programs, would be of benefit. Online tools and documents are available through the MMS and other organizations.

A-17 C Item 7
Physician Call Policy
(Policy Sunset Process: Reaffirmed for One Year at A-17 Pending Review)

CQMP/TFPCC Report A-17 C-7 [A-16 C-6]
Adopted
(1, 2a) Organized Medical Staff Section (and MMS Policy Compendium)
(2b-2e) MMS Policy Compendium
A-18
Ongoing

STATUS:
OMSS
The OMSS is working with legal counsel to update its MMS Model Medical Staff Bylaws (MMSB) to incorporate the policy adopted at A-17 regarding Physician Call, and on-call policies as they relate to their institution. This information is important to support and guide medical staffs as they represent and advocate for their physician members.

This information must be consistent with EMTALA requirements, and if there are state-based EMTALA laws. The MMS MMSB will recommend that such policies be included during the development or review of each institution’s medical staff bylaws. This information should also be included in the hospital bylaws and the emergency department policies regarding on-call physician responsibilities. These recommendations and processes are critical in meeting the needs of our patients and the community, especially with the most vulnerable in underserved populations.

Communicating the important work of the Committee on the Quality of Medical Practice and the Task Force on Physician Call Compensation in response to the Committee on Strategic Planning’s Report from A-16 C-6 is the reason that the OMSS wants to have this information included in the Model Medical Staff Bylaws. Educating medical staffs and hospital administration will lead to creating collaborative policies that will be reflective in the appropriate governing documents and lead to successful solutions.

A-17 C Item 8
Physician Payment/Capitation Policies
(Policy Sunset Process: Reaffirmed for One Year at A-17 Pending Review)

CQMP Report A-17 C-8 [A-16 C-6]
Adopted
MMS Policy Compendium
(1e) Legislation (in consultation with) The Quality of Medical Practice (and MMS Policy Compendium)
A-18
Ongoing
**STATUS:**
**Committee on Legislation**
MMS continues to support multiple payment options for MD reimbursement including risk based contracting, global payments and fee for service. Most national health insurance carriers Unicare,(Anthem), United, Cigna Aetna and Medicare continue to reimburse on a fee for service basis. As payers move to value based insurance design, MMS will continue to advocate for Fee for Service as an option.

MMS advocacy at the federal level has consistently fought for the retention a fee-for-service reimbursement in any new payment or delivery system reforms. During the development of the legislation which ultimately resulted in MACRA and throughout the development of the regulations to implement the new law the MMS joined with the AMA and other national medical organizations in fighting for retaining fee for service as one of the two Medicare payment options. The MMS has always maintained that “one size does not fit all” and that’s fee-for-service must be continued even in the era of a capitation, bundled payments and new payment and delivery systems.

<table>
<thead>
<tr>
<th>Item</th>
<th>Resolution</th>
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<th>Committee</th>
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<tbody>
<tr>
<td>A-17 C Item 9</td>
<td>The Boston Medical Library is the Library of the Massachusetts Medical Society</td>
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<td>Bylaws</td>
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<td>Item 10</td>
<td>Reevaluation of the MMS Voucher Program</td>
<td>Adopted</td>
<td>MMS Presidential Officers, Administration and Management</td>
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<tr>
<td>Item 11</td>
<td>MMS Leadership Promotion and Governance</td>
<td>Referred to the BOT for Report Back at A-18</td>
<td>MMS Presidential Officers, Task Force on Governance</td>
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</table>

**STATUS:**
Please see COB Report I-17 C-2 in I-17 Delegates’ Handbook or www.massmed.org/recentproceedings.

Please see OFFICER/COAM Report I-17-07 in I-17 Delegates’ Handbook or www.massmed.org/recentproceedings.

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<th>Item</th>
<th>Bylaws Changes</th>
<th>COB Report A-17 C-11</th>
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<th>(Update MMS Bylaws and Acts of Incorporation)</th>
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<td>COB Report A-17 C-11</td>
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<td>13</td>
<td>*Membership Dues for Calendar Year 2018</td>
<td>COF Report A-17 C-12</td>
<td>Adopted</td>
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<td>14</td>
<td>*Delegates-at-Large</td>
<td>BOT Report A-17 C-13</td>
<td>Adopted</td>
<td>(NA)</td>
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### Informational Report A-18-09
**Status/Implementation Chart for 2017 Interim Meeting Resolutions/Reports**
**REFERENCE COMMITTEE A: Public Health**

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<td>I-17 Item 2</td>
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<td>I-17</td>
<td>Availability of Intramuscular and Subcutaneous Forms of Naloxone for First Responders and Cost of Auto-Injectors</td>
<td>Resolution I-17 A-101</td>
<td>Adopted as Amended</td>
<td>Task Force on Opioid Therapy and Physician Communication</td>
<td>I-18</td>
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<td>I-17 Item 3</td>
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<tr>
<td>I-17</td>
<td>Naloxone Training for Massachusetts Medical Students</td>
<td>Resolution I-17 A-102</td>
<td>Adopted as Amended</td>
<td>Task Force on Opioid Therapy and Physician Communication</td>
<td>I-18</td>
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<td>I-17 Item 4</td>
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<td>I-17</td>
<td>Medical Aid-in-Dying Survey</td>
<td>OFFICERS Informational Report I-17 06 [I-16 A-102]</td>
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<td>I-17</td>
<td>Engaged Neutrality on Medical Aid-in-Dying</td>
<td>Resolution I-17 A-103</td>
<td>Adopted as Amended</td>
<td>(MMS Policy Compendium) (1) (1a-6) MMS Presidential Officers (5)</td>
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<td>I-17 Item 5</td>
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**STATUS:**
MMS President Dr. Henry Dorkin, sent a letter ([http://www.massmed.org/MAIDPolicyAMA/](http://www.massmed.org/MAIDPolicyAMA/)) dated March 8, 2018, to Dennis S. Agliano, MD, FACS, Chair, Council on Ethical and Judicial Affairs, at the American Medical Association explaining MMS’s change in position and new policy on medical-aid-in-dying.
<table>
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<tr>
<th>Item 6</th>
<th>Medical Parole for the Incapacitated and Terminally Ill</th>
<th>Resolution I-17 A-104</th>
<th>Adopted as Amended</th>
<th>Legislation</th>
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<tr>
<td>Item 7</td>
<td>Urine Drug Screens in Prisoners</td>
<td>Resolution I-17 A-105</td>
<td>Referred for Report Back at I-18</td>
<td>Public Health</td>
<td>I-18</td>
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<tr>
<td>Item 8</td>
<td>Supporting &quot;Good Samaritan&quot; Access to Naloxone by Physicians</td>
<td>Resolution I-17 A-106</td>
<td>Adopted as Amended</td>
<td>The Quality of Medical Practice</td>
<td>A-18</td>
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</tbody>
</table>

**STATUS:**
The MMS composed a letter ([http://www.massmed.org/naloxone/](http://www.massmed.org/naloxone/)) that is being sent to all the health plan medical directors and the life insurance association in Massachusetts. The letter discusses the benefits of naloxone for addicted patients and encourages and advocates for these companies to be supportive of and not penalize or discriminate against individuals who choose to purchase naloxone for “Good Samaritan” purposes.
<table>
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<tr>
<th>Item #</th>
<th>Title</th>
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<th>Action</th>
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<td>I-17</td>
<td>Unbundling Postpartum Contraception from the Global Delivery Payment</td>
<td>Resolution I-17 B-201</td>
<td>Adopted as Amended</td>
<td>The Quality of Medical Practice Legislation</td>
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<td>I-17</td>
<td>Retraining of Immigrant Physicians</td>
<td>Resolution I-17 B-202</td>
<td>Referred to the BOT for Report Back at I-18</td>
<td>IMG Section Legislation</td>
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<td>I-17</td>
<td>Conference on Universal Health Care</td>
<td>Resolution I-17 B-203</td>
<td>Adopted as Amended</td>
<td>Medical Education (In consultation with) MMS Departments of: Advocacy, Government &amp; Community Relations; Health Policy and Public Health; and Practice Solutions &amp; Economics</td>
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<td>I-17</td>
<td>Permitting Massachusetts Physicians to Dispense Prescription Medications from the Office</td>
<td>CSPP Report I-17 B-1</td>
<td>Adopted</td>
<td>Legislation</td>
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<tr>
<td>I-17</td>
<td>Support for Patients and Physicians in Direct Primary Care</td>
<td>CSPP Report I-17 B-2</td>
<td>Adopted as Amended</td>
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<td>I-17</td>
<td>Promoting a Model Medical Staff Code of Conduct and Its Application to Employed Physicians</td>
<td>OMSS Report I-17 B-3</td>
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<td>Organized Medical Staff Section (1) Legislation (2)</td>
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<td>Item 7</td>
<td>Prescription Availability for Weekend Discharges</td>
<td>OMSS Report I-17 B-4</td>
<td>Adopted</td>
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<td>Timeliness in Obtaining Medical Records from Other Providers</td>
<td>OMSS Report I-17 B-5</td>
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<td>Organized Medical Staff Section (1) The Quality of Medical Practice (2) (in consultation with) MMS Office of the General Counsel</td>
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<td>Item 9</td>
<td>Physician-Rating Websites</td>
<td>COC Report I-17 B-6 [A-17 B-209]</td>
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<td>(MMS Policy Compendium)</td>
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<td>Item 10</td>
<td>Independent Surgi-centers Are Safe and Cost Effective</td>
<td>COL Report I-17 B-7 [I-16 B-207]</td>
<td>Adopted (COL’s Recommendation to Not Adopt)</td>
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## Reference Committee C: MMS Administration

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<td>I-17 C</td>
<td>Strengthening the Medical Malpractice Tribunal</td>
<td>CPL Report I-17 C-1</td>
<td>Adopted as Amended</td>
<td>Professional Liability</td>
<td>A-18</td>
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<td>I-17 C</td>
<td>MMS Former Speakers and House of Delegates</td>
<td>Resolution I-17 C-301</td>
<td>Referred to BOT for Report Back</td>
<td>MMS Presidential Officers</td>
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<td>COB Report I-17 C-2</td>
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<td>I-17 C</td>
<td>Special Committee Renewals</td>
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**STATUS:**
Please see COPL Informational Report A-18-06 in A-18 [Delegates’ Handbook](#).