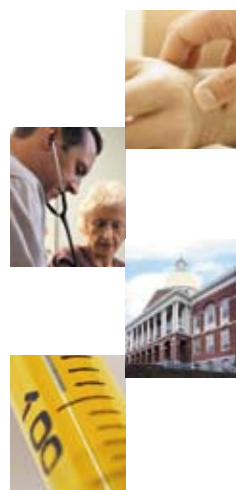




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Practices with Many Medicare Patients Will Face Tough Times if Proposed Cuts Go Through

BY TOM WALSH

Svend Bruun, M.D., began practicing internal medicine three decades ago in Fitchburg, a blue-collar town north of Worcester. He's seen a lot of patients, many of whom have been with his practice for many years because they trust his medical judgment and they appreciate the welcoming atmosphere in his office.

Because of his time in practice and the loyalty of his patients, Dr. Bruun's solo practice today is heavy with Medicare patients — they make up approximately 60 to 70 percent of the patients he sees. That's why hard-edged statements out of Washington about the need to cut Medicare payments to physicians beginning

January 1, 2007, frighten Dr. Bruun — and many other physicians like him.

"Any cut in physician fees would be a big chunk of money out of the practice," said Dr. Bruun, 67. He went on to observe that the overhead of the average physician rises by 7 percent a year, while insurers never seem to boost their payments by more than 1 percent. "There's no place in my practice to make up that kind of money," said Dr. Bruun. "You can't just raise your fees like businesses do."

Dr. Bruun is determined to keep his practice open, come what may. "A lot of my patients are sweet elderly people," he said. "They are not even aware of these money issues." But if the government cuts the sustainable-growth-rate (SGR)

portion of the physician reimbursement by 5.1 percent, "it could be a killer" for some physicians, said Dr. Bruun.

Money Needed to Fix Flawed Formula

Doctors who treat large numbers of Medicare patients have been living on the financial edge for years, and the number of physicians in that category is certain to increase with the aging of America. The federal Centers for Medicare and Medicaid Services (CMS) has long maintained that SGR-driven reimbursement cuts were necessary "because spending

on physicians' services and other Part B services has been growing at a much faster rate than target spending." In recent years, however, Congress has sided with doctors and blunted planned cuts — in some years even voting for modest fee increases.

The AMA and the MMS are battling the threatened January 1 cuts. They have allies in Congress, but averting the next cut would cost a lot of money — money that is not in the federal budget. Physician advocates maintain that the way to fix this problem is to eliminate the SGR part of the formula used to calculate reimbursement. In its place, they propose tying rates to the Medicare Economic Index, which tracks how much doctors' patient-care costs increase. Rep. Michael Burgess, M.D., a Texas Republican, has offered legislation to do that.

However, the Congressional Budget Office (CBO) estimated that the Burgess legislation would cost the federal government an additional \$220 billion over the next decade. And, the CBO added, were the bill to be enacted, Medicare beneficiaries would pay higher premiums for the next 10 years. The MMS has long held that patients and physicians should not be pitted against each other in the Medicare equation.

The AMA maintains that if nothing is done to change the current SGR-based formula, Medicare payments to each Massachusetts physician between 2007 and 2015 will drop by an average of \$19,000 annually. In 2007, Massachusetts doctors overall would lose \$67 million in Medicare fees.

"Fixing the Medicare reimbursement formula will cost a lot of money," said

Kenneth R. Peelle, M.D., MMS president. "There is a lot of agreement that this is a problem, even among legislators. But money is very tight." Dr. Peelle went to Washington in September to ask the Massachusetts congressional delegation for its continued support in stopping the cut and to re-emphasize the need for a long-term solution.

Destructive to Patients and Physicians

In a July 15 letter to Sen. Edward M. Kennedy, Dr. Peelle asserted, "Our number one priority must be finding a true long-term solution — a formula that accounts for the numbers of seniors, the promise and costs of technology, medical inflation, and appropriate quality measurements. A formula that penalizes physicians because the volume of Medicare services has increased, not respecting the longevity of our population and our ability to do more, is destructive to both patients and physicians."

Massachusetts Sens. Ted Kennedy and John Kerry, responding to MMS concerns, were among 80 members who petitioned Senate leaders in July "to ensure that these impending cuts are addressed before Congress adjourns" in October. The letter went on to call for "a positive Medicare payment update [for physicians] for 2007."

While the ideal would be to resolve the Medicare fee issue this year, time is running out before Congress recesses in October for the November elections. Some in Washington see the possibility of a lame duck session of Congress after Election Day that would allow consideration of this issue before the New Year.

continued on page 2



Photo by Gerrilu Bruun, imaging by Chris Twichell

Medicare patients make up 60 to 70 percent of Svend Bruun, M.D.'s Fitchburg practice.

PRESIDENT'S MESSAGE



Your Voice Counts: Physicians Can Help Halt Medicare Cuts

As I write this, the most urgent issue confronting physicians is the prospect of significant cuts in Medicare reimbursements (see lead article on page 1). There's no guarantee that the U.S. Congress, which has reversed proposed cuts in the past, will reconvene for a lame-duck session after the elections, and the target pre-election adjournment date is October 6.

That leaves precious little time to contact your elected representatives in Washington. The quickest way to do that is to use the MMS Legislative Action Center at www.massmed.org/xxxxxxx. When you make contact, let your message be simple but emphatic: "As physicians who care about our patients, we need your help, again, to stop the cuts!" Please add that the physicians of the MMS flatly oppose any increase in premiums for Medicare beneficiaries. The solution to this problem cannot entail turning physicians and patients into economic adversaries.

If you want to voice support for a more permanent, longer-term fix for the Medicare reimbursement formula, all the better. Remember that the most problematic part of that formula — the sustainable growth rate, or SGR — doesn't take into account the aging of the U.S. population or the high cost of new, life-saving and life-prolonging medications and technologies. The SGR, in essence, penalizes us

for helping our patients live longer, healthier lives.

As strongly as I encourage you to contact your U.S. Congresspeople — and to do so now, before adjournment — I also ask you to remember that the entire 12-person Massachusetts delegation has consistently supported the physician community in our advocacy for fair and adequate Medicare reimbursement. But an e-mail, phone call, or fax from you would mean more than merely preaching to the choir. The more we help our legislators understand the whole reimbursement problem, the more likely they are to advocate on our behalf with their fellow lawmakers from other states. Remember, too, that it doesn't matter which side of the aisle you associate yourself with. This is a practice-viability and patient-care issue that transcends partisan politics.

On a more general note, by the time you read this, the Massachusetts primary will be in the books, but campaigning for the November general election will be in full swing. First and foremost, exercise your right to vote. Take the time to understand the candidates' positions on issues important to you, and please support those who really understand the complex problems of health care today and propose viable solutions.

Many of us have become jaded and cynical about politics, but this year, every vote — and every voice — will count.

Kenneth R. Peelle

— Kenneth R. Peelle, M.D.

Medicare Cuts

continued from page 1

Dr. Bruun Will Hang in There

While money and politics swirl around the Medicare fee issue in Washington, the AMA warns of another problem the cuts could cause. According to a 2006 survey by the organization, if proposed payment cuts go into effect January 1, 50 percent of doctors say they will defer buying information technology for their practices. And because many private insurers link their physician reimbursements to rates paid by Medicare, physicians are concerned about a devastating "domino effect."

Despite the uncertainty, Dr. Bruun has no plans to stop seeing Medicare patients, and he fully intends to keep his practice open. But if the reimbursement cuts go into effect, he's still not sure how he will manage.

"I'll stay open, but I'll have to figure out how," he said. "I can't afford to cut the payroll because of the volume of work. I'm already working 12- to 14-hour days. I might have to look at joining up

with another solo practitioner or getting into a group."

Thinking about relinquishing his solo practice gave Dr. Bruun pause. "My patients always say how they love to come to my office," he said wistfully. "My wife works here. People like it. We'd lose an awful lot of the atmosphere." **VS**

Paying for Quality?

Amid the wrangling over Medicare payment cuts arose signals that the federal government wants to introduce physician quality ratings into the Medicare program — and link them to any future physician reimbursement increases. In late August, President Bush signed an executive order requiring four federal agencies — including the Department of Health and Human Services, which oversees Medicare — to work with the private sector to set up programs to measure quality of care.

Helping Physicians Heal Themselves

Fourth in a Series of Vignettes Celebrating the 225th Anniversary of the MMS

Doctors are human, subject to the same problems as their patients.

Massachusetts physicians grappling with health concerns are fortunate to have Physician Health Services (PHS), an MMS subsidiary that provides outreach, support, and monitoring for physicians and medical students coping with addiction and other behavioral health problems.

But the path to creating PHS was winding and steep.

In 1977, the MMS Committee on Mental Health responded to the growing realization of physician impairment problems by examining other state physician health programs. In 1978, the first meeting of the MMS Committee on the Impaired Physician took place in Framingham. The committee's charge was "detection, re-enforcement, and monitoring of all treatment and rehabilitative activities and follow-up on behalf of the impaired physician."

It was a time when many in the medical community, including the state Board of Registration in Medicine (BRM), had yet to recognize substance abuse as a medical problem. However, by the mid-1980s, the board had developed

its Chemically Dependent Physician Policy, which acknowledged that in many cases a chemically dependent physician can be rehabilitated and return to practice while being monitored. In 1994, the BRM further separated physician health matters from the disciplinary process with the Physician Health and Compliance Program, which operated outside the BRM Enforcement Division.

Meanwhile, the MMS committee that first met in Framingham had taken on a more forward-looking name, the Committee on Physician Health. This committee laid the groundwork for Physician Health Services, which was incorporated in 1993. At the same time, the MMS spearheaded legislation that conferred peer-review status upon PHS, thus ensuring confidentiality for PHS records.

Bernard Levy, M.D., a Newton psychiatrist who had been active with the earlier MMS committees, was one of the first directors of the program. He was succeeded by former MMS Vice President John Fromson, M.D., and Luis Sanchez, M.D., heads today's PHS, whose important functions are directed by a seven-member board chaired by Edward J. Khantzian, M.D. **VS**

— Tom Walsh

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Chapter 141 Analysis Indicates Good Health Plan Compliance

The MMS completed its second analysis of health plan compliance with Chapter 141, a section of legislation passed in 2000 that reformed the way managed care is delivered in Massachusetts and expanded the rights and protections afforded to patients and physicians.

Timely Payment

The major local and national health plans are responding to claims within the 45-day timeframe required by Chapter 141. Local health plans report 90 to 99 percent compliance with the law, and many have instituted an automatic payment mechanism for the interest due on claims processed beyond 45 days.

Additionally, according to athenahealth, Inc., during the period from the third quarter of 2005 to the second quarter of 2006, the dominant Massachusetts private payers paid claims within 45 days 98 percent of the time, and national payers hit the 45-day requirement 96 percent of the time. Physicians who have complaints about delayed payments should submit their issue in writing directly to the Division of Insurance Bureau of Managed Care.

External Appeals

Chapter 141 also established an external review process facilitated by the Office of Patient Protection (OPP), which began operating in 2001. After a patient or plan member has exhausted the health plan's internal review process, the patient can request an external review. In 2001, there were only 136 requests for external review (see graph), probably

because providers and patients were not fully cognizant of the new recourse available to them. The number of requests for review reached an all-time high of 446 in 2003, and since then the number of external appeals have leveled out to an average of 27 per month. Based on this trend, an average number of requests came in during the first three months of 2006.

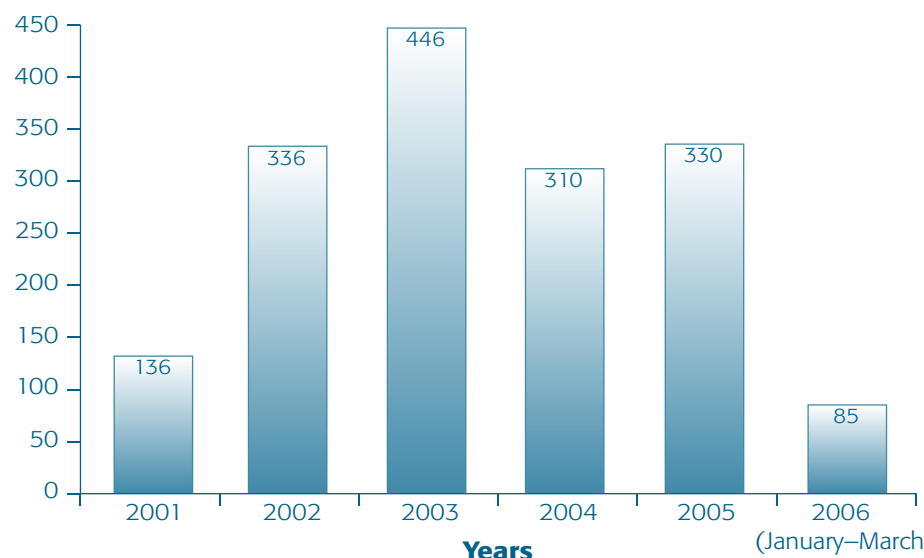
Behavioral health decisions continue to be far and away the most common subject of appeals for denial of coverage, although the percentage has dropped from 52 percent of all cases in 2002 and 2003 to 38.5 percent in 2005. Conversely, external review requests for outpatient services have risen 10 percent since 2001.

The reduction in behavioral health appeals may be due in part to interventions by the OPP, the Department of Mental Health, and the Division of Insurance, all of whom meet with health plans to discuss problems with clinical criteria or the application of those criteria. The Office of the Managed Care Ombudsman can also play a major role in assisting consumers in resolving medical care or coverage issues. Patients and physicians should not hesitate to utilize the services available from these agencies.

The MMS will continue to monitor health plan compliance with Chapter 141 and target additional educational opportunities for physicians and their patients. Physicians can access the entire analysis and get contact information for agencies involved with Chapter 141 at www.massmed.org/pages/chapter141analysis.asp. **VS**

— Dana Cooper

Number of Requests for External Review



HCAS Credentialing Delayed

HealthCare Administrative Solutions (HCAS), a collaborative of several state health plans, announced that it will delay until January 1, 2007, the implementation of its centralized credentialing program. The delay of the rollout, originally scheduled for September 1, is in response to provider organization concerns about resource requirements for the project in light of other initiatives such as implementation of the National Provider Identifier (NPI).

HCAS has held training sessions and met with the MMS and the Massachusetts Hospital Association for feedback and input regarding the credentialing project. HCAS will continue to gather input regarding possible changes to the system from early adopters, and it will hold additional training sessions for the provider community.

The new system for recredentialing Massachusetts physicians (including M.D.s and osteopaths) will start January 1. On February 1, HCAS will begin the process for initial and recredentialing of all other providers, including physicians and allied health professionals in Massachusetts and other New England states.

The new process uses the fields from the existing Integrated Massachusetts Application to streamline credentialing procedures. The new procedures should reduce administrative work for providers by allowing them to apply for credential verification and submit common credentialing information only once for all HCAS-participating health plans.

For information on training dates and other resource materials regarding this initiative, visit www.hcasma.org. **VS**

— Dana Cooper

Additional Studies Support MMS Practice Viability Concerns

Two recent studies reinforce the findings from the 2006 MMS Physician Practice Environment Index (see *Vital Signs*, May 2006, page 1).

A report from the Center for Studying Health System Change (HSC), titled *Losing Ground: Physician Income, 1995-2003*, noted that the inflation-adjusted national average physician net income declined about 7 percent, in contrast with a 7 percent increase in wage trends for other professionals.

Paul Ginsburg, coauthor of the HSC study, cited constrained reimbursement rates as the major cause for the decline in physician incomes. Dr. Ginsburg noted especially sharp income declines for primary care physicians, which is “already limiting the numbers of physicians

entering those specialties and threatens access problems for patients.”

The second report, from Alan Sager and Deborah Socolar of Boston University, noted that the average gross income of Massachusetts physicians is only 70.5 percent of the national average, while MMS data show that overhead expenses have been rising faster in Massachusetts than nationally for the past decade. Dr. Sager concludes that “the state needs meaningful reforms in financing, malpractice law, and the delivery of care to allow Massachusetts’ physicians to ... deliver the best possible care to their patients.” A full summary of these reports is available at www.massmed.org/xxx. **VS**

— Elaine Kirshenbaum

Call for Participation — 2007 Physician Workforce Study

Each year the Society surveys practicing physicians, department chiefs at teaching hospitals, and medical staff presidents at community hospitals to gather data for our annual Physician Workforce Study. The study is instrumental in helping us formulate strategies for our advocacy efforts to improve the viability of physician practices and patient access to care.

Surveys will be mailed during the first week of October 2006. **Your responses**

are crucial to the success of this effort.

If you receive a survey, please complete it and return it to the Society promptly.

If you have any questions about the survey or the Physician Workforce Study, please contact the MMS Health Policy and Health Systems Department at (800) 322-2303, ext. 7222.

Thank you in advance for your help. **VS**

FDA Approves HPV Vaccine for Females 9 to 26 Years of Age

ACIP Recommendations Announced

In June, following the FDA licensing of Gardasil, a quadrivalent HPV vaccine, the Advisory Committee on Immunization Practices (ACIP) voted to recommend the routine use of the vaccine for girls 11 to 12 years of age and permissive vaccinations for those aged 9 and 10 and 13 to 26. The federal Vaccines for Children (VFC) program will cover the cost of the HPV vaccine for those younger than 19 years of age who are VFC eligible.

Studies show the vaccine to be almost 100 percent effective in preventing diseases caused by four HPV types — 6, 11, 16, and 18 — including genital warts and precancers of the cervix, vulva, and vagina.

At least 50 percent of sexually active people will get HPV at some time in their lives, although most will show no symptoms of infection. HPV is most common in people in their late teens and early 20s.

Role of the Physician

When asked whether parents may be concerned about physicians vaccinating 11- and 12-year-olds for a sexually transmitted

virus, David Norton, M.D., pediatrician and chair of the MMS Committee on Public Health, said, "This is a cancer-preventing vaccine, a potential lifesaver."

Judyann Bigby, M.D., of the Harvard Medical School Center of Excellence in Women's Health, said physicians should counsel women who receive the HPV vaccination to practice protective sexual behaviors, because the vaccine does not protect against all HPV types or other sexually transmitted infections, such as HIV and gonorrhea. "This presents an opportunity for people in a position of influence to provide information [about safe sexual behavior]," she said.

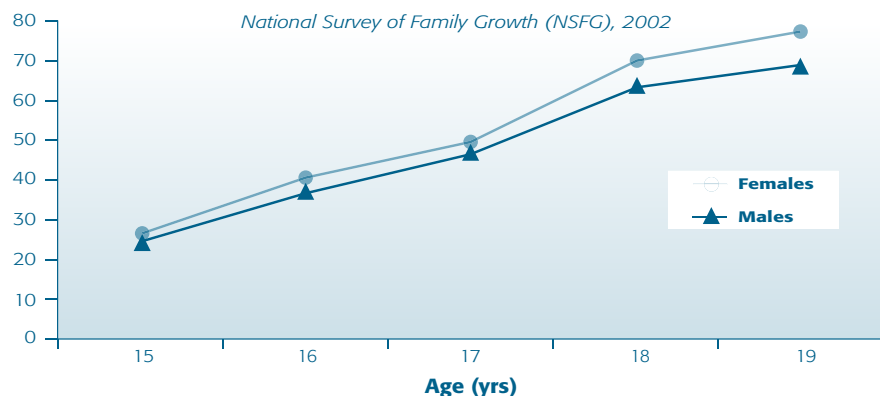
The vaccine, which has been studied mainly in young women not previously exposed to any of the four HPV types in the vaccine, does not protect people who have previously acquired HPV from developing HPV-related disease.

GlaxoSmithKline is in the final stages of testing a bivalent HPV vaccine in women. This vaccine would protect against the two types of HPV (16 and 18) that cause 70 percent of cervical cancers. **VS**

— Robyn Alie

Percentage of Adolescents Who Have Had Vaginal Sex, by Gender and Age

National Survey of Family Growth (NSFG), 2002



WEBSITE OF THE MONTH

National Public Health Meeting in Boston

This year's American Public Health Association (APHA) annual meeting will take place at the Boston Convention and Exhibition Center from November 4 through 8. The theme of this year's meeting is public health and human rights. Featured speakers at the opening session include Paul Farmer, M.D., Ph.D., a founding director of Partners In Health, and Helene Gayle, M.D., M.P.H., president and CEO of CARE USA. More than 13,000 attendees are expected, and they will choose from more than 900 scientific sessions and see booths from nearly 700 exhibitors, including the MMS.

For more details about the APHA annual meeting, visit www.apha.org. The website also contains general information about the APHA and current news in public health.

MMS/MPHA Teamwork Helps Build a Healthy Massachusetts

Disease and injury prevention received a boost on Beacon Hill this year, thanks in part to the cooperative advocacy of the Massachusetts Public Health Association (MPHA) and the MMS.

Collective accomplishments include passage of the mercury bill, passage of legislation that will help prevent AIDS and hepatitis C by legalizing the over-the-counter sale of needles to adults, and increasing the Department of Public Health budget for fiscal year 2007 by \$57 million. These victories resulted from combining credible and compelling information, coalitions built across professional and community lines, and the capacity to mobilize public support.

The most notable public health setback this year was the failure of the school nutrition bill to move beyond the House Ways and Means Committee. A strong, creative campaign was waged to pass Rep. Peter Koutoujian's bill to prevent childhood obesity by prohibiting the sale of sugar-packed drinks and junk food in schools.

Clearly, more work must be done to make public health a priority for State House decision-makers. Improving public health saves lives, prevents pain and suffering, reduces costly medical expenses, and keeps children in school and adults at work. But public health

programs, from anti-smoking campaigns to school health services, continue to be under-funded. Our local public health infrastructure is weak at a time when new threats, such as pandemic flu, are emerging.

To meet these challenges, the MPHA has begun a concerted effort to broaden the constituency for public health. The association formed committees comprised of health and non-health professionals in Central and Western Massachusetts to strengthen regional voices for public health. With organizers in Worcester and Springfield, these committees involve people in both statewide policy and local health concerns. The MPHA's different sections continue to facilitate networking among people with particular interests, and a newly designed website will enable more people to learn about and become involved in public health issues.

Please attend the MPHA annual meeting on Thursday, October 5, at the Royal Plaza Hotel in Marlborough to learn more about our work for a healthy Massachusetts. For more information or to register, visit www.MPHAweb.org.

— Eric Weltman

Deputy Director of Policy and Advocacy
Massachusetts Public Health Association

Giving by MMS Foundation Nears One Million Dollar Mark

Since its inception in May 2000, the Massachusetts Medical Society and Alliance Charitable Foundation has provided nearly one million dollars in grants to programs across Massachusetts that address issues such as violence, obesity, homelessness, and hunger. In 2006, the Foundation awarded more than \$200,000 to programs that address unmet health care needs and provide care for the medically underinsured.

The Foundation is governed by a volunteer board of directors that reviews grant proposals to ensure the grants positively impact the health care of the populations they serve.

"The Foundation is unique because it represents physicians in this state and focuses on health care," said John M. Crowe, M.D., a retired surgeon from Canton who serves as chair of the Foundation's board. Each year, the number of charitable programs that request funding increases.

The Foundation offers several means of making tax-deductible contributions. These include memorials, tributes, directing an honorarium, and planned giving, a charitable opportunity that yields additional tax benefits.

Donated funds can be unrestricted — used at the discretion of the Foundation board of directors to support programs and/or Foundation activities — or directed to specific types of Foundation initiatives such as community action, care for the medically uninsured, international health studies for residents and medical students, or the endowment fund, which is dedicated to long-term financial growth of the Foundation. **VS**

— Jennifer Day

For more information about the Foundation and its programs, visit www.mmsfoundation.org or call Jennifer Day at (781) 434-7044.

STATE UPDATE

MMS Advocacy Efforts Garner Success During 2005–2006 State House “Formal” Session

By the time the gavel came down ending the scheduled “formal” sessions of the House and Senate on July 31, it was clear the session had been a very successful one for physicians and their patients. Significant bills were enacted expanding access to health insurance coverage, increasing Medicaid reimbursements, broadening public health and public safety protections, and encouraging medical research. In addition, attempts by other health professionals to encroach on the practice of medicine were turned aside, as were efforts to limit physician ownership of medical technology and ambulatory surgery centers.

Here’s a summary of some of the key MMS gains at the State House:

Health Access: The passage of “Chapter 58” in April was perhaps the most significant health-related legislation of the decade. This new law should provide health insurance coverage to approximately 90 percent of the state’s nearly 600,000 uninsured over the next three years. The MMS worked closely with the Affordable Care Today

coalition to secure passage of this measure.

The Practice Environment: Protecting the physician practice environment is a top priority of the Society. Thanks to MMS advocacy, “Chapter 58” also included provisions for \$81 million in additional Medicaid funding for physicians over a three-year period. In addition, the MMS successfully prevented several allied health professions — including pharmacists, who sought to gain prescribing authority — from engaging in the practice of medicine. Proposals by optometrists, podiatrists, nurse practitioners, and naturopaths were also thwarted. The Society also led successful efforts to sidetrack bills intended to restrict patients’ access to high-quality, cost-effective surgical and diagnostic services owned by physicians.

Public Health and Public Safety: The MMS worked with an array of coalitions to secure passage of bills to protect the public’s health and safety. These included the “clean needles” bill, the “mercury management” bill, and the “fire-safe cigarettes” bill, which requires cigarettes to

be self-extinguishing if not in active use. The MMS also joined in successful efforts to increase penalties for drunk drivers, provide easier patient access to emergency contraception, and increase funding for immunizations and substance abuse prevention and treatment.

Medical Research: The MMS strongly supported legislation that would allow embryonic stem cell research in the Commonwealth.

The Legislature is now in “informal” sessions through the end of the year, during which legislation must be approved by unanimous consent. While most legislation during informal sessions is non-controversial, the MMS will remain vigilant, particularly regarding efforts to extend the scope of practice of allied health professionals. That vigilance will extend to any special “formal” session that may be convened.

For further information on the fate of specific bills during this legislative session, please contact Steve Shestakofsky at sshestakofsky@mms.org. **VS**

— Steve Shestakofsky

FEDERAL UPDATE

MMS Comments on Proposed Changes to Medicare RVUs

MMS President Kenneth R. Peelle, M.D., submitted comments in response to the Centers for Medicare and Medicaid Services’ (CMS) proposed changes to Medicare relative value units (RVUs), which factor into physician reimbursement levels. By law, every five years, the AMA’s Relative Value Update Committee (RUC) reviews the RVUs and makes recommended changes. This year, the CMS accepted the RUC’s recommendation for RVU increases in 299 services, but disagreed on another 123 services. Because of Medicare’s budget-neutrality requirements, the agency also proposed a 10 percent across-the-board cut in all RVUs.

Dr. Peelle’s comment underscored the Society’s “long-standing opposition to the budget neutrality requirement, which forces otherwise unnecessary adjustments to physician payments.” While applauding the increase in RVUs for some physician services, Dr. Peelle said, “At the same time, we do not believe that the value of other physicians’ work

should be decreased arbitrarily under the pressure of budget neutrality.” The MMS concurs with the AMA that the CMS should make budget-neutral adjustments to the conversion factor, rather than cut RVUs by 10 percent.

Dr. Peelle also noted that because many other payers follow Medicare’s reimbursement methodology, changing

The increase in RVUs for some physician services should not come at the expense of devaluing services rendered by other physicians.

the RVUs might have a more widespread negative impact on physicians. Because the CMS proposal also addressed changes to the method used to calculate physician practice expenses, Dr. Peelle’s comments also supported the AMA’s recommendation that the CMS help

fund a multispecialty survey to collect real practice cost data.

House Passes Health IT Bill

Meanwhile, on Capitol Hill, the House of Representatives passed H.R. 4157, the “Health Information Technology Promotion Act of 2006,” by a vote of 270 to 148. Overall, the legislation aims to speed the implementation and interoperability of health information technology. This bill must now be reconciled with legislation passed by the Senate. Critical differences include provisions regarding privacy of medical records and language creating an exemption to Stark laws that would allow hospitals and other payers to help providers acquire IT software and hardware.

With a short legislative session remaining, the possibility of reconciling the House and Senate bills and final passage is uncertain. **VS**

— Alex. Calcagno

LEGISLATOR OF THE MONTH

Representative

Martha M. (“Marty”) Walz (D)

District: Boston (part), Cambridge (part)

Committees: Education, Housing, Transportation



QUOTE: In addition to health care reform, the Legislature recently addressed other issues important to physicians. One of those was a bill mandating nurse-patient ratios.

The House (but not the Senate) passed that bill. I was one of 20 representatives to oppose it. I do not believe legislators should regulate how hospitals assign nursing staff. Rather, hospitals should take into account the entire care-giving team when deciding how patients will be best served.

As an employment lawyer, I worry about this bill. It gives the bill’s major proponent, the Massachusetts Nurses Association, what it could not win in collective bargaining. The Legislature should not intervene in a dispute between an employer and a union. RNs are in a union for a reason, and the union should do its job at the bargaining table, which is where these issues are best resolved.

I encourage you to participate in this year’s elections, not only by voting, but also by asking the candidates questions and volunteering. Once the Legislature takes office in 2007, I urge you to contact your representative and senator about issues of concern, medical or otherwise. From my own experience, I know how important it is when voters contact their elected officials and let their voices be heard.

Medical Staff Bylaws Help Keep Clinicians in the Driver's Seat

Editor's Note: This is excerpted from an article that originally appeared in *MetroDoctors*, the journal of the Hennepin and Ramsey (MN) Medical Societies.

If hospital practice is important to you financially and/or professionally, you need to pay attention to how you deal with the hospital — and how it deals with you.

Hospitals can wield a lot of power over physicians. Among other things, they can report you to the licensing board, refuse to renew your clinical privileges, require you to take emergency room calls without compensation or limit, and throw you out of an elected position.

However, physicians need not blindly follow hospital administration's orders if solid medical staff bylaws are in place. Bylaws help ensure that clinical decisions are made by clinicians and that the physician's duty to the patient remains paramount.

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has long included requirements for medical staff self-governance in its accreditation standards. Functions for medical staff self-governance include initiating, developing, and approving medical staff bylaws; approving or disapproving amendments to bylaws; selecting and removing medical staff officers; helping

establish and maintain patient care standards; and credentialing and delineation of clinical privileges.

Avoid the Plan/Manual Trap

At a minimum, bylaws should stipulate that medical staff members cannot be fired or lose their exclusive contracts as a result of good-faith participation in medical staff activities or leadership roles.

Some consultants advise medical staffs to place the more contentious issues,

such as members' rights to hearings and representation, in separate "manuals" and "plans." But doing so often prevents the medical staff members from having a voice in these key provisions. Medical staff bylaws are

the key to keeping clinicians in the driver's seat.

Medical staffs may face an uphill battle in obtaining the bylaws amendments necessary to get the hospital-physician relationship back on track. Physicians employed by or under contract with the hospital may be subject to pressure to vote as the hospital sees fit. Yet, even in a medical staff consisting completely of hospital employees, self-governance is a professional obligation and a JCAHO accreditation requirement.

— Elizabeth A Snelson, Esq.

Physician-Hospital Relationships — Where Do You Stand?

**Saturday, November 18
8:00 a.m.–3:15 p.m.
MMS Headquarters, Waltham**

Register online at www.massmed.org
or by calling (800) 843-6356.

Pri-Med East Returns to Boston in October

The MMS is pleased to be a sponsor of Pri-Med East, a comprehensive medical conference that provides extensive continuing medical education opportunities. The conference will be held at the Boston Convention and Exhibition Center from October 27 through 29.

The conference is organized along two tracks. The "Current Clinical Issues in Primary Care" curriculum consists of more than 50 sessions developed and presented by Harvard Medical School faculty. The "Practice Solutions" track addresses the business aspects of running a successful practice.

Interspersed among the clinical and business-oriented sessions are several keynote presentations, including *What Pandemic Flu is Teaching Us about America's*

Preparedness, by Bernadine Healy, M.D., *Update on Avian Influenza*, by Robert C. Moellering Jr., M.D., *The Changing Face of Cancer Research Prevention and Care*, by Edward J. Benz Jr., M.D., and *Nephrology as a Discipline: Historical Perspective and Future Directions*, by Mark L. Zeidel, M.D.

Participants can earn additional CME at independent symposia beginning on Thursday, October 26. An extensive exhibit area will provide opportunities to review the latest in pharmaceuticals, medical devices, and technologies. Be sure to stop by the MMS, NEJM, and *Journal Watch* exhibits. **VS**

— Steve Phelan

For more information and to pre-register, visit www.pri-med.com/east.

PHYSICIAN HEALTH MATTERS

School-Specific Health Services for Medical Students

Second of Two Parts

Medical students seeking help with substance use, behavioral health, or mental or physical illness can work with the resources of the Physician Health Services (PHS) and/or their specific school:

Boston University School of Medicine

Referrals for student support typically start at the Office of Student Affairs. Any student experiencing academic, behavioral, or learning difficulties can be referred or self-refer to the director of Student Support Services. Students needing or seeking a psychiatric consultation can be referred to a staff physician at Boston Medical Center for initial assessment, short-term therapy, and/or referral for ongoing care. The resources of the BU Center for Anxiety and Related Disorders are also available to medical students. The school proactively addresses potentially problematic behaviors at the mid-point evaluation and before the end of a student's clerkship, and it relies on PHS for consultations on the advisability of monitoring.

Harvard Medical School

Harvard Medical School students are assigned to one of five "societies," their home base for both academic and career counseling. The Office of Advising Resources (OAR) is available to students by self-referral or by referral from their societies, course/clerkship directors, or the Promotions Board. The OAR provides initial screening to determine which components (emotional, learning, medical, or situational) might be contributing to the student's difficulties. Two on-site education specialists provide assistance with learning and attentional disabilities, board preparation, and disability accommodations.

The Harvard University Health Services (HUHS) provides medical and mental health care in Boston's Longwood area and in Cambridge. Both HUHS mental health clinicians and the OAR can provide referrals to community providers.

Tufts University School of Medicine

During orientation for first-, second-, and third-year students, the deans in the Office of Student Affairs (OSA) and the director of the Student Advisory and Health Administration (SAHA) discuss medical school stressors and the resources available to manage them.

Periodically during the year, students are reminded of the various support services available.

Academic, personal, and career advising is provided by the OSA deans, and psychiatric evaluation is available through SAHA. Students may be referred to professionals outside the Tufts University academic community for psychotherapy, psychiatric evaluation and treatment, or substance abuse treatment. Mental health services are also available through the student health plan. Students can be referred by their primary care physician, or they may call the plan's mental health referral service.

In addition, the TUSM Wellness Committee, a group of students and faculty, offers confidential support and guides students to available resources.

UMass Medical School

Students may access help through the Office of Student Affairs (which includes advising/career development and a Center for Academic Achievement), through a separate Student Counseling Service (SCS), or through the student Health Service. The Center for Academic Achievement provides assistance in academic counseling and tutoring and offers seminars on test-taking, study skills, and time management. The Health Service handles most general health concerns and is accessed by appointment. In addition, students can utilize, at a discount, the Stress Reduction Clinic at the UMass Center for Mindfulness.

Many students access the on-campus SCS via self-referral, although others can direct students to the service. Appointments are suggested, though urgent/same-day visits can often be accommodated, and staff are available for after-hours emergencies. After psychiatric evaluation by SCS, students may be seen for therapy and/or medication management by the SCS staff.

SCS services are free, and insurance is not billed unless outside services are required. Confidentiality is a focus, and staff members have no academic/grading relationships to students.

For additional information about these resources, contact Physician Health Services at (781) 434-7404 or visit www.physicianhealth.org. **VS**

This article was prepared by the Physician Health Services, Inc. Medical Student Advisory Committee.

ACROSS THE COMMONWEALTH

District News and Events

Barnstable – District Meeting. Mon., Oct. 23, 6 p.m. Location: Oak Crest Cove Yacht Club, Sandwich. CME Program, “The Pediatric Sandwich Cancer Study: Epidemiology, Clinical Application, and Community Health.” Pre-registration is required. For more information, contact the Southeast Regional Office.

Berkshire – District Meeting. Wed., Nov. 8, 6 p.m. Speaker: Donald Burt, M.D. For more information, contact the West Central Regional Office.

Charles River – Delegates Meeting. Tues., Oct. 24, 6 p.m. Location: MMS Headquarters, Waltham. For more information, contact the Northeast Regional Office.

Essex South – Delegates Meeting. Wed., Oct. 25, 6:30 p.m. Location: Danversport Yacht Club, Danvers. For more information, contact the Northeast Regional Office.

Hampden – Fourth Annual Family Night. Fri., Oct. 20, 5:30 to 6:30 p.m. pre-game skating party, and 7:35 p.m. game. Location: pre-game skating at MassMutual Center, Springfield. Cost: \$15 per person. **22nd Annual Medical Ethics Seminar.** Thurs., Oct. 26, 6 p.m. Location: Baystate Health Learning Center, Holyoke. Topic: Ethical Dilemmas in Pandemic Preparedness and Responses. Speaker: Lisa Stone, M.D., hospital preparedness coordinator for the Massachusetts Department of Public Health. **13th Annual Medical Legal Forum.** Tues., Nov. 14, 6 p.m. Location: The Log Cabin, Holyoke. Speaker: Supreme Judicial Court Chief Justice Margaret H. Marshall. For more information, contact Suzanne Skibinski at (413) 736-0661.

Norfolk South – Family Event. Sat., Oct. 14, 12 p.m. Duck Tours followed by luncheon and tours at Boston Museum of Science. For more information, contact the Southeast Regional Office.

Plymouth – District Meeting. Wed., Oct. 18, 6 p.m. Location: Lombardo’s Restaurant, Randolph. CME program, “The Physician and the Pay for Performance Movement.” Pre-registration required. For more information, contact the Southeast Regional Office.

Southeast Districts – Regional Caucus. Tues., Oct. 24, 6 p.m. Location: Lebaron Hills Country Club, Lakeville. Delegates from Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth Districts will meet to review the MMS Interim Meeting resolutions. For more information, contact the Southeast Regional Office.

Suffolk – Delegates Meeting. Thurs., Oct. 24, 6 p.m. Location: East Garden Room, MGH. Delegates will review MMS Interim Meeting resolutions. For more information, contact Thelma Malafey at (617) 236-5864.

Worcester – Health Care in Central Massachusetts CEO Forum. Wed., Oct. 18, 5:30 p.m. Location: Beechwood Hotel, Worcester. Speakers: Presidents and CEOs of Harrington Memorial Hospital, UMass Memorial Health Care, and St. Vincent Hospital. Moderator: George Abraham, M.D. **Fall District Meeting.** Wed., Nov. 8, 5:30 p.m. Location: Beechwood Hotel, Worcester. Meeting includes awards presentations. For more information, contact Joyce Cariglia at (508) 753-1579.

Statewide News and Events

AHH&C MIN Event – Tower Hill Program. Sat., Oct. 14, 6 p.m. Location: Tower Hill Botanic Garden, Boylston. A tour of the grounds and an MMS member artwork display and music program. For more information, contact the West Central Regional Office.

In Memoriam – With respect and sympathy, we note member deaths on the MMS website at www.massmed.org/memoriam.

If you have news for “Across the Commonwealth,” contact Florence Keefe, Northeast Regional Office, at (800) 944-5562 or fkeefe@mms.org; Linda Howard, Southeast Regional Office, at (800) 322-3301 or lhoward@mms.org; Nancy Caron, West Central Regional Office, at (800) 522-3112 or ncaron@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

MMS Expands Member Benefits with Allscripts Discount

The Society recognizes the importance of finding technology solutions, such as electronic health records (EHRs), that will maximize the value of existing information, control costs, and improve practice efficiency. To support informed choices for implementing EHRs, the MMS has endorsed Allscripts, a leading provider of clinical software, connectivity, and information solutions for physician practices. MMS members will receive discounts on all Allscripts EHR products.

The Allscripts business group of particular interest to the MMS is the Clinical Solutions Group, which combines electronic health records with document imaging to deliver critical information to physicians at the point of care.

At the 2004 Healthcare Information Management Systems Society (HIMSS) convention, Allscripts received the highest overall perception rating in a field of

16 EHR vendors providing applications for larger practices. Also, during this year’s HIMSS convention, Allscripts’ TouchWorks™ EHR system received the Best-in-Class award for ambulatory care applications.

“Our vision is to become an indispensable part of the way physicians practice medicine,” said Lee Shapiro, president of Allscripts.

For more information about Allscripts — including the special MMS member discount — contact Adam Shlager, MMS practice management consultant, at (781) 434-7702 or ashlager@mms.org. To receive the Allscripts newsletter, visit www.allscripts.com. If you have questions about MMS member benefits, contact our Member Information Center at (800) 322-2303, ext. 7311, or e-mail info@massmed.org. **VS**

– Emily H. Richardson

Get the Most from Your Membership with the 2007 Member Benefits Guide

The 2007 MMS *Member Benefits Guide* will be distributed with 2007 member identification cards as members join the Society or renew their memberships. The guide is a comprehensive reference for accessing the many benefits of MMS membership.

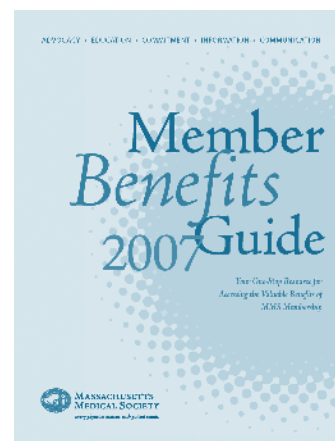
The easy-to-follow guide provides information on MMS advocacy, educational services, practice-management and professional resources, patient education, and public health campaigns. This year’s guide describes new technology-based services designed to assist members with office management and increase the viability of physician practices (see related article above).

The “Benefit Contact Information” section of the guide provides easy access to direct contact phone numbers, e-mail addresses, and websites for all benefit programs and services. The online version of the guide provides members with direct links to other sites for more in-depth descriptions of particular benefits and services.

This members-only Web resource can be accessed by visiting www.massmed.org/benefits.

Renew your membership now to receive your 2007 *Member Benefits Guide*. If you have questions about your benefits, call the Member Information Center at

(800) 322-2303, ext. 7311, or e-mail info@massmed.org. **VS**



Managing Workplace Conflict: Improving Personal Effectiveness

December 14 and 15, 2006, 8 a.m. to 4 p.m.
MMS Headquarters, Waltham

For more information, contact Physician Health Services at (781) 434-7404.



THE MASSACHUSETTS MEDICAL SOCIETY CELEBRATES 225 YEARS!

Much has happened within medicine since 1781, the year the Massachusetts Medical Society was founded. Please join MMS officers for a celebration commemorating our 225 years of service to the Commonwealth's physicians and their patients.

Friday, November 3

MMS Headquarters, Waltham

Featured Speaker: Doris Kearns Goodwin

Reception begins at 5:30 p.m.

Program begins at 7:00 p.m.

For more information or to register, go to www.mms.org/225celebration.

MMS Education Programs

To register for any of these activities, call (800) 843-6356. For more information on these activities, contact the MMS Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to www.massmed.org.

NOTE: (RM) indicates that the activity or a portion of the activity meets the Massachusetts Board of Registration in Medicine criteria for risk management study.

On-Site CME Programs

Federal Funding Opportunities

Oct. 12, 3:00 – 5:30 p.m. Harvard Medical School, Boston. Jointly Sponsored by the MMS and the Biomedical Science Careers Program. CME Credit: 2.5 *AMA PRA Category 1 Credits*TM (RM)

Physicians and the Pay for Performance Movement

Oct. 18, 6:30 – 8:30 p.m. Lombardo's, Randolph. Sponsored by the MMS and the Plymouth District Medical Society. CME Credit: 1.5 *AMA PRA Category 1 Credits*TM (RM)

Garland Lecture:

Consumer Driven Health Care

Oct. 24, 5:30 – 6:30 p.m. Harvard Medical School, Boston. Jointly Sponsored by the MMS and the Boston Medical Library. CME Credit: 1.0 *AMA PRA Category 1 Credit*TM (RM)

The Sandwich Pediatric Cancer Study

Oct. 23, 6:30 – 8:30 p.m. Oak Crest Cove Yacht Club, Sandwich. Sponsored by the MMS and the Barnstable District Medical Society. CME Credit: 2.0 *AMA PRA Category 1 Credits*TM (RM)

Cost Performance Ratings: What You Need to Know about ETGs

Nov. 3, 2:00–3:30 p.m. MMS Headquarters, Waltham. CME Credit: 1.5 *AMA PRA Category 1 Credits*TM (RM)

Online CME Programs

To access the following programs, go to www.massmed.org/cme.

*The following online CME programs are jointly sponsored by the MMS and ProMutual Group. Each program is awarded 1 AMA PRA Category 1 Credit*TM (RM).

• Nursing Home Malpractice Litigation: Physician-Focused Risks*

- Terminating the Physician-Patient Relationship*
- Hospitalists*
- The Electronic Health Record in the Office Practice*
- Medical Malpractice Litigation: The Attorney's Perspective*
- Nonsurgical Cosmetic Procedures: Risk Issues in the Quest for Youth
- Difficult Patients
- Closing a Practice
- Terminating the Professional Relationship With a Patient
- Patient Satisfaction
- The Telephone as an Instrument of Risk
- Nurse Practitioners and Physician Assistants: Some Risk Management Concerns*
- Cultural Diversity

*Asterisked programs are also available in print. For a copy, please call the Department of Continuing Education and Certification at (800) 322-2303, ext. 7306.

*The following online programs are sponsored by the MMS. Each program is awarded 2 AMA PRA Category 1 Credits*TM (RM).

- Clinical Aspects of Bioterrorism
- Medical Perspectives on Impaired Driving
- Medical Errors and Perspectives on Patient Safety
- Patient Safety: Conducting a Root Cause Analysis of Adverse Events
- Medication Safety, Systems and Communication
- Building a Better Delivery System: A New Engineering/Health Care Partnership
- CME Accreditation: A Review for CME Providers and Surveyors