Quarterly Newsletter

Editor
Walter Rayford, PhD, MD, MBA

Executive Assistant
Janice P. Cooper

MISSION STATEMENT

The premier historically minority physician’s organization – leading the way in healthcare for the Mid-South

VISION STATEMENT

• Establishing and maintaining a center of excellence for physician best practices.
• Leading the way in eradication of healthcare disparities.
• Providing mentorship at every level of education.
• Positioning ourselves as an integral player in the setting of healthcare policy and research.
• Promoting the professional and personal viability of our physician members

CORE VALUES

• Encourage, promote and maintain the highest professional standards of our fellow physicians
• Committed to eliminate health disparities in our community
• Concern for the general health & wellness of the community
• Strong support for our members

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**President’s Corner:**

**Lanetta Anderson, MD  
President**

It is with great pleasure and honor that I embrace the role of President of Bluff City Medical Society. Our organization has strengthened its position in the medical community over the past several years and looks forward to even greater success in upcoming year.

The calendar for the 2015-2016 year is a very robust one, but we strive to keep it effective and purposeful for the membership. The Executive Committee has outlined 2015 agenda to accomplish these goals:

- Monthly Academic Meetings for the members, residents and medical students to address a variety of current medical topics  
- Quarterly Newsletter  
- Expansion of our Medical Student Mentorship Program linking first and second year medical students with a practitioner for counseling, support and clinical experience  
- The Fourth Annual Physician Business Symposium which will address ICD-10, Physician Quality and Reporting Systems, Tennessee Payment Reform Initiative, EMR update, Affordable Care Act, Physician Wealth Management, Practice Mergers and Acquisition, Tracking Performance Indicators  
- Annual Lecture/Scholarship Program recognizes and highlights a physician who has made significant contributions to health and medicine; student scholarships are also awarded at this event from BCMS, University of Tennessee (Ed Reed Scholarship) and the BCMS-Auxiliary organization.

- The Fourth Annual Boys and Girls Club of America Fundraiser jointly sponsored by BCMS and the National Bar Association  
- Healthy Eating and Living (HEAL) Initiative represents a joint venture between BCMS and several area churches to tackle diabetes and obesity  
- The Eighth Annual Men’s Health Symposium representing the largest health education and early detection opportunity for men in the tri-state area.

- Community Health Fairs to promote patient education, screening and access to health care. Our past success was made possible because a strong membership and we expect even greater success in the future. Let’s get to work, let’s do it together and make BCMS stronger than it’s ever been.
Timely, accurate, and objective; those are the three words Dr. Albert Morris used when I asked him to summarize his personal mission statement into only three words. I knew timely was accurate as he was already waiting for me as I arrived one minute prior to our meeting time. When I asked him why he chose these words he simply replied, “That’s what a Radiologist does”.

Dr. Albert Morris was raised in Detroit, Michigan. He was a part of a very close-knit family with a home life he describes as calm, stress free, and predictable giving him the right amount freedom at the right time to become a responsible, driven individual. He attended high school at Cass Tech. During high school he took part in the Chemistry/Biology program. This was a school that allowed him to take classes like Organic Chemistry I &II, Latin, and Anatomy and Physiology, just to name a few. This was a part the basis for a strong foundation on which he built his medical career.

Dr. Morris had a very interesting journey to Medicine. He originally started at the College of Pharmacy at Howard University, but after a professor made his undergraduate introductory class to pharmacy harder than necessary, he decided against pharmacy and switched to a major in Chemistry. While he was pledging to become a member of Kappa Alpha Psi Fraternity Incorporated, he applied to the College of Medicine. This action was a result of a competition amongst another fraternity challenging the individual with the highest GPA to apply. While still a sophomore, he was admitted to the College of Medicine with a full scholarship at the age of 20. Prior to his admission, Dr. Morris spent his summers at Harvard University where he had the opportunity to be taught by distinguished professors that nurtured his interest in the sciences. He was even taught Biochemistry by James Watson who received the Nobel Prize for his work on DNA.

After graduation from Howard College of Medicine in 1976, Dr. Morris did a flexible Internship at the University of Tennessee and decided near the end of this that a career in Radiology was of particular interest to him. An African-American Radiology resident in Memphis, TN in 1978, to put it lightly “ruffled a few feathers,” but Dr. Morris overcame each obstacle he faced, learned from each situation, and made himself and others better during the process.

Dr. Morris is more than just a prominent physician, he is also involved with issues that affect people in the Memphis community that are easily overlooked. He has served as the Chairman of the Environmental and Bioterrorism Task Force of the National Medical Association since 2000. This entails addressing concerns of pesticide usage, uncontrolled hazardous waste, and radiation levels within the community. He is also passionate about the current disparity that exists in health care for African-Americans versus other racial groups. Many African-American patients are not being treated by African-American physicians. One of the ways that we can begin to narrow this gap is for African-American physicians to begin to treat these patients or educate those who are treating these patients. This will help to tear down some of the cultural barriers and allow those of other races to talk to our patients rather than talk at them.

Intrepid, loyal, and fearless; these are the three words Dr. Morris’s friends would use to describe him. These words are well-fitting because when I asked Dr. Morris if he could change his career today, he answered he would have been a pilot. He also mentioned that many people do not know he took piano classes for 10 years. He stated he might not have pursued a career in medicine had he known about careers such as musical production. Outside of being a radiologist he enjoys music, traveling, reading, and simply seeing other happy people. He joyfully describes something as simple as watching someone win it big on an episode of the “Price Is Right” as potentially making his entire day brighter. His family consists of his two children and the love of his life, Sandra. His daughter is a successful NYU educated attorney with an international firm and his son is an aspiring pharmacist currently attending Xavier University.

So what could the future hold for a man that has accomplished so much? Dr. Morris gracefully answered he would like to step from success into significance and work to improve some of the issues he is passionate about concerning health care. He also would like his legacy to consist of a means to help support promising students interested in pursuing medicine to alleviate the financial burden that is associated with the cost of professional school. And to students he advises, “In medicine be the type of person that is going to do the right thing when no one is looking.”
“Whatever you do in life, your first chance is your best chance. Give it your all the first time.” This is one of Dr. Morris’s favorite quotes by LaSal Lefall. It is evident that he has lived his life inspired by this quote. He is undoubtedly held in high esteem by his colleagues and those who strive to reach his level of success. He is not only a radiologist but also a father, activist, friend, and inspiration.

Healthy Shelby, a public-private initiative that is part of Memphis Fast Forward, is focused on the triple aim of improving population health, improving the patient care experience and reducing per capita healthcare costs. To achieve these goals for our community, Healthy Shelby and its partners (healthcare institutions, government, businesses, academic institutions, the faith community, philanthropic entities and social service agencies) have taken on three major drivers of Shelby County’s poor health outcomes and high medical costs: infant mortality, chronic disease, and end-of-life care.

Working with the Institute for Healthcare Improvement (IHI), Healthy Shelby’s efforts employ three strategies:

- Community campaigns
- System-level change
- Advocacy

The work of Healthy Shelby’s Infant Mortality team is a good example of how these three strategies are being applied to affect the community’s health, healthcare and cost.

**Community Campaign**

Babies should sleep **Alone**, on their **Backs** and in a **Crib**. That’s the basic message of Healthy Shelby’s recently launched Safe Sleep campaign. Healthy Shelby and its partners hope to reduce by 25% the number of Shelby County babies that die due to sleep-related incidents each year. That’s eight more babies born this year who could live to see their first birthday.

Every year in Shelby County approximately 30 babies suffer preventable deaths -- deaths caused by unsafe bedding, sleeping with an adult, or not sleeping on their backs. Healthy Shelby’s Safe Sleep campaign aims to educate everyone who cares for infants about safe sleep practices for babies.

The national **Back to Sleep** campaign, introduced twenty years ago, contributed to a 50% reduction in the rate of SIDS. But progress has slowed in recent years - in part because of an increase in a phenomenon known as co-sleeping. A paper presented at the 2014 Pediatric Academic Societies meeting in Vancouver reported that 19% of mothers co-sleep or share a bed with their baby. That’s more than double the rate of co-sleeping reported in the early 90s. Although some parents and
healthcare providers maintain that co-sleeping is safe, infants that sleep with adults are three times more likely to suffocate than infants who sleep alone. Bed-sharing is most common among black and Hispanic families; nearly one-third of black parents surveyed in 2010 said their baby slept with an adult or another child. Co-sleeping may be increasing as more mothers choose to breast-feed. So as providers encourage mothers to breastfeed, they must accompany that advice with education about safe sleep practices for the baby. Shelby County data indicates that babies most at risk from sleep-related deaths are the very young and the very small -- infants that are developmentally unable to clear their airways by turning their heads or removing objects that cover their mouths or noses.

In addition to placing babies to sleep on their backs, the new Safe Sleep campaign focuses attention on co-sleeping and other factors that contribute to sleep-related infant deaths. Using social media -- including a free mobile app, Baby2Sleep, a Facebook page (Baby2Sleep) and a text messaging platform (text Safe Sleep to 90105), Healthy Shelby partners (the Shelby County Health Department, LeBonheur Children’s Hospital, the Early Success Coalition, the Office of Early Childhood and Youth, Baptist Women’s Hospital, Regional One Health, Agape Child & Family Services, the Shelby County Breastfeeding Coalition and the Step Ahead Foundation) are encouraging everyone -- including providers -- to save babies lives by spreading the word about safe sleep practices.

System-Level Change and Advocacy
Memphis ranks #49 among the 50 largest cities in the US in the percent of women receiving late or no prenatal care. There are many reasons women may not access prenatal care but poor access is one that Healthy Shelby believes can be alleviated. Last fall, obstetrician practices that accept TennCare patients were contacted to determine whether they accept pregnant patients during the 45-day “presumptive eligibility” period for TennCare. Twenty-two of 40 practices contacted (55%) reported that they do not accept women who are presumptively eligible due to concerns that such patients will not complete the TennCare application process and thus leave the practice at financial risk. Using data compiled by the Department of Human Services, Healthy Shelby staff determined that only 11% of women who apply for TennCare via the presumptive eligibility program fail to obtain TennCare insurance -- a small number considering the potential health risks that result from denying pregnant women access to care. Healthy Shelby plans to address this issue by advocating for changes in the TennCare application process that will make it easier for pregnant women to get insurance and by educating providers about the relatively low risk involved in accepting pregnant patients during the presumptive eligibility period. If you are an obstetrician who accepts TennCare, please contact staff at Healthy Shelby at 901-684-6011 to learn more.

AWKWARD ENCOUNTERS: Best Practices for Collecting From Your Patients
By Jackie Boswell, MBA, FACMPE, SVMIC Senior Medical Practice Consultant


Do you know how many patients left your office today without paying their co-pay or making a payment on a past due balance? Were they even asked to make a payment or informed of their balance? Improving your practice’s collections should start with the practice leadership setting the
expectation. A few small, but concrete steps to set policies and procedures, train and educate staff, and educate and inform patients can go a long way to increase your bottom line.

Patient co-pays have increased from $10 to a norm of $30, $40, and even $50. With the increasing costs for employers to provide health care, coverage has been trending toward larger co-pays and patients are shouldering a larger percentage of health care costs, including purchasing high deductible health care plans (HDHPs) where the patient is responsible for 100% of the cost of non-preventive care up to the deductible limit. Annual patient deductibles have risen from $200 and $500 to $1,000 and sometimes even as high as $5,000. The industry is in agreement that approximately 30% of a practice’s expected payment is due from patients.

According to Elizabeth Woodcock, MBA, FACMPE, CPE, copayment collection is just a start. "You’ll want to add collections of all outstanding balances (one day old – or months past-due) and non-covered services, in order to improve collections and save statement costs. For uninsured patients, collect the full fee or set a minimum “deposit” such as $100.”

**Educate Your Patients**

One of the first steps to increase your up-front collections is education. When patients schedule their appointments over the phone, tell them that co-pays are due at time of service. Why limit this strategy to co-pays? If a patient has a balance for a deductible, coinsurance or uncovered services, configure your computer system to remind the appointment clerk to ask the patient for a credit card payment or to bring the money to the next visit.

**Implement Co-Pay Collections Policies and Procedures**

The ideal time to collect co-pays from the patient is when they are in your office and prior to seeing the physician. Once they leave your office, collections become more expensive and more difficult. Factoring in postage, supplies, and labor, the cost of billing and collecting a co-pay can be nearly as much as the amount of the co-pay itself!

Adopt a written financial policy (approved by the physicians) – to be shared with your staff – that states the collection of co-pays is required prior the patient’s appointment. Collecting co-pays at the point of check-out is not ideal. A written policy helps ensure that all staff members and patients are aware of practice’s expectations and understand the policy.

**Communicate With Patients**

Informing your patients about your new policy is one key to successful implementation. Utilize various means of communication:

- Place prominent but tasteful signage in the office that says, "Your insurance company requires that we collect your co-payment at time of service." (A framed document looks professional...no handwritten signs!)
- Develop a brochure concerning the new policy (and perhaps includes other policies as well) and display it prominently in the waiting room and at the check-out window.
- Post your policy prominently on your website.
- Include an announcement about your new policy on your recorded telephone message.
- Upon check in, assign a patient advocate or counselor to explain your new policy. Have patients read and sign a form acknowledging their understanding of the policy.
- When a patient calls to make an appointment have the scheduling desk to remind them of your policy, inform them of their balance, and ask for payment.

One key to operating a successful medical practice is to run your practice like the business it is. Patient co-pays, co-insurance and deductibles are a growing part of your financial picture and are part of your income. Don’t let them just walk away!
Excuses! Excuses!

Collecting at the time of service should be part of the routine for your front office staff, as normal as verifying and documenting insurance coverage and scheduling appointments. Train your staff to be professional, courteous and kind but also to be consistent and firm. Everyone on the team needs to recognize that co-pays are a significant amount of the total revenue of the practice.

Below are some sample patient collection scripts from Medical Group Management Association (MGMA):

Patient: "I didn't know I owed this."
Response: "Your insurance company and our office sends statements informing you of your obligation. We call all patients with balances and remind them that payments are due. We called you on _______. The doctor has performed a service and should be paid for it."

Patient: "I don't have any money with me."
Response: "We accept all major credit and debit cards. We do require patients to pay for the services the day they receive them, and did inform you of our office financial policy. It is your responsibility to know your insurance and pay for the portion that is not covered. Would you like to go and make the payment or reschedule your appointment?"

Patient: "I forgot my checkbook."
Response: "We accept all major credit and debit cards. I can swipe your card today and preauthorize any future payments so you won't have to worry."

Patient: "I mailed a payment just yesterday."
Response: "Oh, you should have saved the stamp since you had a scheduled appointment and brought the payment with you. That way we would have no questions about a payment being due. I can swipe your credit card and preauthorize a payment. We won't charge your credit card unless we don't receive the payment."

Patient: "I just lost my job."
Response: "I am so sorry. This is affecting so many people. Unfortunately, we are being affected by this economic downturn as well, and unless we collect what is owed, we can't pay our bills here and then we are at risk of losing our jobs. I can offer you a payment plan or refer you to a subsidized clinic."

Patient: "I'll pay you after the doctor sees me."
Response: "I understand your frustration and know that this may seem unusual, but we are bound by our contracts with the insurance company to collect from patients before they are seen. We don't make these rules but are forced to follow them and pride ourselves on running an ethical and legal practice."

Patient: "I never had to do this before. No other doctor's office does this."
Response: "I can't speak for other offices, but we are following our contract requirements with insurance companies or our office policy. I am sure you will start seeing this more in the future. We pride ourselves on being recognized as one of the top 10 urology practices in the country for our administrative procedures since we really try to do everything to the letter of the recommended practices."In sum, the PPACA is a piece of legislation that aims to decrease the number of uninsured individuals in our country through insurance marketplaces or exchanges in each state. PPACA’s reach into our abilities as physicians to practice medicine goes well beyond the abilities of individuals to sign up for coverage through the federal web sites. Important questions include whether or not the physician is in network for that patient's plan, whether the plan carries a high deductible, and whether the patient’s portion of the plan’s monthly premium is currently paid up or is delinquent, since the insurance company may not pay part of the cost for evaluation or treatment after the first 30 days of delinquency of premiums. Accordingly, attention to the details of our patient’s policies is of vital importance.
Select Health Alliance Update
By Henry Sullivant, MD, Chief Medical Officer

Baptist Memorial Health Care Corporation (BMHCC) of Memphis and a group of physician leaders formed Select Health Alliance (SHA) in August 2011. Following a Federal Trade Commission ruling in 1997, physicians and hospitals were permitted to form clinically integrated networks, such as SHA. Once certified by the FTC, these networks can jointly contract and discuss operational delivery of care if their intent is to improve quality, remove inefficiencies in care delivery, reduce costs, and thereby produce a better model for healthcare for their community. Prior to the ruling by the FTC, open discussion of operational matters could have been interpreted as collusion or price-fixing. SHA successfully achieved certification in October 2012. Having served as the chair of the board from the company’s beginning, I was hired as Chief Medical Officer of Clinical Integration for BMHCC in early 2014. In this role I also serve as Chief Medical Officer for SHA.

As treatment has improved for simple and less complicated conditions, most physicians have retreated from the hospital setting to outpatient facilities where care delivery is quicker, simpler, and cheaper. The result has been a loss of collaboration needed to address more complicated patient illnesses. Interrelationships among physicians have suffered, as has coordinated care. Active participation in medical staff meetings and in community medical organizations has declined. Patient trust and respect for physicians and hospitals has also suffered. Dissatisfaction both within the healthcare community and outside, finds “feasibility for change and desirability of a better state exceeds the perceived cost of change.”

The goal of SHA is to provide Memphis and the Mid-South with a superior quality healthcare network that is more efficient, less costly, and improves the patient and family experience as they access care. As it develops a collegial and collaborative relationship among physicians and the hospital system, SHA strives to close gaps in care. Payment model reform, such as ‘pay for performance’ or ‘shared savings’, and the Affordable Care Act have imparted a sense of urgency to change the way care is delivered in our community. Employees and other purchasers of healthcare also recognize the benefits of clinical integration.

In October, SHA secured the contract to manage the Memphis employees of BMHCC, totaling over 8,000 lives. This contract will begin in January 2015. In addition, BMHCC asks SHA to expand its clinically integrated network outside of Memphis to include its hospitals in Mississippi, West Tennessee, and Arkansas. By January 2016, SHA will manage over 22,000 employees in 14 hospitals in three states.

To meet this challenge, SHA needs to quickly expand. Local, regional, and system governance infrastructure needs to be built. The “what’s in it for me” message needs to resonate in small cities throughout the Mid-South whose medical communities culturally differ. The stakeholders in each hospital vary significantly as does the size of each hospital and its medical staff.

The Federal Trade Commission demands that clinically integrated networks have strong internal governance which excludes from the network physicians whose quality performance is lacking. In order to identify performance inadequacy, data extracted from medical records must be accurate and infallible. BMHCC is 18 months into a three-year campaign to convert all points of care delivery (primarily inpatient) to EPIC electronic records. Outpatient and office-based electronic health record systems vary from practice to practice. Inter-connectivity via HIE in Memphis is incomplete and has not yet begun in the healthcare communities outside the city. Accurate data extraction has not been achieved since the EHR conversion started. Proper charting and coding has proved difficult and inadequate. Extracting performance metrics, which measure successful patient care, means practices must trust SHA to protect their proprietary interests as they yield patient information.

Managing the health care of a population of patients in hope of removing redundancy, improving inefficiencies, and reducing the dollars spent, while simultaneously improving their health to minimize future spending, has been the goal of many since Medicare was introduced 40 years ago. The challenge to accomplish these goals is even greater in today’s healthcare marketplace, where congenial and collaborative relationships among physicians only marginally exist. Most care is rendered disparately through outpatient, ambulatory centers where physicians rarely need to interact. Nevertheless, population health management necessitates a collective understanding of the disease states represented and consensus-building to design and successfully implement care models to meet expectations.

As the Chief Medical Officer of SHA, I look forward to working with you to achieve success.
Retirement offers you the chance to finally spend your time and money exactly as you want. But you need a roadmap to ensure that happens.

Building a retirement income plan is one of the best ways to help ensure a financially secure and rewarding retirement. This planning will answer key questions such as: How much income do you need each year or month in retirement to achieve your lifestyle goals? Which assets make sense to build your income stream from, and how do you maximize that income? How do you protect your wealth from risks such as healthcare costs, rising inflation and market downturns?

“An income plan, especially a written one, takes the emotion out of the decisions we make before and during retirement,” says Bill Scofield, Director of Wealth Planning for Regions Private Wealth Management. “We can look at the numbers and say, ‘Here are the needs we project, here are the goals, and here’s what we have to do to get there.’”

FIRST STEPS:

The ideal time to start working on such a plan is well before retirement, Scofield says, because that will give you the most options and flexibility for designing an effective income and investing strategy. If you fail to plan – even if you are very wealthy – you may worry about how long your assets will last. Even worse, you may have to make lifestyle sacrifices as your retirement progresses. But, take heart: Even if you didn’t start early enough, you can still take steps today to create or improve your plan.

PUTTING IT TOGETHER:

Some people start to think about retirement goals in their 20s and 30s. But serious retirement income planning often doesn’t start until the late 40s or early 50s, Scofield says. That’s when you’ll likely start to get a sense of what your retirement lifestyle might look like and how you might pay for it. By starting your planning at this stage of your life, you have the time to make decisions that can make a big impact on your lifestyle years down the line.

Using your current lifestyle as a base, you can imagine what expenses might diminish or disappear – a child’s college expenses or mortgage payments, for example – and which might increase, like travel or healthcare costs.

You can then make projections about your income. What do you expect to receive from your stake in a professional practice, business or land ownership? Rental property income? 401(k) plans or other investments? Pensions? Social Security?

It’s a good idea to review your retirement income plan at least once a year. You’ll also want to review the plan after a major upturn or downturn in the markets or in response to a significant life change.

INVESTING WITH CARE:

Wealthy individuals and couples often have unique retirement planning concerns and more options for how to generate their income. Smart investment management is key. Some key retirement investing questions to address:

- Do you need to access more than the income from your investments (dividends and interest) or will you periodically spend down your principal?
- How much can you afford to withdraw from your principal at different stages in retirement while ensuring your savings last throughout your lifetime?
- How should you invest your assets based on your risk tolerance, time horizon, market conditions and other factors?
- Which assets should you convert into income, and when?
NAVIGATING LOW INTEREST RATES:

Many retirees worry about how to generate sufficient income when interest rates are low. “When the interest our clients can receive from CDs, bonds or the like is not sufficient, then our clients worry they’ll have to start digging into principal to meet their needs,” Scofield says. But selling assets or reducing your spending are not the only ways to address this problem, he adds. Depending on your risk tolerance, more of your portfolio could be invested in assets that create larger income streams, such as high-quality dividend-producing stocks, real estate investment trusts (REITs), or Treasury Inflation Protected Securities (TIPS).

FURTHER OPPORTUNITIES:

Beyond investment management and retirement withdrawal considerations, you may have more complex needs and goals that an advisor can help address. Investors who want the freedom to spend down their principal yet still leave money to heirs or charity, for example, may want to consider using life insurance as a vehicle for achieving both goals, Scofield says. When properly structured, a life insurance policy’s benefit can be held in an irrevocable life insurance trust (ILIT) outside the estate and be exempt from estate taxes.

Other types of trusts, including charitable trusts, grantor retained annuity trusts and living trusts, can also help with trying to couple retirement income planning with longer-term estate planning goals.

FINE-TUNING YOUR PLAN:

As you get older and progress further into retirement, you may have fewer viable options for designing an effective income plan. That’s why it’s so important to plan ahead. But there are always options for adjusting your investments when you’re already retired, Scofield says. “It all comes down to planning, diversification, and monitoring your retirement plan,” he says. “And that’s true both as you’re approaching retirement and when you’re progressing through it.”

In addition to customized Private Wealth services, Regions also provides a variety of personal and business banking needs. Stan McKinney, Branch Sales Manager, can connect you with the appropriate Regions associate to help you realize your goals. Stan can be reached at 901.762.7834 or by email (stan.mckinney@regions.com).

Match Day 2015

Frank Anderson
2015 Match Day
Justin Hunter

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CMS extends meaningful-use deadline, this time for providers

By Darius Tahir  |  February 25, 2015

The CMS, in another show of flexibility on the meaningful-use program, extended the attestation deadline until March 20. That gives eligible providers more time to demonstrate that they have fulfilled the requirements set forth by the electronic health-record incentive program and so avoid payment penalties.

The previous deadline for attestation was Feb. 28. The extension is “not necessarily a surprise,” said Jeff Smith, vice president of public policy at the College of Healthcare Information Management Executives. That’s because of the flexibility CMS already has given to attesting providers and hospitals. “Most anticipated that this announcement could be coming,” Smith said.
The main question Smith has now is how many eligible providers will take advantage of the temporary reprieve. The extension for hospitals was relatively successful, he said, with a “few hundred” taking advantage. But Smith points out that relatively fewer eligible providers participate than eligible hospitals, meaning that the effect could be blunted.

The agency has shown a recent willingness to tinker with the meaningful-use program. Besides the extensions, the agency also has allowed providers and hospitals to attest to meaningful use with earlier versions of EHR technology than originally anticipated, to cite one example.

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**2015 Professional Privilege Tax is Due June 1st**

March 4, 2015

Every physician with an active license from the Tennessee Board of Medical Examiners (BME) or Board of Osteopathic Examination (BOE) is required to pay a professional privilege tax by June 1st of each year. Physicians will not receive a reminder from the licensing board and only those who have previously signed up for e-mail reminders will receive them from the Department of Revenue.

**Exemptions from Payment of the Tax**

There are three exemptions available for physicians:

1. Filing an affidavit of retirement with the appropriate licensing board; or
2. Inactivation of the medical license (available only for physicians practicing solely outside of Tennessee); or
3. Active military service.

Many physicians in the past have called TMA thinking that no tax was due because he/she had retired from practice. As long as the medical license is active, a physician is responsible for the tax. The license must be retired before the June 1st due date. By filing an affidavit of retirement, a physician may no longer engage in the active practice of medicine, including writing a prescription or treating the occasional patient.

   [BME Affidavit Retirement Form](#)

   [BOE Affidavit Retirement Form](#)

**Electronic Payment of Tax**

The tax must be paid electronically unless this causes the individual a hardship and that hardship is approved by the Department of Revenue. Typical hardships approved may be taxpayers who do not own a computer, taxpayers who do not have access to the internet and taxpayers whose religious beliefs prohibit the use of computers and related technology. Call 800.342.1003 to request a hardship waiver from paying the tax electronically. A waiver does not excuse the requirement to timely pay the tax.

**How to Pay the Tax**

To electronically file the professional privilege tax return, you must have either your Social Security Number or your professional privilege tax account number. A licensee may begin paying the tax due on June 1, 2015 beginning January 1, 2015. If you do not know your account number, you can access this information on the [Tennessee Department of Revenue’s website](#).

   [Pay Individual Privilege Tax](#)

   [Company to Pay Multiple Privilege Tax](#)
Once the tax is paid, a confirmation page will come up and it should be printed for your records. This is the only chance you will have to print this confirmation. Call the Electronic Commerce Unit at 866.368.6374 if you encounter any problems paying the tax online.

**Penalty for Nonpayment**

A licensee that does not pay the tax is usually assessed a monetary penalty by the Department of Revenue. Continued nonpayment of the tax could result in the revocation of an individual’s license.

**E-mail Notification**

If a licensee has provided his/her e-mail address to the Department of Revenue in the past, an e-mail reminder to pay the tax will go out sometime in April. Physicians can register to receive e-mail updates from the Department of Revenue.

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Below you’ll find a summary of the highest priority legislative initiatives that the Tennessee Medical Association has won on behalf of Tennessee physicians. Contact us to find out how our government relations team can help you and your practice.

**Neal S. Beckford, MD**

**2015 TMA Legislative Package Beginning to Move**

**URGENT: ACTION REQUIRED**

- **Addiction Treatment** SB871 by Senator Steve Dickerson, MD (R-Nashville)/HB1036 by Representative Ryan Haynes (R-Knoxville)

  **Status:** Scheduled for House Health subcommittee Tuesday at 1:30pm in LP30. The bill was not heard in subcommittee because a few subcommittee members had concerns about the Good Samaritan provision. TMA is working with subcommittee members on their concerns. Senate Health approved the Addiction Treatment Act unanimously on Wednesday. It could be on the Senate floor next week.

  For a number of years the legislature has tried to address Tennessee's prescription drug problem by placing regulations on those writing the prescriptions, without properly addressing issues related to the identification and availability of appropriate treatment. The Addiction Treatment Act of 2015 seeks to address several issues that are barriers to identifying those who need treatment and ensure that some of the most important treatment options are prescribed appropriately. The bill has a three-pronged approach:

  1. Provide Good Samaritan protections for an individual who is having a drug overdose or in good faith seeks medical assistance for another person who is experiencing or believed to be experiencing a drug overdose.
  2. Limit the prescribing of buprenorphine/naloxone to healthcare providers with a DEAx license and only in circumstances in which the FDA has approved the use of the drug.
  3. Repeal a section of the code that discourages providers from identifying individuals who may be under the influence of alcohol or illegal drugs when seeking treatment.

**CALL TO ACTION.** Please contact your legislator and ask that they support the Addiction Treatment Act SB871/ HB1036.

- **Payer Accountability** SB937 by Senator Bo Watson (R-Hixon)/HB963 by Representative Jon Lundberg (R-Bristol)
Status: Scheduled for Joint Committee on Pensions and Insurance Monday at 3:30pm in LP29. The bill was in Senate Commerce this week, but action must first be taken by Pensions and Insurance. Once Pensions and Insurance makes a recommendation, Senate Commerce plans to hear the bill March 17.

Atop the TMA's list of priorities is the return of Payer Accountability. The purpose of the bill is to reduce insurance companies' ability to arbitrarily change reimbursement terms in the middle of a contract. In 2014, Payer Accountability legislation was filed, heard and passed in numerous committees. The bill's sponsors ultimately felt that continued discussions were warranted. TMA staff and members spent countless hours throughout the summer and fall meeting with insurers to discuss options for legislation in an attempt to reach a compromise. While various ideas were discussed, the ultimate goal for Tennessee's physicians remains the same: predictability and stability. Sen. Watson says he wants to move the bill as it passed last year. However, there is a desire to see if both sides can get closer to a compromise. We do not know if that will happen before the Committee meets on Tuesday.

Bill of Interest

Intractable Pain SB157 by Senator Janice Bowling (R-Tullahoma) / HB31 by Representative Ryan Williams (R-Cookeville)

The bill to delete the Intractable Pain Act passed the House Health committee on Wednesday and the Senate floor last week. It could be heard on the House floor as early as next week.

Unlike last session, there has been virtually no debate on repealing the Intractable Pain Act. It is expected to stay the course and go to the governor for his signature in the coming weeks.

The Intractable Pain Act is a law that was designed to encourage prescribers to feel comfortable if they chose to prescribe pain medications to patients who claimed to have intractable pain. It includes language that many believe forces prescribers to give patients these medications even if, in the professional judgment of the prescriber, they are not convinced the patient needs them.

CALENDAR OF EVENTS:

Monthly Meetings: Third Wednesday of each month, Academic Lecture & Monthly meeting

2. NAACP Freedom Gala: March 24, 2015
5. Community Health Fair/UTHSC/MMS: July 18, 2015
6. NMA National Convention, Detroit, MI: August 1, 2015
7. 43nd Annual Walter Evans Memorial Sickle Cell Golf Tournament: September 5-6, 2015
8. BCMS/Auxiliary Picnic: September __, 2015
9. 5K Walk for The Sickle Cell Foundation of TN: October 17, 2015
10. Men's Health Symposium: November 7, 2015
11. Annual Lecture and Holiday Gala, November 13, 2015
Board of Directors

Lanetta Anderson, MD
President
Women's Physician Group
1469 Poplar Avenue
Memphis, TN 38104
(901)276-3222
(901)276-1398
lanetta1@aol.com

LaTonya Washington, MD
Secretary
Regional One Health Extended Care Hospital
890 Madison Ave., 4th Fl., Turner Tower
Memphis, TN 38103
(901)765-3045
drlwashing@gmail.com

Gerald J. Presbury, MD
Past President
UT Medical Group
777 Washington Avenue, P110
Memphis, TN 38105
(901)448-2000
(901)287-6122
GPresbury@uthsc.edu

Perisco Wofford, MD
President-Elect
4567 Millbranch
Memphis, TN 38116
(901)276-6277
(901)276-6220
Perisconnor@aol.com

Henry Stamps, MD
Chaplain
Collierville Medical Specialists
526 Halle Park Dr
Collierville, TN 38017
(901)854-1877
(901)854-6181
HBStamps@pol.net

Brenda M Hardy, MD
Vice President
Women's Healthcare - Office of Obstetrics & Gynecology, P.C.
2900 Kirby Parkway, Ste. 11
Memphis, TN 38119
(901)345-4640
(901)346-2892
brenthayden13@gmail.com

Ottis Anderson, MD
Parliamentarian
First Counseling Inc
5185 Getwell Road
Southaven, MS 38671
(901)662-893-6300
oanderson3@rocketmail.com

Claudette J. Shephard, MD
Past President
UT Medical Group
7945 Wolf River Blvd, Suite 320
Germantown, TN 38138
(901)347-8320
(901)302-2535
Cshephard@uthsc.edu

Brenda M. Cooper
Vice President
Women’s Health Advocacy
1588 Union Avenue
Memphis, TN 38104
(901)322-0251
(901)322-0259
jarvreed@comcast.net,
jreed@westclinic.com

Diane Rayford, PhD, MD, MBA
Immediate Past President
The Urology Group, PC
6029 Walnut Grove, Suite 300
Memphis, TN 38120
(901)767-8158
(901)767-1555
popeyewhr@aol.com

Janice P Cooper
Executive Assistant
The Memphis Medical Society
1067 Cresthaven Road
Memphis, TN 38119
(901)388-8010
(901)761-2944
jcooper@mdmemphis.org

Stanley W. Dowell, MD
Past President
Eastmoreland Internal Medicine
1325 Eastmoreland, #245
Memphis, TN 38104
(901)729-3700
(901)729-3750
smd7730778@aol.com

Danielle H Hassel, MD
Treasurer
Memphis VAMC
1030 Jefferson Avenue SCI 128
Memphis, TN 38104
(901)901-577-7373
(901)901-577-7376
daniellehassel@gmail.com

Jarvis D. Reed, MD
Past President
The West Clinic
1588 Union Avenue
Memphis, TN 38104
(901)322-0251
(901)322-0259
jarvreed@comcast.net,
jreed@westclinic.com

Neal S. Beckford, MD
Past President
Otolaryngology Associates of MidSouth
7675 Wolf River Circle, #202
Germantown, TN 38138
(901)737-3021
(901)737-6063
voicedoc@aol.com

Drs. Esther E. Williams-Neal, Dr. St. Melrose Blackett

The Bluff City Medical Society
P.O. Box 17924 Memphis, TN 38187-1878 901-344-8010(P) 901-761-2944(F)