## Reference Committee C — MMS Administration

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* (Placed on Speakers’ Consent Calendar)
Background
The MMS Committee on Strategic Planning (CSP), a committee of the Board of Trustees (BOT), with broad-based input from MMS leadership, MMS membership, MMS staff, external experts, and informed by comprehensive primary and secondary research, determines the strategic priorities for the Society. These are presented to the House of Delegates (HOD) annually for endorsement, with a comprehensive report about the health care environment. The following report contains the recommendations for A-18.

The one- and three-year strategic plans (see Appendix A for previous plans) continue to provide guidance to leadership, committees, and staff when assessing the resources and initiatives needed to address day-to-day issues and for planning for the future needs of the Society. While MMS officers and senior management use these strategic priorities to develop tactics that guide the Society’s internal and external actions, changes in the environment may require different tactics, scheduling, or focus. Therefore, to be most effective, the strategic planning process must continue to evolve.

Process
As part of the annual strategic planning process, the CSP provides a comprehensive review of the local and national health care environment (see Appendix B), paying specific attention to issues and concerns facing Massachusetts physicians and their patients. As part of this process, in the fall of 2017, the chair and vice chair arranged for a facilitated discussion among members of the CSP about the key issues facing physicians in today’s health care landscape. In addition, the CSP held a retreat in November 2017 to participate in an overview of the health care environment and to continue the discussion about challenges experienced by today’s physicians. Finally, the issues raised during those discussions, coupled with the overview of the health care environment, were synthesized into a recommendation for the key strategic priorities for 2018–2019.

Conclusion
Both physicians and patients are being forced to continue to manage increasing demands from the government, payers, and the marketplace, while balancing costs, quality, and risk. The attached report (Appendix B) covers a wide range of issues detailing the current pressures on the health care environment. The Massachusetts Medical Society is well-positioned to serve as a strong advocate for physicians and patients, providing the leadership needed to navigate rapid, complex change. By focusing on its strategic priorities (sustainable health care delivery, practice viability, and preservation of professionalism) through its commitment to physician and patient...
advocacy, membership value and engagement, and professional knowledge and satisfaction, the Society is working toward fulfilling its mission as an organization:

“The purposes of the Massachusetts Medical Society shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit and welfare of the citizens of the Commonwealth.”

Commonwealth of Massachusetts Act of Incorporation, Chapter 15, Section 2 of the Acts of 1781

Recommendation: One Year Strategic Priorities for Fiscal Year 2018–2019

The Society’s strategic priorities for Fiscal Year 2018–2019 include a focus on physician and patient advocacy, membership value and engagement, and professional knowledge and satisfaction. In order to advance the Society’s mission and serve the needs of the physician community and their patients, the goals of our one-year strategic plan will be the following:

- **Physician and Patient Advocacy**: As a trusted and respected leadership voice in health care, ensure that the perspectives of physicians and patients are represented at the state and national level on the most important issues impacting physicians, the health care environment, and patient care and outcomes.

- **Membership Value and Engagement**: Ensure that the Society is positioned to meet the changing needs of physicians across all demographic segments and practice settings. Align member benefits, services, and communication channels with the needs of the physicians we serve, creating a clear membership value proposition. Ensure that the Society’s governance structure maximizes membership growth, diversity, and engagement and expands access to leadership opportunities. Ensure that communication engages physicians and promotes the Society’s efforts and achievements.

- **Professional Knowledge and Satisfaction**: Advance medical knowledge to develop and maintain the highest standards of medical practice and health care. Support members in developing the skills and knowledge they need to further learning, transform the practice of health care, and achieve lifelong professional growth. Build and promote a sense of community, professional satisfaction, and meaning in practice through support, networking, mentoring, education, and physician wellness programs. Support physicians in building strong patient-physician relationships.
Recommendation:
1. That the Massachusetts Medical Society’s strategic priorities for Fiscal Year 2018–2019 are the following: a focus on physician and patient advocacy, membership value and engagement, and professional knowledge and satisfaction. In order to advance the Society’s mission and serve the needs of the physician community and their patients, the goals of our one-year strategic plan will be the following:

- **Physician and Patient Advocacy:**
  - As a trusted and respected leadership voice in health care, ensure that the perspectives of physicians and patients are represented at the state and national level on the most important issues impacting physicians, the health care environment, and patient care and outcomes.

- **Membership Value and Engagement:**
  - Ensure that the Society is positioned to meet the changing needs of physicians across all demographic segments and practice settings.
  - Align member benefits, services, and communication channels with the needs of the physicians we serve, creating a clear membership value proposition.
  - Ensure that the Society’s governance structure maximizes membership growth, diversity, and engagement and expands access to leadership opportunities.
  - Ensure that communication engages physicians and promotes the Society’s efforts and achievements.

- **Professional Knowledge and Satisfaction:**
  - Advance medical knowledge to develop and maintain the highest standards of medical practice and health care.
  - Support members in developing the skills and knowledge they need to further learning, transform the practice of health care, and achieve lifelong professional growth.
  - Build and promote a sense of community, professional satisfaction, and meaning in practice through support, networking, mentoring, education, and physician wellness programs.
  - Support physicians in building strong patient-physician relationships.

**Fiscal Note:**
No Significant Impact

**Out-of-Pocket Expenses**

**FTE:**
Existing Staff

**Staff Effort to Complete Project**
APPENDIX A
Massachusetts Medical Society One-Year (2017–2018)
and Three-Year (2017–2020) Strategic Plans

The one-year strategic plan, adopted at A-17, is as follows:

- **Physician and Patient Advocacy**: Ensure that the Society is a productive and credible leadership voice for physicians and patients. The Society will continue to monitor the impact of the rapidly transforming health care landscape, advocate to improve the practice environment, and work toward improved patient care and outcomes. Ensure that the voices of physicians and patients are heard during the health care reform debate, while promoting transparency and addressing barriers that impede access to quality care, such as excessive regulations and administrative burdens.

- **Membership Value and Engagement**: Ensure that the Society is positioned to meet the changing needs of its members. Support members in developing the skills and knowledge they need to continue to be successful practitioners, leaders and patient advocates. Create opportunities to grow, diversify, and engage membership across all demographic segments and practice settings. Enhance member participation through innovative education, support, mentoring, and networking opportunities.

- **Governance**: Ensure that the Society stays relevant and is structured to maximize membership growth, diversity, and engagement. Look for ways to create meaningful local and remote participation and promote physician engagement and leadership opportunities.

- **Communication**: Ensure two-way communication that fulfills the needs of our physician members, promotes the Society’s efforts and achievements, and positions the Society as a leadership voice in health care, working on behalf of all physicians and patients. Enhance engagement through social media, online channels, marketing, collaboration, support, mentoring, and networking.

The three-year strategic plan, adopted at A-17, is as follows:

The Massachusetts Medical Society’s strategic priorities for Fiscal Years 2017–2020 are rooted in the long-term objective of quality improvement and the effective control of health care costs, with a focus on sustainable health care delivery, practice viability, and preservation of professionalism. In order to advance the mission of the Society and prepare for the future needs of the physician community and their patients, the three-year strategic priorities are as follows:

- **Sustainable Health Care Delivery**: Play a leadership role in developing a sustainable model of health care delivery by promoting the integration of public health, behavioral health, and the social determinants of health across physician practices; engage physicians and patients in end-of-life and aging patient care issues; develop resources and tools on marijuana and opioid use, misuse, dependence, and abuse; and promote physician-led care teams in support of improved patient care and outcomes.

- **Practice Viability**: Advocate for practice viability and physician professionalism, including the fair practice of clinical and economic integration, appropriately funded
mandates, professional liability reform, a sustainable physician workforce, and an optimal practice environment, which, among other things, combats physician burnout.

- **Preservation of Professionalism**: Advocate for health care settings that foster a culture of professionalism to ensure patient-centered, physician-led care teams; promote a sense of community, professional satisfaction, and meaning through physician wellness, education, training, support, mentoring, and networking opportunities.

*MMS House of Delegates, 4/29/2017*
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APPENDIX B
The Massachusetts Medical Society and the
National and Local Health Care Environment

INTRODUCTION AND SUMMARY

As part of the annual strategic planning process, the Committee on Strategic Planning (CSP) provides the following comprehensive review of the local and national health care environment. The Affordable Care Act (ACA) has significantly improved health insurance coverage rates across the nation, and Massachusetts continues to lead the nation with the highest insurance coverage rate. Overall, access to care is strong in Massachusetts. However, some access issues persist, particularly with respect to timely access to care.

Given the improvements in coverage and the resulting demand for physicians to care for the newly insured, it is not surprising that the Association of American Medical Colleges (AAMC) projects a significant national physician workforce shortage. Beyond workforce and access issues, health care will likely experience uncertainty in the years ahead, given the many changes occurring under health reform and emerging innovations. Health industry experts are optimistic that the health care system will remain resilient if it can manage to collaborate across sectors, make new strategic investments and create efficiencies.

Among the topics addressed in this report:

- **Health care spending.** Slowing the growth in health care spending remains a key concern of policymakers at the local and national level. In Massachusetts, physicians play a leadership role in containing costs as the industry moves toward alternative payment methodologies that emphasize high-quality, efficient care. Insurance coverage in Massachusetts and around the nation continues to improve; however, the trend toward rising insurance premiums and increased cost-sharing continues to create financial pressure and impact patients’ access to care.

- **Complexity, change, and uncertainty.** Physicians and their patients face a health care system undergoing rapid change, resulting in increased uncertainty. To understand and address the complexity of today’s health care environment, the MMS collaborates with a variety of stakeholders, including payers, policy experts, physician-leaders, and practicing physicians in the community, to gather and analyze information to strategically inform and target its efforts.

- **MMS activities and services.** This report also highlights MMS activities, collaborations, and partnerships undertaken to advocate for and address the shared interests of physicians and their patients within the current landscape. The MMS directly supports physicians and patients in several ways, including:
  
  - Conducts research to examine physician practice challenges and sustainability issues, and conducts surveys on focused topics such as physicians’ opinions on medical aid-in-dying;
  - Builds an active membership base through enrollment and outreach efforts, resulting in an all-time high of 25,277 members;
As a leadership voice in health care, the Massachusetts Medical Society is dedicated to educating and advocating for the physicians of Massachusetts and patients locally and nationally. This report reflects the challenges present in today’s health care environment and summarizes the ways in which the MMS is responding to those challenges, by influencing health-related legislation at the state and federal levels, working in support of public health, providing expert advice on physician practice management, and addressing issues of physician well-being.

NATIONAL OVERVIEW

Since the passage of the Affordable Care Act (ACA) in 2010, the percentage of people of all ages who are uninsured has declined and currently stands at 9%.¹ The rate of adults aged 18–64 who are uninsured has decreased to 12.5%. The percentage of adults with public coverage has increased to 19.2%, while those covered by private insurance stands at 69.6% (see trends in coverage for adults in Figure 1 next page).²

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² Ibid.
Post-ACA, the percentage of adults who were uninsured has declined most dramatically for young adults aged 18-24, which is not surprising given the ACA provision that extended dependent child coverage up to age 26. Figure 2 (next page) outlines the long-term declines in uninsurance rates for each adult age group showing that age is inversely related to percentage declines in uninsurance.

Five percent of children aged 0-17 are currently uninsured, which is an all-time low for this population. Experts credit the ACA with an increase in insurance rates led by expansions in children’s coverage under Medicaid, CHIP, the ACA marketplaces, and subsidies. The ACA has also resulted in more streamlined insurance enrollment and renewal processes, and more focused outreach and enrollment efforts for low-income children and their families. Nine million U.S. children are covered by the Children’s Health Insurance Program (CHIP), low-cost health coverage to children in families that earn too much money to qualify for Medicaid. Congress has passed a ten-year extension of CHIP funding, providing stable funding for the program, which had expired in September 2017.

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3 Ibid.
4 Ibid.
5 Ibid.
According to health industry experts from the Price Waterhouse Coopers Health Research Institute, an organization that advises executive decision-makers about health care, 2018 will be “a year of resilience amid uncertainty,” in which the challenges of the uncertainties inherent in the current health care market have the potential to drive innovation and improvement for the overall system, as well as the health and well-being of patients across the country. However, these positive outcomes will likely be predicated on health organizations collaborating across sectors, making new strategic investments, and creating efficiencies (see Figure 3 next page).

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9 Ibid.
Figure 3: Health care businesses should focus on three key areas to overcome risks and uncertainty in 2018

These experts maintain that collaborations across sectors include efforts to address the opioid crisis and social determinants of health, natural disasters, and the rising cost of prescription drugs via state legislation. Strategic investments will likely be needed in Medicare Advantage, Medicare benefits provided through private health plans, as enrollment rates continue to climb. On average, one-third of U.S. Medicare beneficiaries are enrolled in these private Medicare Advantage plans. Figure 4 (next page) provides an overview of enrollment in Medicare Advantage plans by state, with Massachusetts enrollment at 21%, falling well below the national average of 33%.

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10 Ibid.
These experts believe that health reform efforts could grow more uncertain—and, therefore, more complicated—while threats to cybersecurity associated with health care data breaches multiply. Meanwhile, strategic investments will need to also focus on patient engagement to ensure that patients are motivated to get healthy and maintain wellness. For example, physician and other provider reimbursements under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will be tied to, among other measures, patient engagement measures that include promotion of self-management and coaching patients, measures not traditionally used by the health care industry, which has been more focused on other quality measures such as patient satisfaction scores.\(^{11}\) Creating more efficiency in health care will likely be focused on the integration of artificial intelligence into the health care workforce while health care industry middlemen, such as pharmacy benefit managers and wholesalers, will have to prove their value or be eliminated. Real-world data will likely take center stage as changes in the FDA approval process under the 21st Century Cures Act extend beyond the submission of random control trial data to secure approval. Further, tax reform will likely impact business strategies for health care organizations in the new year.\(^{12}\)

### Health Care Spending

In 2016, U.S. health care spending increased 4.3%, similar to the average annual growth rate of 4.2% during the 2008-2015 period, but down from 5.1% in 2014 and 5.8% in 2015. Current spending has reached $3.3 trillion, or $10,348 per person, which is $354 higher than per-capita spending in 2015 and accounts for 17.9% of the health care-

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\(^{11}\) Ibid.  
\(^{12}\) Ibid.
related portion of the gross domestic product (GDP).\textsuperscript{13, 14} This was a deceleration of health spending growth, down from the faster spending growth of 5.1% in 2014 and 5.8% in 2015, attributed to ACA expansions and prescription drug growth spending.\textsuperscript{15}

The slowdown in spending for 2016 was broadly based with decelerating spending growth across all major payers as enrollment growth from the Affordable Care Act slowed. Retail prescription drug spending declined as a result of a decline in Hepatitis C drug spending, the introduction of fewer drugs compared to last year, and slower growth in drug prices. Hospital care and physician and clinical services also contributed to the deceleration in health spending growth due to slower growth in use and intensity of services.\textsuperscript{16} Figure 5 provides an overview of the growth in spending over time for total health expenditures as well as for hospital, prescription drug, and physician and clinical expenditures since the passage of the ACA in 2010.\textsuperscript{17}

\textbf{Figure 5}

![National Health Expenditures Growth in Spending Over Time by Type of Service]

Source: MMS staff analysis of CMS NHE data published in Health Affairs, January 2018.\textsuperscript{18}


\textsuperscript{16} Ibid.

\textsuperscript{17} Ibid.

\textsuperscript{18} Ibid.
Total spending for physician and clinical services increased more rapidly than any of the other health care goods and services categories in 2016, reaching $665 billion and accounting for 20% of total health spending as outlined in Figure 6.\textsuperscript{19}

\textbf{Figure 6}


Note: Physician and Clinical Services covers services provided in establishments operated by Doctors of Medicine (M.D.) and Doctors of Osteopathic Medicine (D.O.), and outpatient care centers, plus the portion of medical laboratories services that are billed independently by the laboratories. This category also includes services rendered by a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) in hospitals, if the physician bills independently for those services. Clinical services provided in freestanding outpatient clinics operated by the U.S. Department of Veterans’ Affairs, the U.S. Coast Guard Academy, the U.S. Department of Defense, and the U.S. Indian Health Service are also included. The establishments included in Physician and Clinical Services are classified in NAICS 6211-Offices of Physicians, NAICS 6214-Outpatient Care Centers, and a portion of NAICS 6215-Medical and Diagnostic Laboratories.\textsuperscript{20}

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.


\textsuperscript{20} Ibid.
For the twelfth year in a row, total spending growth for clinical services has outpaced total spending growth for physician services. Clinical services accounts for about 20% of the total spending in the physician and clinical services category and increased by 8.2% in 2016. This growth was driven by spending for freestanding ambulatory surgical and emergency centers, compared to a growth in spending for physician services of 4.6% in 2016. Medicare and Medicaid experienced slower growth in physician and clinical services spending in 2016 compared to 2015, driven by the slowdown in physician spending under Medicare Advantage and slower growth in spending for physician and clinical services in Medicaid due to a slowdown in enrollment. Figure 7 shows the change in Medicare payments by type of service over the last decade. The portion of payments to physicians has declined by 6% between 2006 and 2016, while the percentage of payments for outpatient prescription drugs and Medicare Advantage plans has grown over time.\(^{21}\)

**Figure 7**

**Medicare Benefit Payments by Type of Service, 2006 and 2016**

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<th>Service Type</th>
<th>2006</th>
<th>2016</th>
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<td>Hospital inpatient services</td>
<td>32%</td>
<td>21%</td>
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<tr>
<td>Physician payments</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>Outpatient prescription drugs</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Hospital outpatient services</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Skilled nursing facilities</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Home health services</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Other services*</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>15%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Note:** *Consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services.

**Source:** Congressional Budget Office, June 2017 Medicare Baseline.

Despite slower growth for physician and clinical services under Medicare and Medicaid, a national survey indicates that more than two-thirds of responding physicians are continuing to take new and current Medicare/Medicaid patients (see Figure 8 next page).

With major ACA expansions in health insurance enrollment complete and 91% of U.S. residents now covered by health insurance, spending growth for health care at the national level will continue to decelerate and will likely return to being influenced primarily by fluctuations in the economy and demographics as it has in the past.22

Physician Workforce

The Association of American Medical Colleges (AAMC) projects a shortage of between 40,800 and 104,900 physicians by 2030.23 Nationally, primary care shortfalls are expected to range between 7,300 and 43,100 physicians by 2030, while demand for non-primary care physicians will exceed supply by approximately 33,500 to 61,800 physicians.24 Population growth and aging are the main demand drivers in the projected shortfalls, with the population aged 65 and older projected to grow by 55%; physician retirements are the main driver impacting supply. The ratio of physicians to APRNs and PAs will fall, while a focus on population health will result in a reduction in the short-term demand for physicians – giving way to an increase in long-term demand for more physicians as these improvements cause Americans to live longer.25

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24 Ibid.
25 Ibid.
In 2017, the average cost of annual premiums for single coverage increased by 4% to $6,690; the cost increased by 3% to $18,764 for family coverage (Figure 9).26

**Figure 9**

Average Annual Premiums for Single and Family Coverage, 1999-2017

- High-deductible health plan premiums were lower for single and family coverage – $6,024 for single coverage and $17,581 for family coverage.27
- Over the past ten years, average family premiums have increased by 55%, while worker contributions toward premiums have increased by 74% (see Figure 10 next page).


27 Ibid.
The number of workers enrolled in employer-sponsored, high-deductible health plans continues to grow, increasing by eight percentage points since 2014.\(^{28}\) Cost-sharing continues to be an issue of concern under both public and private plans and policymakers are concerned that the American public will not have enough savings to meet these out-of-pocket charges. A 2016 national study found that about 40% of all households with private insurance coverage and incomes between 150% and 400% of the federal poverty line do not have enough liquid assets to cover the average employer-provided deductible of $1,500 for single people and $3,000 for families.\(^ {29}\) The White House Administration’s recent decision to stop ACA cost-sharing subsidies to low-income people will likely further negatively impact the affordability of health insurance for patients across the nation. Health insurers warn that the decision to stop these subsidies will likely result in an increase in health insurance costs, less consumer choice for insurance products, and a negative impact on the stability of the insurance marketplace.\(^ {30}\)

\(^{28}\) Ibid.


Given that cost concerns continue to grow among the public, it is encouraging to note that three out of four physicians indicate that they are talking with their patients about health care costs. As outlined in Figure 11, more than one-third of physicians responding to a national survey indicated that they regularly speak to their patients about costs, while an additional 40% speak to their patients about cost occasionally.31

**Figure 11**

![Diagram showing the percentage of physicians discussing costs with patients](image)

Source: Medscape Physician Compensation Report 2017

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**MACRA**

The transition to the new Medicare payment system for physicians under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP) was ongoing in 2017, with “Pick your Pace” decisions made by physicians this past year impacting their payments in 2019. The "Pick your Pace" program was designed to allow physicians to participate in the QPP while minimizing penalties for those who were new to reporting quality and other metrics. As we enter the second year of MACRA implementation, the MMS continues to work closely with other medical societies to refine the QPP requirements and implementation process. The recently finalized CMS regulations to the QPP program include a number of provisions recommended by physicians, such as raising the threshold level for non-participation in the QPP for small practices and an expanded definition of who qualifies as a small practice.

practice, among others. The MMS is also supporting federal legislation that would, among other provisions, allow CMS more time to accurately develop episodic groupers to implement the cost-measure component of MACRA. The MMS worked closely with the local QIO-QIN and contracted with CMS to educate small and large practices on QPP implementation. The MMS will continue its partnership in this area on behalf of practices.

**Accountable Care Organizations (ACOs)**

Findings from the 2017 Medscape Physician Compensation Survey indicate that participation by physicians in ACOs is on the rise nationally, with more than one-third of physicians participating in ACOs, up from less than 3% five years ago (see **Figure 12**).

**Figure 12**

![Physician Participation in Various Payment Models]

Source: Medscape Physician Compensation Report 2017

**Physician Compensation**

Nationally, physician salaries are on the rise, according to the Medscape Physician Compensation Survey (see **Figure 13** next page). According to researchers, the increase in salaries is due to competition among health systems that employ physicians, including hospitals and health care systems, urgent care centers, and community health centers, that are driving up demand for physician services.\(^32\)

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National survey data indicate that average annual full-time compensation is higher for specialist physicians compared to primary care physicians (see Figure 14 next page).  

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Figure 14

Burnout and administrative burdens continue to plague physicians. The Medscape Lifestyle Report 2017 found that burnout is increasing among U.S. physicians. The report authors defined burnout as “a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment.”³⁴ In 2017, more than half (51%) of U.S. physicians surveyed Medscape reported burnout, up from 40% in 2013. Specialties experiencing the highest rates of burnout nationally were emergency medicine (59%) and OB/GYN (56%), followed by family physicians, internists, and infectious disease physicians (all at 55%) (see Figure 15 next page).³⁵


³⁵ Ibid.
**Figure 15: Which Physicians are Most Burned Out?**

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<th>Medical Specialty</th>
<th>Percentage of Physicians Burned Out</th>
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<tr>
<td>Emergency Medicine</td>
<td>59%</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>56%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>55%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>55%</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>55%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>54%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>53%</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>53%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>53%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>52%</td>
</tr>
<tr>
<td>Urology</td>
<td>52%</td>
</tr>
<tr>
<td>Neurology</td>
<td>51%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>51%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>51%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>50%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>50%</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>49%</td>
</tr>
<tr>
<td>Surgery</td>
<td>49%</td>
</tr>
<tr>
<td>Pulmonary Medicine</td>
<td>49%</td>
</tr>
<tr>
<td>Radiology</td>
<td>49%</td>
</tr>
<tr>
<td>Oncology</td>
<td>47%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>46%</td>
</tr>
<tr>
<td>Diabetes &amp; Endocrinology</td>
<td>46%</td>
</tr>
<tr>
<td>Pathology</td>
<td>43%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>43%</td>
</tr>
<tr>
<td>Allergy &amp; Immunology</td>
<td>43%</td>
</tr>
<tr>
<td>Psychiatry &amp; Mental Health</td>
<td>42%</td>
</tr>
</tbody>
</table>

**Source:** Medscape Lifestyle Report 2017: Race and Ethnicity, Bias and Burnout

1. Physicians ranked “too many bureaucratic tasks,” “spending too many hours at work,” “feeling like a cog in a wheel,” EHRs, and low income as the main causes of burnout.
2. Contributing to burnout are the number of hours spent on paperwork and administration.
3. As indicated by the results from the Medscape Physician Compensation Report (see Figure 16 next page), nearly one in five physicians say they are spending 20 or more hours per week on paperwork and administrative tasks.
Figure 16: Physician Hours Spent on Paperwork and Administration per Week

Source: Medscape Physician Compensation Report 2017
MASSACHUSETTS OVERVIEW

Access to Health Care

Massachusetts continues to lead the nation in health insurance coverage, with an uninsurance rate of 4%, compared to the national uninsurance rate of 9%. Uninsured Massachusetts residents are more likely to be male, single, without children, Hispanic, and low-income. The majority (53%) of Massachusetts residents with coverage have employer-sponsored coverage. Access to care is strong in Massachusetts, with 89% reporting a usual source of care and 82% indicating they had visited a doctor during the previous year. However, 18% of patients reported difficulty getting an appointment as soon as needed.

Figure 17 provides trend data for specific difficulties patients have had in accessing care over the past 12 months.

Figure 17

Difficulties Accessing Care Over the Past 12 Months, 2008-2017

Source: Center for Health Information and Analysis (CHIA), 2017 Massachusetts Health Insurance Survey

37 Findings from the 2017 Massachusetts Health Insurance Survey. Center for Health Information and Analysis Website. CHIA, December 2017. Findings from the 2017 Massachusetts Health Insurance Survey.
38 Ibid.
39 Ibid.
A portion of non-emergency care issues may be tied to access difficulties. For example, more than one in three emergency department visits in the Commonwealth are for non-emergency conditions. Of those Massachusetts residents reporting a non-emergent emergency department visit, 58% said the reason for the visit was because they were unable to get an appointment at a doctor’s office or clinic as soon as needed. More than two-thirds (68%) indicated that they needed care after normal operating hours at a doctor’s office or clinic. However, cost is also an important access barrier. Specifically, about one in four (26%) of Massachusetts residents had unmet medical or dental care needs due to cost, while 78% of families with medical debt incurred that debt while insured.

Cost Trends in Massachusetts

Total health expenditures (THE) grew by 2.8% from 2015-2016, below the 3.6% set benchmark (the statewide target for the rate of growth of THE for the year) and below the 3.6% average annual rate of growth for THE from 2012-2016 (see Figure 18).

Figure 18

Total health care expenditures (THCE) per capita grew 2.8% in 2016, below the benchmark rate

Annual per-capita total health care expenditure growth in Massachusetts, 2012-2016

![Chart showing annual per-capita total health care expenditure growth in Massachusetts, 2012-2016. The graph indicates that the growth varied from 2.4% in 2012-2013 to 4.8% in 2014-2015, with a benchmark of 3.6%.]

Notes: 2015-2016 growth is preliminary. All other years represent final data. Sources: Center for Health Information and Analysis, Total Health Care Expenditures Source: Health Policy Commission Board Meeting. December 12, 2017.

40 Ibid.
41 Ibid.
As the trend data in Figure 19 demonstrates, the growth has been decreasing since 2014.

Figure 19: Per Capita Total Health Care Expenditures Growth, 2015-2016

Per Capita Total Health Care Expenditures Growth, 2012-2016

Health care spending in Massachusetts continued a trend begun in 2010, where annual growth in per capita health spending remains below the U.S. growth rate as outlined in Figure 20 (next page).

Source: Center for Health Information and Analysis, Performance of the Massachusetts Health Care System Annual Report, September 2017.

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43 Ibid.
44 Ibid.
Nationally, Massachusetts’ efforts to control costs have resulted in a health care spending growth rate lower than all but three states (see Figure 21 next page).


45 Ibid.
Physicians in Massachusetts play a central role in the state’s efforts to contain costs and are demonstrating an ability to successfully manage and contain total medical costs. Specifically, physician costs in Massachusetts are rising very slowly over time; 1.7% in 2016, according to data from the Center for Health Information and Analysis (CHIA). Physician costs are lower than any of the other claims categories, including pharmacy, hospital, and other professional service category expenditures, as illustrated in Figure 22 and Figure 23, next page.

---

Spending growth on physician and other professionals from 2015-2016 was lower at 3.1%, compared to the 2014-2015 spending growth of 4.1%. Meanwhile, pharmacy drugs and hospital outpatient spending grew faster than physician services from 2015-2016. Despite slower growth in spending, physician and professional services continue to have the largest share of spending at 27% (see Figure 24 next page).
Figure 24

Among categories of care, pharmacy drugs and hospital outpatient spending grew the fastest in 2016

Source: Health Policy Commission Board Meeting. December 12, 2017.47

Commercial Insurance Cost Growth

Private health insurance spending growth rates have declined in recent years and are consistently below national rates (see Figure 25 next page).

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Also, the differences between Massachusetts and U.S. premiums has narrowed over the past five years for both family and individual coverage (see Figure 26 next page).
While employer annual premiums in Massachusetts remain higher than those in the U.S., benchmark premiums for the Massachusetts Health Connector (the Massachusetts marketplace for health and dental insurance) are lower than all but one state in the U.S. (see Figure 27 next page).

Source: Health Policy Commission Board Meeting. December 12, 2017.\(^{49}\)

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\(^{49}\) Ibid.
Prescription drug spending continues to grow in Massachusetts, with mid-single-digit growth anticipated through 2021. Current spending growth for prescription drugs is 6.1% in 2016, down from 7.2% in 2015.

Hospital outpatient spending has increased by 5.5% in 2016; surgery and administered drugs are the highest growth areas for spending (see Figure 28 next page).

Figure 27


Notes: Exchange premiums represent single coverage in the benchmark second-lowest silver plan for a 40-year old male non-smoker in the main metro area of each state.
Medicare in Massachusetts Compared to the U.S.

Medicare prices are higher at the state and national level for hospital-based rates compared to professional service office (community) rates (see Figure 29 next page).

Routine office visits covered by Medicare are twice as likely to take place in a hospital outpatient setting than in a community setting in Massachusetts compared to the U.S. (see Figure 30 next page).

Source: Health Policy Commission Board Meeting December 12, 2017 Presentation, Massachusetts Health Policy Commission

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52 Ibid.
And the cost for these routine visits is substantially higher in Massachusetts than in the U.S. The HPC estimates this excess spending to be $56 million per year (see Figure 31 next page).
Behavioral health emergency department visits are up by 40% for alcohol-related disorders and 54% for substance use-related disorders in Massachusetts (see Figure 32 next page).

Source: Health Policy Commission Board Meeting December 12, 2017 Presentation, Massachusetts Health Policy Commission

Health Care Utilization in Massachusetts

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54 Ibid.
Figure 32

Since 2011, behavioral health ED visits involving alcohol and SUD diagnoses increased 40% and 54% respectively

Behavioral health-related ED visits per 1000 residents, 2011 - 2016

Source: Health Policy Commission Board Meeting, December 12, 2017 Presentation, Massachusetts Health Policy Commission

55 Ibid.

1 Thirty-day readmission rates, once declining in both Massachusetts and the U.S., have started to increase in Massachusetts, while U.S. rates continue to trend downward (see Figure 33 next page).
An uptake in alternative payment methodologies continues to grow in 2016, mainly due to growth in commercial PPO products (see Figure 34 next page).
Figure 34

Uptake of alternative payment methods (APMs) increased in 2016, driven by growth in commercial PPO products

Proportion of member months under APM by insurance category, 2014-2016

Source: Health Policy Commission Board Meeting, December 12, 2017. 57

Figure 35 (next page) shows the uptake in APMs is more limited for smaller Massachusetts insurers and national insurers.

Figure 35

Smaller MA insurers and national insurers have limited growth in APMs

Proportion of commercial member months under APMs by carrier type

<table>
<thead>
<tr>
<th>Year</th>
<th>MA Largest 3 Insurers</th>
<th>Other MA Insurers</th>
<th>National Insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>47%</td>
<td>40%</td>
<td>1%</td>
</tr>
<tr>
<td>2015</td>
<td>46%</td>
<td>36%</td>
<td>1%</td>
</tr>
<tr>
<td>2016</td>
<td>56%</td>
<td>36%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Health Policy Commission Board Meeting, December 12, 2017. 58

Figure 36 (next page) provides an overview of the adoption of APMs by commercial payers. Most commercial payers demonstrated an increase in the adoption of APMs over time, with Unicare, Harvard Pilgrim Health Care, and Blue Cross Blue Shield of Massachusetts leading the way.

58 Ibid.
Tiered and limited-network insurance products also continue to grow in 2016, mainly due to Group Insurance Commission (GIC) plans for state employees (see Figure 37 next page).

Source: Center for Health Information and Analysis, Performance of the Massachusetts Health Care System Annual Report, September 2017.59

Figure 37

Use of tiered and limited network products grew slightly in 2016 due to the GIC

Source: Health Policy Commission Board Meeting, December 12, 2017.60

Cost and Utilization Comparisons for Physician-Led Systems vs. Other Systems

The Massachusetts Health Policy Commission (HPC) conducted an analysis of physician-led system cost and utilization compared to cost and utilization for systems anchored by academic or other hospital-based systems. Findings demonstrated that physician-led systems demonstrate lower spending than non-physician-led systems. As Figure 38 (next page) outlines, physician-led systems demonstrated 17% lower spending than academic medical center (AMC) anchored systems, and 7% lower spending than other hospital-anchored systems.

Physician-led provider organizations had 66% lower spending on per-member, per-year (PMPY) outpatient costs and 9% lower spending on inpatient costs compared to AMC-anchored systems. Physician-led costs were also lower than hospital-anchored system costs for both inpatient and outpatient PMPY spending in 2015 (see Figure 39 next page).

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**Figure 39**

**Hospital outpatient spending in AMC-anchored systems was 66% higher than in physician-led systems**

Average commercial PMPY hospital spending, by system composition, by category of spending, 2015

Notes: PMPY=per member per year, PCP=primary care provider, AMC=academic medical center. Other hospital-anchored includes systems anchored by either a teaching or community hospital. Spending adjusted using ACG risk-adjuster applied to claims data. Data include only privately insured adults (age 18+) covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan. Only members with a PCP affiliated with one of the 14 largest PCP groups, as identified by number of patients attributed in the All-Payers Claims Database, are included here.

Sources: HPC analysis of Massachusetts All-Payers Claims Database, 2014; Registration of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015

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Physician-led systems also had the lowest laboratory and pharmacy spending (see Figure 40).

**Figure 40**

AMC-anchored groups also had the highest laboratory and pharmacy spending

*Average commercial PMPY spending on labs and prescription drugs, by system composition, 2014*


Notes: AMC = academic medical center. PMPY = per member per year. POC = primary care provider. Other hospital-anchored includes systems anchored by either a teaching or community hospital. Laboratory spending includes both professional and outpatient claims. Spending adjusted using ACO risk-adjustment applied to claims data. Data include only privately insured adults ages 18–64 covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. Only members with a PCP affiliated with one of the 14 largest PCP groups, as identified by number of patients attributed in the All-Payers Claims Database, are included here.

Overall, spending in the highest-cost systems was 32% higher than spending in the lowest cost systems as outlined in Figure 41.

**Figure 41**

Member spending in the highest-cost organization was 32% higher than in the lowest-cost organization

Average commercial PMPY spending, by provider organization, 2015

<table>
<thead>
<tr>
<th>System composition</th>
<th>Average PMPY Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMC anchored</td>
<td>$6,601</td>
</tr>
<tr>
<td>Teaching hospital anchored</td>
<td>$5,990</td>
</tr>
<tr>
<td>Community hospital anchored</td>
<td>$5,837</td>
</tr>
<tr>
<td>Physician-led</td>
<td>$5,578</td>
</tr>
</tbody>
</table>

Notes: PMPY=per member per year, PCP=primary care provider, AMC=academic medical center. Spending adjusted using ACG risk-adjuster applied to claims data. Data includes only adults over the age of 18. Commercial payers include Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan. MassHealth includes only MCO enrollees who had coverage through BMC HealthNet, Neighborhood Health Plan, or Network Health/Tufts. Members in the MassHealth Medical Security Program (MSP) were excluded. Shown here are the 14 largest PCP groups as identified by number of patients attributed in the All-Payers Claims Database. Average calculated using all attributed adult members in the sample, not just those with a PCP associated with one of the 14 largest provider groups.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registry of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December 2015

For the most part, physician-led systems also demonstrated fewer avoidable emergency department visits and lower rates of non-recommended imaging than AMC-anchored and other hospital-anchored systems, while two of the three physician-led organizations had low rates of avoidable hospital visits as well (see Figure 42, Figure 43, and Figure 44 next pages.)

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Notes: ED=emergency department; AMC=academic medical center. Adjusted avoidable ED visits by provider group were defined according to the NYU Billings Algorithm and calculated after adjusting for the following patient characteristics: risk score, median community income, area deprivation index, fully insured (commercial patients only), age, gender, and payer. Data include only privately insured adults (age 18+) covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. Shown here are the 14 largest PCP groups as identified by number of patients attributed in the All-Payers Claims Database. The avoidable hospital measure is based on criteria developed by the Agency for Healthcare Research and Quality’s Prevention Quality Indicators to identify ambulatory care sensitive conditions – adapted for use in the APCD.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registration of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December 2015.65

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65 Ibid.
**Figure 43**

Rates of non-recommended imaging were lowest for members in physician-led organizations

Rate of non-recommended imaging among commercial members per 100 eligible encounters, by system composition, 2014

However, physician and other professional spending was slightly higher in physician-led groups – 12% higher than other hospital-anchored systems and 6% higher than AMC-anchored systems for average commercial PMPY spending as indicated in Figure 44.

**Figure 44**

**Physician and other professional spending was slightly higher in physician-led groups**

*Average commercial PMPY professional spending, by system composition, 2014*

Source: Massachusetts Health Policy Commission, Joint Meeting of the Cost Trends and Market Performance and Community Health Care Investment and Consumer Involvement Committees, December 6, 2017.67

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*Health Reform Implementation*

The evaluation of the 2012 Health Care Cost Containment Law in Massachusetts, conducted by the Massachusetts State Auditor’s office in 2017, found the following overall key findings:

- Massachusetts maintained access to care, but continued to grapple with high levels of hospital readmissions and avoidable ED visits.

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67 Ibid.
• There were mixed results on quality measures for population groups and a lack of data on outcomes for people with disabilities.
• Care coordination, more visits to non-physician PCPs, and integration of behavioral health are outcomes that have not yet been achieved according to the evaluation. The report noted that more treatment for mental health and substance abuse is needed. A policy implication of the evaluation findings is that Massachusetts needs to increase the capacity of PCPs to treat behavioral health needs.
• There was growth in both the Massachusetts health care workforce and demand, yet wages remain stagnant. Skill acquisition and enhancement will be critical for these workers in the future, according to the evaluation, with a focus on lower-wage workers such as home health aides and personal care assistants. The report also noted that a recent ban on immigration at the federal level is further exacerbating problems with workforce supply.
• The evaluation found mixed results on prevention and not enough data to assess wellness programs. While racial/ethnic disparities persist, the report noted that social determinants of health were powerful predictors of disparities.
• Survey data from the Massachusetts Health Reform Survey shows that shifting visits to non-physician PCPs, a goal of the law, has not occurred. The data are from 2010, 2012, and 2013. However, separate report findings demonstrate that health care providers are redesigning delivery systems to allow workers to work at the top of their licenses and to increase efficiencies and quality. Both of these findings will likely impact scope of practice discussions in the coming year.

Health Insurance Enrollment Trends

Trends in enrollment and spending varied by market segment in Massachusetts as detailed in Figure 45 (next page). Enrollment in commercial plans increased slightly, by 0.3%, while Medicare enrollment was up by 3% in Advantage plans and 2% in FFS plans. Enrollment in MassHealth declined slightly by 0.8%, despite an increase in spending of 5%. Spending increased in the commercial market by 3.4%, while Medicare spending decreased (-2% in the Advantage market) or remained nearly flat (+0.3% in FFS).
Figure 45

Trends in spending and enrollment differed by market segment

Spending growth per enrollee and enrollment growth by market, 2015-2016

<table>
<thead>
<tr>
<th>Market Segment</th>
<th>Spending Growth</th>
<th>Enrollment Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>3.4%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>MassHealth (PCC and MCO)</td>
<td>5.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>-2.0%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Medicare FFS</td>
<td>2.0%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Source: Health Policy Commission Board Meeting, December 12, 2017. 68

Figure 46 demonstrates commercial enrollment by payer. Blue Cross Blue Shield of Massachusetts has the largest market share, covering over 1.6 million of Massachusetts residents. Tufts and Harvard Pilgrim Health Plans round out the top three insurers with the largest share of enrollees in the Commonwealth.  

Figure 46

Commercial (Private & Public) Enrollment by Payer
March 2017


69 Findings from the 2017 Massachusetts Health Insurance Survey. Center for Health Information and Analysis Website. CHIA, December 2017. Findings from the 2017 Massachusetts Health Insurance Survey.

Under ongoing health reform efforts in the Commonwealth, the Governor's office announced that 17 health care organizations have executed agreements to participate in a major restructuring of the state's Medicaid program, MassHealth. As of March 2018, 850,000 MassHealth members will be covered by Accountable Care Organizations (ACOs) established by the following "networks of physicians, hospitals and other community-based health care providers, and will be financially accountable for cost, quality, and member experience":

- Atrius Health with Tufts Health Public Plans
- Baystate Health Care Alliance with Health New England
- Beth Israel Deaconess Care Organization with Tufts Health Public Plans
- Boston Accountable Care Organization with Boston Medical Center HealthNet Plan
- Cambridge Health Alliance with Tufts Health Public Plans
- Children's Hospital Integrated Care Organization with Tufts Health Public Plans
- Community Care Cooperative, an organization of 13 federally qualified health centers.
- Health Collaborative of the Berkshires with Fallon Community Health Plan
- Lahey Health
- Mercy Health Accountable Care Organization with Boston Medical Center HealthNet Plan
- Merrimack Valley ACO with Neighborhood Health Plan
- Partners HealthCare ACO
- Reliant Medical Group with Fallon Community Health Plan
- Signature Healthcare Corporation with Boston Medical Center HealthNet Plan
- Southcoast Health Network with Boston Medical Center HealthNet Plan
- Steward Medicaid Care Network
- Wellforce with Fallon Community Health Plan

High-Deductible Health Plans

The IRS defines high-deductible plans as those with a minimum deductible of $1,300 for an individual plan and $2,600 for a family policy. About one million Massachusetts residents with private coverage are enrolled in high-deductible health plans. This is an increase of seven percentage points since 2012, impacting an additional 350,000 people.

Findings from the MMS report, Assessment of the Impact of High-Deductible Health Plans on Patient Health and the Financial Impact on Medical Practices, indicate that the numbers of Massachusetts residents covered by high-deductible health plans (HDHPs) will continue to grow in the future. The report recommends that the MMS continue to use its voice and influence at both the state and federal levels to raise concerns about the potentially adverse impact HDHPs can have on patient health and financial security, as well as the impact of the increase in cost-sharing in general on patients in the Commonwealth.

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73 Ibid.
Despite a high cost of living in the Northeast region, physician compensation continues to lag behind many of the other geographic areas of the U.S., as outlined in Figure 47.

**Figure 47**

![Physician Compensation by Geographic Area](image)


According to data from the Bureau of Labor Statistics (BLS), Massachusetts annual mean wages for "Physicians and Surgeons, All Other" (i.e., all physicians and surgeons not listed separately) are the lowest in New England and are among the lowest in the nation. Figure 48 below provides an overview of mean wages by state for all physicians in the U.S.

**Figure 48**

![Annual mean wage of physicians and surgeons, all other, by state, May 2016](image)

The MMS continues to address the key issues of quality, cost-effective care, access to care, price transparency, equity in health care, as well as health reform nationally and locally. As a foundation for understanding these topics, the MMS conducted surveys, interviews, and secondary research, as well as participated in a large number of local and national meetings with the administration, payers, policy experts, physician-leaders of large medical groups and ACOs, and practicing physicians in the community to gather critical input. Understanding key topics such as health reform, payment reform (including MACRA), the rising cost of health care, tiering, limited networks, high-deductible health plans, access to care, new physician practice structures, use of retail and urgent care clinics and telemedicine, the opioid crisis, consolidation (e.g., ACOs), physician employment status, licensure requirements, and new laws and regulations – and how they affect how physicians deliver care – is critical.

Annual Membership Survey – 2017

The MMS continues to monitor general and targeted issues in the physician community through surveys, focus groups, interviews, and daily physician interactions with staff. The following are the results of the 2017 Annual Membership Survey.

Member Satisfaction

- The overall level of satisfaction with MMS membership continues to be very high, with 94% of members surveyed responding that they were either “very satisfied” or “satisfied” with their membership.
- 98% of respondents reported that they were likely to renew their membership in the coming year. This high likelihood of renewal was consistent across all age groups and practice types.

MMS Priorities

- Members consistently rate advocacy on behalf of physicians as the principal responsibility of the MMS. Advocating with the state government was cited as "very important" by 87% of physicians responding to the survey while 79% said advocating for administrative relief with health plans was "very important." More than two-thirds of respondents indicated that advocating for physicians with the federal government (68%) and advocating for patients (69%) was "very important."
- Members also indicated that it is “very important” for the MMS to help Massachusetts physicians by keeping them informed, specifically in the areas of payment reform (67%) and issues facing the profession (78%).
- Education is also an important priority for respondents, with 68% indicating that providing continuing medical education (CME) opportunities is “very important.”
- About half of respondents (51%) indicated that providing public health resources is “very important,” while 41% indicated that assisting physicians with practice management issues is “very important.”

Key Performance Ratings

- Advocacy: The MMS's advocacy efforts received solid ratings. Respondents rated advocacy with state government (87%), federal government (85%), and patients (92%) as either “good,” “very good,” or “excellent.” Respondents also gave the MMS high marks on advocacy related to physician practice challenges.
Specifically, 77% of those responding said the MMS’s advocacy efforts for health plan administrative relief was “good,” “very good,” or “excellent.”

- **Education and Resources:** 98% of members surveyed rated the MMS as “good,” “very good,” or “excellent” at providing CME opportunities, while 94% of physicians responding indicated that the MMS is “good,” “very good,” or “excellent” at providing them with public health resources. 85% percent of respondents said that the MMS is “good,” “very good,” or “excellent” at assisting physicians with practice management issues.

- **Communication:** The MMS’s communication efforts received high marks. 94% of members surveyed rated the MMS as “good,” “very good,” or “excellent” at keeping physicians informed about issues facing the profession and payment reform, and 98% of respondents said that communicating information in a timely way about MMS activities and initiatives was “good,” “very good,” or “excellent.”

**Membership Value**

- Members were asked to rank the aspects of membership that were most valuable to them. The following list demonstrates that respondents ranked advocacy, NEJM products and services, and leadership opportunities as the three most valuable aspects of their MMS membership:

1. Advocacy
2. NEJM Group Products and Services
3. Continuing Medical Education
4. Leadership Opportunities
5. Networking
6. Practice Management Support
7. Public Health Resources
8. Boston Medical Library

**Feedback Related to Practice Issues and Challenges Faced by Physicians**

- Physicians were also asked: “Please tell us how challenging you find the following practice issues.” The following list ranks the practice issues by the proportion of physicians indicating an issue is “Very Challenging” or “Somewhat Challenging”:

<table>
<thead>
<tr>
<th>Practice Issue</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handling health plan administration</td>
<td>71%</td>
</tr>
<tr>
<td>Amount of reimbursement for your services</td>
<td>67%</td>
</tr>
<tr>
<td>Electronic health records (EHR)/Health information technology (HIT)</td>
<td>64%</td>
</tr>
<tr>
<td>Sustainable level of practice income</td>
<td>64%</td>
</tr>
<tr>
<td>High-deductible health plans</td>
<td>62%</td>
</tr>
<tr>
<td>MACRA (Medicare Access and CHIP Reauthorization Act of 2015) / Medicare Quality Payment Program</td>
<td>61%</td>
</tr>
<tr>
<td>Meeting targets for quality measures used by payers, the state, and others</td>
<td>61%</td>
</tr>
<tr>
<td>Meeting targets for cost measures used by payers, the state, and others</td>
<td>59%</td>
</tr>
</tbody>
</table>
Feedback Related to Clinical Issues and Challenges Faced by Physicians

- Physicians were also asked: “Please tell us how challenging you find the following clinical issues.” The following list ranks the clinical issues by the proportion of physicians indicating an issue is “Very Challenging” or “Somewhat Challenging”:

<table>
<thead>
<tr>
<th>Clinical Issue</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining autonomy in clinical decision-making</td>
<td>64%</td>
</tr>
<tr>
<td>Preservation of medical professionalism</td>
<td>62%</td>
</tr>
<tr>
<td>Opioid prescribing</td>
<td>50%</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>43%</td>
</tr>
<tr>
<td>Patient engagement</td>
<td>41%</td>
</tr>
<tr>
<td>Prescribing medication-assisted treatment (MAT) to treat patients with dependence/addiction to opioids (narcotics)</td>
<td>41%</td>
</tr>
<tr>
<td>Access to medical library services</td>
<td>26%</td>
</tr>
</tbody>
</table>

Feedback Related to Professional Issues and Challenges Faced by Physicians

- Physicians were also asked: “Please tell us how challenging you find the following professional issues.” The following list ranks the practice issues by the proportion of physicians indicating an issue is “Very Challenging” or “Somewhat Challenging”:

<table>
<thead>
<tr>
<th>Professional Issue</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work/life balance</td>
<td>81%</td>
</tr>
<tr>
<td>Burnout</td>
<td>69%</td>
</tr>
<tr>
<td>Lack of physician “community”</td>
<td>68%</td>
</tr>
<tr>
<td>Hospital-physician relationship</td>
<td>57%</td>
</tr>
<tr>
<td>Determining which group practice/organization to join</td>
<td>33%</td>
</tr>
<tr>
<td>Determining whether to be self-employed/employed</td>
<td>30%</td>
</tr>
</tbody>
</table>

MMS Physician Practice Survey – 2017

The MMS Physician Practice Survey was developed at the request of the Committee on the Sustainability of Private Practice. The results of the survey enabled the MMS to compare private practice physician members’ issues with employed physician members to better understand the difference and similarities of their practice concerns. However, caution should be used in generalizing the findings to the full population of MMS physician members, due to the potential for non-response bias given the small sample size. The survey was sent to a sample of approximately 7,500 practicing physician members between January and February 2017. The survey yielded a response rate of 7%, with 524 physicians responding to the survey. The following provides an overview of the findings from the survey:

- More than one-half of respondents were employed physicians, while approximately one-third were owners.
Nearly half of respondents (46%) worked for a practice that was wholly owned by one or more physicians in the practice, while slightly more than one in four (29%) worked in a practice that was wholly owned by a hospital or hospital system.

Both employed and owner physicians ranked the following issues as their top five most challenging: administrative simplification, work/life balance, EHR/IT, sustainable level of practice income, and coding/HIPAA compliance (see Figure 49). These issues are similar to those cited by U.S. physicians in the Medscape Survey findings outlined in the national overview section of this report. Some of the top causes of burnout were bureaucracy, EHRs, and low income, as well as the causes reflected in the MMS Membership Satisfaction Survey outlined above.

Figure 49

<table>
<thead>
<tr>
<th>All Physicians</th>
<th>Owners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administrative Simplification</td>
<td>1. Administrative Simplification</td>
</tr>
<tr>
<td>2. Work/Life Balance</td>
<td>2. EHR/IT</td>
</tr>
<tr>
<td>3. EHR/IT</td>
<td>3. Work/Life Balance</td>
</tr>
<tr>
<td>4. Sustainable Level of Practice Income</td>
<td>4. Sustainable Level of Practice Income</td>
</tr>
<tr>
<td>5. Coding/HIPAA Compliance</td>
<td>5. Coding/HIPAA Compliance</td>
</tr>
</tbody>
</table>


Medical Aid-in-Dying/Physician-Assisted Suicide Survey – 2017

A policy adopted at I-16 called for a survey of MMS membership on medical aid-in-dying, also known as physician-assisted suicide (MAID/PAS). In September 2017, the MMS conducted a statewide survey of current members to measure the attitudes of physicians and physicians-in-training in Massachusetts. MMS officers, with the Committee on Public Health (CPH) and the Committee on Geriatric Medicine (CGM), developed a work plan and timeline for implementation of the directive. The MMS contracted with Robert H. Aseltine, Jr., PhD, Professor and Chair in the Division of Behavioral Sciences and Community Health at UConn Health, to consult on the survey.

The MMS hosted five focus groups with MMS physician members across Massachusetts to better understand physicians’ perspectives and guide survey development. The officers and members of CPH and CGM reviewed and approved the final focus group questions. The finalized survey instrument was tested by leadership and members of CPH and CGM. Those completing the survey received a code to waive the fee for an MMS end-of-life focused online CME program.
The initial sample contained all 22,597 members drawn from the membership lists maintained by the MMS as of August 2017. Members without a valid email address on file received a print copy of the survey via postal mail to be completed and returned in a postage-paid envelope (N=5,021). Members who had valid email addresses on file were initially invited to complete the survey online, using a secure link sent through email (N=17,576). Fifty-two percent of those who received the email opened it. Members of the sample not responding to the email invitation within the allotted time received three follow-up email invitations throughout September 2017. A total of 2,294 members completed the survey online and 355 members of the sample completed the survey by mail, for a total of 2,649 and a response rate of 12%. The MMS also attempted to contact a random sample of 219 non-respondents by telephone to determine eligibility; this information was then used to adjust the sample denominator for response rate calculations, resulting in an adjusted response rate of 13%. The response rate for physicians was 16%; the response rate for physicians-in-training (medical students, residents, and fellows) was 5%.

Physician respondents’ opinions on three key questions regarding MAID/PAS are indicated below:

- 60% of physicians responding either supported or strongly supported the practice of physicians giving terminally ill adults prescriptions for lethal doses of medications, to be self-administered at such time as the patient sees fit.
- 62% of respondents either supported or strongly supported the proposed “aid-in-dying” legislation in Massachusetts, An Act Relative to End of Life Options (House Bill 1194/Senate Bill 1225).
- 41% of physicians completing the survey favored changing the MMS’ policy position to support MAID/PAS.
- 30% of respondents favored maintaining the MMS’ current policy opposing MAID/PAS.
- 19% favored changing the policy so that the MMS neither formally supports nor opposes MAID/PAS, with 6.5% choosing “Not Sure” and 3.5% choosing “None of These/Other.”
- 66% of physicians who rarely or never treated patients at the end of life either supported or strongly supported the practice of MAID/PAS, compared to 53% of physicians who often or sometimes treated such patients.
- 68% of physicians who rarely or never treated patients at the end of life either supported or strongly supported the proposed “aid-in-dying” legislation in Massachusetts, compared to 56% of physicians who often or sometimes treated such patients.
- 45% of physicians who rarely or never treated patients at the end of life favored changing the MMS policy position to support MAID/PAS; 24% of such physicians favored maintaining the current MMS policy. In contrast, roughly equal proportions of physicians who more frequently treated patients at the end of life favored changing the policy to support MAID/PAS (38%) and maintaining the current MMS policy opposed to MAID/PAS (37%).

The survey results were taken into account in considering the MMS’ position on end-of-life care moving forward at I-17 by the HOD. At I-17, HOD voted:

1. That the Massachusetts Medical Society rescind the following policy:

   The Massachusetts Medical Society is opposed to physician-assisted suicide.

   (HP)
1a. That the MMS defines medical aid-in-dying as the act of providing care — palliative, hospice, compassionate — to patients at the end of life. The act of a physician writing a prescription for a lethal dose of medication to be used by an adult with a terminal illness at such time as the patient sees fit will, if legalized, be recognized as an additional option in the care of the terminally ill. (HP)

2. That the MMS adopt the position of neutral engagement, serving as a medical and scientific resource to inform legislative efforts that will support patient and physician shared decision-making regarding medical aid-in-dying, provided that physicians shall not be required to provide medical aid-in-dying that involves prescribing lethal doses of medication if it violates personally held ethical principles. (HP)

3. That the MMS asserts that medical aid-in-dying that involves prescribing lethal doses of medication should be practiced only by a duly licensed physician in conformance with standards of good medical practice and statutory authority. (HP)

4. That the MMS will support its members regarding clinical, ethical, and legal considerations of medical aid-in-dying, through education, advocacy, and/or the provision of other resources, whether or not members choose to practice it. (HP)

5. That the MMS notify the AMA and its Council on Ethical and Judicial Affairs of the MMS position on medical aid-in-dying. (D)

6. That the MMS supports effective palliative care, especially at the end of life. (HP)

Membership Activities

Membership in the MMS reached another all-time high of 25,277 members at the close of FY’17.

In April 2017, the MMS extended complimentary membership to physicians practicing in a federally qualified community health center setting. As of November 2017, the MMS has welcomed 440 new members through this program (total of 645 members working in a CHC). Group membership also continues to grow, with 4,900 physicians and 5,367 resident members as of January 1, 2018.

The MMS continues to develop new tactics and channels for general member recruitment, including:

1. Digital advertising campaign in Q1 & Q2 2018 – sponsored posts on Facebook and LinkedIn, and retargeting ads via GoogleAds.
2. Targeted marketing and audience-specific messaging, including:
   - Former MMS members
   - Physicians scheduled for license renewal in 2018 – reminding physicians that MMS members save on required CME.
3. Calculating an ROI for membership; the MMS has begun to promote the value and economic return on membership ($400+ annually).

The MMS also continues to pursue opportunities to enhance the value of membership and, at I-17, announced the addition of a complimentary subscription to *NEJM Journal Watch Online* as a new benefit of membership.
The engagement of diverse demographic groups within the medical profession remains a priority, and the MMS continues to develop initiatives to engage young physicians, women physicians, and physicians from minority communities, including:

- A planning committee working on the formation of the new Minority Affairs Section (MAS) has been formed and is making progress on the development of the section’s operating guidelines. Once formally established, the MAS will provide a pathway for members interested in minority affairs issues to advance policies and increase participation in the MMS and MMS leadership among physicians from underrepresented communities.
- The Task Force on Academic Physicians has convened to determine whether or not to revive the Academic Physician Section. The Task Force is working on assessing and strengthening the ways in which the MMS brings value to academic physician members.
- The Committee on Women in Medicine continues to develop programs that address women’s health and foster women’s networking. The Committee is currently planning a combined Women’s Health and Leadership Forum event for Fall 2018.
- The Committee on LGBTQ Matters recently awarded five grants to medical students and residents/fellows, which will be used for curriculum development or to produce research that addresses lesbian, gay, bisexual, and transgender health disparities.
- Medical Student/Residents/Young Physician legislative briefing and training workshop.
- Young Physician Section Community Service Day(s); students are planning spring community service events.
- Young Physicians have one MMS-funded representative and Residents have two funded representatives attending the AMA National Advocacy Conference with the Massachusetts Delegation. Students have four funded representatives (one from each school) attending the AMA Student Advocacy Conference.
- Financial Focus Series for Young Physicians, Residents/Fellows, and Medical Students – combination of live, webinar, and online educational programs (Financial Literacy 101: Basics, Emerging Payment Models, Understanding Employment, Employment Contract & Benefits Negotiation, and Reading Financial Forms) in collaboration with the HFMA.
- The MMS will introduce regional social/networking events, inviting members and non-members to convene with colleagues from across specialties, disciplines, and organizations.

The MMS’ Committees and Task Forces continue to focus on the MMS key strategic priorities. For example, the Committee on the Quality of Medical Practice continues to work on quality issues such as patient-reported outcome measures, open notes medical records, and physician burnout, as well as state initiatives on price transparency. Beginning January 2018, the MMS will begin a MMS-MHA Joint Task Force on Physician Burnout to raise awareness on the issue and to develop strategic recommendations to reduce burnout. The MMS Committee on Legislation continues to review and assess relevant bills and legislation that impact physicians’ practices and care delivery.
Continuing Education and Certification

The MMS provided or jointly provided learning opportunities to physicians and other
health professionals in a variety of formats, including in-person (live), webinar, online,
journal-based and performance improvement. Most of these activities were developed to
address gaps in practice or performance, and to help physicians meet medical licensure
requirements and state-mandated continuing professional development in subject areas
such as end-of-life care, pain management/opioid prescribing education, electronic
health records, and risk management.

In May 2015, the MMS determined that price should not be a barrier for physicians to
access quality education in pain management and opioid prescribing, and began to offer
its online CME on this topic free of charge. Since that time, more than 40,000 online
courses have been completed by over 6,700 unique users. Data indicates that 77% of
participants are physicians and 52% are in Massachusetts.

Collaboration in education has continued in FY’17, with more than 60% of the MMS’
CME activities were developed and delivered in concert with national and statewide
organizations, including the Department of Public Health, state chapters of national
specialty societies, other state medical societies, and organizations considered to be
clinical content experts.

Advancement of physician knowledge has been addressed through partnerships with
Harvard Medical School Center for Bioethics, the Alzheimer’s Association’s regional
chapter, and the Heller School at Brandeis University (Executive MBA for Physicians), to
name a few examples. The MMS’ Annual State of the State of Health Care event, Public
Health Leadership Forum, Women’s Leadership Forum (Managing Workplace Conflict:
Improving Leadership & Personal Effectiveness), and related online courses continue to
address the complexities of the evolving health care environment.

The MMS continues to respond to the educational needs of physicians at the grassroots
level through its Recognized Accrualor Program. This long-standing MMS service
enables 49 community hospitals, state specialty societies, and other health-related
organizations to provide accredited CME for their medical staff, members, and clinicians
focusing on the health care of the community they serve. During the past year, 11
institutions were surveyed for CME compliance to national education standards and 16
other recognized providers submitted progress reports outlining their improvement
strategies.

As the health care environment continues to change, the MMS will adapt its CME
curriculum to help physicians improve their knowledge and skills, with the goal of
improving the overall health and care of patients. The MMS will continue to collaborate
and jointly provide CME activities to bring relevant content to learners. As new
technologies develop, the MMS will work to improve content delivery formats and
platforms to meet the educational needs of physicians and other health professionals
within Massachusetts and beyond.
Examples of CME Activities include:

**Patient Experience/Satisfaction — Live**
- Clinical Observation and Coaching Program Performance Improvement CME (PICME) — Ongoing through CY'18, jointly provided with LogixHealth
- Amplifying Empathy Forum: Relationship Centered Communication – June 1, 2016

**Health Care Quality/Access/Clinical — Live**
- 14th Annual Symposium on Men’s Health – June 16, 2016
- Evolutionary Biology in Clinical Medicine Webinar – September 19, 2016
- Medication Assisted Treatment Summit: Improving Access to Evidence-Based Care – October 31, 2016
- 2016 Annual Oration: Zika Virus - Consequences for Massachusetts – December 2, 2016
- MACRA: What Physicians Need to Know - offered in several locations in FY’17
- 5th Annual Communication, Apology, and Resolution Following Medical Injury Conference – April 13, 2017, jointly provided with the Massachusetts Alliance for Communication and Resolution Following Medical Injury (MACRMI)
- “Stop the Bleed” Training – April 28, 2017
- Engaging Physicians and Care Teams to Prevent Diabetes Webinar – May 2, 2017, jointly provided with the Massachusetts Department of Public Health

**Health Care Quality Access/Clinical Medicine — Online**
- Firearm Violence: Prevention & Public Health - Reducing Firearm Injury (Modules 1-6)
- Efficacy of FIT-FOBT for Colorectal Cancer Screening
- Starting the Conversation about End-of-Life Care with Patients
- MassPAT: Incorporating the New PMP into Your Practice
- Helping Patients with COPD Breathe Easier
- Avoiding Medical Mistakes and Errors
- Running on Empty? Physicians’ Path to Enjoying Life and Medicine More
- Telehealth: A Primer
- Legal Advisor: Dealing with Difficult Patients and Managing the Risk of Board Complaints

**Practice Research and Resources**

The MMS works closely with Massachusetts Health Quality Partners and the Coalition for the Prevention of Medical Errors to research issues and educate physicians and the public about key health care topics.

The MMS has continued its efforts in providing relevant and timely tools, resources, educational programs, and access to knowledgeable experts with the goal of providing the most up-to-date information necessary to help physicians navigate the rapidly changing practice environment. The MMS has developed resources and support in four key areas, which include:
2. Licensing Requirements for Practicing Medicine in the Commonwealth of Massachusetts
3. Holding the Line: How Massachusetts Physicians Are Containing Costs
4. Stark Series

Practice Education Series – 2017 Education Program Examples:

- Running on Empty? Physicians’ Path to Enjoying Life and Medicine More, January 25, 2017
- Discussion on Concussions: Clinical Headlines, May 10, 2017
- MACRA MIPS Trainings with Healthcentric Advisors, Summer and Winter 2017
- Summer 2017: Independent Claims Consultation Days (Total of 3)
- Restoring Well-Being to the Medical Profession: What Can Individuals, Teams, and Organizations Do?, October 2017
- 4th Annual PPRC Talks: Crucial Conversations in an Era of Transitions – Patient Physician Engagement and Compensation Arrangements
- Current and Future Models of Physician Compensation (Finance Series Component), December 2017

Physician Practice Help Center (PPHC): 2017 Review

The MMS continues to promote awareness of resources and access to assistance for practice management questions. The PPHC responded to approximately 550 calls and emails from physicians, practice managers, and other office staff from across the state from January to December 2017. Work time associated with the calls was approximately 20 minutes per call. Most frequently asked questions received include:

- Physician Retirement Issues
- Payer Issues/Coding
- Human Resources Questions
- BRM Requirements for Re-licensure
- Legal Referrals
- General Practice Management Questions
  - HIPAA/Security
  - Staffing Resources

Practice Management Consulting

The MMS continues to develop innovative programming and service offerings that can be customized and delivered onsite in physician practices. A few examples of 2017 projects include:

- Super Group (multiple practices) – Design, Planning and Implementation
- Patient Experience Trainings for Providers/Practice Staff
- Compliance Review/Assessment
- Organizational and Financial Assessments
- Medical Practice Start-Up (e.g. Cash-Flow Analysis, Demographic Study, Website Design and Online Marketing)
- Physician Recruitment Strategies
- Succession Planning Educational Sessions
- PCMH Transformation
The MMS participates in the Massachusetts Collaborative, a voluntary group of payers and providers working on administrative simplification initiatives. The MMS, MHA, BCBSMA and MAHP are the primary members of the strategy and operations group, and there is representation across the industry in workgroups and on monthly stakeholder calls. A core focus has been reducing the time necessary to credential new physicians in Massachusetts. The Collaborative hired AMS consulting to assess the pain points in the end-to-end credentialing processes. The Collaborative met with key stakeholders (Board of Registration in Medicine or BORIM, Massachusetts Controlled Substance Registration or MCSR, and the health plan credentialing service Healthcare Administrative Solutions or HCAS), presented the consultant’s report and spurred action to address points identified. BORIM is working toward online application processes for late 2018 and has since hired three staff members to support incoming calls and work on backlog information. MCSR should have their processes online by spring/summer 2018, and HCAS has reduced their backlog by working closely with their contacted vendors. The MMS continues to monitor this situation closely, as well as prior authorization form development and the provider directory issue.

**Practice Advocacy**

The MMS advocated with the state regarding the state’s price transparency website. After attending committee meetings, the MMS ensured that specialty societies had input into patient materials created for the site and secured four weeks’ time for practices to review cost data prior to public dissemination. Further, there was considerable input and conversation on cost methodology. The state’s efforts to go live with cost and quality data is expected in February 2018.

The Division of Insurance reached out to the MMS to communicate their plans to put Minuteman Health into receivership, thus prompting notification to physicians via *Vital Signs This Week*. Providers were informed that there were sufficient funds to pay claims for services rendered to the small number of enrollees, so physicians should continue providing care. Within a few months, the DOI notified the MMS that Minuteman would close in 2017. Again, notification was placed in *Vital Signs This Week*.

**Federal and State Government Relations and Advocacy**

This year, the strength of the MMS’ federal advocacy efforts were challenged by a relentless assault on many of the legislative and regulatory health care reforms essential to health and supported by the MMS. The MMS joined with our colleagues from the national and state arena, including other physician, patient, and health care provider organizations, to successfully defeat every legislative proposal to repeal the Patient Protection and Affordable Care Act (ACA). To this end, the MMS worked closely with the Massachusetts Congressional delegation, participating in roundtables, press events, and other forums and venues focusing on the importance of ACA from the physician/patient perspective. The MMS engaged the MMS’ membership in a grassroots campaign to reach out to colleagues in other key states to fight proposals to undermine the ACA. The MMS was a participant on the AMA task force on the ACA and participated in several state-based coalitions.

The MMS worked closely with the delegation, the Governor and state partners in calling for the reauthorization of the CHIP program and Community Health Center Legislation – two additional federal programs critical to our health care delivery system. As with our efforts on the ACA, the MMS participated in press conferences with members of the
Mass. Congressional delegation, co-signed letters with our state partners, and was active in other advocacy efforts designed to support the delegation’s efforts to secure funding for these programs.

The MMS’ advocacy at the federal level to combat the opioid addiction crisis also continued unabated. Following successful passage of the partial-fill bill into law, the MMS worked with the Mass. Congressional delegation to encourage the DEA to upgrade its regulations to enable implementation of the new law. The MMS is also working with members of the delegation to update DEA regulations governing e-prescribing of Schedule II drugs to make implementation more accessible and feasible. Among a number of legislative initiatives, the MMS is continuing to work with Representative Clark, who introduced legislation based on the McPAP model. This model would grant funds to states for experts in pain and substance abuse counseling. The MMS continues to serve on the AMA Task Force on Opioids, which develops education programs and resources at the national level. The MMS is working with the delegation on a Congressional briefing to educate staff about Supervised Injection Facilities (SIFs), informed by the landmark MMS report.

This past year, the MMS was a vocal supporter of the DREAM Act and efforts to restore protections for children protected under Deferred Action for Childhood Arrivals (DACA). The MMS was active in several other arenas at the federal level, including: support for efforts to address the pricing of prescription drugs, support for increased funds for the Substance Abuse and Mental Health Block Grant, support for parity laws for mental and behavioral health, support for legislation that would lift the federal ban on research into preventing gun violence, and support for legislation to address several corrections necessary for MACRA.

At the federal regulatory level, the MMS continued its work to support MACRA implementation and the changes to the Medicare physician fee schedule, such as payment for telemedicine services. The MMS also continued its advocacy seeking regulatory reform, including streamlining of regulations.

This year, the MMS increased its work with Community Servings, a statewide program which provided medically tailored meals at no expense to low income people with illnesses in several communities in the Commonwealth. The MMS serves on the statewide planning committees assessing food insecurity across the state and is developing a plan to expand services.

Recognizing that the MMS’ advocacy program is only as strong as its members, the MMS devoted a significant amount of time to training members on legislative issues and grassroots advocacy. Several programs were hosted for students, residents, and young physicians, as well as for pediatric residents, the Mass. Chapter of the American College of Physicians, district medical societies, and other health care organizations. The MMS is frequently called upon to speak to both MMS staff and other health care organizations about legislation in the state and nationally. Presentations to such organizations as the Medical Group Management Association, the Health Care Financing Organization Home and Health Care organization, the Boston Bar Association, and numerous hospital and physician organizations continue to promote both the reputation and advocacy agenda of Massachusetts physicians and the patients they serve.

This year brought another active advocacy initiative to Beacon Hill. The MMS was engaged with many high-profile issues, including the state budget and dozens of bills affecting the priorities of the MMS.
The FY’17 state budget, as proposed by the Governor and the houses of the state legislature, saw continued threats to the physician practice sustainability. Various versions of the budget included provisions that would cap physician reimbursement in GIC plans to 160% of Medicare, and that would place growth caps on physicians depending on their relative rate of reimbursement. The MMS successfully opposed those provisions, offering alternative policies for consideration aimed at constraining health care costs and addressing the rising cost of prescription drugs.

The MMS spent considerable time on out-of-network billing, or “surprise billing.” As this is a relatively new issue, the MMS educated legislators and regulators and developed its own legislative strategy. Several poorly conceived legislative solutions were successfully opposed by the MMS in 2017.

The MMS continues to advocate in favor of the twenty bills it filed in the legislature this session, and dozens more bills deemed to be consistent with MMS policy. Broadly speaking, the end of 2017 saw two important issues emerge in the legislature: health care cost containment and the opioid epidemic. MMS leadership and staff worked diligently to ensure that cost containment proposals are steered towards policies that promote high-value, high-quality care for patients and physicians. In addition, Governor Baker filed a second bill aimed at addressing the opioid crisis in Massachusetts. The CARE bill includes many provisions relevant to the MMS’ priorities, including a proposed mandate for electronic prescribing of controlled substances, a return to the concept of involuntary civil commitments for persons with substance use disorder, and a “prescribing oversight board” that would oversee compliance with various opioid prescribing laws and regulations. The MMS provided strong oral testimony at the hearing, provided extensive written testimony on the bill, and has been meeting with key legislators to educate them on MMS priorities and positions.

In addition, the MMS has advocated for several other opioid-related bills and budget amendments, including partial-fill legislation, funding for youth education, and expansions in treatment funding. The MMS strongly supported provisions of the MassHealth 1115 waiver that improved substance use disorder treatment in the Commonwealth. Lastly, the MMS continues to balance opioid prescribing policy with an urge to remain cognizant of the importance of maintaining balance with the ability for physicians to adequately treat patients with pain. The MMS has been engaged in extensive dialogue and education on Supervised Injection Facilities (SIFs). A budget amendment offered by the Senate which would have established a SIF task force was supported by the MMS, but ultimately not included in the final budget. Further avenues for advocacy of the MMS’ SIF policy are being explored.

The MMS continues to actively advocate with various regulatory agencies, including the Board of Registration in Medicine, the Department of Public Health, and the Health Policy Commission. This year, BORIM proposed substantial amendments to regulations that the MMS successfully opposed. The MMS also worked with the DPH on several issues, including the reconstitution of the Drug Formulary Commission, and improvements to the Prescription Monitoring Program and the Massachusetts Controlled Substances Registration.

The MMS reviewed thousands of bills filed at the state house, closely tracked hundreds of bills related to MMS priorities, and testified on dozens of bills with both extensive written testimony and at hearings. In addition, MMS leadership and staff met with key figures such as Governor Baker, Secretary Sudders, Commissioner Bharel, and other legislators, regulators, and staff to advance MMS priorities and oppose legislation and policies deemed by the MMS to not be in the interest of patients and physicians.
Communications

The MMS' voice in the media remains frequent and strong, with MMS officers and physician members demonstrating leadership on many health care issues. Our website and other digital communications channels achieve their goals of positioning the MMS as a thought leader, engaging new and current members, and promoting education programs. Highlights include:

- In 2017, the MMS received and facilitated more than 140 media requests; most popular topics included the ongoing opioid crisis and our support for SIFs, gun violence, MAID/PAS, health care cost containment, and ongoing health care reform efforts.
- The MMS engaged in robust, proactive media outreach, distributing nearly 60 media statements or press releases on a wide range of topics, including health care access, contraceptive coverage, drug costs, and the opioid crisis.
- With the influence of video as a growing communication tool, the MMS developed internal filming and editing capabilities. Videos are used to promote educational programs, share perspectives of MMS leadership and members, and reflect on MMS-hosted events. A total of 35 videos were published in 2017.
- The MMS' enhanced social media presence continues to expand the organization's ability to educate the public online. The MMS' Facebook page has more than 9,600 followers and Twitter has more than 7,700 followers. Both are steadily growing; the MMS' Twitter profile (@MassMedical) was recently confirmed as “verified.”

Public Health Activities

Public Health areas of focus for FY’18 include end-of-life care (addressed earlier in this report in the section on MAID/PAS), firearm safety, opioid abuse, and population health/social determinants of health.

Firearms

The MMS' policy, adopted in 2013, states that the MMS is “guided by the principles of reducing the number of deaths, disabilities, and injuries attributable to guns; making gun ownership safer; promoting education relative to guns, ammunition, and violence prevention, for physicians and other health professionals as well as for the public; encouraging research to understand the risk factors related to gun violence and deaths.”

The American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), led by Christopher Barsotti MD, FACEP, FAAEM, Chair of the Trauma and Injury Prevention Section at the American College of Emergency Physicians, and an emergency physician with Berkshire Medical Center, is an independent, physician-led 501(c)(3) organization whose mission is to raise monies from the private sector in order to fund firearm injury prevention research, and to support professional guideline groups in the development of evidence-based, best practice recommendations for health care providers to reduce the incidence and health consequences of firearm-related violence.

Firearm-related victimization, injury and death are among the most urgent public health problems facing our country. A public health approach to gun violence prevention has been inhibited by a lack of funding available for research. Between 2004-2015, U.S. federal agencies invested only $22 million in gun violence research, whereas other medical concerns with similar or lower mortality rates received substantially higher
funding (> $1 billion)\textsuperscript{74}. Although $10 million in appropriations for gun violence prevention research were requested in the CDC FY’14-16 budgets, these were unfunded by Congress, and the CDC budget for firearm injury prevention research remains $0\textsuperscript{75}. Very few private foundations support gun violence prevention initiatives, and those that do focus on a policy agenda related to gun control. Other traditional, private sources of medical/public health research funding, such as biotech or pharmaceutical industries, do not have financial incentives for reducing firearm injuries. Consequently, there exists no reliable source of funding to study the medical and public health issues relevant to firearm injury prevention.

In October 2017, the Board of Trustees voted to adopt a position that supports the mission of AFFIRM:

That the MMS support the mission and goals of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) in so far as AFFIRM reflects the stated policies of the MMS as it reaches out to private and charitable funders to achieve its research aims.

That the MMS authorizes AFFIRM to use this resolution in seeking funding support.

Opioid Abuse

The opioid abuse epidemic continues to be the MMS’ highest public health priority. Three priorities have been the focus this year: pain management, medication-assisted treatment, and access to naloxone.

Pain Management: Addressing the non-opioid treatment of pain is a priority. Physicians seeking other methods of treatment for their patients are desperate for resources to provide care for patients reflecting the best evidence-based practice. Incorporating treatments (where proven efficacious) such as acupuncture, physical therapy, and cognitive-behavioral therapy must be made accessible and affordable.

In October 2017, MMS President Dr. Henry Dorkin attended a meeting convened by BCBSMA team to discuss relevant policies and coverage relating to the challenge of living with chronic pain. Issues discussed included pharmacy coverage, integrative therapies, treatment interventions which can help with pain reduction and avoidance of opioids, and professional support and education.

The MMS Opioid Task Force is also engaged with the Massachusetts Health Quality Partners (MHQP). The MHQP has embarked on a project which seeks to find innovative ways to improve conversations between clinicians and their patients suffering from serious pain to enhance the ways pain is addressed in the outpatient setting. The project will involve the creation of tools to help guide pain assessment conversations. The MMS is supportive of MHQP’s work and looks forward to meaningful progress.

In addition, the MMS sent a mailing to non-members to provide Massachusetts physicians with our guide to the new opioid prescribing guidelines and remind physicians about our free Pain Management and Opioid CME.

\textsuperscript{74} Stark D, and Shah N. Funding and publication of research on gun violence and other leading causes of death. \textit{JAMA} 2017;317(1):84-5.

\textsuperscript{75} \url{https://www.cdc.gov/budget/documents/fy2016/fy-2016-overview-and-detail-table.pdf}. 
Medication-Assisted Treatment (MAT): Substance use disorder can be treated, and those efforts can begin in medical practice settings – whether it is a physician’s office, hospital, or academic setting. To improve access to medication-assisted treatment, the MMS needs to encourage and support all physicians in all specialties to care for patients by providing easily accessible professional education and mentoring. In addition, administrative burdens and barriers to MAT must be addressed. The MMS has discussed with representatives from some of the academic medical centers ways to support physicians in their practices, with many ideas being explored. In March 2018, the MMS will co-sponsor a course on the complications of substance use disorders, including a discussion of MAT.

Access to Naloxone: Massachusetts prescribing guidelines encourage the co-prescription of naloxone when prescribing an opioid. The MMS strongly advocates for affordable and consistent access to naloxone, and it is working with payers to include naloxone with minimal or no cost-sharing.

In addition, the MMS continues to seek new ways to decrease the rising opioid-related mortality in our Commonwealth. While increased naloxone availability is important, the more rapid onset of newer opioids such as synthetic fentanyl and carfentanil decrease substantially the time after opioid injection during which naloxone is effective. SIFs have lowered the absolute death rate in Canada, Australia, and parts of Europe. The MMS continues to advocate for the launch a pilot SIF program under the guidance of a state-led task force, as the MMS believes this program is one approach that will reduce overdose deaths in the Commonwealth. A coalition of groups in support of the establishment of SIFs has formed in Massachusetts, led by SIFMA NOW, AIDS Action, and others, working together to reduce accidental overdose deaths in Massachusetts.

Population Health/Social Determinants of Health

The MMS has long been a supporter of community-based programs that address the impact of physical, economic, environmental and social inequities on health outcomes. By working in partnership with public health, the medical community can help to shift the paradigm from treating disease to improving population health through prevention-based care that recognizes social determinants of health when caring for patients. One example of this partnership is the MMS’ engagement with the Massachusetts Food is Medicine State Plan (mentioned previously in this report). Improving access to food can improve health outcomes, decrease costs, and improve quality of life. Led by Harvard Law School's Center for Health Law and Policy Innovation and Community Servings, the Food is Medicine State Plan is an initiative that will develop a report proposing concrete strategies that community-based organizations, health care providers, and state government can use to improve access to medically tailored nutrition interventions over time. This initiative complements the MMS’ commitment to raising awareness among physicians of the link between food insecurity and health.

CONCLUSION

As a leadership voice in health care, the Massachusetts Medical Society is dedicated to educating and advocating for the physicians of Massachusetts and patients locally and nationally. This report reflects the challenges present in today’s health care environment and summarizes the ways in which the MMS is responding to those challenges, by influencing health-related legislation at the state and federal levels, working in support of public health, providing expert advice on physician practice management, and addressing issues of physician well-being.
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 2
Code: CWIM Report A-18 C-2
Title: Establishing a Women Physicians Section
Sponsor: Committee on Women in Medicine
Kathryn Hughes, MD, Chair

Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background

For the first time in history, there are more women entering US medical schools than men according to data released by the Association of American Medical Colleges. This is an impressive advance from a few decades ago when women represented less than a third of matriculants.\(^1\)

However, women remain a minority in medicine where there are nearly double the number of male physicians (623,054) as there are female physicians (326,902) across the country. In Massachusetts, there are 20,209 male physicians compared to 13,825 female physicians as of October 2017.\(^2\)

The Committee on Women in Medicine, formerly the Committee of Women in Organized Medicine, was established in 1981 and its original mission was to assist women physicians in entering leadership positions in organized medicine, and in the profession in general. The Committee worked to promote the leadership of women physicians in a variety of ways, including leadership training, networking, and educational programs. Over time, the Committee’s mission expanded to include educating colleagues about medical topics effecting women patients.

The Committee realizes that women in medicine and women’s health are two unique topics that should be addressed separately and therefore are proposing that the MMS establish a Women Physicians Section and rename the Committee on Women in Medicine to the Committee on Women’s Health.

MMS Policy

The MMS has the following policy relating to this topic:

**Gender Parity**

The Massachusetts Medical Society endorses the American Medical Association’s policy, “Gender Disparities in Physician Income and Advancement” that reads as follows:


\(^2\) Kaiser Family Foundation. Professionally active physicians by gender. October 2017. [https://www.kff.org/other/state-indicator/physicians-by-gender/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22,%22asc%22%7D](https://www.kff.org/other/state-indicator/physicians-by-gender/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22,%22asc%22%7D).
Gender Disparities in Physician Income and Advancement

1. That our American Medical Association encourage medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist;

2. That our AMA support physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations;

3. That our AMA urge medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession;

4. That our AMA collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and

5. That our AMA provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

(HP)

The MMS will advocate and raise awareness for gender parity, equal pay, and advancement as a fundamental professional standard to ensure equal opportunity within the medical profession in Massachusetts. (D)

MMS House of Delegates, 5/21/11

Relevance to MMS Strategic Priorities

This report relates to enhanced membership value, which is an MMS strategic priority.

Introduction

For over 35 years, the Committee on Women in Medicine has continually strived to address the professional needs of MMS women physicians by serving as the primary advocate regarding issues of importance to women physicians in how they treat their patients. The Committee has served as a valuable resource to MMS leadership in matters related to policy development and strategic planning.

The Committee sponsors a variety of programs, including CME programs, that have addressed both professional and women’s health issues. Through these programs, it has become evident that there is inadequate training for women physicians relating to professional matters such as communication, leadership and advocacy skills. Women physicians are not proportionately represented in medical leadership roles and are paid less for comparable roles. The limited number of women and minority physicians in leadership positions provides a lack of mentors and role models for the growing women physician population.

In 2013, the American Medical Association’s Women Physicians Congress (WPC) transitioned to the Women Physicians Section. Reasoning for the change included that the AMA would benefit from a delegate’s voice to address specific issues of concern for

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women in medicine in the HOD. As with the MMS, female physicians remain under-represented among delegates in the AMA HOD. A group, such as the WPC, with many individuals was not guaranteed access to the HOD process. Consequently, the perspectives of a group may not be truly represented as was the case with the WPC.

Unique concerns of a specific demographic group are also considered as part of the rationale when creating a membership Section at the AMA. Women physicians bring a distinct set of experiences related to medical practice and patient care.

Conclusion
Women physicians have made great strides, but there is still much progress to be made. Women physicians are not advancing to the highest level of the profession and are continuing to encounter discrimination during their training and subsequent careers, including exclusion from leadership positions and discrepancy in income. The creation of a Women Physician Section would reaffirm the MMS’s commitment to promote diversity and address the concerns of an under-represented group in organized medicine. This section would provide a valuable forum for networking, mentoring, advocacy and leadership development for women physicians and medical students.

Renaming the Committee on Women in Medicine to the Committee on Women’s Health would allow the committee to refine its mission to provide to address health issues that disproportionately or uniquely affect women patients.

With the largest proportion of women entering medical school in history, the MMS has an opportunity to strengthen the voice of women in medicine by providing a facilitatory role in the leadership development of women members.

**Recommendations:**

1. That the Massachusetts Medical Society request that the Bylaws be amended as appropriate to create a Women Physicians Section (WPS). The Women Physicians Section would be composed of all women MMS members. Additionally, male MMS members would be welcome to “opt in” to become WPS members. The purpose of the Section would be to provide a forum for networking, mentoring, advocacy and leadership development for women physicians and medical students. The Section would be entitled to one delegate in the House of Delegates, and the delegate shall be elected annually by the section for a one-year term. *(D)*

2. That the Committee on Women in Medicine be renamed to the Committee on Women’s Health to refine its mission to address health issues that disproportionately or uniquely affect women patients. *(D)*

**Fiscal Note:**

Annual Expense of $5,000 (Beginning FY20) *(Out-of-Pocket Expenses)*

Existing Staff *(Staff Effort to Complete Project)*
Background and Discussion

It is important to ensure that the Society stays relevant and is structured to maximize membership growth, diversity, and engagement. Currently, 5.2 to 9.5 million adults (2.2% to 4.4% of the adult population) in the United States identify as lesbian, gay, bisexual, and/or transgender (LGBT)¹ of which approximately 266,000 live in the Commonwealth of Massachusetts.²

Physician diversity that is reflective of patient demographic has been positively associated with improved patient health outcomes, reduced stigmatization of LGBT patients, and enhanced workforce development.³ Medical organizations (e.g. Association of American Medical Colleges) collect sexual orientation and gender identity demographics.⁴ Public policy research groups and research centers focused on LGBT health issues have developed best practices and guidelines for collecting this information in population-based surveys and the clinical setting.⁵,⁶ The MMS has policy dedicated to collecting specific demographic information of its membership, but does not have existing policy to collect sexual orientation and gender identity information of its membership.

Expanding the collection of demographic data to include members’ sexual orientation and gender identities will empower the MMS to identify and address professional needs and concerns of an often-marginalized minority population.⁷,⁸

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Current MMS Policy
There is no specific policy addressing this topic.

Relevance to MMS Strategic Priorities
This initiative relates directly to the MMS strategic priority of creating opportunities to grow, diversify, and engage membership across all physician demographic segments and practice settings.

**Recommendation:**
That the MMS develop a plan to expand the demographics we collect about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner. *(D)*

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)
FTE: Existing Staff
(Staff Effort to Complete Project)
Background
At I-16, CWM Report I-16 C-3, MMS Leadership Promotion and Governance, was referred to the BOT for report back with recommendations at A-17. The BOT referred this report to the MMS Presidential Officers. The officers presented Report A-17 C-10 to the HOD, and it was referred for report back to the HOD with recommendations at A-18. The BOT referred the report to the MMS Presidential Officers.

The report states:
That the Massachusetts Medical Society adopt as amended CWM Report I-16 C-3 to read as follows:

1. That the Massachusetts Medical Society facilitate increased leadership opportunities on its special committees by limiting a special committee member’s service as chair to three consecutive years (not sum total). A committee member who has served as chair for three consecutive years may be re-elected as chair after not serving as chair for at least two presidential years. Years served as chair shall not include time served filling a vacancy in the position of chair. (D)

2. That a Massachusetts Medical Society member’s leadership service as chair be limited to not more than one special committee concurrently. (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 report be adopted. The following is the reference committee’s rationale:

Limited testimony expressed concern about restricting the report to special committees and that the proposed language may have changed the intent of the original report.
proposed by the Committee on Women in Medicine at I-16. However, the testimony was
generally in favor of this report.

The report was extracted at the HOD second session. A motion was made to strike the
word “special” before committees in the resolves and the sentence “A committee
member who has served as chair for three consecutive years may be re-elected as chair
after not serving as chair for at least two presidential years.”

Testimony included the point that limiting the years an individual can serve as chair will
allow opportunities for others serving on the committee to serve as chair, as committee
members have term limits and may not have an opportunity to lead if a chair can serve
again after two years. Additional discussion ensued about the distinction between
standing committees and special committees and the importance of experience and
expertise needed on standing committees such as the Committees on Finance and
Legislation.

Following discussion, a motion was made to refer the report to the BOT for report back
at A-18. A point was made that referral would allow another look at the original report
that came from the Committee on Women in Medicine, commenting specifically
regarding the governance structure for the appointment to committees and appointments
to special committees to ascertain whether there are opportunities for improvement in
process, inclusion, diversity, and representation of best practices. It was also noted that
a Task Force on Governance was appointed to review the Society’s current governance
structure and should provide input.

Current MMS Policy
The following is MMS policy on this topic:

The MMS will continue to seek to broaden the diversity of its membership and
member participation in its activities. (D)

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

The MMS promotes representation in its leadership and committees that reflects the
Society’s membership diversity, demographics, and gender. (D)

MMS House of Delegates, 12/03/16

The MMS obtain secure and confidential race and ethnicity data for MMS members
by utilizing all available sources, including third-party vendors, in order to understand
the current composition of the MMS membership, and assist in the development of
future goals. (D)

MMS House of Delegates, 12/03/16

Relevance to MMS Strategic Priorities
The resolution/report as submitted relates to the MMS strategic priority:
Governance:
- Ensure that the Society stays relevant and is structured to maximize membership
growth, diversity, and engagement.
- Look for ways to create meaningful local and remote participation and promote
  physician engagement and leadership opportunities.

Discussion
The MMS Presidential Officers reviewed the original report from the Committee on
Women in Medicine (CWM) and comments made at the HOD, specifically the comment
regarding the governance structure for the appointment to committees and appointments to special committees to ascertain whether there are opportunities for improvement in process, inclusion, diversity, and representation of best practices, as well as mention of the work underway by the Task Force on Governance (TFGOV).

The current MMS Presidential Officers serve as members of the TFGOV. The TFGOV is currently working with a consultant in a multi-step process to accomplish its charge to review the Society’s current governance structure and formulate a recommendation for a governance structure that would best meet the needs of the membership now and into the future to achieve the Society’s strategic goals.

Currently, the TFGOV is developing a set of conceptual governing principles, which will serve as the guiding principles for the second phase in which they will review the current governance structure and consideration of any redesign or improvement process. It is through these governance principles that the values, history, culture, beliefs, and traditions are balanced with changing conditions and strategies for a more effective and sound governance structure. Before moving into phase two, the guiding principles will be widely shared throughout the organization for review and approval.

The concepts and sentiments as expressed by the CWM and HOD have been brought to the TFGOV as part of the development of the governing principles, stressing the importance of inclusion, diversity, and representation.

Conclusion
In recognition of the importance of inclusion, diversity, and the value of creating opportunities for a diverse audience of membership to participate in leadership and the importance of developing guiding principles to assist in the systematic and holistic review of the current structure and governance processes, the MMS Presidential Officers recommend the following.

Recommendation:
That the Massachusetts Medical Society adopt in-lieu of OFFICERS Report A-17 C-10 the following:

That the Massachusetts Medical Society, when reviewing the current governance structure, consider the process for appointment to standing and special committees and opportunities for committee leadership to ascertain whether there are opportunities for improvement in process, inclusion, diversity, and representation of best practices. (D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)
EXECUTIVE SUMMARY

Background
Per the MMS Procedures of the House of Delegates, “a sunset mechanism with a seven-year time horizon shall exist for all Massachusetts Medical Society policy positions and statements established by the MMS House of Delegates.” Previously, the Committee on Strategic Planning (CSP) oversaw the process of assigning policies to MMS committees to review, and committees would provide feedback to the CSP. At I-16, the House of Delegates adopted an amendment to the procedure to have the MMS Presidential Officers oversee the process. The updated procedure states, “Policies are assigned to the appropriate standing committee/MMS section(s) (in consultation with appropriate special committees) to review whether to reaffirm, sunset, reaffirm for one year, or amend the policy and provide recommendations to the MMS presidential officers for final review and submission to the House of Delegates.”

Fifty-seven policies were reviewed. The following report outlines policies scheduled to be sunset, reaffirmed, reaffirmed for one year, amended (minor amendments only) pending a possible new policy submission. Three policies — indicated with an * — were split between reaffirm for seven years and sunset, and one policy was split between reaffirm for one year and reaffirm for seven years.

Please note that policies approved by the HOD for sunset are placed in the *MMS Sunset Compendium* and can be found at massmed.org/policies.
POLICIES SCHEDULED TO BE SUNSET

ALLY HEALTH PROFESSIONS AND SERVICES

* 1. Physicians and Nurse Practitioners
[*split between Sunset and Reaffirm]*

The Massachusetts Medical Society adopts the following guidelines regarding the relationships of physicians and nurse practitioners:

a) The physician is ultimately responsible for managing the health care of patients in all practice settings.

b) Health care services delivered in a collaborative practice must be within the scope of each practitioner’s professional license, as defined by state law.

c) In a collaborative practice with a nurse practitioner, the physician and nurse practitioner will coordinate care and ensure the quality of health care provided to patients.

d) The extent of involvement by the nurse practitioner in assessment and implementation of treatment will depend on the complexity and acuity of the patient’s condition, as determined by the physician and nurse practitioner.

e) The role of the nurse practitioner in the delivery of care should be defined through mutually agreed upon guidelines for care that are developed by the physician and the nurse practitioner.

f) These guidelines for care should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patient’s condition.

g) A physician must be available for consultation with the nurse practitioner at all times, either in person, through telecommunication systems, or other means.

h) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.

i) In a collaborative practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of and respect for each other’s contributions to patient care.

j) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other’s practice patterns.

(RP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Rationale: The following policy was presented to the BOT in response to a resolution referred for decision, adopted at the October 2017 BOT meeting, and subsequently approved at the 2017 Interim HOD Meeting. The Committee on Legislation advised that the new policy supersedes the above (portion of) the original policy:

The Massachusetts Medical Society will introduce and support legislation requiring that MassHealth will recognize the value of physician supervision of advanced practice nurses (APNs) and physician assistants (PAs), within a physician-led team-based practice, by paying the physicians for services, and especially for supervision, of APNs and PAs, equal to 100% of the physician’s reimbursement rate. (D)
The Massachusetts Medical Society encourage all payers to recognize the value of physician supervision of advanced practice nurses (APNs) and physician assistants (PAs), within a physician-led team-based practice, by continuing to pay for services, and supervision, of APNs and PAs equal to 100% of the physician’s reimbursement rate. (D)

The remaining portion regarding physicians and nurse practitioners is recommended for reaffirmation for seven years.

DRUGS AND PRESCRIPTIONS

2. Return of Unused and/or Expired Medications
The MMS will request that the AMA advocate to the FDA and Congress to require that all pharmacies have a “take back and disposal” policy for unused and expired medications and that disposal of the collected unused and expired medication is handled in an environmentally safe manner, such as incineration or other suitable method. (D)

MMS House of Delegates, 5/21/11

Rationale: Directives that call for AMA advocacy/action and the AMA has adopted policy: if the policy is congruent with the MMS’s position/request and there is nothing in conflict, the item may be sunset. Please see Appendix for AMA policy.

HEALTH CARE DELIVERY

3. Workers’ Compensation Coverage
The Massachusetts Medical Society supports legislative efforts to ensure provision of written information to temporary workers within 72 hours or fewer of hire detailing required personal protective equipment for the job and all information necessary to access workers’ compensation benefits in the event of a workplace injury. (HP)

MMS House of Delegates, 5/21/11

Rationale: Accomplished through legislation.

HEALTH INSURANCE/MANAGED CARE

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

Rationale: This directive is already being done as the AMA continues to study the impact on physician workforce and patient access from the various new insurance models arising all over the country.

5. Universal Access
The Massachusetts Medical Society will utilize existing research and data to explore various options for providing universal access to health care, including single-payer, and convey this information to Society members. (D)

MMS House of Delegates, 5/14/04

Item 2 of Original: Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)

Rationale: Resolution adopted at I-17 directs the following:
The Massachusetts Medical Society will conduct a comprehensive educational conference on Universal Health Care. (D)
**Hospitals**

6. Uniform Application

The Massachusetts Medical Society will work arduously and expeditiously to seek agreement with hospitals and the major managed care networks on the use of a single uniform credentialing form. (D)

The Massachusetts Medical Society will attempt to create some logical system, with the managed care plans, to create a system whereby the providers would receive their recredentialing applications according to a uniform schedule.

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

**Rationale:** This initiative of creating a single uniform credentialing form is underway and being done by the MassCollaborative, of which the MMS is a member.

**Minorities**

7. Minority and Immigrant Populations

*[Split between Reaffirm and Sunset]*

... The MMS endorses the Mission Statement and Vision Statement of the Commission to End Health Care Disparities, which reads as follows:

Commission to End Health Care Disparities

**Mission Statement:**

The Commission to End Health Care Disparities, inspired by the Institute of Medicine report, *Unequal Treatment*, recognizes that health care disparities exist due to multiple factors, including race and ethnicity. We will collaborate proactively to increase awareness among physicians and health professionals; use evidence-based and other strategies; and advocate for action, including governmental, to eliminate disparities in health care and strengthen the health care system.

**Vision Statement:**

Aided by the work of the Commission and its member organizations, physicians, health professionals, and health systems will provide quality care to all people.

(HP)

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

**Rationale:** Commission no longer operational.

**Physician Payment**

8. CPT Codes

The Massachusetts Medical Society will encourage the American Medical Association to create a new CPT code for communication and transmission of data to the admitting hospitalist for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication) and from the hospitalist to the outpatient doctor. (D)
The MMS will encourage the AMA to advocate for reasonable payment for the new
handoff/admission/discharge coordination-of-care CPT code by the CMS-Medicare. *(D)*

The MMS will encourage the AMA and others to advocate for proper recognition of services of
primary care physicians by hospitals and medical schools. *(D)*

**Rationale:** Directives that call for AMA advocacy/action and the AMA has adopted policy: if the
policy is congruent with the MMS’s position/request and there is nothing in conflict, the item may
be sunset. Please see Appendix for AMA policy.

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*9. [Split between Sunset and Reaffirm]*

The Massachusetts Medical Society (MMS) will advocate to the American Medical Association
(AMA) for increased effort to support the concept that third-party payers should provide more
equitable reimbursement for physicians’ services, and that these efforts will be directed to
achieve equitable compensation for all physicians. *(D)*

... 

**Rationale:** Directives that call for AMA advocacy/action and the AMA has adopted policy: if the
policy is congruent with the MMS’s position/request and there is nothing in conflict, the item may
be sunset. Please see Appendix for AMA policy.

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**PROFESSIONAL LIABILITY**

10. **ERISA**

The Massachusetts Medical Society, working through its AMA Delegation together with other
interested parties, will support appropriate Federal legislative initiatives to address the issue of
ERISA preemption of state tort and contract law relating to the imposition of liability on self-
insured health and welfare benefit plans. *(HP)*

**Rationale:** Directives that call for AMA advocacy/action and the AMA has adopted policy: if the
policy is congruent with the MMS’s position/request and there is nothing in conflict, the item may
be sunset. Please see Appendix for AMA policy.

**PUBLIC HEALTH**

11. **Full-Body Airport Scanners**

The MMS will review and consider sharing any forthcoming AMA statements on the safety of
full-body airport scanners with specialty societies and appropriate state agencies. *(D)*

**Rationale:** Completed.

**QUALITY OF CARE**

12. **Risk Contracts**

The Massachusetts Medical Society will work with the health plans to develop a template with
standardized language regarding what valid data should be made available to physicians in a
timely manner to assist them as they undertake risk contracts and strive to improve quality and
provide cost effective care. This language would be reviewed by physicians and other experts who have experience with risk contracts for their input. Final language would be widely disseminated to MMS members. (D)

Rationale: Completed.

MMS House of Delegates, 5/21/11
Recommendation:

A. That the Massachusetts Medical Society reaffirm for seven (7) years the following policies:

1a. ADVANCE CARE PLANNING/END-OF-LIFE CARE

The Massachusetts Medical Society supports patient dignity and the alleviation of pain and suffering at the end of life. (HP)

The Massachusetts Medical Society will provide physicians treating terminally ill patients with the ethical, medical, social, and legal education, training, and resources to enable them to contribute to the comfort and dignity of the patient and the patient’s family. (D)

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 12/3/11
(Item 3 of Original: Rescinded, MMS House of Delegates, 12/2/17)

ALLIED HEALTH PROFESSIONS AND SERVICES

2a. Physicians and Physician Assistants

[*Split between Sunset and Reaffirm]*

... The Massachusetts Medical Society adopts the following guidelines regarding the relationships of physicians and physician assistants:

a) The physician is ultimately responsible for managing the health care of patients in all settings.

b) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner’s authorized practice as defined by state law.

c) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.

d) The physician is responsible for the supervision of the physician assistant in all settings.

e) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines for care that are developed by the physician and the physician assistant, and based on the physician’s delegatory style.

f) The physician must be available for consultation with the physician assistant at all times either in person, through telecommunication systems, or other means.

g) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient’s condition and the training and experience and preparation of the physician assistant as adjudged by the physician.
h) Patients should be made clearly aware at all times whether they are being
cared for by a physician or a physician assistant.

i) There should be a professional and courteous relationship between physician
and physician assistant, with mutual acknowledgment of and respect for each
other’s contributions to patient care.

j) The physician and physician assistant together should review all delegated
patient services on a regular basis, as well as the mutually agreed upon
guidelines for care.

k) The physician is responsible for clarifying and familiarizing the physician
assistant with the physician’s supervising methods and style of delegating
patient care.

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

3a. Radiological Technologists
The MMS will express support of measures that promote patient protection and health
care workers safety in the appropriate and cost-effective use of fluoroscopic medical
services. (HP)

MMS House of Delegates, 5/14/04
Item 2 of Original: Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)

4a. Blood Donation
The Massachusetts Medical Society will continue its efforts to encourage the voluntary
donation of blood. (HP)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

5a. Biosimilar Medications
The MMS will advocate via regulatory or legislative avenues that so-called bioequivalent
(i.e., generic) substitutions for narrow therapeutic index agents (or those prescribed for
treatment of conditions where potential harm of variable bioavailability, prescription to
prescription, of said substitution is substantial) not be mandated and/or be limited to no
more frequently than once a year, especially for economic reasons alone. This should
apply not only to substitutions for branded agents, but also to other generic so-called
bioequivalent agents of the same molecular structure. (D)

The MMS will advocate via regulatory or legislative avenues that biosimilar medications
not be substituted without the express endorsement of the prescribing physician. (D)

MMS House of Delegates, 5/21/11

6a. Education Regarding Industry Marketing and Advertising
The MMS supports the concepts that (a) physicians maintain a heightened awareness at
all times of the implied and perceived obligations regarding all interactions with the
pharmaceutical and medical device industry, and that (b) perception of physicians’ behavior
should be considered with each contact with industry representatives. (HP)

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/14/04

Item 2: Amended and Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)

7a. Prescription Writing/E-Prescribing
The Massachusetts Medical Society opposes psychologists obtaining prescription
privileges in Massachusetts. (HP)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

8a. Return of Unused and/or Expired Medications
The Massachusetts Medical Society supports the policy that all unused nursing home
drugs, which are sealed and dated, be returned for credit. (HP)

The Massachusetts Medical Society, in collaboration with the Massachusetts chapter of
the American Medical Directors Association and the Massachusetts chapter of the
American Geriatric Society, urges the Massachusetts Department of Public Health to
expand its current medication return list. (D)

The Massachusetts Medical Society urges Massachusetts Congressional members to
draft legislation supporting the recycling of unused nursing home drugs, which are
sealed and dated. (D)

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03

Item 1: Reaffirmed MMS House of Delegates, 5/14/10

Items 2 and 3: Amended and Reaffirmed MMS House of Delegates, 5/21/11

ETHICS

9a. Medical Education/Performing Procedures
The Massachusetts Medical Society urges medical schools to adopt and inform medical
students of the policy that they may refuse to perform procedures during medical
education that are contrary to their religious or moral beliefs without repercussions to
the student. (HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

FIREARMS: SAFETY AND REGULATION

10a. Handguns
The Massachusetts Medical Society is strongly opposed to legislative interference in the
right of physicians and patients (or their parents or guardians) to discuss gun
ownership, storage, and safety in the home. (HP)

The MMS records its opposition to any legislative or regulatory limits on a physician’s
ability to take a complete history and document relevant portions of the history into the
permanent medical record. (HP)
The MMS will advocate that the AMA take a leadership role in opposing legislative interference in the physician-patient relationship and the physician’s efforts to discuss and record the patient’s history, including questions about gun safety. (D)

MMS House of Delegates, 5/21/11

HEALTH CARE DELIVERY

11a. Clinical Integration

The MMS will continuously monitor AMA activity regarding health care laws, regulations, and model organizational information for physicians (including independent, small groups) and medical staffs. This information will assist members with communicating, organizing, and participating in care processes for the high quality and efficient service delivery of health care that will permit independent physician practitioners and/or small groups to clinically integrate and provide accountable care. (D)

MMS House of Delegates, 5/21/11

12a. Telemedicine

The Massachusetts Medical Society affirms that any physician practicing telemedicine with a patient in Massachusetts should possess a full and unrestricted license in Massachusetts. (HP)

MMS House of Delegates, 11/21/97
Reaffirmed, MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

HEALTH INSURANCE/MANAGED CARE

13a. Health Insurance

Individual Choice and Support for a Pluralistic System

The Massachusetts Medical Society supports an individual’s right to select, purchase, and own his/her health insurance and to receive similar tax treatment for individually purchased insurance as for employer purchased coverage. (HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

HOSPITALS

14a. Hospital and Health Care Facility Closings

The Massachusetts Medical Society adopts the following principles regarding Health Care Facility Closure—

Physician Credentialing Records:

1. Governing Body to Make Arrangements

The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility. The governing body shall send notification of the impending closure to all those physicians credentialed at that facility at least 30 days prior to the date of closure.
2. **Transfer to New or Succeeding Custodian**
   Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.

3. **Documentation of Physician Credentials**
   The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.

4. **Maintenance and Retention**
   Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records. The records shall be maintained for a period of at least two years from the date the facility closes.

5. **Access and Fees**
   The new custodian of the records shall provide timely access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.

*(HP)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

**MASSACHUSETTS MEDICAL SOCIETY ADMINISTRATION AND ORGANIZATION**

15a. **Membership and Dues**
   The MMS will work with the district medical societies to initiate consistent discounts for both state and district dues, which would provide simplification of the billing process and deliver more comprehensive invoices to the member. *(D)*

   *MMS House of Delegates, 5/21/11*
   *(Item 1 of 3: Auto-Sunset)*

16a. **Student Dues**
   The Massachusetts Medical Society (MMS) will exempt dues for its Medical Student Membership. *(D)*

   In order to offset expenses of exempt dues for Medical Student Membership, an alternative level of benefits will be provided for medical student members, including substitution of the *New England Journal of Medicine (NEJM) Online* for the printed NEJM subscription, and that medical students will no longer have MMS Internet account privileges. *(D)*

   *MMS House of Delegates, 11/6/04*
   Reaffirmed MMS House of Delegates, 5/21/11

17a. **Membership Pilot Projects**
   The House of Delegates delegates to the Board of Trustees the authority to approve the use of pilot membership recruitment/retention projects involving variations of no more than 50% on the current MMS dues structure, as proposed by the Committee on Membership. *(D)*
Such pilot projects shall be required to have a defined time limit, as well as having the prior approval of the Committee on Finance. (HP)

The Committee on Membership shall report annually to the House of Delegates as to the impact of all current pilot projects. (D)

MEDICAID

18a. Preauthorizations

The Massachusetts Medical Society recommends to the Division of Medical Assistance that any requirements for preauthorizations by physicians be reviewed by MMS prior to implementation. (HP)

MEDICARE/ MEDICAID SERVICES

19a. Practice Expenses

HCFA [CMS] should make efforts to broadly survey medical practices for actual expense data. (HP)

MINORITIES

20a. Minority and Immigrant Populations

The Massachusetts Medical Society, in its role as advocate for patients, will promote a coordinated strategy for: increasing access to medical care for minority populations; heightening awareness of cultural practices through education; and creating greater opportunities for minorities and immigrants within the medical profession, including participation in the Massachusetts Medical Society.

I. Increasing Access to Medical Care for Minority Populations

The Massachusetts Medical Society recognizes that access to medical care is the first step to ensuring quality and improved outcomes. Therefore, the Massachusetts Medical Society will continue to strive for universal access to medical care, regardless of race, ethnicity, socio-economic status or geographic location.

MMS will encourage and work with community outreach programs that address the health care needs of minority and immigrant communities. In addition, the Society will continue to develop links with community-based organizations and social service agencies to identify community-wide health problems and organize health education programs that are specifically tailored to the needs of those particular communities.
II. Heightening Awareness of Cultural Practices and Barriers through Education

The Massachusetts Medical Society should promote increased awareness and research among physicians and medical students on the ethnic and cultural differences between patients, physicians and other health care providers that can create barriers to good quality health care and research. The Massachusetts Medical Society supports the expansion of educational opportunities for medical students, residents, and physicians in the areas of cultural awareness and ethnic diversity.

III. Creating Opportunities for More Diversity within the Medical Profession

The Massachusetts Medical Society supports the expansion of educational opportunities in biomedical careers for minority and immigrant populations. The Society encourages physicians and health care organizations to employ culturally diverse staff, at all levels, in order to address the needs of the community.

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
(Item III: Amended and Reaffirmed MMS House of Delegates, 5/21/11)
(Item 5 of Original 5, Sunset: 5/21/11)

21a.
[*Split between Reaffirm and Sunset]
The Massachusetts Medical Society (MMS) will increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. (D)

The MMS supports the elimination of racial and ethnic disparities in health care as an issue of high priority. (HP)

... 

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

PHYSICIAN PAYMENT

22a. Supervising Teaching Physicians
The Massachusetts Medical Society advocates that all payors reimburse the supervising teaching physician for services provided by a resident unless that resident’s service is already fully and explicitly funded by that payor. (HP)

MMS House of Delegates, 5/16/97
Reaffirmed, MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

23a. CPT Codes
[*Split between Sunset and Reaffirm]

... 

The MMS will continue to advocate for reimbursement for all physicians’ services as reflected in the AMA’s Current Procedural Terminology codebook. (D)
24a. Third Party Insurers
The Massachusetts Medical Society (MMS) will advocate for laws, regulations, or
directives for all insurance carriers, including Medicaid and Medicare, to pay for
mandated services required by law or regulation. (D)

25a. The Massachusetts Medical Society will advocate to payers and support legislation
to require payment to physicians and other health care providers for services rendered if
— at the time of the patient’s visit — the provider verified coverage through the insurer’s
available eligibility inquiry system(s), regardless of: future retroactive eligibility changes
by the employer or patient, or errors in the insurer’s eligibility system. (D)

PHYSICIANS
26a. Gender Parity
The Massachusetts Medical Society endorses the American Medical Association’s policy,
“Gender Disparities in Physician Income and Advancement” that reads as follows:

Gender Disparities in Physician Income and Advancement
1. That our American Medical Association encourage medical associations and other
relevant organizations to study gender differences in income and advancement
trends, by specialty, experience, work hours and other practice characteristics, and
develop programs to address disparities where they exist;
2. That our AMA support physicians in making informed decisions on work-life balance
issues through the continued development of informational resources on issues such
as part-time work options, job sharing, flexible scheduling, reentry, and contract
negotiations;
3. That our AMA urge medical schools, hospitals, group practices and other physician
employers to institute and monitor transparency in pay levels in order to identify and
eliminate gender bias and promote gender equity throughout the profession;
4. That our AMA collect and publicize information on best practices in academic
medicine and non academic medicine that foster gender parity in the profession; and
5. That our AMA provide training on leadership development, contract and salary
negotiations and career advancement strategies, to combat gender disparities as a
member benefit.

The MMS will advocate and raise awareness for gender parity, equal pay, and
advancement as a fundamental professional standard to ensure equal opportunity within
the medical profession in Massachusetts. (D)
PREAUTHORIZATIONS

27a. Preauthorizations
The MMS opposes the use of preauthorization where the medication or procedure prescribed is a common and indicated one or commonly used medication for the indication as supported by peer-reviewed medical publications. (HP)

Any reviewer at any level of the preauthorization process be fully identified by full name, title, and location; educational level; and contact information of supervisor. (HP)

Third parties should make available to the Massachusetts Medical Society meaningful, aggregate statistics in usable form in a timely fashion (e.g., broken down by specialty, medication, diagnostic test, or procedure; indication offered and reason for denial and outcomes analysis) of percentages of acceptance or denial as well as other relevant trending information. Individual medical group data should be made available upon request by each group. (D)

MMS House of Delegates, 5/14/11

28a. The Massachusetts Medical Society (MMS) opposes pre-certification programs of third-party payers that interfere with the physician-patient relationship, delay medically necessary care, or impose an undue administrative burden on physicians. (HP)

The MMS will work with third-party payers to develop meaningful hassle-free utilization review programs that are educational in design and enhance quality of patient care. (D)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

PROFESSIONAL LIABILITY

29a. Excess Professional Liability Insurance
In order to enhance freedom of choice in the selection of medical professional liability insurance coverage, the Massachusetts Medical Society will advocate with all health insurance plans, hospital staffs, and other pertinent health care entities that any mandatory malpractice insurance coverage limit requirement higher than the state minimum should be eliminated. (D)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

30a. The Massachusetts Medical Society will continue to advocate for legislation which requires that physician expert witnesses testifying in medical professional liability cases venued in the Commonwealth of Massachusetts must possess the following qualifications: (1) Hold a non-restricted medical license; (2) Be board certified in the same relevant specialty as the defendant physician; (3) Be actively practicing in the same specialty as the defendant physician; (4) Be available at trial if serving as the expert at the tribunal stage of the proceedings. (D)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

*31a.
[*Split between Reaffirm and Reaffirm for One Year]
The MMS will collaborate with appropriate legal representatives, Massachusetts professional liability insurers, and the Massachusetts Board of Registration in Medicine for purposes of implementing the Expert Witness Testimony Standards in the form of MMS policy, an affirmation statement, and/or by other useful and effective means, to improve the quality of clinical evidence introduced at all stages of the litigation process.

(D)

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

RESEARCH

32a. Medical Research
The Massachusetts Medical Society in its program developments will take into consideration the importance of promoting and supporting medical research in the interest of the health and well-being of future generations. (HP)

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

SURGERY

33a. Standards of Care
The Massachusetts Medical Society (MMS) recognizes that minimum frequency standards may be appropriate for some surgical procedures. (HP)

The MMS will continue to monitor the literature and physician feedback concerning the impact and ethic of performing surgical procedures as it relates to surgical volume. (D)

The MMS will continue to monitor and provide feedback, when appropriate, to relevant agencies as they develop standards regarding surgical competency and minimum frequency. (D)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

TOBACCO/ SMOCKING

34a. Government Initiatives: Sale of Tobacco Products, Advertising, Prevention
The Massachusetts Medical Society strongly supports comprehensive prevention, education, cessation, and advocacy efforts to prevent morbidity and mortality associated with tobacco use. (HP)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

VIOLENCE

35a. Domestic Violence Detection Education
The Massachusetts Medical Society supports the establishment of child abuse and domestic violence detection educational programs for physicians, physicians in training and medical students. In addition, the Massachusetts Medical Society strongly encourages and facilitates the participation of physicians, physicians in training and medical students in these programs. It is further recommended that physicians be allowed to use their participation in these programs toward the risk management requirement for relicensure. (HP)

MMS House of Delegates, 5/20/94
Reaffirmed MMS House of Delegates, 5/21/11
36a. Hate Crimes

The Massachusetts Medical Society recognizes the significant negative health outcomes and health care disparities caused by discrimination and hate violence against transgender individuals based on their gender identity and expression. (*HP*)

The Massachusetts Medical Society strongly supports legal protections against discrimination and hate violence against transgender individuals based on their gender identity and expression. (*HP*)

*MMS House of Delegates, 5/21/11*
Recommendation:
B. That the following policies eligible for sunsetting be amended and reaffirmed for seven (7) year (added text shown as “text” and deleted text shown as “text”):

1b. ADVANCE CARE PLANNING/END-OF-LIFE CARE
The Massachusetts Medical Society endorses and encourages statewide dissemination and adoption of the Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) Program, which assists individuals in communicating their preferences for life-sustaining treatments near the end of life. (HP)

The Massachusetts Medical Society will roll-out continue to support continuing medical education appropriate for risk management credit that includes information to assure that clinicians can work with appropriate patients to communicate their preferences for life-sustaining treatment across health care settings, document these preferences on a Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) form, and respond appropriately when they encounter a patient with a MOLST form. (D)

MMS House of Delegates, 5/21/11

DRUGS AND PRESCRIPTIONS
2b. Marijuana: Recreational Use of
The Massachusetts Medical Society affirms its opposition to smoking the use of marijuana for recreational purposes. (HP)

The Massachusetts Medical Society recognizes the importance of clinical trials research on the medical use of marijuana and its derivatives. All such trials should be approved by an Institutional Review Board process. (HP)

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

HEALTH EDUCATION
3b. Student Health
The MMS encourages local communities to provide age-appropriate comprehensive health education to students that incorporates information on the prevention of STIs, including HIV. (D)

MMS House of Delegates, 5/14/04
Item 2 of 2: Reaffirmed MMS House of Delegates, 5/21/11

MENTAL HEALTH
4b. Mental Health Services: Gestation and Postpartum
The MMS supports a culture of awareness, destigmatization, and screening, referral, and treatment for psychiatric illnesses during gestation pregnancy and postpartum to ensure that patients have access to effective and affordable mental health services. (HP)

The MMS will advocate for expanding health insurance coverage and reimbursement of medically necessary mental health services during gestation pregnancy and postpartum. (D)
The MMS will work with other appropriate organizations and specialty societies to support and promote awareness among patients, families, and providers of the risks of mental illness during gestation pregnancy and postpartum. (D)

The MMS will work with all appropriate parties such as insurers, health care systems, providers, consumers, allied health care professionals, and the government to foster integration of mental health care with general medical care. (D)

MINORITIES

5b. Biomedical Sciences Career Project
The Massachusetts Medical Society will support and contribute to programs such as the Biomedical Sciences Career Project to expand educational opportunities in medicine and the biomedical sciences for underrepresented minorities. (D)

The Massachusetts Medical Society will work with Massachusetts medical schools to promote recruitment of underrepresented minorities into medicine. (D)

Physician Payment

6b. Recoupment Limitations
The MMS will immediately draft legislation that establishes a time limit for recoupment of payments which is equal to the time limit that is established by each payer for the submission of claims, only excepting demonstrably fraudulent or criminal activities and actively seek to have this legislation filed in the 2011–2012 state legislative session. (D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)
Recommendation:
C. That the Massachusetts Medical Society reaffirm for one (1) year
the following policies:

ETHICS
1c. Genetic Information and Patient Privacy
The Massachusetts Medical Society will adopt the following General Principles on
Genetic Information and Patient Privacy:

1. Physicians should accord genetic information derived about their patients the
highest possible confidentiality protection. Genetic information in the medical
record should be handled so as to prevent inadvertent disclosure. Such
information should be released to third parties only pursuant to the specific
authorization of the patient. The possibility that genetic information derived about
a patient might be of clinical importance to relatives or other third persons does
not alter the physician’s duty of confidentiality to his or her patients. The
physician should, however, inform patients who are considering a genetic test
about the potential importance of the data that could be derived there from to
relatives. On very rare occasions, a physician may reveal otherwise confidential
genetic information to a third person if withholding the genetic information
derived from the patient will likely cause imminent and serious harm, injury or
danger to that particular third person.

2. Physicians should strive to become aware of the special ethical, legal, social,
financial, and personal issues that may arise when they or others compile genetic
information about their patients.

3. Physicians engaged in genetic testing for clinical, therapeutic or research
purposes should engage in such testing only with the full informed consent of the
patient or, when appropriate, with the informed consent of the patient’s legally
authorized representative. Such informed consent should, at a minimum, involve a
disclosure by the physician to the patient of the benefits, risks and costs
associated with receiving the test, any appropriate alternative procedures or
courses of treatment, the potential results of the test, any possible financial
benefit to the physician, including any research interest, from either performing
the test or utilizing the samples, and any other significant implications of
receiving the test.

4. In cases where genetic samples have been intentionally donated for the purpose
of genetics research in an anonymous manner (i.e., removed of or without
identifiers), physicians need not obtain informed consent in order to engage in
non-clinical use of such genetic testing results or samples.

5. Physicians should not order genetic testing of a child unless the test is intended
to diagnose a disease or condition for which there is a recognized clinical benefit
to acquiring the information before the child reaches the age of eighteen (18).
Clinical benefit should be understood to include issues involving reproductive
risks that are faced by adolescents (girls and boys), including those that arise in
the context of an unplanned pregnancy. Such tests should be ordered only with
the informed consent of the legally responsible person.
6. Physicians should participate in genetic research involving human subjects only if the research protocol has been approved by an institutional review board (IRB) or some comparable group that operates pursuant to federal guidelines involving human subjects research. They should satisfy themselves that adherence to the protocol will result in research subjects having adequate, fair disclosure concerning issues such as informational risk, long-term use and disposition of tissue samples, disclosure of research results to subjects, whether subjects will be recontacted if new information emerges, and relevant economic issues (such as whether the research is sponsored by a for-profit organization and/or whether a subject will or will not receive any economic benefit).

7. Genetic testing results can provide valuable information to be considered by individuals making reproductive choices. MMS opposes, however, the use of genetic testing results by persons or institutions, other than the patient[s] from whom the genetic information was derived, to influence the reproductive choice of the patient[s] from whom the genetic information was derived.

8. The Massachusetts Medical Society hereby affirms existing policy regarding genetic discrimination in insurance coverage which reads as follows:

The Massachusetts Medical Society adopts the AMA Policy H-185.972 regarding Genetic Information and Insurance Coverage, which reads as follows:

(1) Health insurance providers should be prohibited from using genetic information, or an individual’s request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements.

(2) Health insurance providers should be prohibited from establishing differential rates or premium payments on genetic information or an individual’s request for genetic services.

(3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information.

(4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure be made.

9. The Massachusetts Medical Society hereby affirms existing policy regarding genetic discrimination in the workplace, which reads as follows:

The Massachusetts Medical Society adopts the AMA policy E-2.132 regarding Genetic Testing by Employers which reads:

As a result of the human genome project, physicians will be able to identify a greater number of genetic risks of disease. Among the potential uses of the tests that detect
these risks will be screening of potential workers by employers. Employers may want to
exclude workers with certain genetic risks from the workplace because these workers
may become disabled prematurely, impose higher health care costs, or pose a risk to
public safety. In addition, exposure to certain substances in the workplace may increase
the likelihood that a disease will develop in the worker with a genetic risk for the disease.

(1) It would generally be inappropriate to exclude workers with genetic risks of
disease from the workplace because of their risk. Genetic tests alone do not have
sufficient predictive value to be relied upon as a basis for excluding workers.
Consequently, use of the tests would result in unfair discrimination against
individuals who have positive test results. In addition, there are other ways for
employers to serve their legitimate interests. Tests of a worker’s actual capacity to
meet the demands of the job can be used to ensure future employability and
protect the public’s safety. Routine monitoring of a worker’s exposure can be
used to protect workers who have a genetic susceptibility to injury from a
substance in the workplace. In addition, employees should be advised of the risks
of injury to which they are being exposed.

(2) There may be a role for genetic testing in the exclusion from the workplace of
workers who have a genetic susceptibility to injury. At a minimum, several
conditions would have to be met:

(a) The disease develops so rapidly that serious and irreversible injury would
occur before monitoring of either the worker’s exposure to the toxic substance
or the worker’s health status could be effective in preventing harm.
(b) The genetic testing is highly accurate, with sufficient sensitivity and specificity
to minimize the risk of false negative and false positive test results.
(c) Empirical data demonstrate that the genetic abnormality results in an
unusually elevated susceptibility to occupational injury.
(d) It would require undue cost to protect susceptible employees by lowering the
level of the toxic substance in the workplace. The costs of lowering the level of
the substance must be extraordinary relative to the employer’s other costs of
making the product for which the toxic substance is used. Since genetic
testing with exclusion of susceptible employees is the alternative to cleaning
up the workplace, the cost of lowering the level of the substance must also be
extraordinary relative to the costs of using genetic testing.
(e) Testing must not be performed without the informed consent of the employee
or applicant for employment.

(3) That the Massachusetts Medical Society agrees that employers should be
prohibited from requesting, obtaining, or using genetic information to hire or fire
an employee, or set terms, conditions, privileges, or benefits of employment,
unless the employment organization can prove this information is job related and
consistent with CEJA opinion 2.132.

(4) That employers should be prohibited from disclosing genetic information.
(MMS House of Delegates, 11/21/97)
(Reaffirmed, MMS House of Delegates, 5/14/04)
(Reaffirmed MMS House of Delegates, 5/21/11)
10. Appreciating the acceleration of new information in the field of genetics, the Massachusetts Medical Society will develop a plan to educate physicians throughout the state (through venues such as conferences and interactive or online learning tools and curricula suitable for Grand Rounds, etc.), regarding the basic and current principles of genetic information and testing, and the clinical, social and legal implications of such advancing technologies.

(MMS House of Delegates, 11/6/99)

2C. HEALTH SYSTEM REFORM

The Massachusetts Medical Society adopts the following Principles for Health Care Reform:

1. **Physician leadership.** Physician leadership is seen as essential for the implementation of new payment reform models. Strong leadership from primary care and specialty care physicians in both the administrative structure of accountable care organizations (ACOs) and other payment reform models, as well as in policy development, cost containment and clinical decision-making processes, is key.

2. **One size will not fit all.** One single payment model will not be successful in all types of practice settings. Many physician groups will have a great deal of difficulty making a transition due to their geographic location, patient mix, specialty, technical and organizational readiness, and other factors.

3. **Deliberate and careful.** Efforts must be undertaken to guard against the risk of unintended consequences in any introduction of a new payment system.

4. **Fee-for-service payments have a role.** While a global payment model could encourage collaboration among providers, care coordination, and a more holistic approach to a patient’s care, fee-for-service payments should be a component of any payment system.

5. **Infrastructure support.** Sufficient resources for a comprehensive health information technology infrastructure and hiring an appropriate team of physician assistants, nurse practitioners, and other relevant staff are essential across all payment reform models.

6. **Proper risk adjustment.** In order to take on a bundled, global payment or other related payment models, funding must be adequate, and adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors is needed. Current risk adjustment tools have limitations, and payers must include physician input as tools evolve and provide enough flexibility regarding resources in order to ensure responsible approaches are implemented. In addition, ACOs and like entities must have the infrastructure in place and individuals with the skills to understand and manage risk.

7. **Transparency.** There must be transparency across all aspects of administrative, legal, measurement, and payment policies across payers regarding ACO structures and new payment models. There must also be transparency in the financing of physicians across specialties. Trust is a necessary ingredient of a successful ACO or other
payment reform model. The negotiations between specialists, primary care physicians, and payers will be a determining factor in establishing this trust.

8. Proper measurements and good data. Comprehensive and actionable data from payers regarding the true risks of patients is key to any payment reform model. Without meaningful, comprehensive data, it becomes impractical to take on risk. Nationally accepted, reliable, and validated clinical measures must be used to both measure quality performance and efficiency and evaluate patient experience. Data must be accurate, timely, and made available to physicians for both trending and the ability to implement quality improvement and cost effective care. The ability to correct inaccurate data is also important.

9. Patient expectations. Patient expectations need to be realigned to support the more realistic understanding of benefits and risks of tests and clinical services or procedures when considering new payment reform models. Physicians and payers must work together to provide a public health educational campaign, with an opportunity for patients to provide input as appropriate and engage in relevant processes.

10. Patient incentives. Patient accountability coupled with physician accountability will be an effective element for success with payment reform. An important aspect of benefit design by payers is to exclude cost sharing for preventive care and other selected services.

11. Benefit design. Benefit designs should be fluid and innovative. Any contemplation of regulation and legislation with regard to benefit design should balance mandating minimum benefits, administrative simplification, with sufficient freedom to create positive transparent incentives for both patients and physicians to maximize quality and value.

12. Professional liability reform. Defensive medicine is not in the patient’s best interest and increases the cost of healthcare. In an environment where physicians have the incentive to do less, but patients request more, physicians view litigation as an inevitable outcome unless there is effective professional liability reform.

13. Antitrust reform. As large provider entities, ACO definitions and behavior may collide with anti-trust laws. The state legislature may be the adjudicator of antitrust issues. Accountable care organizations and other relevant payment reform models should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.

14. Administrative simplification. Physicians and others who participate in new payment models, including ACOs, should work with payers to reduce administrative processes and complexities and related burdens that interfere with delivering care. Primary care physicians should be protected from undue administrative burdens or should be appropriately compensated for it.

15. The incentives to transition. In order to transition to a new model, incentives must be predominantly positive.
16. **Planning must be flexible.** Accommodations must be made to take into account the highly variable readiness of practices to move to a new system.

17. **Primary care physician.** All patients should be encouraged to have a primary care physician with whom they can build a trusted relationship and from whom they can receive care coordination.

18. **Patient access.** Health care reform must enable patient choice in access to physicians, hospitals and other services while recognizing economic realities.

(HP)  

**HOSPITALS**  

3c. Mergers or Conversions  

Statement of Principles for Conversions and Mergers  

Statement of Principles for Conversions and Mergers  

A. Community Health Impact:

1. Any proposed merger or conversion should assure access to high quality patient care and medically necessary services appropriate to the community’s needs.

2. The proposed new entity should be obligated to provide the same or enhanced levels of services in the following areas:
   - care to the uninsured and other vulnerable populations
   - community health
   - education and teaching
   - research

3. The health services to be provided by the new entity should be defined prior to the approval of the conversion or merger and should be committed to for a defined period. Procedures should be established for effective independent monitoring of those services to assure compliance with the agreed upon commitments and assessment of their effect on the community health status.

4. Public hearings should be held to assure full public discussion of the proposed new entity and community concerns should be given full hearing. The proposed new entity should develop a written plan which addresses those community concerns before final approval of the proposed conversion or merger.

B. Oversight Requirements:

1. There should be full compliance with all requirements set forth by the Office of the Massachusetts Attorney General and the Massachusetts Department of Public Health.

2. An independent appraisal of assets should be completed prior to a for-profit conversion.

3. Private inurement to officers, trustees, directors and employees of the converting or merging entities should be prohibited.
(4) All actual and potential conflicts of interest by officers, trustees, directors and employees of the converting or merging entities should be publicly disclosed.

(5) The mission of any charitable foundation that is established after a conversion should be limited to improving the health of the community. Such foundations should be governed by a local board of directors with meaningful community and physician participation.

(6) The level of compensation for officers, trustees, directors and employees of the newly formed entity and the charitable foundation, when applicable, should be at an appropriate market rate.

Implementation Strategies

(1) Issue: Staffing Levels – With respect to Principle A.1.: “Any proposed merger or conversion should assure access to high quality patient care . . .” One key determinant of the quality of patient care is the adequacy of medical staffing. Strategy: After the conversion or merger, staffing levels should be appropriate to provide high quality patient care.

(2) Issue: Service Changes – With respect to Principle A.3.: "The health services to be provided by the new entity should be defined prior to the approval of the conversion or merger . . ." Appropriate information needs to be made available to the community in a timely manner, so as to enable the community to provide effective input to the process. Strategy: The new entity should identify both current services and those services it proposes to provide. As further modifications of services are proposed, the community should be informed and their input sought.

(3) Issue: Monitoring – With respect to Principle A.3.: "Procedures should be established for effective independent monitoring . . ." Because the affected community has the most at stake, it should be given the mandate and resources needed to perform this task. Strategy: Effective monitoring may be achieved by a local advisory board with significant autonomy.

(4) Issue: Private Inurement – With respect to Principle B.3.: "Private inurement to officers, trustees, directors and employees of the converting or merging entities should be prohibited." Decisions regarding conversions and mergers should be made solely on the basis of the best interests of the converting or merging entity and the community it serves. Strategy: Such abuses of trust should be aggressively investigated and prohibited by law or regulation, with penalties for violations.

(5) Issue: Conflicts of Interest – With respect to Principle B.4.: "All actual and potential conflicts of interest by officers, trustees, directors and employees of the converting or merging entities should be publicly disclosed." The purpose of this recommendation is to inform the community about the possible motives of key decision-makers in the conversion or merger process. Strategy: All disclosures of conflicts of interest should be documented in writing.

(6) Issue: Charitable Foundations – With respect to Principle B.5.: "The mission of any charitable foundation that is established after a conversion should be limited to improving the health of the community. Such foundations should
be governed by a local board of directors with meaningful community and
physician participation." And, Principle B.6., states: "The level of
compensation for officers, trustees, directors and employees of . . . the
charitable foundation . . . should be at an appropriate market rate."
Charitable foundations formed with the assets of a converting entity have
great potential for being misused. Strategy: The mission, governance,
operations and management of such foundations should be subject to public
scrutiny and focused on health care.

(HP)
MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

MINORITIES
4c. Race and Ethnicity data
The Massachusetts Medical Society, recognizing that race and ethnicity are concepts
that are sensitive and difficult to define, and yet important determinants of health
outcomes, supports the use of the uniform and standardized classification system of the
U.S. Bureau of the Census, during the voluntary collection of race and ethnicity data.

(HP)
MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

PROFESSIONAL LIABILITY
*5c. Physician Expert Witnesses
[*Split between Reaffirm for One Year and Reaffirm for Seven Years]
The Massachusetts Medical Society (MMS) adopts the following Expert Witness
Testimony Standards, applicable to all physicians who testify as expert witnesses in
professional liability cases in Massachusetts:
1. The physician expert witness must hold a current, valid, nonrestricted medical
license.
2. The physician expert witness must be board certified in the same specialty as
the defendant physician when providing expert testimony on the standard of
care provided by the defendant, or board certified in their specialty when
providing any other relevant expert testimony in the case. Board certification
shall be with a specialty board recognized by the American Board of Medical
Specialties or the American Osteopathic Association.
3. The physician expert witness must be actively engaged in the clinical practice
of medicine.
4. The physician expert witness must be aware of and comply with the American
Medical Association’s (AMA) policies on Medical Testimony, False Testimony,
Peer Review of Medical Expert Witness Testimony, Expert Witness Testimony,
AMA-ABA Statement on Interprofessional Relations for Physicians and
Attorneys, and other applicable expert witness testimony standards,
guidelines, principles, and codes of ethics established by the American
Medical Association.
5. The physician expert witness must acknowledge and comply with expert
witness testimony standards, guidelines, principles, and codes of ethics
established by the national specialty society for the testifying physician’s
specialty, and sign, if such exists, an affirmation of compliance.
6. The physician must be available at trial if rendering an opinion at the tribunal stage of the proceedings.

7. The physician expert witness must be aware that the Federation of State Medical Boards defines false, fraudulent, or deceptive testimony as unprofessional conduct, and that such testimony may be actionable by the Massachusetts Board of Registration in Medicine or any other state licensing boards with whom the physician expert witness holds licenses to practice medicine.

8. The physician expert witness must be willing to submit transcripts of depositions and courtroom testimony to independent peer review by the appropriate specialty society.

(HP)

... MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

PUBLIC HEALTH
6c. Human Medicine, Veterinary Medicine, and Environmental Sciences
The Massachusetts Medical Society supports and promotes collaboration among the health professions to improve the integration of human medicine, veterinary medicine, and the environmental sciences. (HP)

The MMS will engage in a dialogue with the Massachusetts Veterinary Medical Association and the Massachusetts Public Health Association to determine and implement strategies for enhancing collaboration among the human medical, veterinary medical, and environmental sciences professions in medical education, clinical care, public health, and biomedical research. (D)

MMS House of Delegates, 12/3/11

QUALITY OF CARE
7c. Quality Measurement/Quality Improvement
The Massachusetts Medical Society adopts the following principles, for quality of medical care initiatives that the Society should undertake or embrace:

I. Definition of Quality
   A. Institute of Medicine: “degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”
   B. Physicians’ perspective as patient advocates (in contrast with those of health plans, purchasers) focuses on appropriate clinical decision-making (related to knowledge and judgment) and performance skills

II. Individual Physician Responsibility for Quality Management
   A. There are professional privileges granted from society to physicians. In return, physicians have a professional responsibility to understand and apply scientific and technical knowledge for the benefit of patients (i.e., quality medical care)
   B. Physicians’ claims to the public trust are derived from our unique role as patient advocates

III. Responsibilities of the Massachusetts Medical Society (MMS)
   A. Our mission states: “The purposes of the Massachusetts Medical Society shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical
standards of medical practice and health care, and to promote medical
institutions formed on liberal principles for the health, benefit, and welfare of
the citizens of the Commonwealth.”

B. MMS is the primary “grassroots” organization representing Massachusetts
physicians
C. Our own past history demonstrates concern for quality in areas such as
continuing medical education (CME), advancement of medical knowledge
through the ownership of The New England Journal of Medicine, and
participation in guideline promulgation and implementation
D. MMS has broad experience and readily available expertise in patient care,
research, and education

IV. Many policy decisions regarding medical practice (e.g., legislative and regulatory)
are at the state level. Therefore, a state medical society is the most appropriate
arena for many policy decisions.

V. Role of American Medical Association
A. Promote physician involvement in continuous quality improvement (CQI): data
collection, analyses, and feedback loops
B. Promote standards for physician profiling
C. Promote effective quality improvement models
D. Encourage development and provision of educational and training opportunities
to improve patient care
E. Encourage outcomes research
F. Evaluate quality assurance programs
G. Advocate nationally for quality in medicine

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

8c. Quality of Medical Care Initiatives, which the Massachusetts Medical Society
undertakes, should have the following characteristics:
I. Quality Measures from Physicians’ Perspective: i.e., Appropriate Clinical Decision-
Making, Performance Skills, and Desired Outcomes
II. Medical Services Ranging from Those Performed for Individual Patients to Those
Performed for the Public Health
III. Categories of specific physician groups as participants in quality initiatives
A. Geographic Area
B. Specialty
C. Impaired
D. Outlier Practice Patterns
E. Other Groups

IV. Conceptual Frameworks for Quality Initiatives
A. Measurement: Profiling
   (1) System Focus
      a) Structures: (e.g. credentialing, liability)
      b) Processes: (e.g. compliance to guidelines)
      c) Outcomes: (e.g. mortality, quality of life)
   (2) Role of Massachusetts Medical Society
      a) Set standards for agencies to measure through the development of a set of
attributes or criteria by an expert clinical panel
b) Direct role in the profiling of physicians

B. Substantive Medical Management: Knowledge Base, Judgment, Decision-Making

(1) Curricula
   a) Directly providing and organizing CME and Non-CME courses
   b) Accrediting Other Physician-Affiliated Organizations
   c) Implementing Scientific Advances in Physicians’ Clinical Practices

(2) Mentoring

(3) Clinical Practice Guidelines: Refine, approve, implement, evaluate

(4) Other systems of support

V. Physicians Partnering with Patients, along with other Providers: Academic Consortia, Hospitals, and other Professional Organizations

VI. Establishment of a Quality of Medical Care Program

VII. Clarity of Design and Focus of the Quality of Medical Care Program

A. Substantive content of medical program

B. Program target population

C. Definition of program outcomes

D. Definition of program time-line

E. Program evaluation component

(HP)
APPENDIX

AMA Policy
(Sunset: Item 2)
Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs H-135.936
1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate
disposal of unused medications.
2. Our AMA will work with other national organizations and associations to inform, encourage,
support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in
modifying their US Drug Enforcement Administration registrations to become authorized
medication collectors and operate collection receptacles at their registered locations.
3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to
accept non-controlled medication for appropriate disposal or recycling.

(Sunset: Item 8)
Communication Between Hospitals and Primary Care Referring Physicians D-160.945
Our AMA:
(1) advocates for continued Physician Consortium for Performance Improvement? (PCPI)
participation in the American College of Physicians (ACP), the Society of General Internal
Medicine (SGIM), and the Society of Hospital Medicine (SHM) work to develop principles and
standards for care transitions that occur between the inpatient and outpatient settings;
(2) advocates for timely and consistent inpatient and outpatient communications to occur among
the hospital and hospital-based providers and physicians and the patient's primary care
referring physician; including the physician of record, admitting physician, and physician-to-
physician, to decrease gaps that may occur in the coordination of care process and improve
quality and patient safety;
(3) will continue its participation with the Health Information Technology Standards Panel
(HITSP) and provide input on the standards harmonization and development process;
(4) continues its efforts with The Joint Commission, the Centers for Medicare & Medicaid
Services, and state survey and accreditation agencies to develop accreditation standards that
improve patient safety and quality; and
(5) will explore new mechanisms to facilitate and incentivize communication and transmission of
data for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication)
between the hospital-based physician and the primary physician.

(Sunset: Item 9)
Reimbursement for Telephonic and Electronic Communications D-70.993
Our AMA will request proposals to the CPT Editorial Panel to create better reporting extensions
of face-to-face physician work, recognizing a wide range of communications including telephone
consultation, fax, e-mail, video or other evolving communication forms.

Fair Valuation of Physician Services in Third Party Payer Contracting with Hospitals and
Health Care Systems D-383.985
Our AMA will:
(1) continue to advocate for fair payment for physician services regardless of the employment
status of physicians on organized medical staffs;
(2) develop a new federal antitrust legislative strategy, and reopen a dialogue with the
Department of Justice and the Federal Trade Commission concerning more flexible approaches
to physician network joint ventures;
(3) continue to encourage all physicians who would like to report the unfair business practices of
health insurers and other payers to complete the AMA online health plan complaint form; and

work to ultimately eliminate the need for cross subsidization practices between third party 
payers and hospital systems that result in: (a) a decrease in physician market power, (b) a 
devolution of physician services, and (c) harm to competition.

(Sunset: Item 10)

ERISA H-285.915

1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate 
federal patient protection legislation, through enactment of similar state patient protection 
legislation that is uniform across states, and through targeted elimination of the ERISA 
preemption of self-insured health benefits plans from state regulation, to require that such self-
insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b) 
Clearly disclose to present and prospective enrollees any provisions restricting patient access to 
or choice of physicians, or imposing financial incentives concerning the provision of services on 
such physicians; (c) Be regulated in regard to plan policies and practices regarding utilization 
management, claims submission and review, and appeals and grievance procedures; (d) 
Conduct scientifically based and physician-directed quality assurance programs; (e) Be legally 
accountable for harm to patients resulting from negligent utilization management policies or 
patient treatment decisions through all available means, including proportionate or comparative 
liability, depending on state liability rules; (f) Participate proportionately in state high-risk 
insurance pools that are financed through participation by carriers in that jurisdiction; (g) Be 
prohibited from indemnifying beneficiaries against actions brought by physicians or other 
providers to recover charges in excess of the amounts allowed by the plan, in the absence of 
any provider contractual agreement to accept those amounts as full payment; (h) Inform 
beneficiaries of any discounted payment arrangements secured by the plan, and base 
beneficiary coinsurance and deductibles on these discounted amounts when providers have 
agreed to accept these discounted amounts as full payment; (i) Be subject to breach of contract 
actions by providers against their administrators; and (j) Adopt coordination of benefits 
provisions applying to enrollees covered under two or more plans.

2. Our AMA will continue to advocate for the elimination of ERISA preemption of self insured 
health plans from state insurance laws consistent with current AMA policy.
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 6
Code: CPH Report A-18 C-6 [A-17 C-2]
Title: Prescription Marketing Policy
(Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsor: The Committee on Public Health
Steven Ringer, MD, Chair

Report History: OFFICERS Report A-17 C-2 (Section C)
Original Sponsor: MMS Presidential Officers

Referred to: Reference Committee C
Mangadhar Rao Madineedi, MD, Chair

Background
At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on Public Health. The policy for review states:

PRESCRIPTION AND NON-PRESCRIPTION DRUGS
Prescription Marketing
The Massachusetts Medical Society disapproves of the direct product specific advertising of prescription drugs to the public. (HP)

MMS House of Delegates, 11/8/96
Reaffirmed, MMS House of Delegates, 5/2/03
Reaffirmed, MMS House of Delegates, 5/14/10

Reference Committee Testimony
The reference committee heard testimony in support of the report recommendation.

Relevance to MMS Strategic Priorities
Provide a leadership voice through its advocacy, collaboration, and public health efforts, and will continue to carefully monitor the impact of the rapidly transforming health care landscape on Massachusetts physicians and patients.

Discussion
The Committee on Public Health discussed the prescription marketing policy in relation to existing similar policy on direct-to-consumer advertising as well as MMS engagement regarding drug price transparency by pharmaceutical companies. The committee felt it was not necessary to have two policies with the same intent.

Existing Related Policy
The MMS will advocate for Massachusetts and federal legislation to ban direct-to-consumer drug ads in Massachusetts and in the United States. (D)

MMS House of Delegates, 5/2/15
The Medical Society is a strong advocate at the federal level to enact measures which will protect consumers from direct pharmaceutical marketing, assure transparency, and safeguard the availability of pharmaceuticals at fair and reasonable prices.

Conclusion
The committee recommends the following.

Recommendation:
That the Massachusetts Medical Society sunset the prescription marketing policy reaffirmed at A-10, which reads as follows:

The Massachusetts Medical Society disapproves of the direct product specific advertising of prescription drugs to the public. (HP)

MMS House of Delegates, 11/8/96
Reaffirmed, MMS House of Delegates, 5/2/03
Reaffirmed, MMS House of Delegates, 5/14/10

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

FTE: Existing Staff
(Staff Effort to Complete Project)
**EXECUTIVE SUMMARY**

At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on Ethics, Grievances, and Professional Standards (EGPS) and the Committee on the Quality of Medical Practice (CQMP).

The MMS policy on Ethics and Managed Care is adapted primarily from American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA) opinions. The AMA completed a comprehensive update of its Code of Medical Ethics in 2016 to ensure the language of the code applies to contemporary medical practice. As part of the update, the AMA amended or replaced the CEJA opinions upon which the MMS's policy is based. The topics from the CEJA opinions referenced throughout MMS's existing policy are now found in the AMA Code of Medical Ethics Chapter 11 — *Financing and Delivery of Health Care*. Chapter 11 was crafted to be applicable to all payment models and incentive mechanisms, rather than exclusively managed care.

Considering the changes in the practice environment since the adoption of the MMS’s current policy on Ethics and Managed Care, CQMP and EGPS were in support of the AMA’s approach of replacing the current policy on managed care with a comprehensive policy on the ethics of financing and delivery of health care. CQMP and EGPS reviewed the MMS’s current policy in light of the changes to the AMA Code of Medical Ethics, and recommend that the MMS adopt-in-lieu of the *Ethics and Managed Care* policy, a policy entitled *Ethics of Financing and Delivery of Health Care*. 
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 7
Code: CEGPS/CQMP Report A-18 C-7 [A-17 C-2]
Title: Ethics and Managed Care Policy
(Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsors: Committee on Ethics, Grievances, and Professional Standards
Ronald Arky, MD, Chair
Committee on the Quality of Medical Practice
Barbara Spivak, MD, Chair

Report History: OFFICERS Report A-17 C2
Original Sponsor: MMS Presidential Officers (and Reviewing Committees)
Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background
At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on Ethics, Grievances, and Professional Standards and the Committee on the Quality of Medical Practice. The policy for review states:

ETHICS
Ethics and Managed Care
The Massachusetts Medical Society Policy Statement on Ethics and Managed Care states:

Ethics and Managed Care
Preamble:

The medical profession has long subscribed to a body of ethical standards. Initially developed for the benefit of the patient, ethical principles must also serve to guide the physician in his or her relationship with colleagues as well as other entities in the health care arena. Several relevant principles adopted by the American Medical Association and the Massachusetts Medical Society remain constant:

- A physician shall be dedicated to providing competent medical services with compassion and respect for human dignity, in a cost effective manner.
- A physician shall deal honestly with patients and colleagues.
- A physician shall respect the law and also recognize a responsibility to seek changes in those requirements that are contrary to the best interests of the patient.
- A physician shall make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
A physician shall, in the provision of appropriate patient care, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

Changes in the practice environment now require physicians to examine their professional relationships even more closely. The following principles are offered to reaffirm the primacy of the traditional physician-patient relationship and the standards of conduct between and among colleagues. They also seek to clarify appropriate conduct between physicians and health care organizations that challenge traditional models of medical practice.

PHYSICIAN TO PATIENT RELATIONSHIP

(1) Patient Advocacy Is Fundamental
The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interest of their patients first. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(2) Advocacy for Patient Benefit
Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for care they believe will materially benefit their patients. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care).

(3) Primacy of Patient Welfare over Physicians’ Financial Interests
While physicians should be conscious of costs and not provide or prescribe unnecessary services, concern for the quality of care the patient receives should be the physician’s first concern. Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity: Reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician’s financial benefit is unethical. Similarly, to limit appropriate diagnostic tests, referrals, hospitalization, or treatment, for the physician’s financial benefit is unethical. If a conflict develops between the physician’s financial interest and the physician’s responsibilities to the patient, the conflict must be resolved to the patient’s benefit. (Adapted from AMA CEJA Opinion 8.03 Conflicts of Interest: Guidelines, Adapted from AMA CEJA Opinion 2.09 Costs)

(4) Physician Participation in Allocation Process
Practicing physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create organizational structures that allow practicing physicians to have meaningful input into the plan’s development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis, be evidence based whenever feasible, and updated to reflect advances in medical knowledge and changes in relative costs. (Adapted from AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)
Appeals from Denials of Care

Adequate and timely appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in denial of care that, in the physician’s judgment, would materially benefit the patient. In such cases, the physician’s duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician’s duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan’s policy-making level to seek an elimination or modification of the guideline. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

A physician should be able to assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient’s best interests. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Disclosure of Financial Incentives to Patients by Plan and by Physician

Health Plans must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians must clearly and adequately respond to inquiries by patients regarding any financial incentives. The health plans must make adequate disclosure to patients enrolled in the plan at enrollment and annually thereafter. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage. (Adapted from MA Policy 285.998: Managed Care #4, Financial Incentives)

PHYSICIAN TO PHYSICIAN

(1) Negotiating Contracts between Physicians

Negotiating contracts between physicians in a health plan is ethical and appropriate only if the standard of care is the same for all patients and there is disclosure to the patients of the financial arrangements that may affect their care.

(2) Referrals to Specialists

Patients are entitled to all the benefits outlined in their insurance plan. Therefore, it is unethical for a referring physician to restrict the referral options of patients who have chosen a plan that provides for access to an unlimited or broad selection of specialist physicians. It is also unethical to base the referral of these patients on a discount for the capitated patients in a primary care physician’s practice. Physicians should not be restricted from informing their patients of out-of-plan specialists, when their expertise may offer important advantages to the patient. (Adapted from AMA CEJA Opinion 8.052 Negotiating Discounts for Specialty Care; MMS Policy)
Financial Inducements

Payment by or to a physician solely for the referral of a patient is fee splitting and is unethical. (AMA CEJA Opinion 6.02 Fee Splitting)

A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source. (AMA CEJA Opinion 6.02 Fee Splitting)

These payments violate the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed. (Adapted from AMA CEJA Opinion 6.02 Fee Splitting)

PHYSICIAN TO HEALTH CARE ORGANIZATION

(1) Non-participation in Unprofessional Care

Physicians should not participate in any organization that encourages or requires care at below minimum professional standards, unless actively involved in trying to change and improve the deficient standards. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Physicians who have administrative and/or executive responsibilities in health care organizations should be knowledgeable about medical ethics and should encourage the health care organization to make ethically appropriate medical decisions. (Task Force on Ethical Standards in Managed Care, MMS 1996)

(2) Incentives to Limit Care

Health plans should not establish financial incentives or quotas that interfere with appropriate clinical management such as limiting diagnostic tests, services, referrals, or access to care. (MMS Policy)

When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care. (AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)

Physician payments that provide an incentive to limit the utilization of services should not link financial rewards with individual treatment decisions over periods of time insufficient to identify patterns of care or expose the physician to excessive financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment. When risk sharing arrangements are relied upon to deter excess utilization, physician incentive payments should be based on performance of groups of physicians rather than individual physicians, and should not be based on performance over short...
periods of time. (AMA Policy 285.982: Ethical Issues in Managed Care; Adapted from AMA CEJA Opinion 8.054 Financial Incentives and the Practice of Medicine)

The magnitude of fee withholds, bonuses and other financial incentives should not affect provision of appropriate care. (Adapted from AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)

(3) Allocation Guidelines and Policy Making

Any broad allocation guidelines that restrict care and choices, which go beyond the cost/benefit judgments made by physicians as part of their normal professional responsibilities, should be established at a policy-making level so that individual physicians are not asked to engage in ad hoc bedside rationing. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for care they believe will materially benefit their patients. (Adapted from AMA CEJA Opinions 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(4) Physician Participation in Allocation Process

Practicing physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create organizational structures that allow practicing physicians to have meaningful input into the plan’s development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(5) Appeals from Denials of Care

Adequate and timely appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in denial of care that, in the physician’s judgment, would materially benefit the patient. In such cases, the physician’s duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise in which a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician’s duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan’s policy-making level to seek an elimination or modification of the guideline. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)
A physician should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient’s best interests. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(6) Informed Consent and Plan Disclosure
Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan and on annual re-enrollment. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(7) Full Disclosure to Patients
Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician’s obligation to disclose treatment alternatives to patients is not altered by a limitation in the coverage provided by the patient’s managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(8) Disclosure of Incentives to Patients, by Plan and by Physician
Health Plans must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians must clearly and adequately respond to inquiries by patients regarding any financial incentives. Health plans must make adequate disclosure to patients enrolled in the plan at enrollment and annually thereafter. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage. (Adapted from AMA Policy 285.998: Managed Care)

(9) Medical Judgments and Plan Administration
Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patients they serve. Assuming a title or position that removes the physician from direct patient-physician relationships, such as the title of Medical Director, does not override professional ethical obligations. (AMA CEJA Opinion 8.05 Contractual Relationships, AMA CEJA Opinion 8.021 Ethical Obligations of Medical Directors.)

(10) Physician Contracts and Plan Administration
Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but should be aware of the potential for some types of systems to create conflicts of interest because of financial incentives to withhold medically indicated services. Physicians must not allow such financial incentives to influence their judgment of
appropriate therapeutic alternatives or deny their patient's access to appropriate
services based on such inducements. (Adapted from AMA Policy 285.998:
Managed Care)

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

Reference Committee Testimony
The reference committee heard testimony only in support of the report; therefore,
recommended adoption of the recommendation to reaffirm for one year.

Relevance to MMS Strategic Priorities
The statement of principles below, reaffirming the primacy of the physician-patient
relationship and physicians' role in modern health care delivery systems, supports the
MMS strategic priority of physician and patient advocacy. This policy reaffirms the
MMS's position on many elements of the ongoing debate on health care reform,
promotes transparency, and addresses barriers that impede access to quality care.

Discussion
The MMS policy on Ethics and Managed Care is adapted primarily from the American
Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA) opinions,
including but not limited to, CEJA Opinion 8.13 Managed Care Guidelines, CEJA
Opinion 8.03 Conflicts of Interest: Guidelines, CEJA Opinion 8.054 Financial Incentives
and the Practice of Medicine; CEJA Opinion 8.05 Contractual Relationships, and CEJA
Opinion 8.021 Ethical Obligation of Medical Directors. The AMA completed a
comprehensive update of its Code of Medical Ethics on June 13, 2016. This update was
undertaken to ensure that the language of the code applies to contemporary medical
practice, and to improve the code's clarity and consistency. As part of the update, the
AMA amended or replaced the CEJA opinions upon which the MMS's policy on
Ethics and Managed Care is based.

The Committee on Quality of Medical Practice (CQMP) and the Committee on Ethics,
Grievances, and Professional Standards (EGPS) reviewed the MMS's current policy in
light of the changes to the AMA Code of Medical Ethics. The most notable change was
the AMA's deletion of CEJA Opinion 8.13 — Managed Care Guidelines, which is the
primary source of 12 of the 18 sections of the MMS's policy on Ethics and Managed
Care. The concepts from CEJA Opinion 8.13, and majority of the CEJA opinions
referenced throughout MMS's existing policy, are now found in the AMA Code of Medical
Ethics Chapter 11 — Financing and Delivery of Health Care. Rather than focus only on
managed care, the principles set forth in this Chapter 11 are crafted to be applicable to
all payment models and incentive mechanisms.

Conclusion
Considering the changes in the practice environment since the adoption of the MMS's
current policy on Ethics and Managed Care, CQMP and EGPS were in support of the
AMA's approach of replacing the managed care policy with a comprehensive policy on
the ethics of financing and delivery of health care. Both committees met on several
occasions to review the existing MMS policy and the new CEJA opinions. The
committees worked to adapt the relevant CEJA opinions to ensure the resulting MMS
policy recommendation represented appropriate and consistent guidelines for
Massachusetts physicians. At its March 5, 2018, meeting, CQMP provided its final
comments to EGPS on the language of the proposed policy. EGPS met on March 7,
2018, to review and incorporate CQMP’s comments, and voted to recommend the
following statement of ethical principles which provide guidance with respect to
relationships between physicians and their patients and between physicians and health
care institutions and payers. The recommended policy continues to affirm that a
physician’s primary ethical obligation is to promote the well-being of individual patients.
Both EGPS and CQMP felt strongly that these principles should be offered as ethics
guidance for physicians and are not intended to establish clinical practice guidelines or
rules of law.

Recommendation:
That the Massachusetts Medical Society adopt-in-lieu of the Ethics and Managed
Care policy reaffirmed at A-10 the following:

Ethics of Financing and Delivery of Health Care

Preamble:
The medical profession has long subscribed to a body of ethical standards.
Initially developed for the benefit of the patient, ethical principles must also
serve to guide the physician in his or her relationship with colleagues as well
as other entities in the health care arena. Several relevant principles adopted
by the American Medical Association and the Massachusetts Medical Society
remain constant:

- A physician shall be dedicated to providing competent medical services
  with compassion and respect for human dignity, in a cost-effective
  manner.
- A physician shall deal honestly with patients and colleagues.
- A physician shall respect the law and also recognize a responsibility to
  seek changes in those requirements that are contrary to the best
  interests of the patient.
- A physician shall make relevant information available to patients,
  colleagues, and the public, obtain consultation, and use the talents of
  other health professionals when indicated.
- A physician shall, in the provision of appropriate patient care, be free to
  choose whom to serve, with whom to associate, and the environment in
  which to provide medical services.

Changes in the practice environment require physicians to examine their
professional relationships even more closely. As health care has become more
complex and costlier, new challenges have emerged. Payment models and
incentive mechanisms intended to contain costs and improve quality may
create conflicts of interest that work against the goal of providing care that is
responsive to the unique needs, values, and preferences of individual patients.

The following principles are offered to reaffirm the primacy of the physician-
patient relationship and the standards of conduct between and among
colleagues. Further, they provide general recommendations related to
physicians’ ethical responsibilities to address questions of access to care, for
individuals and for populations of patients, in their role as practicing
clinicians, as leaders of health care organizations and institutions, and
collectively as a profession.
These principles are offered as ethics guidance for physicians and are not intended to establish clinical practice guidelines or rules of law.

PROFESSIONALISM IN HEALTH CARE SYSTEMS (Adapted from AMA CEJA Opinion 11.2.1)

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism, are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients’ choices, the patient-physician relationship, and physicians’ relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians’ exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:

(a) Are transparent.
(b) Reflect input from key stakeholders, including physicians and patients.
(c) Recognize that over reliance on financial incentives may undermine physician professionalism.
(d) Ensure ethically acceptable incentives that:
   (i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;
   (ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
   (iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
   (iv) mitigate possible conflicts between physicians’ financial interests and patient interests by minimizing the financial impact of patient
care decisions and the overall financial risk for individual
physicians.

(e) Encourage, rather than discourage, physicians (and others) to:
   (i) provide care for patients with difficult to manage medical
       conditions;
   (ii) practice at their full capacity, but not beyond.

(f) Recognize physicians’ primary obligation to their patients by enabling
    physicians to respond to the unique needs of individual patients and
    providing avenues for meaningful appeal and advocacy on behalf of
    patients.

(g) Are routinely monitored to:
   (i) identify and address adverse consequences;
   (ii) identify and encourage dissemination of positive outcomes.

All physicians should:

(h) Hold physician-leaders accountable to meeting conditions for
    professionalism in health care systems.

(i) Advocate for changes in health care payment and delivery models to
    promote access to high-quality care for all patients.

PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES (Adapted from
AMA CEJA Opinion 11.2.2)

Physicians’ primary ethical obligation is to promote the well-being of
individual patients. Physicians’ have a secondary obligation to promote public
health and access to care. Part of this secondary obligation includes physician
awareness of health care resource limitations. It is incumbent upon physicians
to consider these limitations when making medical decisions. With this in
mind, physicians should:

(a) Base recommendations and decisions on patients’ medical needs.

(b) Use scientifically grounded evidence to inform professional decisions
    when available.

(c) Help patients articulate their health care goals and help patients and
    their families form realistic expectations about whether a particular
    intervention is likely to achieve those goals.

(d) Endorse recommendations that offer reasonable likelihood of achieving
    the patient’s health care goals.

(e) Choose the course of action that requires fewer resources when
    alternative courses of action offer similar likelihood and degree of
    anticipated benefit compared to anticipated harm for the individual
    patient but require different levels of resources.

(f) Be transparent about alternatives, including disclosing when resource
    constraints play a role in decision making.

(g) Participate in efforts to resolve persistent disagreement about whether
    a costly intervention is worthwhile.

Physicians are in a unique position to affect health care spending. But
individual physicians alone cannot and should not be expected to
address the systemic challenges of wisely managing health care
resources. Medicine as a profession must create conditions for practice
that make it feasible for individual physicians to be prudent stewards by:

(h) Encouraging health care administrators and organizations, including insurance companies, to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.

(i) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending.

(j) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

ALLOCATING LIMITED HEALTH CARE RESOURCES (Adapted from AMA CEJA Opinion 11.1.3)

Physicians’ primary ethical obligation is to promote the well-being of their patients. Policies for allocating scarce health care resources may impede physicians’ ability to fulfill that obligation.

As professionals dedicated to protecting the interests of their patients, physicians thus have a responsibility to contribute their expertise to developing allocation policies that are fair and safeguard the welfare of patients.

Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients.

Allocation policies should be based on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life and use of lower cost alternatives of equal quality. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics.

FINANCIAL BARRIERS TO HEALTH CARE ACCESS (Adapted from AMA CEJA Opinion 11.1.4)

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.

In view of this obligation:

(a) Individual physicians should help patients obtain needed care through public or charitable programs when patients cannot do so themselves.
(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.

(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to appropriate health services.

(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure necessary access to appropriate health care for all people.

CONFLICTS OF INTEREST IN PATIENT CARE (AMA CEJA Opinion 11.2.2)
The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients.

Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. Physicians should not provide wasteful and unnecessary treatment that may cause needless expense solely for the physician’s financial benefit or for the benefit of a hospital or other health care organization with which the physician is affiliated.

Where the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority.

CONTRACTS TO DELIVER HEALTH CARE SERVICES (AMA CEJA Opinion 11.2.3)
Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires them to consider carefully the terms and conditions of contracts to deliver health care services before entering into such contracts to ensure that those contracts do not create untenable conflicts of interests.

Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes may be intended to enhance quality, efficiency, and safety in health care, they may also put at risk physicians’ ability to uphold professional ethical standards of informed consent and fidelity to patients and can impede physicians’ freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, or other entities—they should be mindful that while many arrangements have the potential to promote desired improvements in care, some arrangements also have the potential to impede patients’ interests.
When contracting to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts or have a representative do so on their behalf to assure themselves that the arrangement:

(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;
(iii) allows the physician to appropriately exercise professional judgment;
(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
(v) permits disclosure to patients.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical standards.

TRANSPARENCY IN HEALTH CARE (AMA CEJA Opinion 11.2.4)

Respect for patients' autonomy is a cornerstone of medical ethics. Patients must rely on their physicians to provide information that patients would reasonably want to know to make informed, well-considered decisions about their health care. Thus, physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives; and formularies, guidelines or other tools that influence treatment recommendations and care. Restrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of care.

Although health plans and other entities have primary responsibility to inform patient-members about plan provisions that will affect the availability of care, physicians may share in this responsibility.

Individually, physicians should:

(a) Disclose any financial and other factors that could affect the patient's care.
(b) Disclose relevant treatment alternatives, including those that may not be covered under the patient's health plan.
(c) Encourage patients to be aware of the provisions of their health plan. Collectively, physicians should advocate that health plans with which they contract disclose to patient-members.
(d) Plan provisions that limit care, such as formularies or constraints on referrals.
(e) Plan provisions for obtaining desired care that would otherwise not be provided, such as provision for off-formulary prescribing.

(f) Plan relationships with pharmacy benefit management organizations and other commercial entities that have an interest in physicians’ treatment recommendations.

CONSULTATION, REFERRAL, SECOND OPINIONS (AMA CEJA Opinion 1.2.3)
Physicians’ fiduciary obligation to promote patients’ best interests and welfare can include consulting other physicians for advice in the care of the patient or referring patients to other professionals to provide care. When physicians seek or provide consultation about a patient’s care or refer a patient for health care services, including diagnostic laboratory services, they should:

(a) Base the decision or recommendation on the patient’s medical needs, as they would for any treatment recommendation, and consult or refer the patient to only health care professionals who have appropriate knowledge and skills and are licensed to provide the services needed.

(b) Share patients’ health information in keeping with ethics guidance on confidentiality.

(c) Assure the patient that he or she may seek a second opinion or choose someone else to provide a recommended consultation or service. Physicians should urge patients to familiarize themselves with any restrictions associated with their individual health plan that may bear on their decision, such as additional out-of-pocket costs to the patient for referrals or care outside a designated panel of providers.

(d) Explain the rationale for the consultation, opinion, or findings and recommendations clearly to the patient.

(e) Respect the terms of any contractual relationships they may have with health care organizations or payers that affect referrals and consultation. Physicians may not terminate a patient-physician relationship solely because the patient seeks recommendations or care from a health care professional whom the physician has not recommended.

FEE SPLITTING (Adapted from AMA CEJA Opinion 11.3.4)
Patients must be able to trust that their physicians will be honest with them and will make treatment recommendations, including referrals, based on medical need, the skill of other health care professionals or facilities to whom the patient is referred, the quality of products or services provided, and consistent with all federal and state laws.

Payment by or to a physician or health care institution solely for referral of a patient is fee splitting and is unethical.

Physicians may not accept:

(a) Any payment of any kind, from any source for referring a patient other than distributions of a health care organization’s revenues as permitted by law.

(b) Any payment of any kind, from any source for prescribing a specific
drug, product, or service.

(c) Payment for services relating to the care of a patient from any health care facility/organization to which the physician has referred the patient.

(d) Payment for referring a patient to a research study.

Physicians in a capitated primary care practice may not refer patients based on whether the referring physician has negotiated a discount for specialty services.

(HP)

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

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

Item #: 8
Code: CQMP/CEGPS Report A-18 C-8 [A-17 C-2]
Title: Principles on Medical Professional Review of Physicians
(Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsors: Committee on the Quality of Medical Practice
Barbara Spivak, MD, Chair
Committee on Ethics, Grievances, and Professional Standards
Ronald Arky, MD, Chair

Report History: OFFICERS Report A-17 C-2
Original Sponsor: MMS Presidential Officers
(and Reviewing Committees)

Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

EXECUTIVE SUMMARY

At A-17, through the sunset policy review process, the MMS policy, Principles on Medical Professional Peer Review, was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on the Quality of Medical Practice (CQMP) and the Committee on Ethics, Grievances, and Professional Standards (EGPS).

The MMS’s Principles on Medical Professional Review of Physicians were developed in accordance with, and with guidance from, Massachusetts and federal law, American Medical Association (AMA) Council on Judicial and Ethical Affairs (CEJA) opinions, and standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission). Prompted by the AMA’s comprehensive update to the AMA Code of Medical Ethics, completed on June 13, 2016, EGPS and CQMP undertook a review of the relevant laws and policies, specifically with regard to changes that have taken place since these principles were last reviewed and amended at A-10.

The most notable change since 2010, which is not already addressed in the principles, is in the updated CEJA Opinion 9.4.1 Peer Review and Due Process, which includes the recommendation that physicians and medical students who are involved in reviewing the conduct of fellow professionals, medical students, residents or fellows should disclose relevant conflicts of interest and, when appropriate, recuse themselves from a hearing.

EGPS and CQMP support emphasizing the role of physicians on a peer review committee in mitigating conflicts of interest in peer review, and recommend that the MMS Principles of Professional Review of Physicians be amended to include language to this effect.
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 8
Code: CQMP/CEGPS Report A-18 C-8 [A-17 C-2]
Title: Principles on Medical Professional Review of Physicians
(Policy Sunset Process: Reaffirmed One Year at O-00 Pending Review)
Sponsors: The Committee on the Quality of Medical Practice
Barbara Spivak, MD, Chair
The Committee on Ethics, Grievances, and Professional Standards
Ronald Arky, MD, Chair

Report History: OFFICERS Report A-17 C2
Original Sponsor: MMS Presidential Officers (and Reviewing Committees)
Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background
At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on the Quality of Medical Practice and the Committee on Ethics, Grievances, and Professional Standards. The policy for review states:

Principles on Medical Professional Review of Physicians
The Massachusetts Medical Society adopts the following amended policy and Principles on Medical Professional Review of Physicians within Health Insurance Companies and Medical Professional Review of Physicians within Health Care Facilities.

These principles are separate from the model principles that apply to medical peer review of physicians for health care facilities. The following principles include an independent appeal and review process for disputed peer review outcomes by a health insurance company.

Massachusetts Medical Society Policy on Medical Professional Review of Physicians within Health Insurance Companies

Introduction:
Activities conducted by health insurance companies to evaluate the performance of physicians may or may not constitute “peer review” or “professional review activity” under Massachusetts or federal law, depending on whether or not such activities fall within the requisite statutory definitions. The MMS believes that all such activities, however, should follow a fair, evidence-based, ethical, and coherent process, and has therefore adopted the following Model Principles for Professional Review of Physicians within Health Insurance Companies as guidance for such activities as may be applicable to their setting.
The following recommendations are made based on the above considerations in order to enhance:

- Quality improvement
- Credibility in the process of medical professional/peer review of physicians
- Fairness and due process
- Patient access — by not inappropriately terminating, removing or sanctioning physicians
- System approaches to patient safety and quality of care

Model Principles for Medical Professional Review of Physicians within Health Insurance Companies

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event should include not only pre-event factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician on a confidential basis. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the “incident” and explore alternate courses of action, all on a confidential basis.
4. The process should be mindful of, and attuned to, prevention; and the outcome should include recommendations, if appropriate, for individual remediation.
5. Triggers that initiate a medical professional review within a health plan should be valid, transparent and available to all credentialed, participating provider or contracted physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process. Such cases should be referred to Physician Health Services, Inc., or another appropriate physician health or wellness program.
7. At a minimum, the standards set by the Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity for “professional review bodies” should be followed if a disciplinary process is engaged during medical professional review. These standards are the most elementary safeguards of due process for medical professional review activities. Section 11112 Standards for professional review actions “a. In general…professional review action must be taken—
(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).”
“Adequate notice and hearing—A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action
   The physician has been given notice stating—
   (A) (i) that a professional review action has been proposed to be taken against a physician
   (ii) reasons for the proposed action
   (B) (i) that the physician has the right to request a hearing on the proposed action
   (ii) any time limit (of not less than 30 days) within which to request such a hearing, and
   (C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing—If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—
   (A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and
   (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice—If a hearing is requested on a timely basis under paragraph (1)(B)—
   (A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—
      (i) before an arbitrator mutually acceptable to the physician and the health care entity,
      (ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
      (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
   (B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
   (C) in the hearing the physician involved has the right—
      (i) to representation by an attorney or other person of the physician’s choice,
      (ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
      (iii) to call, examine, and cross-examine witnesses,
      (iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
      (v) to submit a written statement at the close of the hearing; and
   (D) upon completion of the hearing, the physician involved has the right—
      (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
      (ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.”

In addition, the notice of hearing should contain a summary of the allegations and of the episodes of care under evaluation.
8. Summary termination of credentials or of participating provider contract or status (or, if applicable, suspension or restriction of clinical privileges) should only be used to prevent “imminent danger to the health of any individual.” Such summary actions should be followed by adequate notice and hearing procedures prior to becoming final.

9. All parties involved in the medical professional review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the medical professional review process should be available to the subject physician to the fullest extent legally permissible.

10. A medical professional review panel or peer review committee, engaged in a formal medical professional/peer review, corrective action or disciplinary proceeding, should not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician, and should, whenever feasible, include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty from among credentialed, participating provider or contracted physicians within the health plan. The subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to the commencement of the proceedings. Such challenge would be part of the procedure specified in the health insurance company bylaws outside of peer review protections and not a part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

11. Health plans should employ mechanisms to rotate service on their medical professional review panels or peer review committees among their credentialed, participating provider or contracted physicians.

12. Membership on the medical professional panel or peer review committee should be open to all credentialed, participating provider or contracted physicians in the health plan and not be restricted to one or more groups such as employed or salaried physicians only. The committee should include more than just medical directors, medical officers or other administrative officers of the health plan.

13. Only physicians are peers of the subject physician, and only physicians should be voting members of committees conducting medical professional review of physicians.

14. Whenever a medical professional review panel or peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the health plan while excluding direct economic competitors, or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution (e.g., medical specialty society) authorized to conduct peer review of physicians should be appointed in accordance with the health plan’s bylaws if such actions fall within statutory medical professional/peer review protections.

15. Physicians serving on the medical professional review panel or peer review committee should receive information and, where available, training, in the elements and essentials of medical professional/peer review.

16. The health plan should ensure that the physicians serving on any medical professional review panel or peer review committee are provided with
appropriate indemnification and insurance for medical professional/peer review acts taken in good faith. The health plan should also provide assistance to the panel or committee in abiding by the requirements of HCQIA to be eligible for federal immunity if applicable.

17. The medical professional review panel or peer review committee of a health plan should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination on matters of quality care or professional competency. When the matter before the medical professional review panel or peer review committee involves professional conduct, such as an allegation of disruptive behavior, the medical professional review panel or peer review committee should be guided by applicable professional ethical principles (e.g., MMS Code of Ethics, AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards, practices and principles should be made available in a timely manner to the subject physician before any hearing on the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and, if available, multiple reviewers should be used to increase reliability.

20. Where feasible, statistical analysis to compare with peers’ performance should be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.

22. All the pertinent information obtained by the medical professional review panel or peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.

23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.

24. Any conclusion reached or action recommended or taken should be based upon the information presented to the medical professional review panel or peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a “reasonably prudent person” standard.

25. If the conclusion reached is that improvement is necessary, any action recommended by a health plan should include, as an important focus, steps for remediation, as needed, for the subject physician.

26. The findings, recommendations and actions of the medical professional review panel or peer review committee of a health plan should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician’s act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it should address what specific remediation, if any, is recommended for the physician (whenever feasible, in terms that permit measurement and validation of remediation, when completed).

27. A process should be available to appeal any disciplinary finding of a health plan following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An
appeals process before a disinterested third party, not connected to the health
plan, should be made available to the subject physician within statutory medical
professional/peer review protections. If the original action was part of a peer-
review protected process, the appeal should be part of the peer-review protected
process as well.

28. In all instances of medical professional review activities conducted within health
insurance companies, the applicable processes and procedures should be
clearly stated, with specific detail, in health plan provider manuals or written
policies, of uniform application, made available in advance to the subject
physician. Such processes and procedures should contain the particular due
process, hearing and appeals rights available to the subject physician, and, to
the extent that medical professional review or peer review privilege,
confidentiality and immunity legal protections are available to such medical
professional review activities, such processes and procedures should conform to
the requirements of federal and state law. In conformity with Principle No. 12, to
avoid or at least mitigate conflicts of interest, or the perception thereof, the
medical professional review panels or peer review committees of health
insurance companies should include as members with full participation and
voting rights physicians who are not employees or contractors (other than
contracting as a participating provider) of the health insurer.

29. The Society recognizes that when a physician performs a medical peer review
function he/she should render the same opinions that would pertain if he/she
were the treating physician with responsibility to provide appropriate patient care.
These opinions should not be rendered solely on the basis of cost containment.
(MMS Council, 5/17/91; Reaffirmed, House of Delegates, May 7, 1999)

30. These Model Principles for Medical Professional Review of Physicians within
Health Insurance Companies are intended to apply to all medical professional
review activities conducted by health insurance companies of their credentialed,
participating provider or contracted physicians, however designated: e.g.,
professional review, peer review, credentialing appeals, corrective actions or
otherwise.
(MMS House of Delegates, 5/08/09)

The Massachusetts Medical Society amends its existing Model Principles for
Incident-Based Peer Review for Health Care Facilities to include an independent
appeal and review process for disputed peer review outcomes by a hospital and
to update the principles to account for changes in regulations and standards
developed since the principles were created in 2003 as to read as follows:

Massachusetts Medical Society Policy
Model Principles for Medical Peer Review of Physicians for Health Care Facilities

The following recommendations are made based on the above considerations in
order to enhance:
• Quality improvement
• Credibility in the process of medical peer review of physicians for health care
facilities
• Fairness and due process
• Patient access — by not inappropriately removing or sanctioning physicians
System approaches to patient safety and quality of care

That the Massachusetts Medical Society Model Principles for Medical Peer Review of Physicians for Health Care Facilities are as follows:

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event in a health care facility must not only include pre-event factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the “incident” and explore alternate course of action.
4. The process must be mindful and attuned to prevention and recommend appropriate individual and system changes for remediation.
5. Triggers that initiate a medical peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process.
7. At a minimum, the standards set by Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity must be followed if a disciplinary process is engaged during professional review. These standards are the most elementary safeguards of due process in a health care facility.

Section 1112 Standards for professional review actions

“a. In general…professional review action must be taken—
(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).”

“Adequate notice and hearing—A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):
(1) Notice of proposed action
   The physician has been given notice stating—
   (A) (i) that a professional review action has been proposed to be taken against a physician
   (ii) reasons for the proposed action
   (B) (i) that the physician has the right to request a hearing on the proposed action
(ii) any time limit (of not less than 30 days) within which to request such a hearing, and
(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing—If a hearing is requested on a timely basis under paragraph
(1) (B), the physician involved must be given notice stating—
(A) the place, time and date of the hearing, which date shall not be less than
30 days after the date of the notice, and
(B) a list of the witnesses (if any) expected to testify at the hearing on behalf
of the professional review body.

(3) Conduct of hearing and notice—If a hearing is requested on a timely basis
under paragraph (1)(B)—
(A) subject to subparagraph (B), the hearing shall be held (as determined by
the health care entity)—
(i) before an arbitrator mutually acceptable to the physician and the health
care entity,
(ii) before a hearing officer who is appointed by the entity and who is not
in direct economic competition with the physician involved, or
(iii) before a panel of individuals who are appointed by the entity and are
not in direct economic competition with the physician involved;
(B) the right to the hearing may be forfeited if the physician fails, without good
cause, to appear;
(C) in the hearing the physician involved has the right—
(i) to representation by an attorney or other person of the physician’s
choice,
(ii) to have a record made of the proceedings, copies of which may be
obtained by the physician upon payment of any reasonable charges
associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing officer,
regardless of its admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and
(D) upon completion of the hearing, the physician involved has the right
(i) to receive the written recommendation of the arbitrator, officer, or
panel, including a statement of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a
statement of the basis for the decision.”

In addition, the notice of hearing should contain a summary of the allegations and the
episodes of care under evaluation.

8. Summary suspension or restriction of clinical privileges may only be used to
prevent “imminent danger to the health of any individual.” Such summary actions
must be followed by adequate notice and hearing procedures prior to becoming
final.

9. All parties involved in the peer review process must preserve the confidentiality
of all records, information and proceedings. However, all of the facts obtained for
and in the peer review process shall be available to the subject physician to the
fullest extent legally permissible.

10. A peer review committee, engaged in a formal peer review or disciplinary
proceeding, may not include direct economic competitors of the subject physician
or those for whom there may be bias or lack of objectivity vis-à-vis the subject
physician and should include a fair representation of specialists/subspecialists
from the subject physician’s specialty/subspecialty whenever feasible. The subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures specified in the health care facility bylaws, outside of peer review protections and not part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

11. Physicians should rotate service on the peer review committee (round robin).

12. Membership on the peer review committee must be open to all physicians on the medical staff and not be restricted to one or more groups such as those practicing exclusively at a given institution, salaried physicians only or faculty physicians only.

13. Only physicians should be voting members of committees conducting medical peer review of physicians.

14. Whenever a peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the institution while excluding direct economic competitors or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution authorized to conduct peer review of physicians should be appointed in accordance with the medical staff bylaws and medical peer review protection statutes.

15. Physicians serving on the peer review committee should receive information and where available, training, in the elements and essentials of medical peer review.

16. The hospital or the organization on whose behalf the peer review is done must ensure that the physicians serving on any peer review committee are provided with appropriate indemnification and insurance for peer review acts taken in good faith. The organization must also provide assistance to the committee in abiding by the requirements of HCQIA to be eligible for federal immunity.

17. The peer review committee of a health care facility should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination. When the matter before the peer review committee involves professional conduct such as an allegation of disruptive behavior, the peer review committee should be guided by applicable professional ethical principles (e.g., the MMS Code of Ethics, the AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards and practices must be made available in a timely manner to the subject physician before any hearing on the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and multiple reviewers should be used to increase reliability.

20. Where feasible, statistical analysis to compare with peers’ performance must be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.
22. All the pertinent information obtained by the peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.

23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.

24. Any conclusion reached or action recommended or taken should be based upon the information presented to the peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a “reasonably prudent person” standard.

25. If the conclusion reached is that improvement is necessary, any action recommended by a health care facility should include, as an important focus, steps for remediation, as needed, for the subject physician and for the system.

26. The findings, recommendations and actions of the peer review committee of a health care facility should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician’s act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it must address what specific remediation, if any, is recommended for the physician and what, if any, for the system (whenever feasible, in terms that permit measurement and validation of remediation, when completed).

27. A process should be available to appeal any disciplinary finding of a health care facility following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the medical staff or the hospital, should be made available to the subject physician within statutory peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.

(MMS House of Delegates, November 8, 2003; Amended, 5/14/10)

28. The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment.

(MMS Council, 5/17/91; reaffirmed House of Delegates, May 7, 1999)

(HP)

MMS House of Delegates, 11/08/03

*Health Care Facilities Principles Amended and Reaffirmed, MMS House of Delegates, 5/08/09

Amended and Reaffirmed, MMS House of Delegates, 5/14/10

(Item 2 of Original: Sunset)

Reference Committee Testimony

The reference committee heard only support for this report and therefore, recommended adoption of the recommendation to reaffirm for one year.
Relevance to MMS Strategic Priorities

Providing principles on medical professional review of physicians by insurance companies and within health care facilities supports the MMS’s strategic priority on physician and patient advocacy. A fair, evidence-based, and ethical peer review process helps to improve patient care and outcomes, as well as the physician practice environment in general.

Discussion

The MMS’s Principles on Medical Professional Review of Physicians were developed in accordance with, and with guidance from, Massachusetts and federal law, American Medical Association (AMA) Council on Judicial and Ethical Affairs (CEJA) opinions, and standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission). Prompted by the AMA’s comprehensive update to the AMA Code of Medical Ethics, completed on June 13, 2016, the Committee on Ethics, Grievances, and Professional Standards (EGPS) and the Committee on Quality of Medical Practice (CQMP) undertook a review of the relevant laws and policies which underlie the MMS’s Principles on Medical Professional Review of Physicians. In consultation with MMS legal counsel, EGPS and CQMP reviewed peer review requirements and recommendations from the law, CEJA opinions and the Joint Commission, specifically with regard to changes that have taken place since these principles were last reviewed and amended at A-10.

The most notable change since 2010, which is not already addressed in the principles, is in the updated CEJA Opinion 9.4.1 *Peer Review and Due Process*. This opinion includes language stating that:

Individually, physicians and medical students who are involved in reviewing the conduct of fellow professionals, medical students, residents or fellows should:

[...]

Disclose relevant conflicts of interest and, when appropriate, recuse themselves from a hearing.

The AMA’s updated opinion is in line with Joint Commission standards from 2007, which place a greater emphasis on identifying and mitigating conflicts of interest in medical professional peer review.

Conclusion

The current *Principles on Medical Professional Review of Physicians* state that a peer review proceeding should be free of bias, and that the subject physician has the right to challenge the participation of anyone on the peer review committee who lacks objectivity vis-à-vis the subject physician. EGPS, at its March 7, 2018, meeting, and CQMP, at its March 5, 2018, meeting, voted to recommend emphasizing the role of physicians on a peer review committee in mitigating conflicts of interest in the peer review process.

Proposed Amendments

EGPS and CQMP proposes amending the MMS *Principles of Medical Professional Review of Physicians* as follows (added text shown as “text” and deleted text shown as “text”):

Relevance to MMS Strategic Priorities

Providing principles on medical professional review of physicians by insurance companies and within health care facilities supports the MMS’s strategic priority on physician and patient advocacy. A fair, evidence-based, and ethical peer review process helps to improve patient care and outcomes, as well as the physician practice environment in general.
Massachusetts Medical Society Policy on Medical Professional Review of Physicians within Health Insurance Companies

10. A medical professional review panel or peer review committee, engaged in a formal medical professional/peer review, corrective action or disciplinary proceeding, should not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician, and should, whenever feasible, include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty from among credentialed, participating provider or contracted physicians within the health plan. Participants on a medical professional review panel or peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the corrective action or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to the commencement of the proceedings. Such challenge would be part of the procedure specified in the health insurance company bylaws outside of peer review protections and not a part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

Massachusetts Medical Society Policy Model Principles for Medical Peer Review of Physicians for Health Care Facilities

10. A peer review committee, engaged in a formal peer review or disciplinary proceeding, may not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician and should include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty whenever feasible. Participants on a peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the peer review or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures specified in the health care facility bylaws, outside of peer review protections and not part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

Recommendation: That the Massachusetts Medical Society adopt as amended the Principles on Medical Professional Review of Physicians policy amended and reaffirmed at A-10 to reads as follows: [amending item 10 of Massachusetts Medical Society Policy on...
Medical Professional Review of Physicians within Health Insurance Companies, and
item 10 in Massachusetts Medical Society Policy Model Principles for Medical Peer
Review of Physicians for Health Care Facilities]

Principles on Medical Professional Review of Physicians

The Massachusetts Medical Society adopts the following amended Principles
on Medical Professional Review of Physicians within Health Insurance
Companies and Medical Professional Review of Physicians within Health Care
Facilities.

These principles are separate from the model principles that apply to medical
peer review of physicians for health care facilities. The following principles
include an independent appeal and review process for disputed peer review
outcomes by a health insurance company.

Massachusetts Medical Society Policy on Medical Professional Review of
Physicians within Health Insurance Companies

Introduction:
Activities conducted by health insurance companies to evaluate the
performance of physicians may or may not constitute “peer review” or
“professional review activity” under Massachusetts or federal law, depending
on whether or not such activities fall within the requisite statutory definitions.
The MMS believes that all such activities, however, should follow a fair,
evidence-based, ethical, and coherent process, and has therefore adopted the
following Model Principles for Professional Review of Physicians within Health
Insurance Companies as guidance for such activities as may be applicable to
their setting.

The following recommendations are made based on the above considerations
in order to enhance:

- Quality improvement
- Credibility in the process of medical professional/peer review of
  physicians
- Fairness and due process
- Patient access — by not inappropriately terminating, removing or
  sanctioning physicians
- System approaches to patient safety and quality of care

Model Principles for Medical Professional Review of Physicians within Health
Insurance Companies

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event should
   include not only pre-event factors, but also the contributory effects of
   the health care system.
3. All the relevant information should be obtained promptly from the
   subject physician on a confidential basis. In addition, relevant
   information from other sources should be obtained and made available
to the subject physician to the fullest extent legally permissible
followed by early discussion with the subject physician to evaluate the
“incident” and explore alternate courses of action, all on a confidential
basis.

4. The process should be mindful of, and attuned to, prevention; and the
outcome should include recommendations, if appropriate, for individual
remediation.

5. Triggers that initiate a medical professional review within a health plan
should be valid, transparent and available to all credentialed,
participating provider or contracted physicians and should be uniformly
applied, with objective and evidence-based pre-screening, to all cases
and physicians.

6. Physician health and impairment issues should be identified and
managed by a medical peer review committee which is separate from
the disciplinary process. Such cases should be referred to Physician
Health Services, Inc., or another appropriate physician health or
wellness program.

7. At a minimum, the standards set by the Healthcare Quality Improvement
Act of 1986 (HCQIA) for eligibility to federal immunity for “professional
review bodies” should be followed if a disciplinary process is engaged
during medical professional review. These standards are the most
elementary safeguards of due process for medical professional review
activities.

Section 11112 Standards for professional review actions
“a. In general...professional review action must be taken–
(1) in the reasonable belief that the action was in the furtherance of
quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the
physician involved or after such other procedures as are fair to the
physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts
known after such reasonable effort to obtain facts and after
meeting the requirement of paragraph (3).”

“Adequate notice and hearing–A health care entity is deemed to have met
the adequate notice and hearing requirement of subsection (a)(3) of this
section with respect to a physician if the following conditions are met (or
are waived voluntarily by the physician):
(1) Notice of proposed action
The physician has been given notice stating –
(A) (i) that a professional review action has been proposed to be taken
against a physician
(ii) reasons for the proposed action
(B) (i) that the physician has the right to request a hearing on the
proposed action
(ii) any time limit (of not less than 30 days) within which to request
such a hearing, and
(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing—If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—
(A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and
(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice—If a hearing is requested on a timely basis under paragraph (1)(B)—
(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—
(i) before an arbitrator mutually acceptable to the physician and the health care entity,
(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
(C) in the hearing the physician involved has the right—
(i) to representation by an attorney or other person of the physician's choice,
(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and
(D) upon completion of the hearing, the physician involved has the right—
(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.”

In addition, the notice of hearing should contain a summary of the allegations and of the episodes of care under evaluation.

8. Summary termination of credentials or of participating provider contract or status (or, if applicable, suspension or restriction of clinical privileges) should only be used to prevent “imminent danger to the health of any individual.” Such summary actions should be followed by adequate notice and hearing procedures prior to becoming final.

9. All parties involved in the medical professional review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the medical professional review process should be available to the subject physician to the fullest extent legally permissible.

10. A medical professional review panel or peer review committee, engaged in a formal medical professional/peer review, corrective action or disciplinary proceeding, should not include direct economic
competitors of the subject physician or those for whom there may be
bias or lack or objectivity vis-à-vis the subject physician, and should,
whenever feasible, include a fair representation of
specialists/subspecialists from the subject physician’s
specialty/subspecialty from among credentialed, participating provider
or contracted physicians within the health plan. Participants on a
medical professional review panel or peer review committee should
disclose relevant conflicts of interest and, when appropriate, recuse
themselves from the corrective action or disciplinary proceeding.
Additionally, the subject physician shall have the right to challenge, in
writing, proposed peer review committee participants for cause prior to
the commencement of the proceedings. Such challenge would be part
of the procedure specified in the health insurance company bylaws
outside of peer review protections and not a part of the actual conduct
of peer review and shall not be protected by peer review statutory
protections.

11. Health plans should employ mechanisms to rotate service on their
medical professional review panels or peer review committees among
their credentialed, participating provider or contracted physicians.

12. Membership on the medical professional panel or peer review
commitee should be open to all credentialed, participating provider or
contracted physicians in the health plan and not be restricted to one or
more groups such as employed or salaried physicians only. The
commitee should include more than just medical directors, medical
officers or other administrative officers of the health plan.

13. Only physicians are peers of the subject physician, and only physicians
should be voting members of committees conducting medical
professional review of physicians.

14. Whenever a medical professional review panel or peer review
commitee adequately representing the specialty/subspecialty of the
subject physician cannot effectively be constituted with physicians
from within the health plan while excluding direct economic
competitors, or at the request of the subject physician, qualified
external consultants or an external peer review panel through another
appropriate institution (e.g., medical specialty society) authorized to
conduct peer review of physicians should be appointed in accordance
with the health plan’s bylaws if such actions fall within statutory
medical professional/peer review protections.

15. Physicians serving on the medical professional review panel or peer
review committee should receive information and, where available,
training, in the elements and essentials of medical professional/peer
review.

16. The health plan should ensure that the physicians serving on any
medical professional review panel or peer review committee are
provided with appropriate indemnification and insurance for medical
professional/peer review acts taken in good faith. The health plan
should also provide assistance to the panel or committee in abiding by
the requirements of HCQIA to be eligible for federal immunity if applicable.

17. The medical professional review panel or peer review committee of a health plan should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination on matters of quality care or professional competency. When the matter before the medical professional review panel or peer review committee involves professional conduct, such as an allegation of disruptive behavior, the medical professional review panel or peer review committee should be guided by applicable professional ethical principles (e.g., MMS Code of Ethics, AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards, practices and principles should be made available in a timely manner to the subject physician before any hearing on the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and, if available, multiple reviewers should be used to increase reliability.

20. Where feasible, statistical analysis to compare with peers’ performance should be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.

22. All the pertinent information obtained by the medical professional review panel or peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.

23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.

24. Any conclusion reached or action recommended or taken should be based upon the information presented to the medical professional review panel or peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a “reasonably prudent person” standard.

25. If the conclusion reached is that improvement is necessary, any action recommended by a health plan should include, as an important focus, steps for remediation, as needed, for the subject physician.

26. The findings, recommendations and actions of the medical professional review panel or peer review committee of a health plan should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician’s act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it should address what specific remediation, if any, is recommended for the physician.
(whenever feasible, in terms that permit measurement and validation of remediation, when completed).

27. A process should be available to appeal any disciplinary finding of a health plan following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the health plan, should be made available to the subject physician within statutory medical professional/peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.

28. In all instances of medical professional review activities conducted within health insurance companies, the applicable processes and procedures should be clearly stated, with specific detail, in health plan provider manuals or written policies, of uniform application, made available in advance to the subject physician. Such processes and procedures should contain the particular due process, hearing and appeals rights available to the subject physician, and, to the extent that medical professional review or peer review privilege, confidentiality and immunity legal protections are available to such medical professional review activities, such processes and procedures should conform to the requirements of federal and state law. In conformity with Principle No. 12, to avoid or at least mitigate conflicts of interest, or the perception thereof, the medical professional review panels or peer review committees of health insurance companies should include as members with full participation and voting rights physicians who are not employees or contractors (other than contracting as a participating provider) of the health insurer.

29. The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment. (MMS Council, 5/17/91; Reaffirmed, House of Delegates, May 7, 1999)

30. These Model Principles for Medical Professional Review of Physicians within Health Insurance Companies are intended to apply to all medical professional review activities conducted by health insurance companies of their credentialed, participating provider or contracted physicians, however designated: e.g., professional review, peer review, credentialing appeals, corrective actions or otherwise.

(MMS House of Delegates, 5/08/09)

The Massachusetts Medical Society amends its existing Model Principles for Incident-Based Peer Review for Health Care Facilities to include an independent appeal and review process for disputed peer review outcomes by a hospital and to update the principles to account for changes in regulations and standards developed since the principles were created in 2003 as to read as follows:
Massachusetts Medical Society Policy

Model Principles for Medical Peer Review of Physicians for Health Care Facilities

The following recommendations are made based on the above considerations in order to enhance:

- Quality improvement
- Credibility in the process of medical peer review of physicians for health care facilities
- Fairness and due process
- Patient access — by not inappropriately removing or sanctioning physicians
- System approaches to patient safety and quality of care

That the Massachusetts Medical Society Model Principles for Medical Peer Review of Physicians for Health Care Facilities are as follows:

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event in a health care facility must not only include pre-event factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the “incident” and explore alternate course of action.
4. The process must be mindful and attuned to prevention and recommend appropriate individual and system changes for remediation.
5. Triggers that initiate a medical peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process.
7. At a minimum, the standards set by Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity must be followed if a disciplinary process is engaged during professional review. These standards are the most elementary safeguards of due process in a health care facility.

Section 1112 Standards for professional review actions

“a. In general...professional review action must be taken—
(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).”

“Adequate notice and hearing–A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating –

(A) (i) that a professional review action has been proposed to be taken against a physician

(ii) reasons for the proposed action

(B) (i) that the physician has the right to request a hearing on the proposed action

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing–If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating –

(A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice–If a hearing is requested on a timely basis under paragraph (1)(B) –

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) –

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right –

(i) to representation by an attorney or other person of the physician’s choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.”

In addition, the notice of hearing should contain a summary of the allegations and the episodes of care under evaluation.

8. Summary suspension or restriction of clinical privileges may only be used to prevent “imminent danger to the health of any individual.” Such summary actions must be followed by adequate notice and hearing procedures prior to becoming final.

9. All parties involved in the peer review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the peer review process shall be available to the subject physician to the fullest extent legally permissible.

10. A peer review committee, engaged in a formal peer review or disciplinary proceeding, may not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician and should include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty whenever feasible. Participants on a peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the peer review or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures specified in the health care facility bylaws, outside of peer review protections and not part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

11. Physicians should rotate service on the peer review committee (round robin).

12. Membership on the peer review committee must be open to all physicians on the medical staff and not be restricted to one or more groups such as those practicing exclusively at a given institution, salaried physicians only or faculty physicians only.

13. Only physicians should be voting members of committees conducting medical peer review of physicians.

14. Whenever a peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the institution while excluding direct economic competitors or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution authorized to conduct peer review of physicians should be appointed in accordance with the medical staff bylaws and medical peer review protection statutes.

15. Physicians serving on the peer review committee should receive information and where available, training, in the elements and essentials of medical peer review.
16. The hospital or the organization on whose behalf the peer review is done
must ensure that the physicians serving on any peer review committee are
provided with appropriate indemnification and insurance for peer review
acts taken in good faith. The organization must also provide assistance to
the committee in abiding by the requirements of HCQIA to be eligible for
federal immunity.

17. The peer review committee of a health care facility should be guided by
generally accepted clinical guidelines and established standards and
practices, when available, in making their determination. When the matter
before the peer review committee involves professional conduct such as
an allegation of disruptive behavior, the peer review committee should be
guided by applicable professional ethical principles (e.g., the MMS Code of
Ethics, the AMA Principles of Medical Ethics, relevant specialty society
ethical codes). Those guidelines, standards and practices must be made
available in a timely manner to the subject physician before any hearing on
the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality
of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and multiple
reviewers should be used to increase reliability.

20. Where feasible, statistical analysis to compare with peers’ performance
must be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject
physician for any formal hearing or appeal.

22. All the pertinent information obtained by the peer review committee
regarding the subject matter should be made available to the subject
physician to the fullest extent legally permissible in a timely manner before
the hearing.

23. To the extent feasible, the reviewers should evaluate the process of care
given while blinded to the outcome.

24. Any conclusion reached or action recommended or taken should be based
upon the information presented to the peer review committee and made
available to the subject physician. Indefensible and vague accusations,
personal bias and rumor should be given no credence and should be
carefully excluded from consideration. Any conclusion reached should be
defensible under a “reasonably prudent person” standard.

25. If the conclusion reached is that improvement is necessary, any action
recommended by a health care facility should include, as an important
focus, steps for remediation, as needed, for the subject physician and for
the system.

26. The findings, recommendations and actions of the peer review committee
of a health care facility should not be vague or stated in general terms, but
should clearly and specifically state in writing the nature of the physician’s
act or omission, how it deviated from the standard of care or ethical
principle, what the standard or ethical principle is and its source, and what
specific step the physician could have taken or not taken to meet the
standard of care or ethical principle. Where applicable, it must address
what specific remediation, if any, is recommended for the physician and
what, if any, for the system (whenever feasible, in terms that permit
measurement and validation of remediation, when completed).

27. A process should be available to appeal any disciplinary finding of a health
care facility following the hearing, and the requirements and procedures for
all existing appeal mechanisms should be made available to the subject
physician. An appeals process before a disinterested third party, not
connected to the medical staff or the hospital, should be made available to
the subject physician within statutory peer review protections. If the
original action was part of a peer-review protected process, the appeal
should be part of the peer-review protected process as well.

(MMS House of Delegates, November 8, 2003; Amended, 5/14/10)

28. The Society recognizes that when a physician performs a medical peer
review function he/she should render the same opinions that would pertain
if he/she were the treating physician with responsibility to provide
appropriate patient care. These opinions should not be rendered solely on
the basis of cost containment. (MMS Council, 5/17/91; reaffirmed House of
Delegates, May 7, 1999)

(MMS House of Delegates, 11/08/03

*Health Care Facilities Principles Amended and Reaffirmed,
MMS House of Delegates, 5/08/09
Amended and Reaffirmed, MMS House of Delegates, 5/14/10
(Item 2 of Original: Sunset)

(HP)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)
FTE: Existing Staff
(Staff Effort to Complete Project)
Item #: 9
Code: CQMP Report A-18 C-9 [A-17 C-2]
Title: Physician Call Policy
(Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsor: Committee on the Quality of Medical Practice
Barbara Spivak, MD, Chair

Report History: OFFICERS Report A-17 C-2
Original Sponsor: MMS Presidential Officers (and Reviewing Committees)
Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background
At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on the Quality of Medical Practice (CQMP). (The CQMP also consulted the Committee on Legislation.) The policy for review states:

PHYSICIANS
Physician Call
1. The Massachusetts Medical Society adopts the following principles:

MMS On-Call Principles:
The MMS On-Call Principles apply to all physicians. These principles are separate and distinct from the formal regulations governing resident work hours that must be followed by hospitals for residency program accreditation by the Accreditation Council for Graduate Medical Education (ACGME).

1. The MMS opposes government regulation of physician work hours.
2. The MMS opposes uniform limits or any other consecutive time constraints, as these can compromise patient care and limit flexibility of scheduling within individual physician practices. Furthermore, the broad diversity of specialty practices indicates that a uniform or standardized approach to regulation of physician work hours would not be appropriate.
3. Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for all physicians. To this end, clinical responsibilities must be organized in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.
4. The individual physician can most appropriately determine whether the clinical schedule allows the physician to meet her/his ethical obligations to the patient.

5. There should be adequate backup if sudden, unexpected patient care needs create fatigue sufficient to jeopardize patient care during or following the on-call period. Institutions and other practice organizations should ensure that such backup is available if required. No institution or call system should require a physician to provide clinical care when the physician believes that she/he will not be able to meet her/his ethical obligations to the patient.

6. Health care delivery systems must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment.

7. As there are different duties defined by each specialty, guidelines for work-hour responsibilities should be made in consultation with each physician, given that responsibilities vary by setting, region, and specialty. In addition, what constitutes excessive fatigue and sleep deprivation will vary by physician.

8. Each specialty department should determine who among its members are required to serve on-call for the emergency department, subject to appropriate compensation to be determined at the local level. In making the determination for who is required to serve on-call, the specialty department may exempt from call service members above a certain age, or with a certain number of years service to the medical staff, or those serving in medical staff leadership positions. Other individual exemptions, for hardship, temporary disability, or other reasons may be granted by the chair on a case-by-case basis.

9. Physicians and hospitals should work collaboratively to develop solutions to on-call needs for emergency departments; adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage; the organization and function of on-call services should be determined through hospital policy and medical staff by-laws; and include methods for monitoring and assuring appropriate on-call performance.

10. It is in the best interests of patients when physicians practice in a fair, equitable, safe, healthy, and supportive environment.

(HP)

2. The MMS will explore working with the Massachusetts Hospital Association (MHA) to develop systems for on-call coverage. (D)

3. The MMS will explore other solutions to on-call coverage, including the development of a “surgicalist” or “acute care surgery” specialty, locum tenens, and assistance from larger medical centers for smaller hospitals. (D)

4. The MMS will advocate for malpractice reform to specifically address increased liability associated with emergency call coverage. (D)

MMS House of Delegates, 5/14/10
Reference Committee Testimony

The reference committee heard only support for the complete sunset report and, therefore, recommended to reaffirm this policy for one year.

Relevance to MMS Strategic Priorities

An MMS strategic priority is to advocate to improve the physician practice environment and work toward improved patient care and outcomes.

Discussion

After reviewing work done since A-11, the Committee on Quality Medical Practice recommends reaffirming the on-call principles and removing directives 2 and 3. Prior reports have demonstrated that sufficient work has been done to complete these directives. Informational Report A-11–27 details the Society’s current activities on directives 2 and 3. The MMS had previously talked with the MHA regarding a system of on-call coverage. Additionally, the A-11 informational report explored the benefits and challenges of different solutions to on-call coverage, including a surgicalist specialty, locum tenens, and assistance from larger medical centers for smaller hospitals. These prior reports confirm that the MMS has sufficiently explored this issue.

During discussion at the January 29, 2018, CQMP meeting, a point was made to distinguish between “on-call,” “working,” and “awake.” For instance, being “on-call” does not mean the physician is necessarily awake or actually working (directly caring for patients). The CQMP recognizes that delivering care to patients (working) for extended hours of time can be detrimental to the effectiveness of the provider and the safety of the patient. Nevertheless, work hour restrictions alone will be ineffective if, when working nights, for example, providers do not also limit daytime activities to obtain adequate rest. Therefore, the individual provider is ethically obligated to restrict or extend his own work hours as he sees fit.

Conclusion/Proposed Amendments

The CQMP recommends amending and reaffirming the policy to read as follows (added text shown as “text” and deleted text shown as “text”):

1. The Massachusetts Medical Society adopts the following principles:

   **MMS On-Call Principles:**
   
   The MMS On-Call Principles apply to all physicians. These principles are separate and distinct from the formal regulations governing resident work hours that must be followed by hospitals for residency program accreditation by the Accreditation Council for Graduate Medical Education (ACGME). The term on-call includes hours providing patient care as well as administrative duties and hours awaiting call.

   1. The MMS opposes government regulation of physician work hours.
   2. The MMS opposes uniform limits or any other consecutive time constraints, as these can compromise patient care and limit flexibility of scheduling within individual physician practices. Furthermore, the broad diversity of specialty practices indicates that a uniform or standardized approach to regulation of physician work hours would not be appropriate.
3. Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for all physicians. To this end, clinical responsibilities must be organized in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.

4. The individual physician can most appropriately determine whether the clinical schedule allows the physician to meet her/his ethical obligations to the patient.

5. There should be adequate backup if sudden, unexpected patient care needs create fatigue sufficient to jeopardize patient care during or following the on-call period. Institutions and other practice organizations should ensure that such backup is available if required. No institution or call system should require a physician to provide clinical care when the physician believes that she/he will not be able to meet her/his ethical obligations to the patient.

6. Health care delivery systems must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment.

7. As there are different duties defined by each specialty, guidelines for work-hour responsibilities should be made in consultation with each physician, given that responsibilities vary by setting, region, and specialty. In addition, what constitutes excessive fatigue and sleep deprivation will vary by physician.

8. Each specialty department should determine who among its members are required to serve on-call for the emergency department, subject to appropriate compensation to be determined at the local level. In making the determination for who is required to serve on-call, the specialty department may exempt from call service members above a certain age, or with a certain number of years service to the medical staff, or those serving in medical staff leadership positions. Other individual exemptions, for hardship, temporary disability, or other reasons may be granted by the chair on a case-by-case basis.

9. Physicians and hospitals should work collaboratively to develop solutions to on-call needs for emergency departments; adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage; the organization and function of on-call services should be determined through hospital policy and medical staff by-laws; and include methods for monitoring and assuring appropriate on-call performance.

10. It is in the best interests of patients when physicians practice in a fair, equitable, safe, healthy, and supportive environment.

(HP)

2. The MMS will explore working with the Massachusetts Hospital Association (MHA) to develop systems for on-call coverage. (D)
3. The MMS will explore other solutions to on-call coverage, including the development of a “surgicalist” or “acute care surgery” specialty, locum tenens, and assistance from larger medical centers for smaller hospitals. (D)

4. The MMS will advocate for malpractice reform to specifically address increased liability associated with emergency call coverage. (D)

**MMS House of Delegates, 5/14/10**

**Recommendation:**

That the Massachusetts Medical Society adopt as amended the physician call policy adopted at A-10 to reads as follows:

1. The Massachusetts Medical Society adopts the following principles:

   **MMS On-Call Principles:**
   The MMS On-Call Principles apply to all physicians. These principles are separate and distinct from the formal regulations governing resident work hours that must be followed by hospitals for residency program accreditation by the Accreditation Council for Graduate Medical Education (ACGME). The term on-call includes hours providing patient care as well as administrative duties and hours awaiting call.

   1. The MMS opposes government regulation of physician work hours.
   2. The MMS opposes uniform limits or any other consecutive time constraints, as these can compromise patient care and limit flexibility of scheduling within individual physician practices. Furthermore, the broad diversity of specialty practices indicates that a uniform or standardized approach to regulation of physician work hours would not be appropriate.
   3. Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for all physicians. To this end, clinical responsibilities must be organized in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.
   4. The individual physician can most appropriately determine whether the clinical schedule allows the physician to meet her/his ethical obligations to the patient.
   5. There should be adequate backup if sudden, unexpected patient care needs create fatigue sufficient to jeopardize patient care during or following the on-call period. Institutions and other practice organizations should ensure that such backup is available if required. No institution or call system should require a physician to provide clinical care when the physician believes that she/he will not be able to meet her/his ethical obligations to the patient.
   6. Health care delivery systems must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment.
7. As there are different duties defined by each specialty, guidelines for
work-hour responsibilities should be made in consultation with each
physician, given that responsibilities vary by setting, region, and
specialty. In addition, what constitutes excessive fatigue and sleep
deprivation will vary by physician.

8. Each specialty department should determine who among its members
are required to serve on-call for the emergency department, subject to
appropriate compensation to be determined at the local level. In
making the determination for who is required to serve on-call, the
specialty department may exempt from call service members above a
certain age, or with a certain number of years service to the medical
staff, or those serving in medical staff leadership positions. Other
individual exemptions, for hardship, temporary disability, or other
reasons may be granted by the chair on a case-by-case basis.

9. Physicians and hospitals should work collaboratively to develop
solutions to on-call needs for emergency departments; adequate
compensation or other appropriate incentives as the preferred method
of ensuring on-call coverage; the organization and function of on-call
services should be determined through hospital policy and medical
staff by-laws; and include methods for monitoring and assuring
appropriate on-call performance.

10. It is in the best interests of patients when physicians practice in a fair,
eQUITABLE, safe, healthy, and supportive environment.

(HP)

4. The MMS will advocate for malpractice reform to specifically address
increased liability associated with emergency call coverage. (D)

MMS House of Delegates, 5/14/10

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

FTE: Existing Staff
(Staff Effort to Complete Project)
PHYSICIAN PAYMENT

Third Party Insurers

The Massachusetts Medical Society (MMS) will continue to communicate to the health plans that a uniform minimum time allowance for the submission and resubmission of nonfederal claims would enhance physicians’ ability to meet administrative requirements. (D)

The MMS will advocate for a uniform minimum time allowance for nonfederal claims of at least 90 days for:

(a) the initial submission of claims;
(b) the resubmission or initial submission of claims to another health plan, in which 90 days would be calculated from the date of the first insurer’s remittance advice;
(c) the submission of additional information, in which 90 days would be calculated from the date the physician receives a communication from the health plan requesting additional information; and
(d) the submission of a claim to a new insurer after retroactive notification of loss of eligibility due to insurer change. (D)

The MMS will monitor health plans’ adherence to their filing-limit policies and communicate noncompliance to the appropriate parties. (D)

The MMS will continue to utilize administrative and legislative activities to promote the establishment of equitable physician recoupment policies at health plans. (D)
Reference Committee Testimony
The reference committee heard only support for the entire sunset report and therefore, recommended to reaffirm this policy for one year.

Relevance to MMS Strategic Priorities
An MMS strategic priority is physician and patient advocacy: advocate to improve the physician practice environment and work toward improved patient care and outcomes.

Discussion
The CQMP met on January 29, 2018, and reaffirmed the MMS policy and also amended it. The amendment supports the need to allow time for claims to be submitted given unforeseen circumstances.

The Committee on Legislation noted that through its legislative and regulatory advocacy, the MMS will continue to promote the establishment of equitable physician recoupment policies at health plans.

Conclusion/Proposed Amendments
The CQMP and COL recommend that the policy be amended as follows and reaffirmed (added text shown as "text"): The Massachusetts Medical Society (MMS) will continue to communicate to the health plans that a uniform minimum time allowance for the submission and resubmission of nonfederal claims would enhance physicians’ ability to meet administrative requirements. (D)

The MMS will advocate for a uniform minimum time allowance for nonfederal claims of at least 90 days for:
(a) the initial submission of claims;
(b) the resubmission or initial submission of claims to another health plan, in which 90 days would be calculated from the date of the first insurer’s remittance advice;
(c) the submission of additional information, in which 90 days would be calculated from the date the physician receives a communication from the health plan requesting additional information; and
(d) the submission of a claim to a new insurer after retroactive notification of loss of eligibility due to insurer change; and (D)
(e) the submission of claim that was hindered by unforeseen circumstances.

(D)

The MMS will monitor health plans’ adherence to their filing-limit policies and communicate noncompliance to the appropriate parties. (D)

The MMS will continue to utilize administrative and legislative activities to promote the establishment of equitable physician recoupment policies at health plans. (D)
Recommendation:
That the Massachusetts Medical Society adopt as amended the third-party
insurers policy reaffirmed at A-10 to reads as follows:

The Massachusetts Medical Society (MMS) will continue to communicate to the
health plans that a uniform minimum time allowance for the submission and
resubmission of nonfederal claims would enhance physicians’ ability to meet
administrative requirements. (D)

The MMS will advocate for a uniform minimum time allowance for nonfederal
claims of at least 90 days for:
(a) the initial submission of claims;
(b) the resubmission or initial submission of claims to another health plan,
in which 90 days would be calculated from the date of the first insurer’s
remittance advice;
(c) the submission of additional information, in which 90 days would be
calculated from the date the physician receives a communication from
the health plan requesting additional information;
(d) the submission of a claim to a new insurer after retroactive notification
of loss of eligibility due to insurer change; and
(e) the submission of claim that was hindered by unforeseen
circumstances. (D)

The MMS will monitor health plans’ adherence to their filing-limit policies and
communicate noncompliance to the appropriate parties. (D)

The MMS will continue to utilize administrative and legislative activities to
promote the establishment of equitable physician recoupment policies at
health plans. (D)

MMS House of Delegates, 11/9/02
Amended MMS House of Delegates, 11/8/03
Reaffirmed and Item 1 Amended and Reaffirmed MMS House of Delegates, 5/14/10

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

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

Item #: 11
Code: CQMP Report A-18 C-11 [A-17 C-3]
Title: Patient Safety Policy
(Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsor: The Committee on the Quality of Medical Practice
Barbara Spivak, MD, Chair

Report History: OFFICERS Report A-17 C-3
Original Sponsors: MMS Presidential Officers (and Reviewing Committees)

Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background

At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on the Quality of Medical Practice. The policy for review states:

QUALITY OF CARE
8c. Patient Safety

The Massachusetts Medical Society accepts the Institute of Medicine’s (IOM) recommendations on Identifying Priority Areas for Quality Improvement, IOM Report *Priority Areas for National Action, Transforming Health Care Quality* (2003):

1. That the priority areas collectively:
   - Represent the U.S. population’s health care needs across the lifespan, in multiple health care settings involving many types of health care professionals.
   - Extend across the full spectrum of health care, from keeping people well and maximizing overall health; to providing treatment to cure people of disease and health problems as often as possible; to assisting people who become chronically ill to live longer, more productive, and comfortable lives; to providing dignified care at the end of life that is respectful of the values and preferences of individuals and their families.

2. Use of the following criteria for identifying priority areas:
   - Impact – the extent of the burden – disability, mortality, and economic costs – imposed by a condition, including effects on patients, families, communities, and societies.
   - Improvability – the extent of the gap between current practice and evidence-based best practice and the likelihood that the gap can be closed through change in an area; and the opportunity to achieve dramatic improvements in the six national quality aims identified in the Quality Chasm report (safety, effectiveness, patient-centeredness, timeliness, efficiency and equity).
• Inclusiveness – the relevance of an area to a broad range of individuals with regard to age, gender, socioeconomic status, and ethnicity/race (equity); the generalizability of associated quality improvement strategies to many types of conditions and illnesses across the spectrum of health care (representativeness); and the breadth of change effected through such strategies across a range of health care settings and providers (reach).

3. That DHHS, along with other public and private entities, focus on the following areas for transforming health care:
   • Care coordination (cross-cutting)
   • Self-management/health literacy (cross-cutting)
   • Asthma – appropriate treatment for persons with mild/moderate persistent asthma
   • Cancer screening that is evidence-based – focus on colorectal and cervical cancer
   • Children with special health care needs
   • Diabetes – focus on appropriate management of early disease
   • End of life with advanced organ system failure – focus on congestive heart failure and chronic obstructive pulmonary disease
   • Frailty associated with old age – preventing falls and pressure ulcers, maximizing functions, and developing advanced care plans
   • Hypertension – focus on appropriate management of early disease
   • Immunization – children and adults
   • Ischemic heart disease – prevention, reduction of recurring events, and optimization of functional capacity
   • Major depression – screening and treatment
   • Medication management – preventing medication errors and overuse of antibiotics
   • Nosocomial infections – prevention and surveillance
   • Pain control in advanced cancer
   • Pregnancy and childbirth – appropriate prenatal and intrapartum care
   • Severe and persistent mental illness – focus on treatment in the public sector
   • Stroke – early intervention and rehabilitation
   • Tobacco dependence treatment in adults
   • Obesity (emerging area)

4. That the Agency for Healthcare Research and Quality (AHRQ), in collaboration with other private and public organizations, be responsible for continuous assessment of progress and updating of the list of priority areas. These responsibilities should include:
   • Developing and improving data collection and measurement systems for assessing the effectiveness of quality improvement efforts.
   • Supporting the development and dissemination of valid, standardized measures of quality.
   • Measuring key attributes and outcomes and making this information available to the public.
   • Revising the selection criteria and the list of priority areas.
   • Reviewing the evidence base and results, and deciding on updated priorities every 3 to 5 years.
Assessing changes in the attributes of society that affect health and health care and could alter the priority of various areas.

Disseminating the results of strategies for quality improvement in the priority areas.

5. That data collection in the priority areas:
- Go beyond the usual reliance on disease – and procedure-based information – to include data on the health and functioning of the U.S. population.
- Cover relevant demographic and regional groups, as well as the population as a whole, with particular emphasis on identifying disparities in care.
- Be consistent within and across categories to ensure accurate assessment and comparison of quality enhancement efforts.

6. That the Congress and the Administration provide the necessary support for ongoing process of monitoring progress in the priority areas and updating the list of areas. This support should encompass:
- The administrative costs borne by the AHRQ.
- The costs of developing and implementing data collection mechanisms and improving the capacity to measure results.
- The costs of investing strategically in research aimed at developing new evidence on interventions that improve the quality of care and at creating additional, accurate, valid, and reliable measures of quality.

Such research is especially critical in areas of high importance in which either the scientific evidence for effective interventions is lacking or current measures of quality are inadequate.

(MMS House of Delegates, 5/2/03)
Reaffirmed MMS House of Delegates, 5/14/10

Reference Committee Testimony
At A-17, the Reference Committee agreed that this policy be reaffirmed for one year.

Relevance to MMS Strategic Priorities
Sustainable health care delivery is an MMS strategic priority.

Discussion
Since the IOM’s seminal report in 2003, no updates have been issued except an IOM’s Committee on Quality of Health Care in America evaluation on the existing knowledge about diagnostic error as a quality of care challenge. The IOM examined definitions of diagnostic error and illustrative examples; the epidemiology, burden of harm, and costs associated with diagnostic error; and efforts to improve diagnosis. This report was a continuation of the IOM’s Quality Chasm Series.

The IOM developed recommendations to reduce diagnostic error in health care. Action items for key stakeholders focused on education, the culture of health care, information technology, systems engineering, measurement approaches, changes in payment, and further research.

The Committee on the Quality of Medical Practice has decided to reaffirm this policy and during the 2018–19 fiscal year will review the report on diagnostic error issued in 2015 by the IOM’s Committee on Quality Health Care in America and make appropriate recommendations.
Conclusion

CQMP recommends that this policy be reaffirmed for seven years.

Recommendation:
That the Massachusetts Medical Society reaffirm the patient safety policy reaffirmed at A-10 and which reads as follows:

QUALITY OF CARE
Patient Safety
The Massachusetts Medical Society accepts the Institute of Medicine’s (IOM) recommendations on Identifying Priority Areas for Quality Improvement, IOM Report Priority Areas for National Action, Transforming Health Care Quality (2003):

1. That the priority areas collectively:
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   - Extend across the full spectrum of health care, from keeping people well and maximizing overall health; to providing treatment to cure people of disease and health problems as often as possible; to assisting people who become chronically ill to live longer, more productive, and comfortable lives; to providing dignified care at the end of life that is respectful of the values and preferences of individuals and their families.

2. Use of the following criteria for identifying priority areas:
   - Impact – the extent of the burden – disability, mortality, and economic costs – imposed by a condition, including effects on patients, families, communities, and societies.
   - Improvability – the extent of the gap between current practice and evidence-based best practice and the likelihood that the gap can be closed through change in an area; and the opportunity to achieve dramatic improvements in the six national quality aims identified in the Quality Chasm report (safety, effectiveness, patient-centeredness, timeliness, efficiency and equity).
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   • Supporting the development and dissemination of valid, standardized measures of quality.
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   • Revising the selection criteria and the list of priority areas.
   • Reviewing the evidence base and results, and deciding on updated priorities every 3 to 5 years.
   • Assessing changes in the attributes of society that affect health and health care and could alter the priority of various areas.
   • Disseminating the results of strategies for quality improvement in the priority areas.

5. That data collection in the priority areas:
   • Go beyond the usual reliance on disease – and procedure-based information – to include data on the health and functioning of the U.S. population.
• Cover relevant demographic and regional groups, as well as the population as a whole, with particular emphasis on identifying disparities in care.
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Such research is especially critical in areas of high importance in which either the scientific evidence for effective interventions is lacking or current measures of quality are inadequate.

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

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

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

Item #: 12
Code: BOT Report A-18 C-12
Title: Delegates-at-Large
Sponsor: Board of Trustees
Henry Dorkin, MD, FAAP, Chair

Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background
The Massachusetts Medical Society (MMS) Bylaws, Chapter 6.00, Section 6.02, (9), provides that delegates-at-large, as recommended by the Board of Trustees (BOT), may be elected by the House of Delegates. Item number 9 further provides that delegates-at-large must be members of the MMS, must be elected individually, and will have the right to vote.

Historically, the MMS has provided delegate-at-large status to the deans of the Commonwealth of Massachusetts’ medical and public health schools. At its January 17, 2018, meeting, the BOT voted to make the following recommendation for election to delegate-at-large status for consideration by the House.

Recommendation:
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.

(D)

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

The Committee on Finance met on February 15, 2018, and in conjunction with the Committee on Membership, presents the following schedule of membership dues for calendar year 2019.

Recommendation:

That the House of Delegates approve the proposed membership dues for calendar year 2019, with no changes from 2018.

Physicians:

- Introductory: $100
- Family (two phys. in same household): $225
- Regular (second year and beyond): $300
- Military: [Current member price of NEJM*]
  *Dues exempt if in active military duty
- Out-of-state: $150
- Life Membership: [Calculated based on age]
- Senior/Emeritus: Free

Residents:

- One-year resident membership: $40
- Three-year resident membership: $90
  Renewable for the length of training
- Out-of-state resident membership: $40
- Residency/Fellowship Programs: Free
  With 100% participation

Medical Students: Free

Multi-year Membership:

- Pre-paid enrollment for 2 years: 5% discount
- Pre-paid enrollment for 3 years: 10% discount
- Pre-paid enrollment for 5 years: 20% discount
- Pre-paid enrollment for 10 years: 30% discount

Group Enrollment:

- Groups with 75% to 79% participation: 5% discount
- Groups with 80% to 89% participation: 10% discount
- Groups with 90% to 99% participation: 20% discount
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<th>Groups with 100% participation</th>
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<td>2</td>
<td>Additional rates may apply for large group enrollment using Board of Trustee approved guidelines.</td>
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<td>Residency/Fellowship Programs:</td>
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<td>Fiscal Note:</td>
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