



RHODE ISLAND

MEDICAL NEWS

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RHODE ISLAND MEDICAL SOCIETY
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Proposed federal rules on Accountable Care Organizations (ACOs)

The joke going around is that "ACO" really stands for "Abundant Consulting Opportunities" for attorneys and practice management experts. A nationwide scramble to make sense of ACOs was touched off on March 31. That was the day five federal agencies – the Centers for Medicare & Medicaid Services (CMS), the Inspector General, the Department of Justice, the Federal Trade Commission and the Internal Revenue Service – all released their coordinated proposals for how Accountable Care Organizations will be implemented, supposedly starting as early as January 1, 2012.

A sixty-day public comment period opened on April 7 and will run through June 6. The agencies will then draft final regulations for ACOs, a process that could take months and result in ACOs that look substantially different from what is currently proposed.

The Rhode Island Medical Society provided its members with a free two-hour introduction to ACOs and COOPs (Consumer Operated and Oriented Plans) on April 14. The seminar attracted 89 registrants and featured three experts on the still-emerging ACO and COOP models: Henry Allen, Esq., Senior Attorney for Advocacy with the AMA; Elias Matsakis, Esq., partner in the Chicago law firm Holland & Knight; and RIMS' own general counsel, Jeffrey F. Chase-Lubitz, Esq., of Donoghue, Barrett & Singal (Providence office).

The AMA offers all physicians a rich and growing online library of resources on ACOs and COOPs at <http://www.ama-assn.org/go/aco> under the title *Manual for Physicians Navigating a Post-Health Reform World*.

AMA, RIMS and other national and state medical societies continue to analyze the

proposals and will cooperate in providing feedback to the federal agencies by the June 6 deadline.

In addition, RIMS has been meeting with its counterparts in Connecticut, Massachusetts, New Jersey, New York and Pennsylvania and with AMA representatives to explore possibilities for regional collaboration. The medical societies want to help doctors seize whatever opportunities ACOs, COOPs and MEWAs (Multi-Employer Welfare Arrangements) may present to boost physician leadership and influence in the changing landscape of health care.

The year-old federal health care reform law and the new first draft of regulations envision ACOs as voluntary groupings or networks of independent doctors and/or large medical practices, potentially in partnership with hospitals, federally qualified health centers, suppliers and even commercial health insurance plans. By working together to coordinate care, the ACO participants are supposed to share in the money they save for Medicare, while maintaining quality.

In order to be certified as an ACO and thus become eligible to share in the anticipated savings, the organization must include enough primary care physicians (defined by the proposed regulations as general internists, family physicians or geriatricians) to care for a minimum of five thousand Medicare patients. Those primary care physicians must be exclusively committed to a single ACO. Medical and surgical subspecialists, hospitals, health centers, rural clinics or other potential ACO partners need not be exclusively committed to a single ACO.

**CMS expects
only
75 to 140
ACOs nationwide
next year.**

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The Rhode Island Medical Society
was founded in 1812 to promote
the art and science of medicine.
RIMS is the eighth oldest state
medical association in the country.

In cooperation with the Brown
University School of Medicine,
the Rhode Island Department
of Health, and Quality Partners
of Rhode Island, the Society also
publishes a monthly magazine,
Medicine and Health Rhode Island.

FROM PAGE ONE

"Sorry" gets a hearing in the House



On March 22, the House Judiciary Committee of the Rhode Island House of Representatives took up H-5255, a Medical Society initiative that would enable physicians to express sympathy and regret for a patient's disappointing outcome without incurring immediate liability by the simple act of making such natural, human gestures of empathy. The bill was introduced again this year at the Medical Society's request by Representative Joseph McNamara (D-Cranston, Warwick). A companion bill (S-348) has once again been introduced in the Senate at RIMS' request by Senator Rhoda Perry. The legislation makes "benevolent gestures" inadmissible as evidence, in themselves, of liability in a lawsuit alleging medical malpractice.



The Medical Society led off the hearing with coordinated testimony by Dr. Michael Migliori, Dr. Nitin Damle, Dr. Alyn Adrain, Dr. Elaine Jones and Brown medical students Steve Lee, MD '11, and Reshma Ramachandran, MD '13. RIMS was supported by testimony from representatives of the Rhode Island Hospital Association, the NORCAL Mutual Insurance Company, and the professional associations of Rhode Island dentists, podiatrists and pharmacists.

Opposing RIMS' bill again this year is the Rhode Island Association for Justice (formerly known as the Rhode Island Trial Lawyers Association). The RIAJ and some members of the House Judiciary Committee questioned whether the disclosure requirements imposed by The Joint Commission make RIMS' legislation superfluous. Supporters of RIMS' bill explained that, on the contrary, current Rhode Island law puts physicians in an untenable position, because it is inconsistent with Joint Commission rules and leaves physicians open, in effect, to being punished for complying with Joint Commission requirements.

Widely known as "I'm sorry" legislation, the idea of encouraging rather than punishing dialogue between doctors and patients and their families is no longer new. Thirty-five states, including all five other New England states, have already enacted legislation

similar to what RIMS has proposed for Rhode Island. In the wake of the abundant publicity surrounding the Michael Woods case and its resolution in 2009, the 2010 General Assembly session seemed ready at last to enact the Medical Society's bill. However, opponents still managed to kill RIMS' bill last year, as in previous years.

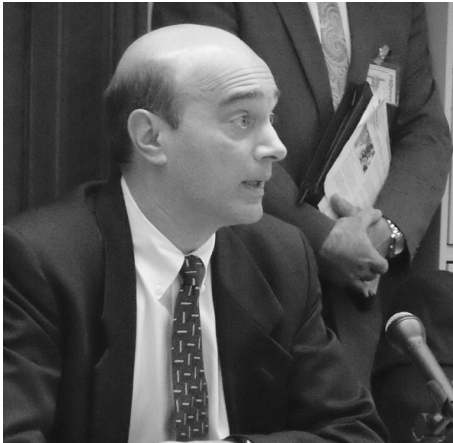
Other objections raised by opponents to the bill are that its reference to The Joint Commission impermissibly cedes state authority to an outside organization and that physicians could preempt adverse litigation

Congressional committees move medical liability bill

By a vote of 18 to 15, the Judiciary Committee of the U.S. House of Representatives approved HR-5, the HEALTH Act, (Help Efficient, Accessible, Low-cost Timely Health Care). The bill would institute a \$250,000 cap on non-economic damages in states without caps. State laws that provide for higher or lower damage caps on non-economic damages would not be preempted.

Committee deliberations became contentious when a minority of Republicans agreed with Democrats that medical liability is traditionally regulated by the states and that the federal government should not pass a bill that allows for the preemption of state law. The bill is currently before the House Committee on Energy & Commerce.

A Senate companion bill, S.218, has been referred to the Judiciary Committee. ❖



simply by proactively apologizing. The preemption argument is easily dismissed: the evidentiary privilege that RIMS' bill would establish is narrow and would exclude from admissibility only the doctor's benevolent gestures in the wake of an unanticipated outcome. Like any other viable case, a meritorious lawsuit against the doctor would still have to be built on substantial evidence.

A hearing in the Senate is expected to take place within the next few weeks. ❖



Members of the House Judiciary Committee are as follows:

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Rep. Edith H. Ajello	Chairperson	rep-ajello@rilin.state.ri.us
Rep. Michael J. Marcello	Vice Chairperson	rep-marcello@rilin.state.ri.us
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**GARY BUBLY, MD
PRESIDENT**

In mid-February, while I was working a busy emergency department shift, I overheard one of our stellar emergency medicine residents introduce himself to a patient with, "Hi, I am Dr. _____, and I am part of the **team**

that will be taking care of you today." The nurse who was at the head of the bed tending to a laceration on the forehead of this patient looked up and beamed. The sense of inclusion and acknowledgement of everyone's value on the health care **team** was palpable. Although I was running around trying to juggle the care of a dozen sick patients, I stopped mid-stride in awe. I was inspired.

When the resident presented the case to me, I heaped praise upon him for that introduction. As a faculty member, I confess I am frequently learning from the residents, and everyone else around me. I quickly borrowed this play from his playbook, and incorporated the phrase into my own introduction to the same patient.

However, the family's reaction startled me. The patient's daughter assertively fired back, "We don't want a goddamn team taking care of my mother! We want one doctor who knows what's going on! Not a team that has to rely on one telling the next what's going on with my mother!"

Wow. Not what I expected, but even more thought-provoking. I reassured her I was the captain of the ship on that emergency department visit, with sole responsibility for everything that happened to her mom. At the same time I knew I would be staying late on that shift to keep my promise to her.

The concept of a single trusted caregiver remains central to the doctor-patient relationship. That concept has not faded in patients' minds despite shorter resident hours imposed by the ACGME, the enormous growth of hospitalists, and the complexities of EHRs that do or do not interface. Keeping our promise to patients means taking overarching responsibility for care, and ensuring excellent communication with consultants and colleagues in the inevitable handoffs in our system. Will Patient Centered Medical Homes, and projects on improving communication and transitions of care solve that issue? I think we will always want one doctor who is there for us, who "knows what's going on."

Communication between providers is but one element embedded in Accountable Care Organizations, aka **ACOs**. For months we were awash in discussion about the nebulous concept of ACOs without much detail, awaiting clarification from CMS, the Department of Justice and the Federal Trade Commission. Some physicians had not even heard the term yet, while others were racing to form them.

As most of you know, the hotly anticipated draft regulations were finally released March 31, 2011. RIMS hosted an educational session on April 14th with 3 outstanding attorneys who have pored over the roughly 500 pages of regulatory clarifications on ACOs, COOPs and MEWAs. The event was well attended, and RIMS members engaged our panelists with insightful questions and comments.

We all want to be prepared and positioned for the future, but it is difficult trying to navigate through the fog without radar, a chart plotter, or even an exact destination. Now that the fog is lifting, many think ACO is a destination they will bypass for now. Yet on some level ACOs, COOPs and MEWAs seem to be timely catalysts for physicians to consider aggregating into larger groups. Experience has shown that larger groups empower their physician members. And physician empowerment has been an issue for many of our members, for many different reasons. Physicians have been trained to fly solo, to think and practice independently—to be that "one doctor who knows what's going on." Forming larger groups may result in some loss of individuality and autonomy, but if you speak to colleagues in larger groups, they generally agree that the overall gains for physicians outweigh these sacrifices.

OK, change gears. On January 13th we had a **reception at RIMS for the newly elected legislators** in Rhode Island. This was the day after the blizzard, and surprisingly, at least to me, we had an excellent turnout despite the weather. Hearty legislators and many RIMS members from leadership, Council, PAC, and Public Laws turned out for a casual meet and greet. I had a great time there! It was a nice opportunity to get to know several of our newest representatives. We had some personal and thoughtful discussions about issues, which for me at least, were rather encouraging about the future! Hopefully, they won't get burned out or worn down too fast.

Our legislative agenda: the "I'm sorry" legislation; repeal of the provider tax; freedom to delegate "prior auth" for imaging; a tax on sugar-containing beverages; immunity for those administering naloxone in drug overdoses; immunity for PA's serving in a disaster or emergency situation; primary seatbelts; ignition interlock for DUI; marriage equality, and stricter regulation on teens using tanning salons.

We have met with **Senate President Teresa Paiva-Weed**, **Senator Domenic Ruggerio**, and **House Majority Leader Nicholas Mattiello** to discuss our legislative agenda.

In early February, **Drs. Damle, Migliori, Mr. Steve DeToy** and I headed to Washington for the AMA National leadership and Advocacy meeting. That was eye opening for me in terms of how relatively good we have it compared to other parts of the country. The AMA has 4 major items on its legislative agenda this year, which we discussed in our meetings with the RI delegation: the SGR fix (currently good till end of December 2011), Medicare private contracting, truth in advertising (i.e., credentials of practitioners), and liability reform.

Back home, we met with **UnitedHealthcare** to discuss United's Premium Designation Program, which was to be rolled out simultaneously in all 39 markets where United has a foothold. The program is supposedly one of quality and efficiency. The measures reportedly are evidence-based, take into account a case mix adjustment, and require at least 10 data points to report. There is an appeal process before results are posted online. Physicians and patients will have online access to this data. This will feed in to select reimbursement incentives. As in the past, we expressed concerns for the accuracy of data, the soundness of the methodology and the usefulness of the information.

MinuteClinic has apparently again postponed plans to open locations here in Rhode Island. As I mentioned in the last newsletter, our RIMS leadership team met with the leadership of MinuteClinic back in November to discuss their plans to enter the state. At that time, they accepted our invitation to them to address the February RIMS Council meeting. However, prior to that Council meeting, they apparently withdrew their plans to open locations here in RI. We will keep an ear to the ground.

We bade farewell to **Dr. David Gifford, Director of Health**. At our last meeting with him in February, we reminisced a bit and reviewed a long list of topics of mutual interest, from our legislative agenda to regulatory issues. We wished him well in his new endeavors, but also encouraged him to stay involved with us on advocacy, particularly areas he was passionate about.

I was pleased that RIMS member **Dr. Michael Fine** was appointed Interim Director of Health, while the search continues for a new Director. We met with Dr. Fine in March and again in April. He is still seeing patients at the ACI, which is admirable. Although I can only imagine the incredible time and budgetary constraints the Director has to deal with, wouldn't it be fantastic if the Director of Health was able to see patients for even a half day per month in any setting, just to keep a finger on the pulse of what clinicians struggle with?

I reluctantly accepted the resignation of **Nick Tsiongas** as president of the **Rhode Island Medical Political Action Committee**. We graciously thanked him for his years of service to the organization in this capacity. Big shoes

to fill, but **Mickey Silver** has agreed to serve as RIMPAC president, and **Elaine Jones** agreed to step up to Treasurer. I have asked **Brandon Maugham** to serve as the resident representative, and **Mark Schwager** and **Chris Luttman** to join the board of directors of RIMPAC as well.

We recently met with **Ed Quinlan, President of the Hospital Association of Rhode Island** and Craig Sayata, HARI's government relations director, to discuss areas of mutual interest.

In addition, **Daren Girard**, current president of RIACEP, Steve DeToy and I met with **Craig Stenning**, Director of BHDDH, regarding the issue of ED psych holding. We are seeking more transparency in the process of psychiatric placement.

I continue to represent RIMS on the **Special Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals**. The Commission's recommendations were released at the end of March and are summarized elsewhere in this newsletter. I also serve on the Rhode Island Health Promotion Policy Council and HealthCare Community Exchange Council (of BCBSRI, along with Dr. Nitin Damle, Dr. Marlene Cutitar, Dr. Phil Rizzuto and many others).

Finally, at the April meeting of the RIMS Council, we hosted **Lieutenant Governor Elizabeth Roberts** and her Chief Counsel, **Jennifer Wood**. Many of you read the minutes and commented. Glad you are reading this stuff! And I am grateful she took the time to write a response to clarify our minutes. She is sincerely interested in including providers in the health care reform process.

That's all for now. ❖

Lt. Governor Roberts addresses RIMS Council



Lieutenant Governor Elizabeth Roberts addressed RIMS Council on April 4, focusing on the federal Patient Protection and Affordable Care Act of 2010 and its progressive implementation in Rhode Island. A full report is available on www.rimed.org under "Working for You," along with Lt. Governor Roberts' response.

ACOs, continued

Additional basic requirements for federal recognition as an ACO include a governing board and a formal legal structure through which shared savings payments can be distributed to the ACO's professional and institutional participants. An ACO must also be able to provide regular reports to CMS and to the public regarding participants, governance, quality and expenses; and it must commit

to participating in Medicare as an ACO for at least three years at a time.

ACOs were conceived to provide a unique opportunity for physicians to take the initiative in creating and being the leaders of new models for integrated health care delivery.

The government's prime objective with the ACO program, of course, is to save money for Medicare while maintaining the quality of patient

care. However, it is clearly not the expectation of federal policy-makers that ACOs will become the dominant model for delivering and paying for health care, at least not any time soon. CMS is saying that it expects only 75 to 140 or so ACOs nationwide to begin operations next year.

In essence, then, ACOs are another experimental step in the government's search for structures and formulas that simultaneously control cost and promote quality.

Will they fly?

Some observers question the economic viability of ACOs and doubt that they will attract many participants at all. Some already dismiss the ACO idea as old wine in new bottles – or worse, as potentially costly dead-ends for doctors who venture into them.

Naturally, the answers come down to dollars and cents. Are the numbers realistic? Are they sufficient to have the desired impact on cost and quality in the long term?

CMS proposes to pay physicians in ACOs under the familiar Medicare Part B fee-for-service schedule. To establish annual benchmarks for ACOs, CMS will look back at six months' past claims experience of the Medicare population that CMS attributes to the ACO (a problematic process in itself: see below), aggregate it, and convert it to a per-beneficiary benchmark as a spending target for the coming year.

Providence attorney Don E. Wineberg of the firm Chace Ruttenberg and Freedman suggests some simple calculations to get a rough idea of the possibilities. Nationwide, Medicare's average actual expense per beneficiary in 2009 was \$10,400. Taking that number as a hypothetical ACO capitation benchmark and assuming that the ACO a) chooses to optimize its gain-sharing by accepting downside risk from day one and b) is very successful in achieving both high efficiency and high quality, then the

ACO would earn the maximum return, which is capped at 10% of its benchmark. That would amount to \$1040 per beneficiary or \$5.2 million for an ACO that has the minimum enrollment of 5000 Medicare beneficiaries.

Alternatively, if that same successful ACO more cautiously participates only in upside gain-sharing in the first two years, its maximum return would be \$780 per Medicare beneficiary or \$3.9 million per year.

Would such numbers be sufficient to stimulate and sustain ACOs, given the necessity of sharing among the ACO participants and bearing in mind that gain-sharing will be contingent and prorated, based upon the ACO's success in demonstrating sufficient quality in five "domains" involving 65 quality measures?

Moreover, ACOs are likely to have start-up costs that will need to be amortized. The ten ACO pilots, which started in 2005 in various parts of the country, incurred start-up costs of \$1.76 million on average. (And, by the way, when all was said and done, most of those ten pilots actually earned little or nothing in shared savings between 2005 and 2009.)

One additional caveat: CMS plans to withhold 25% of shared savings as a hedge against future losses that the ACO might incur and be required to share in as well.

Another sample calculation

RIMS' legal Counsel Jeffrey F. Chase-Lubitz took a different approach in gauging how an ACO might work (or not work) for physicians. In Providence County, Medicare spent an average of \$9,024 per Medicare beneficiary (fee-for-service) in 2008. Multiplying that number by the ACO minimum of 5000 Medicare beneficiaries yields a total potential benchmark budget of \$45,120,000 within which the ACO would have to provide the full spectrum of care to those beneficiaries for one year.

Assuming that the ACO succeeded in reducing hospital admissions by fully 10% in that year (from about 1600 to about 1440 in Providence County) and assuming further that each such admission is worth about \$12,800 to Medicare, then the ACO would realize savings of \$2,048,000 or 4.54% of its benchmark. For a small ACO that opted cautiously for upside sharing only with no downside risk, Medicare would claim the first 3.9% of the benchmark (\$1,759,680), leaving just \$288,320 available for sharing. Between zero and 50% of that amount (i.e., up to \$144,160, depending on the ACO's success in returning good quality measures) could be returned to the ACO to amortize its start-up costs and distribute among its participants. Medicare would keep the remainder.

Alternatively, a small ACO could opt to place itself at down-side risk from the start and thereby reduce

**Gain-sharing
will be
contingent upon
good scores
on 65 quality
measures.**

**How achievable
are the
benchmarks
set by CMS
likely to be?**

the initial threshold for sharing from 3.9% to 2%, producing \$1,145,600 available for sharing under the above scenario. How much of that \$1,145,600 would actually be returned to the ACO in shared savings could vary from zero up to a maximum of 60% (\$687,360), depending again upon the ACOs simultaneous success in meeting 65 measures across five “domains” of quality. (See “Quality reporting” below.)

Again, a further caveat is that CMS will impose a 25% withhold, which will reduce the flow of shared savings.

Surprise: ACOs will share in losses as well as savings

Under Section 3022 of the year-old federal health care reform law, the formation of ACOs is incentivized by the promise that ACO participants will share in the

eventual savings to Medicare.

But when the new regulatory proposal came out at the end of March, it included downside risk as well as upside rewards.

Sharing of both savings and losses would kick in only when there is a difference, whether positive or negative, of at least

2% between the benchmark and the actual experience for the calendar year. The smallest ACOs (those closer to the minimum of 5000 Medicare patients) would have to better their benchmark by almost twice as much – 3.9% – in order to trigger shared savings. After the minimum differentials are reached or exceeded, ACO and CMS will roughly split the difference retroactively, up to a capped proportion in relation to the original benchmark. The cap would vary between 7.5% and 10% of the benchmark, with the higher percentage reserved for ACOs that are also exposed to downside risk.

ACOs can choose to be at risk for losses from the start or to postpone downside risk until the third year of their operation; however, by the third year and in all subsequent three-year agreements, all ACOs will be “accountable” for downside risk as well as upside savings, according to the proposed regulations.

The shared loss arrangement would roughly mirror shared savings. That is, if losses amount to at least 2% of the benchmark, CMS and the ACO would split the negative difference roughly in half, up to a cap of 5% of the benchmark for a fully at-risk ACO in the first year, up to 7.5% in the second year, and up to 10% in the third. For those ACOs that opt to postpone risk-sharing until the third year, a loss cap of 5% would be applied only in that last year.

The proposed ACO regulations foresee a sliding scale of thresholds for gain-sharing, ranging between 2% and 3.9%, depending upon the size of the ACO. Citing the experience of the ten government ACO pilot programs during 2005–2009, the American Medical Group

Association estimates that the proposed 2% threshold for shared savings will be a challenge for ACOs to achieve and that the 3.9% threshold foreseen for the smallest ACOs will be “very difficult.”

Quality reporting

Even if an ACO succeeds in substantially improving upon its spending benchmark, actually sharing in any of the realized savings is contingent upon, and proportional to, good scores on sixty-five quality measures distributed across five “domains” of patient care. Each domain is weighted equally in a point system that totals 130 points (two points for each of the 65 measures).

The five domains are: patient experience; care coordination; patient safety; preventive health; and at-risk/frail elderly health. The measures and the domains may expand in the future to include things like hospice care and nursing home measures.

A closer look at the five domains offers some clues to the government’s thinking and betting. The domain of

“care coordination,” for example, includes a subcategory called “management of ambulatory sensitive conditions.” It turns out that these “conditions” include the following seven disease categories: diabetes with short-term complications; diabetes with long-term complications; COPD; heart failure; dehydration;

pneumonia; and urinary tract infection. The quality measures for these seven conditions account for 14 out of the total 130 quality points.

Where will the savings come from?

CMS believes that the number of hospital admissions and readmissions for these “ambulatory sensitive conditions” are an index to how well the outpatient primary care system is functioning. CMS further assumes that managing those same “ambulatory sensitive conditions” is a key to significant savings through lower rates of hospital admission and readmission.

For those contemplating the formation of an ACO, it might appear that partnering with a hospital might invite internal disharmonies, since shared savings would be unlikely to fully offset the financial consequences of a lower inpatient census for the institution.

CMS will control the benchmarks and quality measures

Every ACO will be assigned its own new benchmark annually, based on recent claims experience for the ACO’s retroactively assigned Medicare patient population and adjusted in light of nationwide spending trends. How reasonable, challenging or achievable are the benchmarks set by CMS likely to be? The answer may vary from

**Antitrust
enforcement
is not
going away.**

**ACOs forming now
need to anticipate
changes in Medi-
care’s payment
structure.**

year to year and from ACO to ACO. CMS plans to apply managed care's "hierarchical condition categories" risk-adjustment methodology to ACO populations.

Definition of "primary care physician"

The federal health care reform law and the proposed regulations call for each ACO to be built on a foundation of primary care physicians, who are defined as general internists, family physicians and geriatricians. This definition may be contested by other specialty groups who seek more direct inclusion in the ACO model. Already the Neuropathy Association and the American Academy of Neurology are promoting legislation in Congress (S. 597) which would amend the ACA's definition of "primary care physician" to include neurologists.

"Meaningful use" will be required of at least 50% of ACO primary care physicians by the ACO's second year of operation

This requirement may prove to be a barrier for some would-be ACOs, especially in underserved and rural areas of the country. Perhaps the final regulations will drop this requirement. After all, given the incentives that already exist under the HITECH Act for achieving "meaningful use" of electronic health records, the inclusion of an additional requirement under the ACO regulations may have little additional impact.

ACOs will not control their assigned population of beneficiaries

Patients will remain free to seek care wherever they like. CMS will automatically assign (and reassign) patients to ACOs, based retroactively on Medicare claims data that indicate where the patient has been seeking the greatest proportion of his or her care. Thus, snowbirds may present a challenge to the ACO model.

What about HIPAA?

The proposed data sharing and information technology provisions of the ACO regulations suggest that ACOs should be prepared to shoulder some extra burdens for HIPAA compliance. CMS proposes to provide ACOs not only with aggregated data on the Medicare population the ACO serves, but also, upon the ACO's request, individually identifiable beneficiary information. No doubt ACOs will need such information to improve care coordination and overcome inefficiencies. However, since ACO participants may include both "covered entities" and "business associates" in HIPAA parlance, ACOs will need to have all necessary "Business Associate Agreements" in place and otherwise be up to snuff with HIPAA.

What about antitrust?

In the past, independent medical practices and other competitors who cooperated in sharing information and resources without being financially and/or clinically integrated risked draconian anti-trust sanctions. Now, to encourage collaboration and coordination, the Justice Department and the Federal Trade Commission propose to amend their rules to define new safety zones for ACO participants.

However, antitrust enforcement against "non-competitive behavior" is not going away. Physicians will need to familiarize themselves with the new rules and make sure they get good legal advice.

ACO applicants will have to move quickly once the final ground rules are known.

What about Stark (self-referral) and anti-kickback laws?

Here again, the federal authorities propose to carve out safety zones to permit ACOs to function and engage in collaborative gain-sharing. The initial new proposals were published on March 31 and are currently open for public comment. ACO aspirants will have to follow these developments carefully and make sure to be in compliance.

What about future payment models?

The proposed regulations are predicated on fee-for-service Medicare, but clearly CMS is planning more bundled payments in the future, with more global fees for "episodes" of care. ACOs forming now need to anticipate changes coming soon in the payment structure used by Medicare and commercial payers.

Will CMS stick to the January 1, 2012, start date for ACOs?

Straws in the wind suggest the implementation schedule will slip. The public comment periods close on or before June 6, after which CMS and the other agencies may take months to digest the feedback and draft final regulations. ACO applicants will have to move quickly once the final ground rules are known. A secondary start date of July 1, 2012, was already foreseen in the proposed regulations and required a 3.5 year commitment rather than three years. Perhaps July 1, 2012, will, by default or by regulation, become the real start date for everyone.

How significant will the differences be between the proposed ACO regulations issued on March 31 and the final version that we will see at an unknown time later this year?

Changes may be highly significant for some ACO applicants and insignificant for others. Early movers may have an advantage, if they are reading the tea leaves and their own circumstances correctly. On the other hand, early movers may find themselves tripped up if the regulators change their ACO vision in unanticipated ways. ❖

RI Senate commission on hospital costs releases report

At the end of March after four months of study, a state Senate commission including RIMS President Gary Bubly, MD, and sixteen other citizens released findings and recommendations regarding hospital costs.

The Special Senate Commission to Study Cost Containment, Efficiency and Transparency in the Delivery of Quality Patient Care and Access by Hospitals, chaired by Senator Joshua Miller (D-Cranston), made the following recommendations, some of which are already reflected in new legislation that is currently before the General Assembly:

- Supporting the “affordability standards” that the Office of the Health Insurance Commissioner has outlined for health insurers, including OHIC’s requirement that payers direct more resources to primary care.
- Establishing a provider payment reform task force.
- Implementing alternative payment models, including greater use of global or bundled payments for hospitals and doctors, with the possibility of requiring a complete transition by 2014.
- Enhancing transparency in the hospital rate-setting and negotiation process.
- Requiring all patients to designate a primary care provider.
- Reducing readmission rates (currently over 20% for adults in Rhode Island within thirty days of discharge); “safe transitions” programs are seen as a key to such reductions.
- Creating an all-payer claims database within the RI Department of Health. (Lack of funding for such a project is a major obstacle to realizing this idea. RIMS has reservations about the usefulness of any system that gathers only claims data.)
- Recommitting to comprehensive, statewide health system planning, as is required by the RI Coordinated Health Planning Act of 2006 but has lacked funding.
- Expanding options for hospital emergency departments to perform behavioral health evaluations and enable less costly, more effective behavioral interventions.
- Exploring possibilities for interstate coordination of certificate of need processes and moving toward a regional approach to health system needs.

The complete Senate Commission report is available online at www.rilin.state.ri.us/SpecialReports ❖

Information for consumers on health system reform

The “Health Care and You Coalition” has launched a website <http://www.healthcareandyou.org> designed to give consumers state-by-state information about how the national health care reform act affects them. Members of the Coalition are the American Academy of Family Physicians, the American College of Physicians, the American Medical Association, the American Nurses Association, the National Community Pharmacists Association, the AARP, the American Cancer Society Cancer Action Network, and the Catholic Health Association. ❖

“The Point” is a central resource for RI seniors, disabled

The Rhode Island Department of Elderly Affairs offers a central, one-stop resource that can connect seniors, adults with disabilities and their caregivers with a variety of social services for families caring for loved ones at home. “The Point” (401-462-4444, www.ThePointRI.org) has multilingual benefit specialists who are trained in the needs of the elderly and adults with disabilities. The Point can provide information, referrals, and access to short-term case management and long-term care services. The Point is funded by a grant from the federal Administration on Aging. More information is available from Deborah Correia Morales at Quality Partners of RI: 401-528-3249 or DMorales@riqio.sdps.org. ❖

Patient Centered Medical Home Accreditation Guidelines from AAFP, AAP, ACP, & AOA

On March 8, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) released joint Guidelines for Patient-Centered Medical Home Recognition & Accreditation Programs building upon Joint Principles of the Patient-Centered Medical Home issued by the four groups in February 2007. More information is available at <http://www.aap.org/advocacy/releases/pcmh3811.pdf>. ❖

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information**

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The RI Regional Extension Center (RI REC) is a service of the Rhode Island Quality Institute, a non-profit organization dedicated to improving the healthcare system in Rhode Island. To learn more, visit www.DocEHRtalk.org.

The REC and its services are made possible through a grant from the Office of the National Coordinator for Health Information Technology with US Department of Health and Human Services support.



U.S. court backs AMA, halts “red flag” implementation

A U.S. Court of Appeals has validated the AMA's tenacious stand against the Federal Trade Commission on the “red flags” issue. For years the FTC has asserted that physicians are “creditors” and are therefore subject to the Red Flag Rule, which requires financial institutions to adopt procedures and protocols to protect clients against identity theft. The FTC has argued that doctors and dentists are “creditors” because they accept delayed payments for their services.

The Appeals Court found the regulations of the FTC are invalid in light of last December's Red Flag Program Clarification Act of 2010, which the AMA successfully pressed Congress to enact. Thus, the AMA has fought the “red flags” issue on regulatory, legislative and judicial fronts to protect doctors from government overreach.

A year ago, the Litigation Center of the AMA and the State Medical Societies and other physician groups filed a federal lawsuit to stop the FTC from extending “red flags” to doctors. Further litigation is now obviated by the March 2011 Appeals Court ruling. The AMA's lawsuit has therefore been formally terminated. More information is available at: <http://www.ama-assn.org/ama/pub/news/news/ama-welcomes-clarification-red-flags-rule.page>. ♦

AMA urges changes in health IT program

The AMA and 37 specialty societies have sent a strong letter to the Obama Administration calling for more flexibility in the next stages of Medicare's electronic health records (EHR) incentive program. The Administration's draft recommendations, now pending, would significantly expand the Stage 1 requirements, including bi-directional data exchange. The AMA is pushing for greater flexibility for individual practices and circumstances, rather than a rigid, one-size-fits-all approach. The AMA comment letter is available at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/comments-hitpc-proposed-measures-25feb2011.pdf>. The AMA continues to seek input from both the state and specialty societies on meaningful use of EHRs and advocate for reasonable requirements. ♦

AMA introduces AMAGINE™, health IT solutions platform for physicians

The AMAGINE™ physician platform has successfully completed pilot testing and is now available to physicians nationwide.

Amagine, Inc., a subsidiary of the American Medical Association (AMA), is now offering physicians a new, affordable, easy and individualized way to step into the electronic world.

The system offers physicians three different electronic medical record products, electronic prescribing software, claims management, clinical decision support and reference tools. The choices include Dr. First, Allscripts, DocSite, WellCentive, CareTracker, Quest Care360, and NextGen, among others. The platform helps physicians determine their own practice needs, select the right system and qualify for federal health IT incentives.

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The AMAGINE™ platform has been pilot tested by the Michigan State Medical Society and its members since 2009.

More information is available at www.amagine.com ♦

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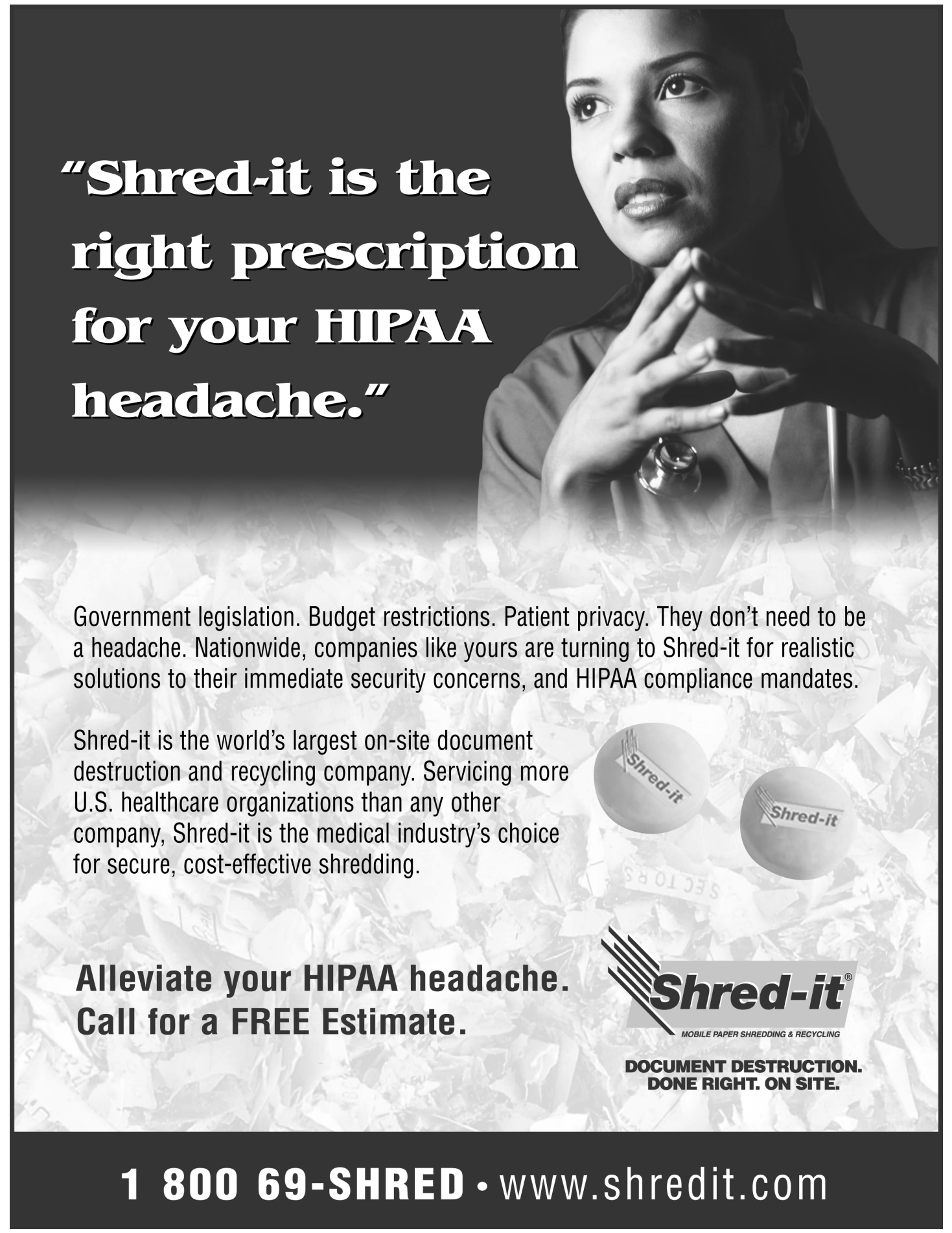
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RIMS issues policy statement on prior authorization

Background At its regular February meeting, the RIMS Council approved the statement below as a summary of the Medical Society's position with regard to prior authorization requirements that many, perhaps most, third-party payers in the U.S. now impose upon physicians and their patients for a variety of services. Concern about prior authorization (also known as "prospective utilization review") currently runs high in Rhode Island because of relatively new policies imposed by the state's largest insurer, Blue Cross, with respect to non-emergent, high-end imaging studies. RIMS' statement applies most immediately to imaging, but it is also intended to be generic enough with regard to the spectrum

of pre-authorization requirements that payers commonly impose upon tests, procedures, pharmaceuticals and referrals as a strategy that has proven effective in reducing utilization. RIMS finds that unfocused use of prior authorization requirements imposes wasteful burdens that affect primary care and subspecialty physicians and their patients and unnecessarily introduce inefficiencies into the health care system. RIMS has shared the statement below with all local payers. In addition, RIMS is seeking relief for doctors through legislative channels. These are just the latest efforts by RIMS in more than ten years of work to avert, and more recently to ameliorate, prior authorization requirements in Rhode Island.

Prospective Utilization Review ("Prior Authorization") for advanced medical imaging: A RIMS Policy Statement

The Rhode Island Medical Society (RIMS) opposes the indiscriminate use of prospective utilization review ("prior authorization") by health plans as a technique to control the utilization levels of a growing variety of products and services for patients. Broad imposition of prior authorization requirements by third-party payers impedes optimal patient care and has seriously degraded the efficiency of care delivery in Rhode Island in recent months and years. While blanket prior authorization rules may produce apparent savings for insurers in the short term, these same rules impose insidious burdens throughout the health care delivery system, particularly upon the fragile infrastructure of primary care, which bears the brunt of the prior authorization onus. The false economies of unfocused prior authorization programs inevitably diminish patient access to appropriate care and drive up costs in both the short and long term.

This paper addresses the use of prior authorization requirements in the specific area of advanced medical imaging.

Advanced medical imaging has come to play a critical role in the practice of high quality, cost-effective medicine. There can be no question that judicious use of today's highly sophisticated imaging modalities enhances diagnostic precision and

results in better care for patients, as well as long-term efficiencies and overall savings to the health care system. That said, the rising use and attendant high cost of advanced medical imaging are matters that deserve attention, both nationally and in Rhode Island.

Payers locally and nationally have responded to the rise of utilization and cost by hiring vendors that specialize in reducing the volume of elective, non-emergent, advanced imaging studies. These vendors achieve these reductions primarily by the technique of requiring prior authorization.

The legitimate objective of any imaging management program can only be to achieve consistently optimal efficiency in the provision of consistently optimal patient care. In practice, however, indiscriminately broad implementation has exposed prior authorization to be little more than a crude cost-cutting measure that is insensitive to the needs of patients and unfairly punitive to the great majority of hard-working, competent and conscientious physicians. Prior authorization should be the last tool out of the box, not the first.

RIMS advocates for a high quality, comprehensive, longitudinal and cost conscious health care system with access for all. RIMS supports efforts to contain costs through the coordinated,

patient-centered, evidence-based, and efficient medical practice.

In no case does RIMS condone the imposition of prior authorization requirements purely or primarily as a strategy to reduce costs and utilization. Prior authorization may have limited usefulness in promoting appropriate utilization if implemented with the following attributes:

Collaborative education: Health plans that endeavor to manage imaging utilization have the responsibility to collect accurate and complete data and to provide clinicians with individual imaging profiles that include comparisons with state and national patterns on a twice yearly or other appropriate interval based on volume and performance improvement goals. Outliers may be educated in the appropriate use of advanced medical imaging based on guidelines developed by national medical specialty societies.

Selective focus: Any program of prior authorization should focus first on identifying and working with those individual professionals whose ordering and prescribing patterns appear to depart from community norms and from guidelines developed and promulgated by national medical specialty societies. Prior authorization mechanics should leverage the capacity of electronic records, predictive

algorithms and other technical advances. Only persistent outliers who fail to respond to education should be required to seek prior authorization for advanced medical imaging, and then only as long as they remain outliers in their ordering patterns.

Administrative efficiency:

Streamlined processes should guide the ordering physician to the best test or, as the case may be, to no test, for the patient's clinical condition. As currently implemented by some payers in Rhode Island, prior authorizations are excessively time-consuming and approvals generally entail delays of one to two business days. Such delays are disruptive to patient care. Ordering physicians should have the option to obtain prior authorization themselves or delegate the task to imaging centers. Prior authorizations for all health plans should follow standard processes and use the same format to capture all necessary information for a particular imaging test. Demographic information required from ordering physicians should be limited to the patient's name and policy number.

Transparency in recognizing costs:

Prior authorizations entail substantial administrative cost both to insurers and to medical offices. Physicians' time spent securing prior authorizations for particular services is not recognized in the "work" component of the RBRVS system and is therefore wholly uncompensated. This is unacceptable and must be addressed to make medical offices whole for performing the extra work imposed by insurers. Moreover, any valid measure of the cost-effectiveness of a prior authorization program must include the full continuum of costs, including physicians' incurred costs and fair compensation.

Scientific integrity: Criteria for approval must be based upon the best scientific evidence as developed and validated by national medical specialty societies.

"Prior Authorization" controversy sparks a U.S. Senate investigation of MedSolutions; process is found "burdensome and confusing"

Investigative reporting by the Wilmington, Delaware, *News Journal* a year ago touched off parallel investigations by the U.S. Senate Commerce Committee and the Delaware Insurance Commission. The story eventually got national exposure on NBC news, and the flood of negative publicity prompted Blue Cross of Delaware to terminate MedSolutions of Tennessee as the Blues' vendor for prospective utilization review ("prior authorization") for high-end imaging studies.

Both the Senate Committee and the state Commission issued reports on their findings on April 15, 2011.

The case that attracted public, regulatory and Senatorial attention to health plans' prior authorization requirements was the experience of one forty-five year-old man who came close to dying in February 2010 after MedSolutions had repeatedly rejected his nuclear stress test as medically unnecessary.

Noteworthy is the fact that the Rhode Island Chapter of the American College of Cardiology proactively succeeded in getting MedSolutions and BCBSRI to modify their protocols, specifically in the area of nuclear cardiac imaging. Perhaps the Delaware incident would have been prevented in Rhode Island, thanks to the vigilance and activism of the local ACC.

In any case, after months of study, the U.S. Senate Commerce Committee, chaired by Senator Jay Rockefeller, found that the "pre-authorization process is burdensome and confusing for consumers and health care providers" and that "many medically appropriate test requests were likely denied on 'administrative' [i.e., essentially clerical rather than clinical] grounds."

The Senate investigators also found that MedSolutions' "Cardiac Imaging Guidelines" "diverge in key ways from the 'appropriate use criteria' established by the American College of Cardiology. This conflict created situations in which MedSolutions denied requests for tests that the cardiologists' professional guidelines deemed appropriate.

"Moreover, MedSolutions' failure to develop its 'evidence-based' guidelines through a transparent process leaves it vulnerable to criticisms that the purpose of MedSolutions' guidelines is to deny test requests, rather than reflect the strongest available scientific evidence."

However, the Senators also found that doctors themselves do not always comply with professional guidelines in ordering tests and that MedSolutions properly denied requests for inappropriate tests in some cases. ❖

Risk-adjustment: Any valid comparison of clinicians based on their utilization rates must systematically take into account differences in patient populations and adjust for such differences.

In sum, the Medical Society opposes the current overuse of prior authorization for imaging studies and recommends a carefully targeted

educational and collaborative approach to resolving questions of appropriateness in utilization. Insurers have an obligation to collect, manage and share complete and accurate data and to use such data to focus their utilization review activity, always with the goal of optimal patient care provided with optimal efficiency. ❖

RIMS wins high marks (again) from ACCME

For the fifth time in a row, covering a span of twenty years, the national Accreditation Council for Continuing Medical Education has renewed the Rhode Island Medical Society's recognition as the Ocean State's official accrediting agency for hospital CME programs through 2015. The ACCME found RIMS to be compliant with all thirty-six elements of ACCME's "Markers of Equivalency." The evaluation was based on RIMS' application, evidence of performance and a survey team interview. The four-year recognition awarded to RIMS is the maximum normally available to state medical societies; it indicates once again that the accreditation services RIMS offers to all hospitals in Rhode Island are of consistently high quality.

Members of the RIMS Committee on Continuing Medical Education are the Chair, **Patrick Sweeney, MD, PhD, MPH**; **Glenn G. Fort, MD**, of Landmark Medical Center; **Jonathan Gates, MD**, of Kent County Hospital; **Miriam Giles** of Coastal Care Medical Management; **Daniel Harrop, III, MD**; **Mark Mancini, MD**, of Westerly Hospital; **Louis J. Marino, Jr., MD**, of Butler Hospital; **Scott Wang, MD**, of Newport Hospital (temporarily represented by **Tosca Carpenter**); and **Bernard Zimmermann, MD**, of Roger Williams Medical Center. RIMS staff support is provided by **Catherine Norton**.

RIMS President Gary Bubly, MD, praised Dr. Sweeney, Ms. Norton and the Committee members for their diligence in staying abreast of the continually evolving requirements of CME. The RIMS Council congratulated Dr. Sweeney and the Committee by acclamation on April 4.

The ACCME is comprised of the American Medical Association, the American Hospital Association, the American Board of Medical Specialties, the Association for Hospital Medical Education, the Association of American Medical Colleges, the Council of Medical Specialty Societies, and the Federation of State Medical Boards of the U.S. ❖

Marlene Cutitar, MD named RIMWA Woman Physician of the Year



The Rhode Island Medical Women's Association (RIMWA) honored Marlene Cutitar, MD, as the 2011 Woman Physician of the Year. Lt. Governor Elizabeth Roberts gave welcoming remarks at RIMWA's 30th Annual Meeting held on May 3. Dr. Cutitar serves on the RIMS Council and Executive Committee and is immediate past president of the RI Chapter of the American College of Surgeons.

BRIEFLY NOTED

ROBERT H. JANIGAN, JR., MD, is the new president of the Rhode Island Society of Eye Physicians and Surgeons, succeeding **PHILIP R. RIZZUTO, MD**. **DAVID R. RIVERA, MD**, is Vice President. **FRANCIS FIGUEROA, MD**, is Secretary. **MAGDALENA KRYZSTOLIK, MD**, is Treasurer. Dr. Rizzuto is now chair of EyePAC. Terms of office are two years.

MELISSA LUDWIG, MD, is the new president of the Rhode Island Psychiatric Society, succeeding **RUSSELL PET, MD**. **JAMES K. SULLIVAN, MD**, is president-elect. **ARNOLDO BERGES, MD**, is Secretary-Treasurer. **ANDREA MERNAN, MD**, represents the Psychiatric Society on the Council of the Rhode Island Medical Society. Terms of office are two years.

AMA Board of Trustees has appointed **PETER A. HOLLMANN, MD**, to serve as Chair of the Current Procedural Technology (CPT) Editorial Panel, effective in June for a two-year term. Dr. Hollmann, who has served on the Trustee-appointed CPT Panel since 2003, will succeed Dr. William Thorwarth, a radiologist from North Carolina. Dr. Hollmann has served on the RIMS Council continuously in various capacities since 1990, originally as Speaker of the RIMS House of Delegates. He is currently Rhode Island's Alternate Delegate to the AMA.

DAVID R. GIFFORD, MD, MPH, is the new Senior Vice President of Quality and Regulatory Affairs for the American

Health Care Association and National Center for Assisted Living. The AHCA/NCAL is headquartered in Washington, DC, and serves the long-term care provider community. Dr. Gifford stepped down as Rhode Island's Director of Health in February 2011 after seven years in that position.

MICHAEL D. FINE, MD, was appointed by Governor Chafee to serve as Interim Director of the Rhode Island Department of Health while the state conducts a search for a successor to Dr. David R. Gifford, who stepped down in February and is now a Senior Vice President at the American Health Care Association and National Center for Assisted Living in Washington, DC.



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PHILLIP R. LUKAS, MD, has received the 2011 Dr. Milton Hamosky Outstanding Physician Award from the medical staff of Rhode Island Hospital.

YUL D. EJNES, MD, former RIMS President, is Chair of the Board of Regents of the American College of Physicians. The ACP Board also includes two other Rhode Islanders: **NITIN S. DAMLE, MD**, President-Elect of RIMS, and **MICHELE CYR, MD**. The 29-member Board is the principal policy-making body of the ACP.

MARLENE CUTITAR, MD, is the Rhode Island Medical Woman's Association 2011 Woman Physician of the Year. Dr. Cutitar is a member of the Executive Committee of the Rhode Island Medical Society.

STEVEN R. DETOY, RIMS' Director of Government Relations and Public Affairs, has received a 2011 Community Partner Award from Dorcas Place for "outstanding leadership and sustained philanthropic support as a founding partner of the Rhode Island Welcome Back Center." The Welcome Back Center helps foreign-trained health professionals apply their training in Rhode Island.

ROSEMARY MAHER, LICSW, Director of RIMS' Physician Health Program, will be honored as Social Worker of the Year in Health/Mental Health by the Rhode Island Chapter of the National Association of Social Workers and the local NASW's Annual Awards Celebration on Wednesday, June 22.

JEANNE LAMBREW, PHD, formerly of Portland, ME, and daughter of Portland cardiologist Costas "Gus" Lambrew, MD, has left the U.S. Department of Health and Human Services to lead the newly consolidated health care office at the White House. Dr. Jeanne Lambrew is co-author with former Senate Majority Leader Tom Daschle of *Critical: What We Can Do About the Health-Care Crisis*. Andrea Palm, former chief health advisor Hillary Clinton, is an assistant to Dr. Lambrew in her new White House post.

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SI-10-368

(12/10)

MedPAC Proposes 2012 Medicare Update

Unless Congress intervenes, Medicare actuaries now predict that Medicare payments to physicians will fall by 29.5% in 2012. The projection is contained in a recent letter to the Medicare Payment Advisory Commission (MedPAC). The Commission is recommending that Congress avert such draconian cuts (as it did five times in 2010 alone) and act instead to increase payments for physician services by 1% in 2012.

In a report released March 15, the Commission noted that although a permanent fix to the sustainable growth

rate (SGR) formula carries a very high price, the "mounting frustration in the provider community stemming from the uncertainty of future Medicare payments, with looming payment cuts in the balance" is not without its own unacceptably high cost. The report suggests that MedPAC will explore alternatives to the SGR and consider additional "levers for enhancing beneficiaries' access to high-quality primary care."

The MedPAC report notes that between 2006 and 2011 payments for primary care services increased

by 22.5%, but more changes are necessary. Such changes could include "an expansion of nurses' scope of practice in primary care" and reimbursement for "patient-clinician communication [by phone or email] when it avoids the need for office visits."

The AMA has worked to educate Commissioners regarding the destructiveness of the multiple, temporary SGR fixes of the past ten years and the urgent need for a permanent solution.

The full report is available on MedPAC's web site at: <http://www.medpac.gov/>. ♦



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CMS Limits RAC Documentation Requests

In response to advocacy by the AMA and other medical societies, RACs (Medicare Recovery Audit Contractors) are now limited to requesting 10 records in 45 days from offices with 5 or fewer physicians and non-physician practitioners.

This is a significant improvement over prior CMS proposals to base Additional Documentation Request (ADR) limits on a percentage of annual claims submitted, a methodology the AMA strongly and successfully opposed. The new ADR limits will be based on the physician or non-physician practitioner's billing Tax Identification Number (TIN) as well as location. Examples and additional information are available from CMS at <https://www.cms.gov/RAC/Downloads/PhyADR.pdf>. ❖

RIMS leadership attends AMA National Advocacy Conference



[L-R] AMA Delegate Michael Migliori, MD; Representative David Cicilline; RIMS President-elect, Nitin Damle, MD; and RIMS President Gary Bubly, MD; met in Washington, DC during the AMA National Advocacy Conference on February 8 to discuss SGR, liability reform, free contracting, and truth in advertising.

2011 Medicare benefits for preventive services

Effective in 2011 as part of the new federal health care reforms, Medicare patients no longer pay out-of-pocket deductibles or copayments for most preventive health services.

Beneficiaries covered through a Medicare Advantage plan may have a different mix of benefits, depending upon the plan. Most Medicare Advantage plans already offer Medicare-covered preventive services without cost-sharing.

In addition to the new annual wellness visit benefit (distinct from the one-time "welcome to Medicare physical," which is only available to beneficiaries in the first year of their enrollment in Part B), the following preventive services now entail no out-of-pocket cost:

- **Breast cancer screening:** Yearly mammograms for women age 40 and older with Medicare.
- **Colorectal cancer screening:** This includes a flexible sigmoidoscopy or colonoscopy for all beneficiaries age 50 or older.
- **Cervical cancer screening:** Pap smear and pelvic exams are available every two years, or annually for those at high risk.
- **Cardiovascular screenings:** Free blood test to check cholesterol, lipid and triglyceride levels offered every five years to all Medicare beneficiaries.
- **Diabetes:** Twice-a-year screening for those at risk.
- **Medical Nutrition therapy:** Available to help people manage diabetes or kidney disease.
- **Prostate cancer screening:** An annual digital rectal exam and PSA test for all male beneficiaries age 50 or older.
- **Bone mass measurements:** Available every two years to those at risk, or more often if medically necessary.
- **Abdominal aortic aneurysm screening:** Available to men ages 65 to 75 who have ever smoked.
- **HIV screening:** Available to those Medicare beneficiaries who are at increased risk or who ask for the test.
- **Vaccinations:** Annual flu shot, and vaccinations against pneumococcal pneumonia and hepatitis B. ❖

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Physicians boost RI's economic health by \$4B a year

A study sponsored by the Rhode Island Medical Society and the American Medical Association shows that office-based physicians in the state generate \$4 billion in revenue annually, provide \$2.9 billion in total wages and benefits and support more than 15,000 jobs. Office-based physicians also generate some \$185 million in state and local tax revenue in Rhode Island.

In releasing the study to local media, RIMS President Gary Bubly said the study quantifies for the first time some of the economic importance of creating a more positive environment for medical practice in Rhode Island. Attracting and retaining physicians in all specialties is vital not only for the future health of Rhode Islanders but also for the health of the Rhode Island economy. Currently, both the practice environment and the economy of Rhode Island are among the worst in the Northeast. Making the state hospitable to doctors benefits the Rhode Island population directly by bringing better access to health care and a strengthening the state economy.

In addition to the impressive direct economic impact measured in the study are the still greater and unmeasured economic benefits of maintaining a healthy and productive workforce and educational systems filled with students who are healthy and able to learn.

The study was conducted by The Lewin Group. ❖

Does RIMS have your email address?

Email has become the preferred medium by which RIMS communicates timely information to its members.

Please keep Sarah Stevens (sstevens@rimed.org) apprised of your address.

RIMS never gives members' email addresses to third parties.

RIMS uses its broadcast email judiciously and exclusively for communications that are timely, important, informative and concise.