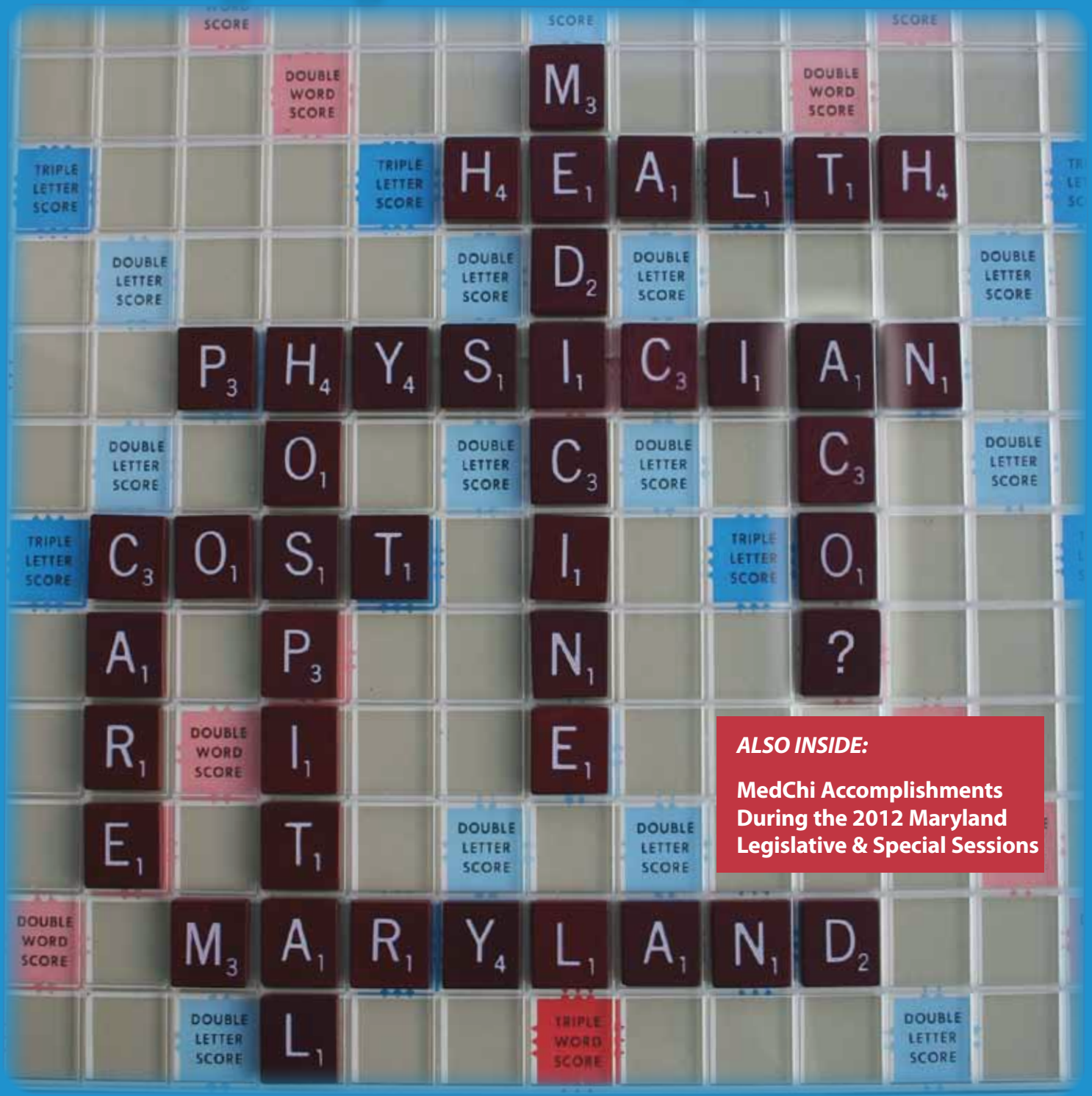
Maryland Medicine
The Maryland Medical Journal Volume 13, Issue 2

The Development of ACOs in Maryland: Strategic Alignment of Care, Health & Cost



ALSO INSIDE:

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EHR INCENTIVE PROGRAM

INSIDE

MedChi President Dr. Ajrawat and Craig Behm discuss ACOs and how they are formed.

Departments

Features

Scan the code with your smart phone and download *Maryland Medicine* to your mobile device.

CORRECTION...

Please note that in Maryland Medicine, *Volume 13, Issue 1, Page 37, it should be noted in Dr. Barton J. Gershen's biography description at the end of the article, the following was omitted: Dr. Gershen was elected into the Alpha Omega Alpha (AOA) Medical Honor Society. We apologize for inadvertently not including this information.*

MedChi: Upholding the Standard of Medical Care for More than 200 Years

PRESIDENT'S MESSAGE

Harbhajan S. (Harry) Ajrawat, MD

MedChi was incorporated by an act of the Maryland General Assembly in 1799 with the express understanding by the General Assembly that the "establishment and incorporation of a … Society of Physicians and Surgeons … will be attended by the most beneficial and salutary consequences, by promoting and disseminating Medical and Chirurgical knowledge throughout the State, and may in the future, prevent the citizens thereof from risking their lives in the hands of ignorant practitioners or pretenders to the healing art." Pursuant to that charter, MedChi set up a board composed of the "twelve persons of the greatest Medical and Chirurgical abilities in the State" to assess those wishing to provide healthcare in Maryland.

Thus began both MedChi and medical licensure in Maryland. Public policy has swung back and forth since that time on the issue of how strictly the quality of healthcare will be regulated: at times, "laissez-faire" has been the guiding principle, and, at other times, there has been a keen interest on the part of policy makers to ensure that only practitioners meeting the highest of quality standards are providing care. After the 1799 creation of MedChi, the pendulum swung back in the middle part of the 19th century and medical practice was effectively deregulated due to the populist sentiments of the Jacksonian era. However, public mood changed again in the latter half of the 19th century as medicine's scientific underpinnings became increasingly robust and policy makers gained new respect for the contributions of science-based healthcare. In 1892, separate boards of allopathy and homeopathy were created. These boards were required to be composed of actual practitioners of medicine and no academics were allowed to participate in the examination process. Although the Board of Naturopathy ended up being abolished in 1957 following a bizarre corruption scandal in which it was taken over by an individual who began selling licenses, the basic principle of a medical licensing board has continued to this day.

Curiously, however, in our time, the pendulum sometimes seems to be swinging in both directions at once. In the last session of the General Assembly, legislators considered bills both to open up the practice of healthcare by licensing "naturopaths" and to increase the regulation of physicians by tinkering with the Board of Physicians statute. Both these initiatives can best be handled by consulting the principles that lie behind our foundation.

In the last session of the General Assembly, legislators considered bills both to open up the practice of healthcare by licensing "naturopaths" and to increase the regulation of physicians by tinkering with the Board of Physicians statute. Both these initiatives can best be handled by consulting the principles that lie behind our foundation.

As the Act of Incorporation shows, MedChi has always been concerned with persons attempting to provide healthcare who are unqualified to do so, either because what they are attempting to do is beyond the scope of their training or because it is without basis in recognized scientific principles. Unfortunately, the appeal of laissez-faire principles (see http://en.wikipedia.org/wiki/Laissez-faire for an explanation) often leads some in the general public to call for the deregulation of the practice of medicine and for all who proclaim themselves to be healers be allowed the privileges associated with the practice of medicine. What isn't always understood is that medicine is licensed because of the enormous amount of trust that the public places in persons who assert themselves to be healers. Understandably, a person with a serious health condition is not in a position to dispassionately evaluate the claims of someone who claims to have a cure. Ironically, the naturopaths who advocated for naturopathic licensure unsuccessfully in the past legislative session recognized this, asserting that they wanted licensure so as to be able to keep "unqualified" persons from calling themselves "naturopaths." Unfortunately, these naturopaths themselves were unable to submit any significant evidence that their therapies have a scientific basis for claiming efficacy. The therapies and procedures that they were seeking as a privilege of their licensure —for example, "hot or cold hydrotherapy," "electromagnetic energy," "colon hydrotherapy," and "antibiotic therapy." In addition, the individuals seeking licensure of naturopaths proposed that they be allowed to utilize "oral, nasal, auricular, ocular, rectal, vaginal, transdermal, intradermal, subcutaneous, intravenous, and intramuscular" methods of drug administration. I am sure you will understand why MedChi concluded that opposing this legislation was in accord with the founding principles set forth above.

Likewise, over the past decade we have engaged in numerous legislative struggles over proposed expansions of the scope of practice of other health occupations. A common theme to these debates is the failure by some to appreciate that the physician brings to the patient not only the basic knowledge of how to perform a therapeutic procedure but the depth of knowledge and experience that is necessary to recognize when a procedure is appropriate or when the signs and symptoms indicate a greater complexity of disease process than is superficially apparent. For these reasons, MedChi has been con-

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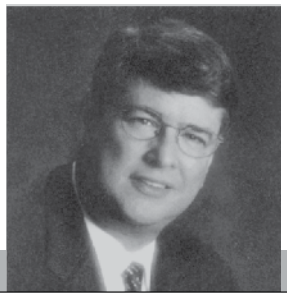

That Old College Try

EDITOR'S CORNER

Bruce M. Smoller

I recently returned from an early summer fixture, my wife's college reunion. I knew many of the alumni at the reunion, and was familiar with so many of the settings as I had graduated from the same university two years before she did. The weekend was magical…old friends, the thrill of being back in a locale we both loved, seeing the old standby's like Louie's Lunch, a rolling wagon of delights for meal or snack which served as a survival station after dropping my date (now my wife) off for curfew. I can hear my daughter now… "CURFEW!!!! What's that and why didn't you protest?" ("We didn't protest, my dear, because it gave all of us a little breathing room") I viewed, from the bottom this time, the chemistry labs, up a flight so steep and high that ambulances had to park at the top and bottom to minister to the victims of claudication, myocardial infarcts or fractures from the ice laden cement at 8:00 in the morning. The campus was beautiful, the people…well, we all age, don't we…but the people were really there as we remembered them many years ago. So it was a really nice weekend. Aside from all of those nice benefits, I experienced something else.

Weekends such as these give us a chance to reflect from a distance. Some aspects of that (I'm thinking paunch and hair here) are not so wonderful. But reflection can also bring a sense of peace and harmony… and that is exactly what happened. Had I done what I always wanted to do and was I happy in the direction I took? The answer was a resounding yes! I was happy with my life's vocation. I was proud of my life's vocation. I wasn't rich and I didn't profit from the financial world as did some of our classmates. But I was fulfilled and satisfied. I had done what I wanted, but more to the point, what I had done had, for the most part, filled me up.

This issue of *Maryland Medicine* highlights two of the most important functions of a medical society…advocacy and innovation. As Dr. Stephen Rockower points out in the comprehensive legislative section in this issue, and Dr. Burt Littman notes in his 2012 Compendium of Maryland Law which can soon be found on MedChi's web site (www.medchi.org), the medical society advocated well. We won some tough battles and defeated some glaringly offensive bills (mostly spouting from the fecund imaginations of those ever entertaining lawyers) and all in all did what we had to do for the practicing physicians of Maryland and their patients. Much of the coming new federal legislation (if it passes muster) would impose significant modifications on medical practice. These innovations come in the form of alternate methods of practice, notably Accountable Care Organizations (ACOs).Whether ACOs make it or not, MedChi and its leadership are in the forefront of development and organization, as explained in several articles found in this issue.

I continue to read about the ridiculous excesses of The Centers for Medicare and Medicaid Services (CMS). I watch the talking heads debate about medicine as if they know of what they speak. I even listen to some inanities about medicine from people who should know better. But I am filled with reflection in a most positive way. The reunion gave me that chance at perspective. Those ridiculous excesses and inanities and the pseudo-intellectual drivel of the ersatz expert consultants don't bother me quite so much. I realize I am filled with the satisfaction of much of my life choices...and medicine is a big part of those choices. My nostalgic weekend was a tonic for the concentration of storms roiling medicine and each of us these days. It was good.

Now I have to get to bed…curfew, you know!

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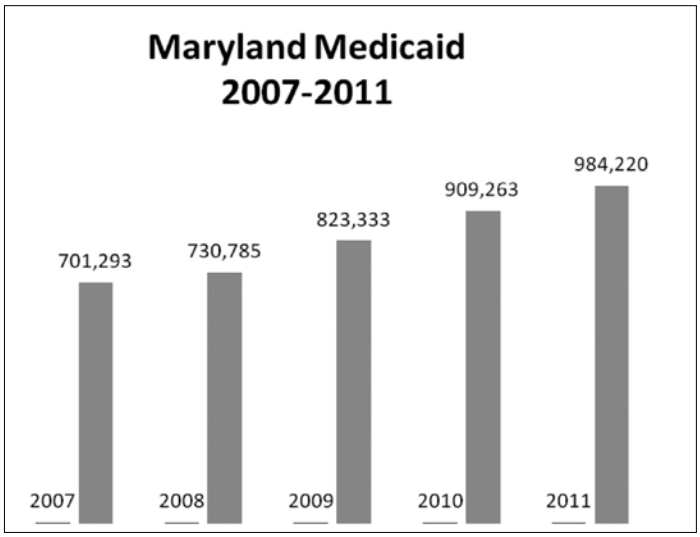
Maryland Medicaid: MedChi Works to Strengthen the Infrastructure

CEO'S MESSAGE

Gene Ransom, III, Esq.

MedChi, the Maryland State Medical Society, focused an incredible amount of time, energy and talent to improve Medicaid in the last two years. Medicaid needed the attention. Maryland budget woes have combined with an increasing Medicaid population to place growing pressure on the program. Since 2007 the number of patients enrolled in Medicaid increased by nearly thirty percent, and physicians continue to face problems with the management and reimbursement of Medicaid patients. Over a year ago MedChi outlined a plan to improve Medicaid by fixing the Medicaid data management system, fighting for full achievement of technology incentives, and improving the Medicaid network with better physician reimbursement. The plan has been delivered to the public, the Medicaid Advisory Committee (MAC) and a very responsive Department of Health and Mental Hygiene (DHMH). MedChi and the State of Maryland have been implementing change collaboratively to move Medicaid forward and protect our weakest and most vulnerable patients.



MedChi proposed, rather than stripping services from Maryland's most at-risk populations to balance Medicaid budgets, we should shore up the infrastructure that supports, facilitates and delivers Medicaid services. Such measures would substantially improve efficiencies in the delivery of services, reduce staggering administrative costs associated with the coordination of care, and improve patient access to Medicaid providers. We have been working with Maryland on the following four major reforms:

1. Replace Medicaid's Outdated Management Information System

MedChi pushed aggressively to finally find a replacement for the notoriously inefficient Medicaid Management Information System (MMIS). The existing MMIS is an ancillary component of almost every other problem that confounds Maryland's Medicaid program. Now, more than ever before, we need innovative thinking in healthcare delivery. The archaic MMIS is stymieing creativity in the development of payment models that would incentivize better management of care and costs. Equally troubling, the administrative costs associated with MMIS rob both the DHMH and its contracting providers of resources that would be better allocated directly to patient care. DHMH fully supported MedChi on this endeavor and earlier this year the contract was awarded to CSC to upgrade the system. Fortunately, the majority of the funds used for this contract were federal.

2. Grant Medicaid Physicians Access to Federal Technology Incentives

MedChi worked with DHMH to establish the administrative framework set forth by the federal government, so that Maryland's Medicaid physicians could access federal financial incentives for adopting electronic medical record (EMR) systems. Maryland was a touch behind with regard to the Medicaid program, but with the personal involvement of Secretary Joshua Sharfstein, MD, the necessary framework was in place by October 1st of last year. Increased adoption of EMRs among Medicaid contracting physicians will result in more efficient coordination of patient care. That means fewer medical errors and less duplication of services. It also means fewer patients will experience delays or denials in care as communication between providers, pharmacies and Medicaid is streamlined and standardized. Collectively, the changes brought about by widespread adoption of health information technology among Medicaid providers will improve patient outcomes and reduce spending.

3. Foster the Development of Innovative Payment Models

The development of creative new payment models could ultimately provide some of the greatest permanent improvements to Maryland's Medicaid program. MedChi is ready to partner with DHMH in the development of such programs. Payment models – such as the Medical Home Network – that support better care management and reward cost savings will help increase physician participation in Medicaid, improving patient access to care particularly in rural areas where fewer physicians are currently willing to contract with Medicaid. Medicaid is already participating in the Health Care Commission's patient-centered medical home pilot program, but the DHMH must also consider other pilot programs based on models that have been successful in saving money, increasing physician participation and improving quality of care.

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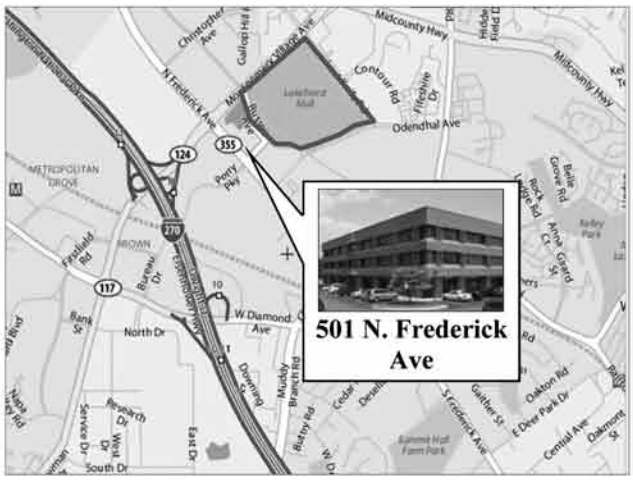

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LETTERS

The following is a letter from Delegate Bonnie Cullison explaining her support of the Civil Marriage Protection Act (HB438) which passed the Maryland General Assembly during the 2012 session. Opponents of the bill did not respond to contributing an opposing view. The opinions of Delegate Cullison are hers and not necessarily reflective of members of the Maryland Medicine *editorial board.*

Support for the Civil Marriage Protection Act

As a consumer, I have had a great deal of experience in medical settings. Two of the most frightening things that one can hear in those settings are, "We are doing everything we can" and "If you are not family, you cannot see her now."

I have heard both of those statements, many times. My domestic partner of 28 years has severe peripheral vascular disease. Over eight years she had 26 vascular surgeries, two ruptured aortic aneurysms and an amputation.

There is more to that story, but the one I want to bring attention to is the discrimination that we encountered during some of the most horrifying moments because we were not defined in law as "family." The first time I was not allowed into the emergency room (ER), it was a compassionate nurse who sneaked me into the back. After that I carried a medical power of attorney with me at all times—which I often had to show in hospital admitting rooms and to ER staff.

The passage of HB438—the Civil Marriage Protection Act— recognizes the relationship for what it is. This law gives same-sex couples the legal right to enjoy the benefits and take on the responsibilities of marriage. These include all of the property rights, medical decision rights, inheritance rights and other legal rights otherwise available only to female-male couples. It extends the definition of "families" in our communities. As medical professionals, you understand the role of families in the welfare of all people.

In the 2010 census, about 11,000 households self-identified as homes of same-sex couples in Maryland. There are likely even more who did not feel they could be honest about their relationship because of social stigma. Many of these households include children. Rights granted to parents in civil marriage did not extend to same-sex couples, which means that there were many, many legal hurdles to clear in order to ensure the health, safety and well-being of these children. This law eliminates those hurdles and parents—even same-sex parents—can focus on the challenges of raising responsible children.

This law is respectful of religious freedoms. It includes language with some of the strongest protections for religious institutions in the country. No priest, rabbi, imam, or any other religious official can be held civilly or criminally liable in any way for refusing to perform a marriage that is contrary to the dictates of his or her religion or conscience.

There are those who believe that same-sex marriage weakens the institution of marriage. A 2009 American University study published in *Social Science Quarterly* found no statistically adverse affect on divorce rates in states that legalized same-sex marriage. In fact, I would offer that same-sex couples are the most ardent supporters of all marriage because of the emotional bonds and stability it offers to both partners.

If the Civil Marriage Protection Act is petitioned to referendum in November, Marylanders will have the chance to make history by becoming the first state to approve of this historic extension of equal rights by popular vote. In fact, failure to uphold this law would result in same-sex couples being denied these benefits and relegate them to a position of second class citizens in a country that is proud of and values its diversity.

There are same-sex couples in every community; they are our friends and our relatives. The Civil Marriage Protection Act recognizes them legally and allows them to participate completely in our civil society—as families in our neighborhoods.

Delegate Bonnie Cullison (D) is a member of the Maryland House of Delegates, District 19, Lowe House Office Building, Room 220, 6 Bladen Street, Annapolis, MD 21401
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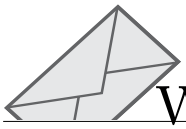

WRITE TO US

The Editorial Board of *Maryland Medicine* welcomes your letters, comments, and opinions. Readers may respond to the authors or the editors by e-mail at sraskin@montgomerymedicine.org or by mail to Editor, *Maryland Medicine,* c/o Montgomery County Medical Society, 15855 Crabbs Branch Way, Rockville, MD 20855.

Introduction

"The Times, They Are A-Changin'"

Stephen Rockower, MD

The words of Medal of Freedom Winner Bob Dylan are as true now as they were in 1964. There are a dizzying array of new concepts, changing concepts, and revisions of old concepts for all of us to grasp and process. Medicine is changing, especially the financing of medical care. Much of what was passed in "ObamaCare" will either go ahead or be revamped, even with the recent decision of the Supreme Court.

This issue of *Maryland Medicine* provides insight into a smorgasbord of issues of vital interest and concern to physicians of Maryland. The so-called Accountable Care Organizations (ACOs), as outlined in the President's Patient Protection and Affordable Care Act are becoming more and more likely. Attorney Sarah Swank provides an overview of the process for establishing an ACO. MedChi President Harbhajan (Harry) Ajrawat and Craig Behm outline more of the characteristics of ACOs, and discuss a Maryland-centric ACO being formed in the eastern part of the state.

The Maryland Legislature recently completed not one but two sessions. The main session did not accomplish all it needed within the prescribed 90 day limit, and the Governor called a "Special Session" to finish the people's business. There were many issues of interest to physicians, including truth in advertising, pre-authorizations, and tanning beds. Many scope-of-practice bills were defeated, including a bitterly disputed naturopath authorization. We must be vigilant to prevent such bills from passing in the future. Sandra Rowland, Director Center for a Healthy Maryland, provides an interesting historical perspective specifically showing that the disputes over naturopathy go back to the earliest origins of MedChi in 1799.

The concept of a patient-centered medical home is gaining strength as a vehicle for providing optimum care to a patient while limiting unnecessary costs. Dr. Herrera of the Department of Health and Mental Hygiene outlines the Maryland model of the medical home, and shows how providing the proper capacity and financing can provide optimal care.

Doctors Mills, Dane and Cymet present an overview of a curriculum for health policy for physicians. This compendium provides useful reference materials for those of us (which should be all of us!) who are interested in learning more about current concepts in health policy from various viewpoints.

Another highly charged topic that threatened to halt the entire proceedings of the Legislature this year was marriage equality. After many years, the Legislature passed and the Governor signed a bill to provide marriage equality for gay, lesbian and transexual people. All Marylanders, including physicians, come to this issue from many divergent viewpoints, and many of the traditional political alliances have been strained and re-worked. MedChi and *Maryland Medicine* do not take a position in this matter, but we felt that honest discussion of the issues, especially as they relate to medicine and medical care would be in order. We solicited articles from both sides of the issue, but were unable to secure a response from one side. We present a Letter to the Editor from Delegate Cullison, outlining her views on this volatile subject.

Dr. Gershen, as always, enlightens and illuminates with his "Word Rounds." We always come away with an "increase[d] understanding of the world" and, of words.

We trust, dear reader, that these articles will provide some thought, concerns, and delight. We are, as always, interested in your thoughts and responses. Please send letters to the editor to 301.921.4368 (fax) or sraskin@montgmerymedicine.org.

Stephen Rockower, MD, is a practicing orthopaedic surgeon in Rockville, Maryland and a member of the Maryland Medicine *editorial board. He can be reached at DrRockower@CORdocs.com or on Twitter@DrBonesMD.*

A Physician's Guide to Forming and Operating an Accountable Care Organization

Sarah E. Swank, Esq.

In March 2010, President Obama signed the Affordable Care Act (ACA) establishing the accountable care organization program (ACO) to achieve a three-part aim: lower costs, improved care and better health. Last year, several federal agencies came together to create a legal framework and remove legal barriers to make way for the concept of accountable care. The Center for Medicare and Medicaid Services (CMS) recently announced 29 new ACOs, signaling a movement away from the current fragmented fee-for-service world to a new world with payments based on high quality and cost efficiency.

What Is an ACO?

ACOs are legal entities that apply and are approved to participate in a voluntary three-year program with CMS. Originally specific to the Medicare program, the term ACO has come to mean accountable or integrated care. For example, several payors now use the term *commercial ACOs* to describe an integrated risk sharing approach to managed care contracting reminiscent of capitation, but with more emphasis on quality data.

Who Can Form an ACO?

Only "*ACO Participants*" can form an ACO:

- Professionals in a group practice
- Network of individual practices
- Partnership or joint venture between hospitals and professionals
- Hospital employing professionals
- Critical access hospitals
- Federal Qualified Health Centers
- Rural Health Centers

An ACO must include at least one ACO Participant. Other providers, health plans and investors may partner with ACO Participants to form ACOs, but they cannot independently form one. Other than primary care physicians, ACO Participants may participate in multiple ACOs. CMS encourages ACOs of all shapes and sizes to apply to the program.

How to Form an ACO

Legal Entity and Tax Identification Number

An ACO must be a legal entity under state law with a tax identification number, such as:

- Corporations
- Partnerships
- Limited liability companies
- Foundations

The ACO may use an existing entity if it meets the requirement for independent governance. Two or more independent entities must form a new legal entity.

Governance

Governing bodies must have the following characteristics:

- Oversight
- Transparency
- Fiduciary duty
- Conflict of interest policy
- Composition and control

Unlike in other healthcare transactions, ACO Participants must have at least 75 percent control of the governing body of an ACO to ensure that the ACO will remain provider-driven and

the governing body must include a Medicare beneficiary who does not have a conflict of interest or whose family members do not have a conflict of interest.

Leadership

An ACO must include specific leadership positions:

- **Manager.** The manager must be an accountable executive who reports to and can be removed by the governing body. The manager must demonstrated the ability to influence or direct clinical practice to improve efficiency processes and outcomes.

- **Medical Director.** The medical director must be a board-certified, senior-level physician, licensed in at least one state in which ACO operates. The medical director can be part-time.

- **Compliance Officer.** The compliance officer must report to the governing body and be responsible for overseeing the compliance plan required by the ACO regulations.

ACO applicants may request CMS approval of alternative management and governance structure by describing how the alternative structure will be capable of accomplishing the goals of the ACO.

Contracts

An ACO must be able to start operation on or before the assigned January 1 start date including all contracts:

- Between the ACO and all ACO Participants
- With other providers, suppliers and vendors
- If approved, between the ACO and CMS

The contracts between the ACO Participants and the ACO must be finalized and executed prior to submission of an application.

Paying for Information and Infrastructure ACO Costs

One of the greatest concerns regarding ACOs is formation and operating costs. These costs include both *financial investments* such as electronic health records (EHRs), staff training and other infrastructure costs, and *human investments*, such as development of clinical protocols and evidence-based medicine. The current fraud and abuse laws create obstacles to financial incentive programs under the ACA, especially between hospitals and physicians. The Centers for Medicare and Medicaid and Office of the Inspector General provided ACO-specific waivers making way for sharing savings and losses among providers.

Operating an ACO

Patient Centeredness

CMS seeks to move the healthcare industry towards this patient-centered care approach. ACOs must include Medicare beneficiaries in the governance structure, monitor and report patient satisfaction data and focus on care coordination.

Know Your Beneficiaries and Primary Care Providers

Primary care providers drive assignment of Medicare beneficiaries for purposes of quality and shared savings payments. To remain qualified under the program, an ACO must include at least 5,000 Medicare beneficiaries. Beneficiaries can seek care from providers outside the ACO, so assignment is based on CMS retrospective reports.

Getting Paid

Under the ACO model, providers are paid their normal fee-for-service rates, but are eligible to receive a part of the shared savings based on performance against benchmarks and on the quality measures. During the application process, ACOs can select whether or not to be at risk and share losses under their agreement with CMS. CMS pays ACOs shared savings, if any, earned at the end of each of the performance years.

Quality Reporting and Monitoring

ACOs must maintain physician-led quality assurance programs and meet 33 quality performance standards. Currently, the performance measures are in four domains:

- Patient/caregiver experience
- Care coordination/patient safety
- Preventive health
- At-risk populations

ACOs are responsible for completely and accurately report data on all program measures, although the measures move from pay-for-reporting to pay-for-performance. ACOs face possible sanctions or even termination for failure to comply with the quality reporting requirements.

The Role of Electronic Health Records (EHR)

Currently, EHRs are not required under the ACO regulations. CMS strongly encourages the use of EHRs, but for now, the *meaningful use* of certified EHRs by physicians in an ACO is a doubly counted quality measure. CMS may reconsider EHR technology requirements once providers gain more experience with it.

Other Legal Concerns

In forming an ACO, physicians must consider antitrust issues depending on their market share, as well as Internal Revenue Service issues if contracting with not-for-profit hospitals. The Health Insurance Portability and Accountability Act concerns arise while sharing data among the separate entities that make up the ACO.

Coming Together

The ACO program is one way to help bring hospitals, physicians and providers together to provide improved quality outcome and cut costs. ACOs seek to reward providers who put patients first and make high quality health care more affordable.

Sarah E. Swank Esq., is a Principal in the Health Law Section of Ober | Kaler in the firm's Washington, D.C. and Baltimore, Maryland offices. She can be contacted at 202.326.5003 or seswank@ober.com.

Accountable Care Organizations in Maryland

Harbhajan S. (Harry) Ajrawat, MD, and Craig Behm, MBA

Introduction to Shared Savings Models

The Patient Protection and Affordable Care Act (P.L.111-148) has been in the news a lot lately because of the individual mandate and other controversial components. Something that has not been highlighted, however, is a lesser-known aspect that has manifested itself as the Medicare Shared Savings Program (MSSP).

The MSSP was created to establish integrated care delivery across multiple healthcare providers.The goal of this and other Centers for Medicaid and Medicare Services (CMS) initiatives is to achieve a three-part aim of better care for individuals, better health for populations, and lower costs.

Under the MSSP, groups of healthcare providers and suppliers can join together to form Accountable Care Organizations (ACOs). Each ACO is then held accountable for the overall cost and quality of care delivered to its patient population. In return for this increased accountability, Medicare will share a portion of the savings generated with the ACO—and its participating providers.

Program History and Evolution

CMS issued a notice of proposed rulemaking for the MSSP in spring 2011. In that original iteration, ACOs were largely unfavorable to physicians. The American Medical Association (AMA) and MedChi, the Maryland State Medical Society, worked to improve the proposed rule in three major categories.

First, to allow for the successful operation of ACOs, a level of relief from Stark laws as they relate to ethics in patient referrals, antitrust, and other similar provisions must be provided. Without these legal protections, physicians would be unable to take necessary steps to develop and operate ACOs to coordinate and improve care to Medicare beneficiaries and other patients. The Department of Justice, Federal Trade Commission, and Internal Revenue Service responded positively to this request.

Second, the proposed rule only included a two-sided shared savings model, wherein both positive and negative risk must be assumed by the ACO. The AMA and MedChi strongly believe that it is impossible for independent physicians to assume negative risk in a shared savings program because of the proportion of Medicare spending that is not directly attributable to professional services. Physicians are eager for the opportunity to improve care and reduce cost, but cannot be asked to take on additional liability.

Third, the ACO pilot programs demonstrated that ACOs will only be successful if direct care providers have an active voice in the governance of the ACO. The proposed rule requires at least 75 percent of the control of the governing body of an ACO to be made up of ACO participants (i.e. healthcare providers within the ACO). Further, the proposed rule requires the clinical oversight of the ACO to be conducted by a senior-level medical director licensed and present in the state where the ACO is located. The AMA and MedChi advocated for those requirements originally and fought to ensure that they remain in the final rule.

The three primary changes presented by the AMA and MedChi were accepted by CMS, as were other requests. Two additionally accepted requests are better quality care measure alignment with existing federal programs, and a hybrid methodology for assigning beneficiaries. The result is an ACO program that places the appropriate emphasis on physician integration and leadership, while allowing for flexibility to care for a diverse patient population.

ACO Characteristics

ACOs can take a variety of forms, and the final regulations provide flexibility for programs to be designed that support the specific needs of a community or region. In all iterations, an ACO is a group of healthcare providers that strives to improve the coordination and delivery of care to a specific patient population.

A medical director chosen from the group of ACO physicians works with the board of directors (made up primarily of physician participants) to develop a patient-centered plan for providing high quality care. Care plans encourage preventive services to keep patients healthy, which reduces hospitalizations and instances of chronic disease. In addition to better health outcomes, the overall cost of care is reduced through these interventions.

The MSSP program share the savings generated by the ACO with the participating providers. In Track 1 ACOs, the potential savings are split 50/50 and there is no downside risk in the event that no savings are realized. In Track 2 ACOs, the potential savings are split 60/40 but there is a sharing of excess cost if it increases.

Physician-led, rural ACOs were given an opportunity to participate in the Advance Payment Program. The Advance Payment is a non-recourse loan paid to an ACO to assist with the initial capitalization and a portion of the operating expenses. If there are savings then the loan must be repaid, if there are no savings the loan is forgiven. The Advance Payment Program was a competitive process made available to support physician groups that would otherwise not have the resources necessary to participate in a CMS MSSP.

Who Runs ACOs Now?

The number of ACOs grew to 221 in 45 states as of the end of May, according to a report released June 13 by Leavitt Partners, a consultancy based in Salt Lake City. A small majority of ACOs are run by hospitals.

Number of ACOs by Sponsoring organization

118 Hospital system
70 Physician group
29 Health plan
4 Community-based organization

Source: "Growth and Dispersion of Accountable Care Organizations: June 2012 Update," Leavitt Partners June 13

Physician-Led ACO Development in Maryland

MedChi, with support from physicians across the state and healthcare organizations such as Health Prime International and Innovative Health Services, created four ACOs. They are located in distinct regions of the state: Western Maryland, the Eastern Shore, Southern Maryland, and Prince George's County. Approximately 200 physicians chose to work together to lower costs and provide integrated care for as many as 40,000 Medicare beneficiaries.

Primary care physicians are the main resource for patients' healthcare needs. Unfortunately, both the public and private payment systems restrict primary care physicians' ability to fully manage their patients' care. Fee-for-service payment systems do not allow physicians to be reimbursed for total patient care. Each community of physicians that formed an ACO is excited by the opportunity to receive fair compensation for providing broader services.

Over the coming weeks and months, physicians in each ACO will work together to design patient-centered healthcare programs. From the patient perspective, there will be better integration of care among their primary care physician, specialists, and hospitals. A robust health information technology infrastructure will allow for the real-time processing of information, which will reduce the likelihood of unnecessary testing. Care managers will work directly with Medicare beneficiaries to schedule appointment dates, manage medications, and answer healthcare questions around the clock.

The direction of healthcare is changing and physicians and their patients must be at the forefront. The leadership of MedChi, the AMA, partner organizations, and, most importantly, physicians comprise an essential component to ensuring that Marylanders continue to receive the high quality of care they deserve.

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Late Breaking News at Press Time:

MedChi Creates Accountable Care Organizations to Support Physicians and their Patients

MedChi, The Maryland State Medical Society, announced today that it is participating in the Medicare Shared Savings Program to provide better care to patients while reducing costs. Along with partners from Health Prime International, a health care management and information technology firm located in National Harbor, Maryland, MedChi is starting three Accountable Care Organizations (ACOs).

The Affordable Care Act established ACOs to integrate care delivery across multiple health care providers. The goal of this and other Centers for Medicaid and Medicare Services (CMS) initiatives is to achieve a three-part aim of better care for individuals, better health for populations, and lower costs. "MedChi is proud to be a leader in the effort to enhance care and control costs," said Harry Ajrawat, MD, President of MedChi. "Physicians throughout the state will gain freedom to work directly with their patients to keep them healthy."

Under this new program, groups of health care providers such as physicians, nursing homes, and home health agencies can work together to care for Medicare patients. Each ACO strives to achieve the three part goal of CMS: better population health, better individual outcomes, and lower costs. In return for the increased accountability, Medicare will share a portion of the savings generated with the ACO – and its participating providers.

Gene Ransom, CEO of MedChi, is optimistic about this new program. "The final regulations eliminate physician downside risk, and require ACOs to be led by the physicians within the ACO who are directly providing care," he said. "This is an essential part of the program and guarantees that patient care remains paramount."

Implementation through Collaboration:

The Brookings-Dartmouth ACO Learning Network

Mark McClellan, MD, PhD

The Accountable Care Organization Model

The Accountable Care Organization (ACO) model is an explicit organizational focus on achieving higher quality and lower cost healthcare through combining payment reform and healthcare delivery reform. ACO reforms can be implemented through incremental changes in the current system, while providing a mechanism to get to fundamental improvements in care that are not supported by traditional fee-for-service payment systems. By promoting more strategic integration and care coordination, the ACO model offers a potential win-win for providers, payers, and patients alike. The ACO approach builds on current reform efforts that focus on one key group of providers, as in the medical home model, or on a discrete episode of care, as in bundled payments. On their own, these important initiatives may help strengthen primary care and care coordination by primary care providers and improve services within an episode involving specialty care, but they do not necessarily provide support or accountability for getting the best results at the lowest cost at the overall patient level.

What is an ACO?

The ACO model brings together networks of providers with shared responsibility and support to provide the highest value care to their patients. ACOs involve a benchmark based on both expected spending and on improvements in important measures of quality of care. If an ACO can improve quality while slowing spending growth, it receives shared savings from participating payers.

Because providers receive a share of the savings beyond a predetermined threshold level, steps that achieve better outcomes with fewer resources result in greater provider reimbursement. These steps pay off and are sustainable in a way that current reimbursement systems are not. Especially for a physician audience, it is important to include concrete examples of how ACOs provide support for care improvement where fee-for-service does not, for example:

- If physicians spend extra time answering e-mails from patients with chronic diseases like diabetes, or hire a nurse practitioner to help them improve their medication adherence the result may be better health outcome at lower costs, but there are expenses are not reimbursed.

- If a primary care physician and specialist use a common electronic health record or take time to coordinate care in other ways.

The shared savings approach provides an incentive for ACOs to avoid expansions of health care capacity that drive both regional differences in spending and variations in spending growth and that do not improve health. More advanced ACOs, with better established systems for coordinating and improving care and thus more confidence in taking on accountability for results, may move more of their reimbursement from the traditional track to the accountability track. For example, ACO providers might take a lower payment rate or a capitated rate for at least a share of healthcare services, in conjunction with a greater share of payments tied to quality and cost, because that means more flexibility in redirecting resources to where they can most improve care.

The Brookings-Dartmouth Accountable Care Organizations Learning Network

In 2009, the Engelberg Center for Health Care Reform at Brookings, in collaboration with the Dartmouth Institute for Health Policy and Clinical Practice, launched the ACO Learning Network to disseminate the results from ACO implementation

efforts and create a collaborative forum to address implementation challenges and improve ACO implementation strategies. The ACO Learning Network is helping to design, guide, and implement accountable payment reform across the country and continue to serve a critical role in the policy community by documenting, translating, and disseminating experiences and input from leading private sector health systems and plans.

Learning Network Members

As part of the core Learning Network, members have exclusive access to the following:

- A wide and growing range of content and opportunities, implementation tools, and research products developed, reviewed, and produced by ACO workgroups;
- A webinar series that keeps members informed of key developments in national ACO implementation efforts;
- Member-driven workshops to discuss and dissect practical ACO implementation solutions; and
- Online ACO resources and research, including profiles of organizations implementing ACOs, a library of ACO publications, over 40 archived webinars, and past ACO event materials.

Members also have the opportunity to take part in one of four workgroups:

- Implementing Performance Measures Workgroup
- Structuring Payment Models Workgroup
- Clinical Transformation Workgroup
- Addressing High-Risk and Vulnerable Populations Workgroup

The Path to Success

Hundreds of provider organizations, payers and key stakeholders have participated in the ACO Learning Network to collaborate on and advanced ACO implementation. ACO Learning Network members include many provider organizations with ongoing accountable care contracts with Medicare, states and leading commercial health plans. One example is Tucson Medical Center (TMC), a locally governed, nonprofit, community-based acute care hospital system in Tucson, Arizona.

- TMC started participating in the ACO Learning Network in 2007 to become accountable for the quality and overall cost of care for its patients.
- In 2008, TMC started working with United Healthcare to launch a virtually-integrated ACO for approximately 8,000 Medicare Advantage beneficiaries and 23,000 preferred provider organization patients through a new legal entity called Arizona Connected Care.
- On April 1, 2012, Arizona Connected Care was selected to participate in the three-year Medicare Shared Savings Program to become accountable for the quality and cost for Medicare fee-for-service beneficiaries.
- Participating in the ACO Learning Network has provided TMC and Arizona Connected Care an opportunity to learn and benefit from other leading ACOs experiences and share and contribute their own ACO implementation experiences to help accelerate national ACO implementation.

Learn more about TMC's experience launching Arizona Connected Care through The Commonwealth Fund's "Toward Accountable Care" case study series released in January 2012.

Mark McClellan, MD, PhD, is Director, Engelberg Center for Health Care Reform, Senior Fellow, Economic Studies, Leonard D. Schaeffer Chair in Health Policy Studies at Dartmouth College. He may be contacted through Sara Tetreault at STetreault@brookings.edu. *To learn more about the ACO Learning Network, visit www.acolearningnetwork.org or follow us on Twitter at @ACO_LN.*

The Patient-Centered Medical Home in Maryland—

Another Maryland Payment Reform Initiative

Laura Herrera, MD, MPH

Where you live has a major impact on your ability to access healthcare and the quality of care received.[1] There is a presumption that living in one of the wealthiest states in the United States would provide you with access to healthcare that is the highest in quality. Additionally, it's assumed that spending more per capita[2], as is the case in Maryland, translates into better quality healthcare.

But poor coordination of care plagues the health system which impacts its accessibility and quality. The system in which care is delivered is fragmented, especially for patients with chronic diseases whose care may be provided by multiple physicians at different points in time. There is a lack of incentives for coordinating care across providers. Weak attachments to primary care—either because of poor access due to shortages of providers or because of a system that has enabled the use of more costly care due to convenience—perpetuates the systems fragmentation. This lack of coordination has lead to increasing utilization of emergency department services and increasing hospital admissions for preventable illnesses.

Maryland is focusing on payment reforms that can help control the growth of health expenditures and improve quality of care as part of its larger healthcare delivery reform efforts. Efforts that develop capacity at the right levels of care and provide incentives that tilt away from expensive setting are key to the success of any effort. The patient-centered medical home (PCMH) is one key component of Maryland's payment reforms initiatives.

A "medical home" is an enhanced model of primary care that provides patients with access to comprehensive and integrated healthcare. The focus is on quality and safety through ongoing relationships with medical providers. Its goal is to allow the primary care provider to serve as the "quarterback" of a team of health professionals that focus on coordinating care and rewards clinicians for keeping their patients healthier.

The rationale for choosing the medical home is multifactorial. As a payment reform initiative, it improves the efficiency of resources by rewarding processes of care and improved health outcomes. It moves the system towards the triple aim of better quality health, improved experience of care and lower costs. As a clinical reform initiative, the team-based model of care that is coordinated by the patient's primary care provider renews interest in primary care. It strengthens the foundation in primary care, essential to improving quality and allows for improved provider-patient relationship that will lead to the expansion of clinical preventive interventions and improved clinical management of patients.[3]

Increasing interest in an innovative payment model has led to several medical home models. There are multiple care processes and practice capabilities that have been identified for a practice to be considered a medical home.[4] Some medical homes focus on their entire patient panels while others direct their efforts to a subset of patients. Several efforts to standardize medical homes are underway and several organizations now provide for medical home certifications. The most widely recognized is the National Committee for Quality Assurance (NCQA) PCMH program. NCQA has identified six standards that determine whether a practice is functioning as a medical home: enhanced access and continuity, and the ability to identify and manage populations, plan and manage care, provide self-care and community support, track and coordinate care, and measure and improve performance. The choice to pick one certifying agency over another is often based on payment incentives that are linked to the certification process as is the case in Maryland.

There are two large medical home initiatives in Maryland. In March of 2010, the Maryland General Assembly passed HB 929, the Patient-Centered Medical Home Program whose intent was to contain health care costs due to uncoordinated care and difficulties accessing primary care. The bill directed the Maryland Health Care Commission (MHCC) to establish a Medical Home Program. The intent was for medical homes to promote the delivery of higher quality healthcare that could also slow the rising costs seen in Maryland.

The program is part of a three-year pilot program that is focused on transforming primary care practices into PCMHs. Medical practices are provided with a fixed payment to transform their practices. In addition, medical practices that are successful in keeping their patients out of the emergency room (ER) or from being hospitalized, they will receive a percentage of the shared savings. To date, 52 practices (all of which have received certification from NCQA as a medical home) and 335 providers are participating with more than 240,000 patients receiving their primary care in a medical home.

In 2011, CareFirst BlueCross BlueShield launched its PCMH program. Based on lessons learned in the organization's medical home pilot, the program incentivizes primary care providers to focus on the needs of chronic patients and those at greatest risk for chronic diseases. Incentives are similarly based on a fixed component for setting and monitoring care plans as well as shared savings based on quality and cost outcomes. The implementation of care plans by nurse case managers that can track patients across settings and time is the key element of CareFirst's initiative. Approximately 300 medical care panels with approximately 3,300 primary care providers are currently participating in the program.

In addition to the two large initiatives, practices around the state are transforming into medical homes providing innovative patient-centered care. They are working through what supports are needed as they shift away from diseases and back to the patient and similarly are evaluating how the medical home affects ER utilization and hospitalizations. Some of these practices are community-based with long histories of focusing on high-risk patients and case management. They have the experience to move their communities and influence their local healthcare system to save money. They also have the potential to reduce health disparities because of their knowledge of the health needs of the communities they serve.

Opportunities to road test the medical home to address disparities will be made possible with the Maryland Health Improvement and Disparities Reduction Act of 2012. This Act will prioritize expansion of the PCMH to primary care practices in Health Enterprise Zones, which are areas of the state with documented health disparities and poor health outcomes. The bill recognizes the medical homes ability to modify local healthcare systems and provides an avenue for participation for practices that have chosen not participate in either the state's or CareFirst's medical home initiative.

Though data evaluating the medical home and its potential savings to the healthcare system are limited many states in addition to Maryland have developed policies and programs that advance the medical home. The Maryland model has the potential to build capacity in the right place and orient financing to the right time and right setting. Evaluations of both the state and the CareFirst initiatives are expected in summer 2012.

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1. *Rising to the Challenge. The Commonwealth Fund Commission on a High Performance Health System*. March 2012: ES 1- 13.

2. *Spotlight on Maryland: State Health Expenditures. The Maryland Health Care Commission*.April 2012: 1-7.

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4. Berensen R.A., Devers K.J., Burton R.A.. *Will the Patient Centered Medical Home Transform the Delivery of Health Care? Timely Analysis of Immediate Health Policy Issues*. Urban Institute. August 2011: 116.

President's Message ...

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sistent in opposing certain expansions of the scope of practice by such health occupations as nurse practitioners, pharmacists, and optometrists. Most recently, we opposed an attempt by podiatrists to expand their ordinary scope of practice beyond the ankle.

As mentioned earlier, we live in contradictory times. Although there is a great push to open up the practice of healthcare to more and more individuals, there is also a strong push to *increase* the regulation of physicians. Once again, the medical licensing board, now known as the Board of Physicians, is being scrutinized to determine if it is effective in carrying out those same goals with which MedChi was founded. Significant alteration of the Board will await the report of the Department of Health and Mental Hygiene's special study, headed by University of Maryland President Jay Perman, MD. Be assured that MedChi will insist on a comprehensive approach that ensures that the goals of our founders continue to be served.

MedChi CEO Message ...

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4. Improve Reimbursement and Improve the Network.

Physician shortages, low reimbursement rates and inadequate physician participation in the program threaten the State's ability to provide adequate access to high quality health care for Maryland's low income citizens. Physician participation becomes especially critical with the increased enrollment that will result from the implementation of federal health care reform but without funding and new program initiatives, physician participation is unlikely to increase. The Governor proposed an increase in Medicaid physician fees in his budget at the urging of MedChi. The issue of Medicaid physician rates was decided on the last day. The Senate had voted to retain the increase in reimbursement for evaluation and management codes to Medicare levels for all physicians as it was included in the Governor's Medicaid budget. The House amended the Senate version to recommend the increase only apply to primary care physicians. In the end, the Senate position prevailed so that all physicians will be the beneficiary of the evaluation and management (E&M) code rate increases.

Medicaid must be reformed. How we do this matters. Shoring up Medicaid's infrastructure is the better way to achieve change. If we get this wrong now, thousands of Marylanders stand to receive inadequate, substandard healthcare for years to come.

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A Curriculum on Health Policy for Medical Students

Dora Ann Mills, MD, MPH, Peter Dane, DO and Tyler Cymet, DO

To understand legislative policy a core knowledge is needed. Policy, politics and the legislative process have a specific way of making decisions that affect constituents. It is important to understand the language relating to ACOs and how they were developed. The following curriculum is meant to provide the key readings, videos, and links to help understand the issues from the perspective in which they were created.

Practicing medicine requires making decisions. Physicians routinely use the knowledge and thought processes that they bring to the healthcare relationship to gain more information about their patients. A license to practice medicine does not convey complete autonomy in practice decisions. Rules that govern decision-making and policies are defined by the government, by insurance companies and by health systems as well as others affect how physicians practice.

The following curriculum provides core reading and information to help promote an understanding of the direct and indirect regulations for practicing medicine. Differentiating between policy and practice management means understanding the origins of rules and how to approach changing the structure of that practice.

Background Reading for Health Policy

Affordable Care Act (ACA)

- Kaiser Family Foundation Health Reform Explained Video (9 minute)
- http://healthreform.kff.org/the-animation.aspx
- Kaiser Family Foundation Summary of New Health Reform Law (13 pp)
- http://www.kff.org/healthreform/8061.cfm
- Kaiser Implementation Timeline for Health Reform (reference table)
- http://healthreform.kff.org/timeline.aspx

Access to Health Insurance

- The Uninsured: A Primer (Kaiser Issue Brief) (20 pp)
- http://www.kff.org/uninsured/7451.cfm
- Commonwealth Fund's *Washington Health Policy Week in Review*. "HHS Rule: Women's Free Preventive Services Will Include Contraception" 8/1/2011 (2 pp)
- http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2011/Aug/August-8-2011/Womens-Free-Preventive-Services.aspx

Healthcare Costs

- *NEJM* "What We Talk about When We Talk about Health Care Costs" Peter Neumann 2/16/2012 (2 pp)
- http://www.nejm.org/doi/full/10.1056/NEJMp1200390
- *NEJM* "Defining Essential Health Benefits – The View from the IOM Committee." John K. Iglehart.10/20/2012 (3 pp)
- http://www.nejm.org/doi/full/10.1056/NEJMp1109982.
- *NEJM* "The Independent Payment Advisory Board – Congress's 'Good Deed'", Henry J. Aaron, PhD. 6/23/2011. (2 pp) http://www.nejm.org/doi/full/10.1056/NEJMp1105144
- Kaiser "The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending" 4/13/2011 (20 pp)
- http://www.kff.org/medicare/8150.cfm

Health Quality and Health Status

- CMS Innovation Center: ACOs; Bundled Payments; FQHC Initiatives; Primary Care Initiative; HCIC; Partnership for Patients; Strong Start.
- http://innovations.cms.gov/initiatives/ACO/index.html (4 minute video)
- AHRQ: Clinical Effectiveness Research (1 p)
- http://effectivehealthcare.ahrq.gov/index.cfm/what-is-comparative-effectiveness-research1/
- Kaiser Timeline for ACA (read the initiatives under Prevention, Quality, and Workforce provisions for each year
- http://healthreform.kff.org/Timeline.aspx
- Commonwealth Fund "Guiding Transformation: How Medical Practices Can Become Patient Centered Medical Homes" Ed Wagner, et al from the MacColl Institute for

Healthcare Innovation 2/27/2012 (2 pp) http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Feb/Guiding-Transformation.aspx

Legal Issues, the Supreme Court Decision

- Kaiser Guide to the Supreme Court's Review of the 2010 Health Care Reform Law (9 pp)
- http://www.kff.org/healthreform/8270.cfm
- *NEJM* "Supreme Court Review of the Health Care Reform Law" Gregory D. Curfman, Brendan S. Abel, and Renee M. Landers. 2/29/2012 (3 pp)
- http://www.nejm.org/doi/full/10.1056/NEJMp1114933?query=TOC#t=article
- Commonwealth Fund "Individual Mandate and Consumer Protections Must Stay Together, DOJ Tells Justices". 12/28/2012. (1 p)
- http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2012/Jan/January-30-2012/Individual-Mandate-and-Consumer-Protections.aspx
- *NEJM* "The Value of Federalism in Defining Essential Health Benefits" Alan Weil. 2/23/2012 (2 pp)
- http://www.nejm.org/doi/full/10.1056/NEJMp1200693

Questions for Discussion

Access to Care

- Describe the differences between Medicaid, Medicare and private health insurance, and how all are affected by the ACA.
- If a patient is enrolled in an Accountable Care Organization (ACO) can they receive their primary care from a physician who is not a member of the ACO, and if so, are there penalties and against whom?

Health Care Costs

- What effect will the Affordable Care Act (ACA) have on physician fees?
- Describe ways the ACA is supposed to lower health care costs.
- If the ACA does not lower health care costs, what are the consequences and how does this differ from the cost protection for payors in the Sustainable Growth Rate (SGR)?

Health Quality and Health Status

- In terms of ACA-related health quality and health status initiatives, compare the roles of the following"
  - Centers for Disease Control and Prevention (CDC)
  - Agency for Healthcare Research and Quality (AHRQ)
  - Center for Medicare & Medicaid Services (CMA)
- List some ACA prevention and health quality initiatives.
- Define the Patient-Centered Medical Home and list its advantages and challenges.

Legal Issues, the Supreme Court Decision

- Describe the specific issues related to the Affordable Care Act (ACA) before the U.S. Supreme Court.
- Discuss the major possible outcomes of the Court's decisions, and the ramifications for each.
- Explain the tension between federalism versus states' rights in ACA.

NOTE: This curriculum was initially put together for students at the University of New England College of Osteopathic Medicine.

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MedChi Accomplishments During the 2012 Maryland Legislative & Special Sessions

Stephen Rockower, MD

Introduction

The 90-day Maryland legislative session in Annapolis was, as usual, filled with intrigue, controversy, and difficulties. As has been reported by the news media, the legislative session ended without passage of a definitive budget for the State of Maryland.

The MedChi legislative agenda was ambitious and comprehensive. For the most part, we were able to fulfill our desires.

The agenda of the 2012 General Session was established by the House of Delegates at its annual meeting. This agenda was further discussed and formulated by the Legislative Council, and approved by the Board of Trustees. MedChi's legislative team of Jay Schwartz, Pam Metz, and Steve Wise worked with the Legislative Council to analyze every bill that was submitted to the Legislature and considered all of those that had some connection to MedChi's medical agenda, medical practice, public health or concerns for patients. Of the 2605 bills submitted in this year's General Assembly, 222 were reviewed and discussed at MedChi Legislative Committee meetings. In addition, the Society worked with legislators to submit bills that reflected its agenda.

During the session, the MedChi Legislative Committee and our lobbyists worked to shepherd the bills through the legislative process, including the various committees of the Senate and House of Delegates. The Legislative Council, led by Doctors James York and Brooke Buckley, met weekly during the session to consider the relevant bills and decide whether to support, oppose, or take no position on them. These discussions were often very spirited, reflecting the diversity of opinions within the MedChi membership. Once a decision was reached, Council and other MedChi members supported the policy in discussions with legislators and during testimony.

There is a short review at the end of the article discussing the first of what will probably be two special sessions.

Medical Practice Bills

One of our high priority items was the Preauthorization of Health Care Services Bill (SB540/HB470). Our goal was to provide legally enforceable regulatory power to the Maryland Health Care Commission (MHCC) to regulate the insurance industry's handling of authorizations of medication requests. In previous years, the industry had agreed to "voluntary" standards, but there were no enforcement provisions. There was much wrangling and negotiating, because the insurance companies were not willing to be held to the standards to which they had previously agreed. The bill that passed, as amended, provides for the use of electronic pre-authorization systems to allow physicians to initiate and track pre-authorizations via a company's Web site. The MHCC will issue regulations to help simplify and standardize the process, and will make reports to the General Assembly on the progress of the implementation of these systems.

Another priority of MedChi was the Truth in Advertising Bill (SB395/HB957). In 2011, the MedChi House of Delegates passed a resolution calling for the adoption of the American Medical Association's (AMA) model legislation on truth in advertising. This provides for standardization of advertising by physicians and other medical professionals as to their credentials, "board certification" status, and use of identifiable name tags in all patient encounters. There were objections to many of the AMA provisions by one medical group or other, and the bill was amended significantly to limit the use of the term "Board Certified" in advertising only when an individual is indeed certified by a board approved by the American Board of Medical Specialties. More work needs to be done in this regard to further tighten the language to prevent patient confusion as to the actual credentials of the person providing their medical care. In the future, the health occupations boards (including physicians, nurses, dentists, podiatrists, osteopaths, chiropractors, etc.) will compile information

concerning their own regulations regarding advertising, and new legislation will be introduced in 2013.

MedChi fought for patients' rights with the Chemotherapy Parity Act (SB179/HB243). This requires insurance companies to treat both oral and intravenous chemotherapy in similar ways, so that patients are not burdened by extraordinary financial expenses. This bill has already been signed into law by Governor O'Malley.

Public Health Bills

The Tanning Bed Bill (SB213/HB207) was another of MedChi's legislative priorities, endorsed by the dermatological community. This would prohibit the use of tanning beds by children under the age of 18. This currently is the law in Howard County, Maryland, and was recently passed in California. Current Maryland law allows children to use a tanning bed with a parent's consent. There was significant controversy over this bill, and an amended form was ready to pass in the Senate Finance Committee, but one Senator was unable to attend the voting session due to a medical emergency, and the bill died 5–5 in committee. This will surely be re-introduced in 2013.

The Tobacco Tax bill, which was endorsed by the MedChi House of Delegates as a first step in making Maryland a "tobacco free" state, had a very tortuous passage. This bill would significantly increase taxes on "other tobacco products" such as small cigars and smokeless tobacco products (snuff, chewing tobacco, etc.), but leave unchanged the tax on cigarettes and premium cigars. This bill was agreed to by House and Senate leadership, but was unable to be enacted before the midnight deadline on April 9. This will be re-examined in a Special Session.

Scope of Practice Bills

There were many scope of practice bills introduced by groups with interests other than that of physicians. The naturopaths tried to create a Board of Naturopathic Medicine to allow them full, independent practice within Maryland without supervision by medical professionals. This bill passed in committee, but was withdrawn on the floor of the Senate after vigorous opposition by many MedChi physicians from Montgomery, Prince George's, Anne Arundel and Baltimore Counties and Baltimore City and staff making door-to-door visits in the Senate Office Building. The podiatrists tried to expand their ability to operate on "acute ankle fractures," but this bill was withdrawn after vigorous opposition by the orthopaedic community in conjunction with MedChi. The pharmacists have been very aggressive in pursuing increases in their ability to administer vaccines. The current legislation would have allowed them to administer any vaccine approved by the Centers for Disease Control and Prevention (CDC) to any individual over the age of nine. Current law allows them to administer flu vaccines to people nine years and older, and pneumococcal and herpes vaccines to adults. The pediatric community was opposed to thisbecause the record keeping and prescription requirements were not in keeping with good medical practice. The Midwives Bill would have given licensure to certified midwives. The requirements for certification included having only a high school diploma and limited experience, and thus was opposed by MedChi. The hearing was dominated by proponents of the "home birth" movement, and the bill got limited support. A scope of practice bill that passed was the Dispensing Bill (SB603). This allows physicians to dispense medications under regulations promulgated by the Board of Physicians (not the Board of Pharmacy, as the pharmacists wanted). An amendment that was defeated would have prohibited a physician who was within 10 miles of a pharmacy from dispensing medications.

Malpractice Issues

There was not much in the way of malpractice legislation this year. The Maryland Trial Lawyers Association, newly renamed the Maryland Association for Justice (sic), introduced two bills to limit the use of expert witnesses and to try to introduce the availability of malpractice insurance coverage of defendant physicians, contrary to current practice where NO insurance coverage discussions are allowed in court.. These were both unsuccessful in the Judiciary committees.

Other Legislative Initiatives

Maryland strengthened the prohibitions against the use of wireless communications for young drivers and clarified the ban on text messaging for all drivers. We are trying to be a national leader in addressing distracted driving, and MedChi is fully supportive of the effort. SB529/HB55 is helpful in promoting safe driving practices. In addition, HB313/SB185 clarified the use of child safety seats based on the recommendations of the National Highway Safety Administration. Weight was removed as a factor in whether a child was required to use safety seats. This prevents inappropriate seat belt placement in smaller but heavier children.

In view of the recent events at Pennsylvania State University, there was some fervor to increase the penalties for and criminalize the failure to report child abuse and neglect. There has been a bill introduced every year for the past several years to criminalize even physicians who do not report abuse. Physicians are already liable to sanctions by the Board of Physicians, leading up to loss of license, so they have always felt that the recently proposed remedies were too draconian. SB63, as amended, was drawn very narrowly to criminalize only the most egregious form of "knowingly and willfully" failing to report a case where the individual had actual and direct knowledge of abuse. This bill passed the Senate, but died in the House Judiciary Committee in the final days of the Session.

The perennial bill to allow non-radiologist (ie, orthopaedists, urologists, etc.) to own and operate advanced medical imaging equipment (MRIs) as is allowed in 49 other states was again considered and not passed by House or Senate committees. HB634 would have allowed physicians assistants to operate certain "mini C-arm" devices, especially in nighttime urgent care practices. This passed the House but not the Senate.

The Board of Physicians bill (SB629/HB824) was a required "sunset" legislation to re-authorize and extend the existence of the Board for another 10 years. Most of this bill was delayed until next year's session while a report ordered by Maryland Secretary of Health Joshua Sharfstein, MD is prepared. In the meanwhile, the substantial change was to make the Chair of the Board a gubernatorial appointment, rather than an appointment from within the Board, as it was 10 years ago. There was considerable opposition from the Board, but the bill passed.

So, where are we with respect to legislative issues? For the most part, MedChi's agenda was successful, and very little of what could be called injurious to us passed. Our

legislative team worked tirelessly on our behalf. Executive Director Gene Ransom was an ever-present force. Dozens of MedChi physicians, led by our President, Harbhajan S. (Harry) Ajrawat, were present in Annapolis to lobby, testify and otherwise cajole the Legislature. Physicians from across the state volunteered to be "Doctor of the Day." People matter in this process. The more contact you have with your local legislators, the better chance you have to talk to them and help shape their views to match the views of MedChi. The legislative year is not yet finished—Governor O'Malley will be calling a Special Session to pass a budget for the state and to consider the tobacco tax. The MedChi Legislative Committee is always in need of more voices. Continue to be active. Encourage your colleagues to be active. With continued diligence and activism, we continue "to serve as Maryland's foremost advocate and resource for physicians, their patients and the public health."

Special Session May 14-17, 2012

The Special Session of the Legislature was called by the Governor in mid-May. The bills passed were the "Budget Reconcilliation and Financing Act" and a revenue act to help pay for the budget. These had been essentially agreed to during the regular session, but time ran out before they were enacted. They were passed mainly on party lines, with the Republicans arguing for no new taxes and that the state should be forced to drastically cut expenses (the "doomsday" budget). Democrats and the Governor were unwilling to live with the cuts to education and jobs.

The main part of the budget from a medical standpoint is the increase in funding for Medicaid payments for evaluation and management services to match Medicare. This increase should take effect in January 2013. Unfortunately, it only affects patients with primary Medicaid. The 20 percent Medicare co-pay cut remains in effect.

The other outcome of the Special Session was an increase in the tax on "other tobacco products." MedChi initiative will slow or decrease the rate of youth use of these products (cigarillos, smokeless tobacco, etc). While we could not get cigarettes into the bill, this will go a long way to making Maryland a tobacco-free state.

The next session will center around gambling matters. While not specifically a medical issue, physicians should be aware of certain relevant elements: the potential dangers of gambling addiction, to be balanced by the additional revenues generated to help close our budget gap.

Additional matters of concern to physicians will be the topic of discussions over the summer months: implementation of federal healthcare reform, "scope of practice" interim discussions, behavioral health integration, health disparity enterprise zone designations, and the Board of Physicians sunset review issues.

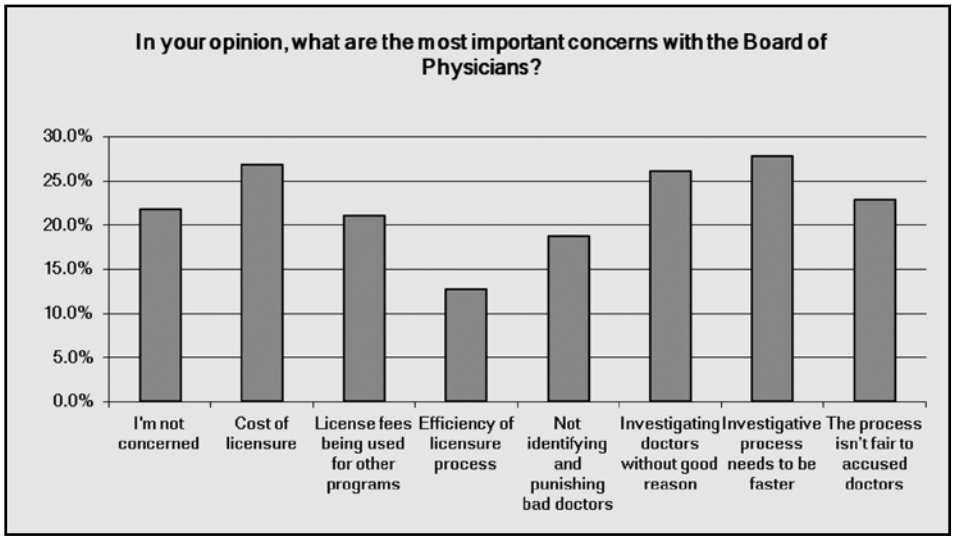
These are all vitally important for our continued success. As I said above: get involved, know the issues, talk to legislators. Be an advocate for physicians and our patients!

Stephen Rockower, MD, is a practicing orthopaedic surgeon in Rockville, Maryland and a member of the Maryland Medicine *editorial board. He is also an active member of MedChi's Legislative Council. He can be reached at DrRockower@CORdocs.com or on Twitter @DrBonesMD.*

MedChi Survey Reveals Physician Concerns With the Board of Physicians

Stephen H. Johnson, Esq.

Editor's Note: DHMH Secretary, Joshua Sharfstein, MD, requested a special study of the Board of Physicians. The study is being led by University of Maryland President Jay Perman, MD. As input for the study, MedChi surveyed its members about the functioning of the Board of Physicians. The results are outlined in the following article.

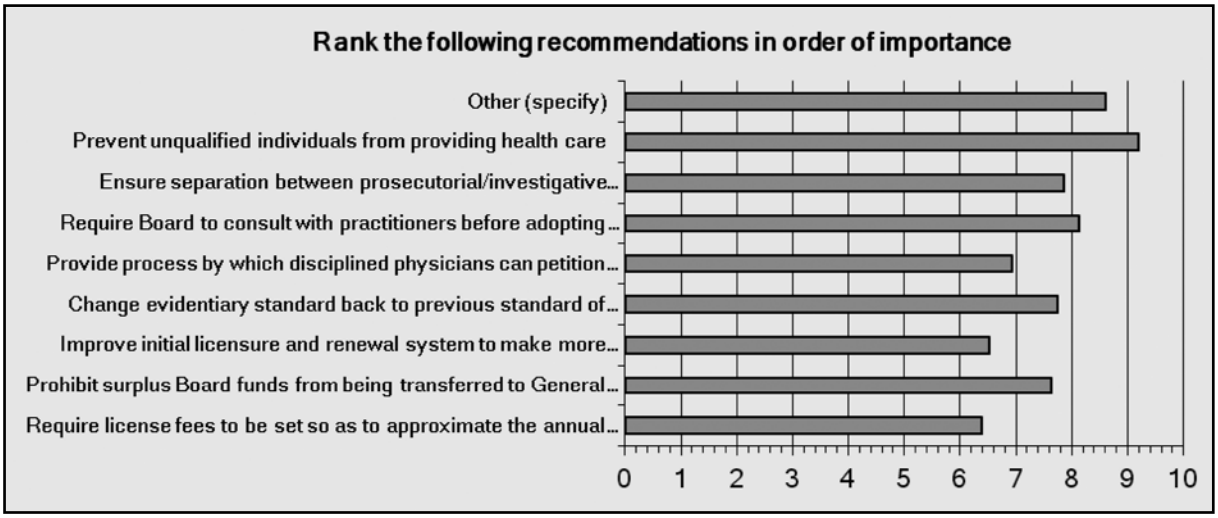


The result of a recent survey by MedChi indicates significant concerns with the work of the Maryland Board of Physicians. Four hundred fifty-three persons responded to the survey, most of whom were licensed physicians and MedChi members. This is the largest number of respondents to a MedChi survey ever recorded. The top concerns identified by respondents were that the "investigative process needs to be faster" (28 percent), the "cost of licensure" (27 percent), the "investigation of doctors without good reason" (26 percent), and "the process isn't fair to accused doctors" (23 percent).

Other concerns indicated by a significant number of respondents were, "license fees being used for other programs" (21 percent), and "not identifying and punishing bad doctors" (19 percent). However, 22 percent indicated that they did not have concerns with the Board's performance.

From a list of recommendations for the Board, the highest rated one was that it prevent unqualified persons from providing healthcare (9.19 average rating on a 10-point scale). Also rated highly were recommendations that the Board be required to consult with practitioners before instituting new regulations (8.14), that the prosecutorial investigative functions be further separated from the adjudicative function (7.85), that the evidentiary standard be returned to the "clear and convincing" standard that it was for many years, and that the transfer of funds from the Board fund to general funds be prohibited (7.62).

Individual suggestions by respondents included comments that there should be a less punitive system for handling first-time complaints that helped the practitioner make constructive changes while providing close monitoring and preventing the "economic turmoil" that a public disciplinary action would cause for a practice. Another respondent suggested that physician testimony in malpractice cases should be reviewed and potentially be the basis for disciplinary action. Several suggested that the process of screening complaints needs to be more rigorous to prevent patients from using the process as a means of retaliating against practices for appropriate actions such as bill collection or refusal to deliver unnecessary treatment. It was also suggested that regular updates be provided to physicians on the status of investigations against them.



These responses suggest the perception among the physician community that it has not been

treated fairly by the Board and other state regulators. Close to 40 percent of respondents having been the subject of a complaint to the Board.

Most complaints were closed within six months but about 20 percent of respondents reported that an investigation took more than one year to be resolved. Only one percent reported that the complaint resulted in administrative charges.

Approximately 40 percent of those who were the subject of a complaint hired an attorney. Although many respondents who hired an attorney had the costs covered by insurance, the majority did not and about 26 percent reported paying more than $5,000 to resolve the matter.

However, the respondents also made it clear that they are concerned about intentional misconduct, substandard care, and practice by impaired physicians. A slim majority believe that adequate measures currently exist to detect and prevent physicians from harming the public through intentional misconduct or substandard care.

About 38 percent reported that they were aware of substandard care being practiced by other physicians. When asked how they handled those situations, 43 percent reported using procedures internal to their institution or practice, 36 percent discussed the problem with physicians other than the one with whose care they were concerned, and 32 percent discussed the issue with the physician in question. Contacting the Board of Physicians was the least likely option to be chosen, elected by only 13 percent.

In individual responses to this question, many indicated that concerns about the Board's process made them hesitant to inform it of problematic performance. The following comment is not untypical of sentiments expressed:

As long as this Board is unduly influenced by politics and the egregious overreach of attorneys in its service it behooves physicians to first seek corrections to this Board's error-prone processes and positions before submitting their opinions on colleagues to the Board. This make-up, politics and limited intuitions and understandings of this Board as to the vast variety and scope of the practice of medicine have made it into a pawn in the hands of vested interests of institutional and corporate entities. The Board's recent series of decisions in this area have been to please proceduralists

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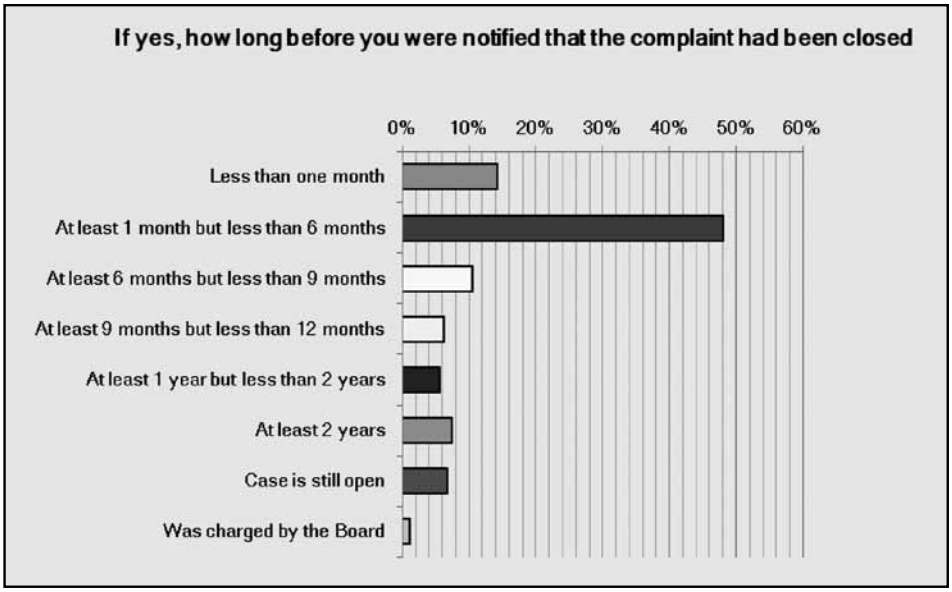

What were the approximate costs of that attorney?

Answer Options	Response Percent	Response Count
Covered by insurance	44.3%	31
Less than $1,000	12.9%	9
Between $1,000 and $5,000	17.1%	12
Between $5,000 and $25,000	17.1%	12
Between $25,000 and $50,000	1.4%	1
More than $50,000	7.1%	5

Do you believe adequate measures exist to detect and prevent doctors from harming the public through intentional misconduct or substandard care?

Answer Options	Response Percent	Response Count
Yes, adequate measures exist with respect to both intentional misconduct and substandard care.	51.4%	219
Adequate measures exist with respect to intentional misconduct but not with respect to substandard care	28.6%	122
Adequate measures exist with respect to substandard care but not with respect to intentional misconduct	5.9%	25
No, adequate measures do not exist for either intentional misconduct or substandard care	14.1%	60
answered question		**426**
skipped question		**27**

Medical Licensure: Setting the Standards in Maryland

HISTORICAL PERSPECTIVES

Sandra Rowland, MS, MA

During this year's legislative session, MedChi was successful in achieving several legislative victories. Many of the bills that MedChi had a voice in concerned scope of practice issues for non-physician healthcare practitioners. The debate around Senate Bill 180/House Bill 620, to create a new licensing board for "naturopathic doctors" and allow them to practice "naturopathic medicine" independently of physicians was particularly striking from a historical perspective, because it echoes back to earlier eras in Maryland when medicine and medical practitioners were just defining what it meant to be a physician practicing in the state. At the time of the Medical Society's founding in 1799, there were few established medical schools and none in Maryland. Physicians could receive training in Europe, at an out-of-state medical school, or through an apprenticeship with a physician. There was no formal licensing or examining of physicians. In fact, much of the impetus to form the Medical Society was to provide just this type of structure to the profession. The founders believed that establishing the Society would prevent the citizens of Maryland, "from risking their lives in the hands of ignorant practitioners or pretenders to the healing arts."[1]

The Act of Incorporation gave the initial 101 leaders of the medical profession who established the initial charter the authority to license and regulate physicians. It states in part that, "no person, not already a practitioner of medicine or surgery, shall be allowed to practice in either of the said branches and receive payment for his services, without having first obtained a license, certified as this law directed, under penalty of fifty dollars for each offence…one half for the use of the faculty and the other for that of the informer."[2] It is nice to see that our forefathers were already considering the Faculty's financial stability even in the founding documents.

After the Medical and Chirurgical Faculty was established, Faculty members from around the state were chosen to examine applicants for licensure in their jurisdiction and they were also charged with the task of reporting unlicensed medical practice to the Faculty so that the organization could conduct proceedings of censure. However, the physician examiners were reluctant to serve as the enforcement division and in this environment, many unlicensed medical practitioners emerged and experienced periods of popularity in the 1800s and up until the mid twentieth century.[2]

One of the earliest challengers to the established medical community was the Thomsonians. These practitioners were considered a "medical sect" by the Faculty physicians. The practice was based on the teachings of Samuel Thomson who rejected some of the methods of physicians of the day and focused mostly on herbal remedies especially those made from lobelia, commonly known as pukeweed.

A clash developed between the physicians who had been educated in medical schools and apprenticeships and the Thomsonians. The Thomsonians believed that, armed with the knowledge of herbal remedies, the populace could cure themselves and thus there would be no need for physician. Families paid twenty dollars for the rights to Thomson's patented herbal remedies so they could treat themselves. People who subscribed to the Thomsonian treatments organized into "friendly societies" thus presenting a rivalry with the "regular" physicians and the medical society.

The Thomsonians were successful initially when in 1838 the Maryland Legislature passed a new law that undercut the Medical and Chirurgical Faculty's authority to license and regulate medical practitioners by authorizing the Thomsonians or Botanic Physicians to charge and receive compensation for their services and medicine.[2] As the rhetoric between the two intensified, the Thomsonians countered that the regular practitioners "were still in their swaddling clothes with their practices of Calomelising and blood-letting and that their system was in rapid decline and will die, rot and be forgotten in less than half a century."[2] While, in the short term, the Faculty lost this battle, over time the Thomsonians faded away, and by 1873 there were virtually no practitioners left in the state.

Another group of practitioners to challenge the "regular physicians" were homeopaths. Homeopathic healing gained popularity in the early 1800s with the teachings of Dr. Samuel Hahnemann in Germany and spread throughout Europe and North America. Hahnemann questioned the medical community's practice of bloodletting and the use of pharmaceutical preparations which he felt were a means of masking the symptoms instead of curing disease. His focus was on healing through what we would call today, better health habits such as improved diet, fresh air, and exercise. Additionally, a central tenant of Homeopathy is the approach of "like cures like" which postulated that patients should be given a specific medicine, that when given to a healthy person, most closely mimics the symptoms of the disease in its natural state. Much of the development of homeopathy involved creating these remedies for specific illnesses.[2]

Homeopathic medicine was popular in Maryland among the well educated and middle and upper classes. Many "regular physicians" or allopathic practitioners incorporated some of the therapeutic techniques of homeopathy into their practices. Given that physicians at the time still employed bleeding, blistering and purging among their prescribed remedies, it's easy to see the attractiveness of the homeopathic alternative. However, the Medical Society stopped short of endors-

ing the homeopathic approach. When one of MedChi's active members on the Eastern Shore, Dr. Samuel Harper, began advertising himself as a homeopathic physician in 1858, the Medical and Chirurgical Faculty promptly withdrew his membership on the grounds of his "alleged union with homeopathists."[2]

Homeopathic practitioners had their own licensing board beginning in the late 1800s until it finally disbanded in 1957. In 1890 homeopathic practitioners founded the Southern Homeopathic Medical College and Hospital of Baltimore as well as several competing homeopathic medical societies in the state. These societies would last for a few years then break apart because of fighting between the doctors, and new societies would be formed. Enoch Pratt offered to give a million dollars to found a homeopathic hospital in Baltimore on the condition that all the competing medical societies would agree to work together to support it. When he saw that any such agreement was impossible, he changed his will instead to leave the money to the Sheppard-Pratt Hospital. http://homeopathy.inbaltimore.org/history.html

By the late 1800s the AMA changed its tactics from opposing homeopaths and punishing allopathic doctors who consulted with homeopaths to wooing them and allowing them to join the AMA. (http://homeopathy.inbaltimore.org/history.html)

By the end of the 19th century much of medicine and the healing arts began to coalesce around modern, scientific and evidence based medicine. The advent of the modern medical school which was ushered in by Johns Hopkins University helped to set us on the course we have today of recognizing a path for achieving the status of Medical Doctor with standard exams for medical licenses, state licensure, and specialty board certification. While the initial path of so called "regular or allopathic medicine" included some areas we wouldn't consider good medical practice by today's standards, such as purging and blood letting, it did become the standard bearer of medicine and medical practice. MedChi should be proud of its role in shepherding in the era of modern medicine and helping to set and maintain the standard of what it means to be a physician in Maryland. As seen in this last legislative session, it's an important heritage to embrace.

Sandra Rowland, MS, MA is Executive Director of the Center for a Healthy Maryland. She may be reached at 1.800.492.1056, ext.3336 or srowland@medchi.org.

1. French, John C., *A Brief History of the Medical and Chirurgical Faculty of Maryland*, Baltimore: Medical and Chirurgical Faculty of the State of Maryland, 1949

2. Sewell, Jane Eliot *Medicine in Maryland: The Practice and the Profession, 1799-1999*, Baltimore: Johns Hopkins University Press, 1999.

MedChi Survey Regarding Board of Physicians ...

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and to penalize senior physicians who have a solid track record of great outcome with competitive costs and who enjoy the strongest measure of support of their colleagues in the community and institutions.

MedChi conveyed a summary of the results to Dr. Jay Perman, recently named the next President of the University of Maryland, Baltimore Campus, who is reviewing the work of the Board for the Department of Health and Mental Hygiene (Maryland DHMH). Dr. Joshua Sharfstein, Secretary of Maryland DHMH, asked Dr Perman to lead a review of the Board of Physicians and report back with recommendations for improvement. MedChi conducted the survey referred to above and informed Dr. Perman of the results to help him understand what the licensees believe are the most important issues with the Maryland Board of Physicians. Dr. Perman's report will likely have a significant impact on the General Assembly as it considers the renewal of the Medical Practice Act.

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Microbe Hunters

WORD ROUNDS

In 1295, Marco Polo returned to his home in Venice after a 24 year sojourn in Asia with his father Niccolo and his uncle Maffeo. During their excursion, these Venetian businessmen established an agreement with Kublai Khan resulting in the famous "Silk Road," a major route from Venice through Asia into China. Substantial trading between Europe and China ensued.

In 1346, Mongol raiders attacked an Italian trading post at Caffa, located on the Silk Road. During that siege, an epidemic of Bubonic Plague erupted among the Mongol fighters, forcing them to withdraw from the conflict. As they departed Caffa, the Mongols catapulted many of their dead comrades over the wall and into the trading post - a tactic frequently employed by the Golden Horde. The Italian merchants eventually resumed their homeward journey, unaware that among them were some who were incubating the Plague. They would soon become the vector of Europe's Black Death, resulting in the loss of 40-50 percent of its population.

Bubonic Plague is the result of infection with the gram negative bacterium *Yersinia pestis*, contracted from the bite of the oriental rat flea *Xenopsylla cheopis*. Bubonic is from Greek *boubon*: "groin swelling" referring to the tender, enlarged lymph nodes in the groin and axilla often prominent in this disease. *Yersinia* is derived from the name of the scientist who first identified the plague organism – **Alexandre Yersin**, a French bacteriologist working at the Pasteur Institute. (The organism was initially called *Pasteurella pestis*.) The flea genus **Xenopsylla** is derived from the Greek words *xenos*: "foreign" and *psylla*: "flea." Its species name, *cheopis* stems from the fact that the flea was initially discovered in Egypt near the tomb of the Pharaoh **Cheops.** Therefore, the insect is the "foreign flea of Cheops."

Xenos ("foreign or strange") may be noted in **Xenon**, one of our trace atmospheric noble gases, discovered in 1898 and thought to be "strange" because it was then an unidentified component of air. **Xenophobia** is a fear of strangers, and a **xenograft** is a graft of skin or bone from an individual of another ("foreign") species.

The Decameron, written by Giovanni Boccaccio during the years of the Black Death (1348-1353), is the story of ten young adults who escape the city of Florence in order to avoid the plague. To pass the time, each of them tells ten stories – comprising the 100 stories in the book. The title derives from Italian *decamerone*, which in turn derives from Greek *deka*: "ten" plus *hemera*: "a day." It refers to the ten days during which the group was away from Florence. (A **decade** stems from *deka* as well.). *Hemera* is also found in the word **ephemeral,** from Greek *epi*: "upon" plus *hemera*: "a day." This is an event that lasts but a short time – about a day. An **ephemeris** is an astronomical table describing the precise location of celestial bodies for each day of the year. The delicate **Mayfly** belongs to the order *Ephemeroptera* – from *hemara* and *pteron*: "wing." These are winged insects that live for only a day. (A **pterigium** is a thin, wing-like structure extending from the inner canthus of the eye, attaching the conjunctiva to the cornea. **Helicopter** is derived from Greek *helix*: "rotary or spiral-shaped" plus *pteron*: "wing.")

Although physicians of the 14th century were unaware of the microbial cause of infectious illnesses, they recognized that a period of time must elapse between exposure to a plague victim and the onset of symptoms in those who had contact with him. Therefore, Venetian officials barred travelers from entering their city for an interval of 40 days. After that time, if there were no signs of the plague, the visitors were admitted. In Italian, a period of 40 days is a *quarantina*, from which we obviously derive the term **quarantine**, and which no longer implies its etymologic origin.

Illnesses, such as plague, were believed to arise as a result of poisonous air. For example **Typhus**, a Rickettsial infection, derives its name from the Greek *typhos*: "smoke or vapor," and **Malaria** stems from Italian *mala*: "bad" and *aria*: "air" – both of these names resulting from the mistaken belief that these diseases arose from foul or noxious air.

Howard Ricketts (1871-1910), an 1897 graduate of Northwestern University Medical School, discovered the organism causing Rocky Mountain Spotted Fever. The microbe was subsequently named for him – *Rickettsia rickettsii* – and his name has also been applied to the genus of related organisms. Sadly Dr. Ricketts died at age 39 of another Rickettsial illness – **Murine Typhus** – while he was investigating that disease in Mexico. Murine Typhus is caused by *Rickettsiae typhi*, and is also spread by the bite of the oriental rat flea *Xenopsylla cheopis*. The flea ingests these organisms while feeding on its animal reservoir – mice. The term **murine** stems from Latin *mus*: "mouse," the genitive form of which is *murinus*: "of mice." **Epidemic Typhus** is caused by *Rickettsia prowazekii*, and is named for the zoologist **Stanislas von Prowazek**, who died from that disease while exploring its origin.

(The word **muscle** also derives from *mus*: "mouse". Some early and imaginative anatomist thought that muscle contractions – which cause ripples beneath the skin – resembled mice running back and forth.)

Rickettsial organisms not only cause several forms of Typhus and Rocky Mountain Spotted Fever, they are also responsible for Rickettsial Pox and Scrub Typhus (Tsutsugamushi Fever), among other diseases. (**Q Fever** was originally thought to be caused by a Rickettsial organism, but *Coxiella burnetii* was eventually identified as the actual source. Since its cause was unknown, early investigators named the illness "Q Fever" - the Q standing for "Query". The genus name *Coxiella* derives from H.R.Cox who isolated the germ from ticks in Montana in 1938. The species designation stems from Frank Macfarlane Burnet, who isolated the pathogen from a patient. Burnet went on to receive the 1960 Nobel Prize in medicine for his work on

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CLASSIFIEDS

EMPLOYMENT

DIRECTOR OF OPERATIONS: MedStar Physician Partners - Montgomery County. Will oversee multiple physician practices (specialties include Endocrinology, Surgery, Family Practice and Internal Medicine) located throughout Montgomery County area. Requires a Bachelor's degree in Business/Health Administration or equivalent combination of education/experience and experience managing multiple physician practices. 7 or more years of experience in a managed care or ambulatory care setting preferred. To apply, please visit: www.mpp-jobs1.com.eoe.

INTERNAL MEDICINE: Call Sharing. Solo physician in Olney, MD, looking to share call with other physician(s) in nearby area. Flexible. Call 301.768.2169.

INTERNIST: To join a solo internist in Riverdale, MD. Benefits include a great salary, CME, retirement plan, etc. Call 301.277.8100.

INTERNIST: Part-time. Join an extremely successful internal medicine group practice in Bethesda, Maryland. Seeking a part-time BC/BE Internist to job share with an established female physician as part of our group of 8 Internal Medicine physicians. Position is 5 sessions per week and is out-patient only. This practice is busy, growing, and offers the potential for partnership. Please email curriculum vitae to alt@ppa.md.

PEDIATRICIAN: Growing practice in Baltimore County is seeking a BC/BE Pediatrician to work at its vibrant pediatric practice close to Franklin Square Hospital. Please email your CV/resume to info@wbeachpediatrics.com or fax to 410.719.6338.

PEDIATRICIAN: Retiring Pediatrician seeking physician to take over practice in Gaithersburg. Contact physician at 301.938.1651.

PRIMARY CARE PHYSICIAN: Growing practice in Silver Spring seeks part-time physician. Friendly environment, flexible schedule, competitive salary. Contact us at office@mhcmd.com or 301.452.4062.

URGENT CARE PHYSICIANS AND STAFF: Rockville, MD. Need enthusiastic Physicians, PAs or NPs, Nurse Administrator, techs, LPNs, X-ray techs, & MAs for FT & PT positions. Reg: BC/BE physicians in EM or FP. IM with PEDS experience. Flex work hours. Competitive compensation. Great community! Paid malpractice and tail. Send resume to Urgentcare@myphysiciansnow.com

PRACTICE SALES, MERGERS, ETC.

FREDERICK: (See FOR SALE OR LEASE below)

LEASE/SUBLEASE/SALE

BETHESDA: Attractive office space for rent in physician's practice w/private office, exam rooms, and shared waiting room ready for use. Walking distance to Metro, parking garage, or on street and county garage across street. Please call Avelene at 301.656.0220.

CATONSVILLE: For sale or lease. 1.000 sq.ft. medical office at 716 Maiden Choice La. Suite 206 with 2 exam rooms, 2 physician offices, lab area. Located across from Charlestown Retirement Center. Close to St. Agnes Hospital and I-695. Ample parking. View of woods from all windows. Monthly rent: $ 1,675 for sale: $ 180,000. Call Anna at 410.321.8889.

COCKEYSVILLE: Available May 2011. 2000 sq.ft., 6 exam rooms, 4 business/physician offices, one lounge, lab area, large waiting room, storage, and excellent parking. Call 410.628.6100 for more information.

FOREST HILL: Office space available in a quiet professional building. Includes utilities, phone, copy, fax machine, receptionist area, waiting room, and parking. Two examination rooms and all other necessary accommodations for an MD (sink, closets, file areas, etc.). Part-time availability (1-3 days a week). Please contact Dr. Schmitt at 443.617.0682 or Dr. Legum at 410.852.0582.

FREDERICK: Office space to share. Approx. 2000 sq.ft. Bright & modern office on Guildford Dr. available to share (with some PT equipment). Waiting room and front desk. Perfect for internal medicine/family practice looking to expand to Frederick area. Hours and rent negotiable. Inquiries to goldfay2011@gmail.com.

FREDERICK: (FOR SALE OR LEASE) Available immediately fully fitted out Medical Suite in a medical condominium building. This medical suite is fitted with 5 private offices, 10 exam rooms, waiting area, lab, storage, conference room and break room. Call Jay Nathan at 240.405.1023 or 301.471.8251.

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Microbe Hunters...

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autoimmunity and graft-host reactions. The term **Tsutsugamushi** derives from Japanese *tsutsuga*: "illness" and *mushi*: "insect.")

Typhoid Fever was so- named because many of its symptoms resembled those of Epidemic Typhus – thus *typhus* plus Greek *oides*: "like or resembling," that is "typhus-like." Typhoid Fever is caused by the gram negative rod *Salmonella typhosa*. Its genus name is derived from Daniel Elmer Salmon (1850-1914), a veterinary surgeon who spent his career researching animal diseases for the U.S. Department of Agriculture. The organism was named in honor of Dr. Salmon by his assistant.

Gonorrhea, caused by the pathogen *Neisseria gonorrhoeae*, was misnamed since early physicians believed that the urethral discharge consisted of semen. Thus Latin *gonos*: "seed" plus *rhein*: "to flow" – "flowing seeds or flowing semen." The Latin word *rhein*: "to flow" can be found in such terms as **rhinorrhea** (from Greek **rhinos**: "nose" plus *rhein* – that is a "runny nose," **diarrhea** (Greek *dia*: "through" plus *rhein* – that is, "to flow through"), and **dysmenorrhea** (Greek *dys*: "bad or painful" plus *men*: "month" plus *rhein*: "to flow," that is painful monthly menstruation. The Greek word *men* became *mensis* in Latin, and ultimately generated the English words **moon** and **month**. Women have often referred to their menstrual periods (**menses**) as "the monthlies".) The **Rhine River** derives its name from *rhein* – it flows as well. Albert Neisser (1855-1916) was a German physician and bacteriologist who identified the pathogen responsible for gonorrhea, and for whom it was named.

By now it must be obvious that many pathogenic organisms have been named for investigators who were involved in their discovery. We note such scientists as Theodor Klebs, Theodor Escherich, Kiyoshi Shiga, Sir David Bruce, Joseph Lister, Alberto Leopoldo Barton, Henrique da Rocha Lima, Amédée Borrel and Willy Burgdorfer, among others. These men are associated with infections caused by **Klebsiella**, **Escherichia**, **Shigella**, **Brucella**, **Listeria**, **Bartonella**, **Rochalima**, and the agent that causes **Lyme Disease** – *Borrelia burgdorferi*. (Lyme Disease was first reported in children from **Lyme, Connecticut**.)

However, not all infectious diseases are named for people. The *Hanta virus* was first discovered during an outbreak near the **Hantan River** in South Korea, the *Marburg virus* initially caused an epidemic in **Marburg, Germany**, the *Ebola virus* was isolated from patients living near the **Ebola River** in Zaire, *Bornholm Disease* (epidemic pleurodynia) was first described on the Danish island of **Bornholm**, and *Coxsackie virus* was first recovered from patients living in the small village of **Coxsackie, New York**. It is obvious that etymology not only applies to everyday words, but also to names of people, places – and even the genus and species of organisms.

In Shakespeare's *Hamlet* there are two minor characters named Rosencrantz and Guildenstern, who make brief appearances in acts II and III. In 1966, Tom Stoppard wrote a play titled *Rosencrantz and Guildenstern are Dead*. The premise of the play is that the two fictional characters are suddenly brought to life, but find themselves strictly confined to their scenes within Shakespeare's play. They try desperately, but cannot recall any of their past lives (they don't have any past "life" – Shakespeare did not include those details). The two unfortunate men don't know why they are there, and in fact don't even know which of them is Rosencrantz and which Guildenstern.

In some respects we are all like those two lamentable characters. At birth, we abruptly emerge into a confusing world that is incredibly complex, with a long human history preceding our arrival, and a language that has evolved over millennia. We quickly learn the native jargon, but have little or no idea how that flowing river of words and phrases evolved. A bit of investigation reveals that each word has a past history – some terms commonplace and uninteresting, some fascinating and unique.

Knowing a word's origin will not add a dime to your pocket, but will inevitably increase your understanding of the world – and that, as Hamlet says, is a consummation devoutly to be wished.

Barton J. Gershen, MD, Editor Emeritus of Maryland Medicine, *retired from medical practice in December 2003. He specialized in cardiology and internal medicine in Rockville, Maryland. If you are interested in purchasing a copy of* Word Rounds: A History of Words (Both Medical and non-Medical) and Their Relationship to One Another *by Dr. Gershen, please contact Flower Valley Press, P.O. Box 83925, Gaithersburg, Md. 20883, or www.amazon.com.*

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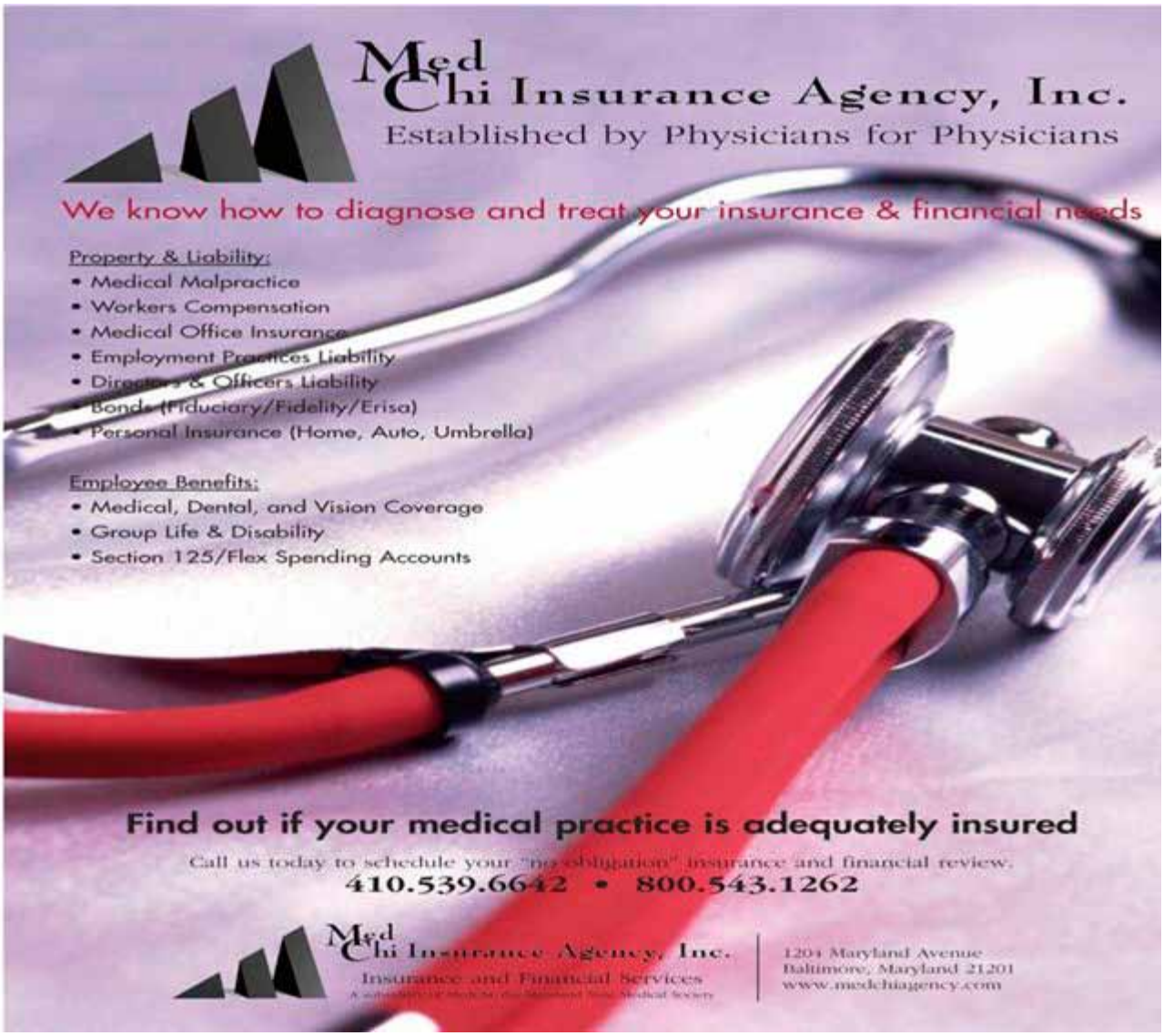

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