MARCH/APRIL 04

Maine medicine

MAINE MEDICAL ASSOCIATION

In this issue...

This year's Keynote Speaker, U.S. Attorney Paula Silsby

U.S. Attorney Paula Silsby to Keynote 13th Annual Seminar

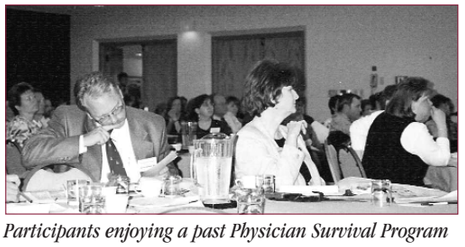
U.S. Attorney Paula Silsby will update physicians and practice managers on enforcement/compliance issues at MMA's 13th Annual Physician Survival Seminar. Program details and registration materials are enclosed with this issue of Maine Medicine.

The annual survival program gives physicians and practice managers an opportunity to get caught up, in one setting, on the myriad of compliance issues requiring attention. In addition to the U.S. Attorney's presentation, attendees will learn about Maine's new electronic prescription monitoring system (effective July 1, 2004), Dirigo Health, MaineCare, and the following additional topics:

- Enforcing Your Payor Contracts
- Your Relationship with Drug Reps
- Preventing Drug Diversion
- Legislative/Regulatory Update
- Board of Licensure in Medicine Update
- HIPAA Security Regulations
- Human Resource Track
- The Criminalization of Medical Practice
- Common Sense Compliance for Physician Offices
- Impact of C.O.N. Changes on Your Practice
- Preventing Medical Malpractice; Partnering with Patients
- Employment Law
- Disease Management
- Reimbursement

The popular programs will be held this year on Wednesday, May 26 at the Hilton Garden Inn in Auburn and Wednesday, June 23 at Spectacular Event Center in Bangor.

Any questions concerning the program can be addressed to Chandra Leister at 622-3374 or through e-mail at cleister@mainemed.com.



Participants enjoying a past Physician Survival Program

"Doctor of the Day" Program Heightens Physician Visibility

The Maine Medical Association and Maine Osteopathic Association again this year sponsored a "Doctor of the Day" Program at the State House during the legislative session. Each day during the session, an M.D. or D.O. donated time to be available to assist in any medical emergencies that might occur. After being introduced in the House and Senate, the physician was free to observe the legislative action and attend any hearings or work sessions of interest. Many thanks to the volunteers who participated this year.

Any physicians wishing to participate next year may contact Charyl Smith at 622-3374 or e-mail csmith@mainemed.com.

State Representative Darlene Curley (R, Scarborough) (on left) greets Lisa Letourneau, M.D. on her day serving as "Doctor of the Day" at the State House.

"Doctor of the Day" Volunteers for 2004

William Atlee, M.D.
Mark Bolduc, M.D.
Adele Carroll, D.O.
Ned Claxton, M.D.
Laurel Coleman, M.D.
Craig Curtis, M.D.
W. Gregory Feero, M.D.
Tracy Haas, D.O.
Jennifer Hartman, M.D.
Jennifer Hayman, M.D.
Richard Kappelmann, M.D.
Joel Kase, D.O.
Kathleen Lees, PAC
Lisa Letourneau, M.D.
Richard Marino, M.D.
Peter Mason, D.O.
Sean McCloy, M.D.
Sarah Morgan, M.D.
Ray Nichols, M.D.
Lucien Ouellette, M.D.
Stephanie Phelps, M.D.
Kristine Pleacher, M.D.
Edward Pontius, M.D.
David Preston, M.D.
Victoria Rogers, M.D.
Alan Ross, M.D.
Lisa Ryan, D.O.
Dave Salko, M.D.
Peter Sedgwick, M.D.
A. Catriona Shepherd, M.D.
Curtis Smith, M.D.
Chris Stenberg, M.D.
Kathleen Thibault, D.O.
Edward Tumavicus, M.D.

President's Corner

Maroulla Gleaton, M.D., President, MMA

Collaboration

Things are a little tense down at the State House these days surrounding the issue of balancing the supplemental budget for July 2004 – June 2005. Patients have expressed themselves quite clearly: once you have given out the benefits you can't just turn around and take them away without a public outcry. Even if there is not enough money to go around you have to find a way to fund the benefits. Providers are feeling the pressures as well.

Physicians are at the rock bottom of the Medicaid reimbursement scale so that they really can't go much lower. We are being asked to see more and more patients at below the cost of delivering the care. We are burdened with ever increasing paperwork and hassles in terms of justifying and switching drug therapies through PDL formularies to save the state pharmacy costs for Maine Care patients. Already indignant about justifying therapeutic modalities, doctors patiently fill out the lengthy paperwork to explain why the patient needs a certain treatment that can still be turned aside. It is easy to throw up one's hands in frustration.

The Government has turned to hospital providers as a way to slash funding because their reimbursement through Medicaid has been much better over the years compared with physician providers. Hospitals were dubious about tax and match in the first go round of cuts. Now that it is time to pass yet another supplemental budget, they are apoplectic about the second set of cuts. Hospital interests have accused the MMA of lobbying the Baldacci administration to reduce fees paid to hospital employed physicians. This affects at least seven hospital systems: CMMC, EMHC, Franklin Memorial, Maine Coast, Mayo, Mid-Coast and Maine Health. MMA would never advocate a position that would put one group of physicians at a financial disadvantage to favor another group of physicians. The MMA takes great pain and effort to try and fairly represent and advocate for all physicians in Maine. We would never lobby to reduce physician reimbursement, period. Rather we have asked that the state bring up the Medicaid reimbursement to make things more equitable across the board.

> "We all must work harder and exercise the "C" words of COLLABORATION, COMMUNICATION, & COMPROMISE."

Despite explaining this formally to hospital CEO's and everyone else verbally and in a written reply, some still do not choose to believe us. I would submit that it is to their benefit that physicians are pitted against each other and the entity they are affiliated with somehow benefits from this divisiveness between doctors who are hospital-based verses those who are in private practice. The proposed cuts do not affect all hospital employed physicians or Rural Health Centers, but physicians that have been brought into the hospital by converting to "Provider-based." The MMA formally testified in opposition to the decreased physician reimbursement for hospital based physicians.

Let me make a plea. We are all patients at one time or another in this state of Maine. We have large health care issues to solve here: cost shifting; a geographically scattered, poor population; a relatively ill and aging population; a less than robust public health infrastructure; high insurance premiums compared to other states; etc. It is going to take all of us together - patients, physicians, hospitals, ancillary personnel, and carriers to solve these health care delivery problems to any degree at all. We all must work harder and exercise the "C" words of COLLABORATION, COMMUNICATION, and COMPROMISE. I submit it is the only reasonable means to a more healthy future for all of us and our progeny.

Any thoughts, comments or questions can be directed to me, Maroulla Gleaton, M.D., by calling 207-622-3185, faxing 207-622-5697, or emailing gleaton@adelphia.net.

Upcoming Specialty Society Meetings

APRIL 15-16, 2004 *The Marriott Sable Oakes - South Portland, ME*
Maine Academy of Family Physicians and Maine Psychiatric Association Joint Educational Session
Note: *In addition, the Maine Psychiatric Association will hold a general membership meeting on Friday evening, 4/16.*
MMA Contact: Warene Chase Eldridge 207-622-3374 or weldridge@mainemed.com

MAY 7, 2004 *The Harraseeket Inn - Freeport, ME*
Maine Society of Eye Physicians and Surgeons – The Eye MDs Spring Meeting
12:00pm - 4:30pm
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

MAY 8-9, 2004 *Samoset Resort - Rockport, ME*
Maine Chapter, American Academy of Pediatrics Spring Conference
MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

JUNE 4 - 6, 2004 *Asticou Inn - Northeast Harbor, ME*
Maine Chapter, American College of Surgeons Meeting
Contact: Joel D. Lafleur, M.D. 207-596-6636 or jlafleur@penbaysurgery.com

OCTOBER 1, 2004 *Bar Harbor Regency - Bar Harbor, ME*
Maine Society of Eye Physicians and Surgeons Fall Business Meeting
(To be held in conjunction with the 3rd Annual Downeast Ophthalmology Symposium)
10:30am – 12:30pm
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

OCTOBER 1-3, 2004 *Bar Harbor Regency - Bar Harbor, ME*
3rd Annual Downeast Ophthalmology Symposium
(Presented by the Maine Society of Eye Physicians and Surgeons)
MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

OCTOBER 1-3, 2004 *The Colony - Kennebunkport, ME*
District I ACOG Meeting
MMA Contacts: Chandra Leister or Ann Verrill 207-622-3374 or cleister@mainemed.com or averrill@mainemed.com

NOVEMBER 13, 2004 *Augusta Civic Center - Augusta, ME*
Maine Chapter, American Academy of Pediatrics Fall Conference
MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

MMA Welcomes Our Newest Corporate Affiliates:

Apgar Office Systems
Appletree
Integrity
Morning Glory Enterprises, Inc.
Schering-Plough Corporation

We appreciate their support!

September

10 11 12

MMA's 151st Annual Session

The Colony – Kennebunkport, ME
"Using Technology to Improve Your Practice"

MMA Welcomes the Following New Members

STEPHEN G. COMEAU, M.D., 417 State Street, Suite 321, Bangor, ME 04401. M.D. from St. Louis University School of Medicine, St. Louis, MO. ***Internal Medicine.***

DAVID H. DUMONT, M.D., P.O. Box 39, Lincoln, ME 04457. M.D. from University of Vermont College of Medicine, Burlington, VT. ***Family Practice.***

THOMAS HANF, M.D., 87 Access Highway, Limestone, ME 04750. M.D. from Ohio State University College of Medicine, Columbus, OH. ***Family Practice.***

SUZANNE HUMPHRIES, M.D., 417 State Street, Suite 321, Bangor, ME 04401. M.D. from Temple University School of Medicine, Philadelphia, PA. ***Internal Medicine.***

MICHAEL LEKE, M.D., 97 Campus Avenue, Suite 6, Lewiston, ME 04240. M.D. from Universite Federale du Cameroun, Centrale Universite des Science. ***General Surgery.***

CHRISTOPHER MAHONEY, M.D., 28 Arsenal Street, Augusta, ME 04330. M.D. from Dalhousie University, Faculty of Medicine, Halifax, Nova Scotia. ***Radiology.***

NATHAN MURRAY-JAMES, M.D., 9 Union Street, Hallowell, ME 04347. M.D. from University of Massachusetts Medical School,Worcester, MA. ***Family Practice.***

MARK B. NAPIER, M.D., 22 Bramhall Street, Portland, ME 04102-3175. M.D. from Boston University School of Medicine, Boston, MA. ***Pulmonary Diseases.***

MAHENDRA R. SHETH, M.D., 140 Academy Street, Suite 5, Presque Isle, ME 04769. M.D. from Medical College MS University of Baroda, Baroda, India. ***General Surgery.***

BARBARA D. SLAGER, M.D., 96 Campus Drive, US Route One, Scarborough, ME 04074. M.D. from University of Texas Southwestern Medical Center, Medical School, Dallas, TX. ***Obstetrics and Gynecology.***

CHARLES A. STALEY, M.D., P.O. Box 200, 8 South Main Street, Madison, ME 04950. M.D. from University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, NC. ***Family Practice.***

RENEE WOLFF, M.D., 10 Andover Road, Portland, ME 04102. M.D. from George Washington University School of Medicine and Health Science, Washington, DC. ***General Surgery.***

Resident Members:

MELISSA COLLARD, M.D., 22 Bramhall Street, Portland, ME 04102. M.D. from Albany Medical College, Albany, NY. She is a resident at Maine Medical Center.

CARL A. GERMANN, M.D., 55 Morning Street, #41, Portland, ME 04101. M.D. from University of Illinois College of Medicine, Chicago, IL. He is a resident at Maine Medical Center.

BYRON P. HATHCOCK, M.D., 190 Pleasant Street, Yarmouth, ME 04096. M.D. from University of South Carolina School of Medicine, Columbia, SC. He is a resident at Maine Medical Center.

GLENN R. LEAVITT, D.O., 22 Bramhall Street, Portland, ME 04102. D.O. from University of New England, College of Osteopathic Medicine, Biddeford, ME. He is a resident at Maine Medical Center.

PETER MANNING, M.D., 22 Bramhall Street, Portland, ME 04102. M.D. from University of Vermont College of Medicine, Burlington, VT. He is a resident at Maine Medical Center.

AMY MATHERS, M.D., 22 Bramhall Street, Portland, ME 04102. M.D. from Loyola University of Chicago Stritch School of Medicine, Maywood, IL. She is a resident at Maine Medical Center.

JOE P. MCKENNA, M.D., 64 Rockland Avenue, Portland, ME 04102. M.D. from University of New Mexico School of Medicine, Albuquerque, New Mexico. He is a resident at Maine Medical Center.

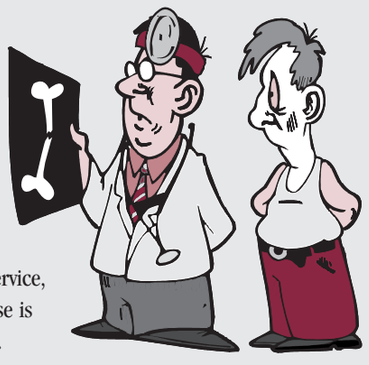
CHRISTOPHER NAUN, M.D., 23 Independence Drive, Windham, ME 04062. M.D. from University of Massachusetts Medical School, Worcester, MA. He is a resident at Maine Medical Center.

TIFFANY P. SEGRE, M.D., 26 Payson Road, Falmouth, ME 04105. M.D. from Temple University School of Medicine, Philadelphia, PA. She is a resident at Maine Medical Center.

Physicians Wanted

NO WEEKENDS, NIGHTS OR HOLIDAYS

The Maine Workers' Compensation Board is searching for physicians to perform independent medical exams under Section 312 of the Workers' Compensation law. The health care provider must be licensed/certified by the State of Maine, have an active, treating practice, be board certified and demonstrate experience in the treatment of work-related injuries. Any exams performed under Section 207 (second opinion) will disqualify physicians from performing Section 312 exams until 52 weeks have elapsed since the last Section 207 exam. Various specialists are needed, including orthopedics, general medicine, physiatry, neurology and psychiatry. In addition to generous compensation for this service, the satisfaction of offering fair, unbiased expertise is a professional contribution to the public interest.



Interested practitioners may send questions or submit CV's to:

Elizabeth A. Inman, Deputy Director
Office of Medical and Rehab Services
Workers' Compensation Board
106 Hogan Road
Bangor, ME 04401
(207) 941-4557
Betty.Inman@maine.gov

Or Contact:

Richard C. Dillihunt, M.D.
41 Berkeley Street
Portland, ME 04103
Dillihunt8@aol.com

UPCOMING AT MMA

APRIL 12, 2004
12:30pm – 3:00pm
Maine Center for Public Health

APRIL 15, 2004
8:30am – 4:30pm
Home Care Alliance

5:30pm – 8:30pm
Committee on Membership and Member Benefits

APRIL 17, 2004
11:00am – 2:00pm
Downeast Association of Physician Assistants

APRIL 21, 2004
6:15pm – 9:00pm
Payor Liaison Committee

APRIL 29, 2004
2:00pm – 7:30pm
Committee on CME and Accreditation

MAY 4, 2004
1:30pm – 3:00pm
Stop Stroke

MAY 5, 2004
2:00pm
Executive Committee

5:30pm
Budget and Investment Committee

MAY 10, 2004
6:00pm – 9:00pm
Committee on Physician Health

MAY 19, 2004
4:00pm – 6:00pm
Public Health Committee

MAY 20, 2004
8:30am – 4:30pm
Home Care Alliance

6:00pm
Maine Psychiatric Association

JUNE 1, 2004
1:30pm – 3:00pm
Stop Stroke

JUNE 3, 2004
Noon – 4:30pm
Home Care Alliance

JUNE 4, 2004
12:30pm – 3:00pm
Maine School Health Education Coalition

JUNE 9, 2004
2:00pm
Executive Committee

THE CODING CENTER

Laurie Desjardins, CPC

Documenting Medical Necessity

We have received many questions lately regarding reviews by NHIC (our local Medicare Part B Carrier) regarding medical necessity for diagnostic tests. As you well know, more and more tests and procedures are being subjected to either prior authorization or formal medical coverage policies. So I thought this might be an opportune time to discuss the dangers of under documenting.

It's important to remember that what you document is key to supporting the medical necessity for the service. Remember that from a coding and auditing perspective, nothing can be assumed. You may look at a note and clearly see from the symptoms or examination why a test is necessary, but if you don't document that thought process, it won't be clear to the reviewer.

Let's talk about everyone's favorite, "Removal of Skin Lesions." NHIC lists the following as indications for coverage:

"Skin Lesions are covered IF medically necessary (not cosmetic). To support medical necessity, you must meet AND document one or more of the following:

1. For benign skin growths, one or more of the following conditions must be present for this procedure to be considered a medically necessary service:
   - The lesion has one or more of the following characteristics: bleeding, intense itching, pain, change in physical appearance (reddening or pigmentary change), recent enlargement, increase in the number of lesions, or
   - The lesion has physical evidence of inflammation, e.g., purulence, oozing, edema, erythema, tenderness, etc., or
   - The lesion obstructs an orifice or clinically restricts vision, or
   - The lesion is in an anatomical region subject to recurrent physical trauma and there is documentation that such trauma has in fact occurred, or
   - Wart removals will be covered when one of the above conditions (1) through (4) are met. In addition, wart destructions will be covered when any one of the following clinical circumstances is present:
     - Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesional virus shedding, or
     - Warts showing evidence of spread from one body area to another, particularly in immunosuppressed patients.
     - Suspicion of malignancy, or to rule out malignancy in a lesion clinically resembling a malignancy, or for histologic diagnosis of a lesion with an uncertain clinical diagnosis.
2. Pre-cancerous lesions can sometimes have a benign appearance, and only after removal are they pathologically determined to be malignant.
3. Treatment of pre-cancerous lesions is considered medically necessary."

(You can find all the Local Coverage Determinations (LCD's) at http://www.medicarenhic.com/ne_prov/policies_final_index.shtml)

Note that some skin tag removal is covered. There isn't, however, a diagnosis you can use to support the need for the removal. This is a perfect example of why documentation is so important. If you do not indicate the reasons for removal the service will be denied as cosmetic and the patient may be responsible for payment (if you have a valid waiver of liability form on file). That information may be documented somewhere in the chart or may seem clear to you, but if you don't reference that information to explain the removal of the tag, you have failed to support the medical necessity of the service. It may seem redundant to you to have to do this, but remember, the reviewer doesn't have the benefit of having the complete chart or listening in on your conversation. (You may have to submit your notes, if the diagnosis alone does not support the medical necessity. So be sure to be clear as to why you felt it was necessary or what you indicated was the need.)

Remember, a little additional information goes a long way to support why you're doing the service or ordering the test. Providing that information at the time of the service will save you the hassle and headache of refunding the payor as a result of an unfavorable review.

By Laurie Desjardins, CPC, Coding/Reimbursement Specialist
Maine Medical Association/NH Medical Society/VT Medical Society
Tel: 888-889-6597, Fax: 207-787-2377
ldesjardins@thecodingcenter.org, jpurrell@thecodingcenter.org

Prescription Drug Abuse

By Tom McDermott, M.D., Chair, Committee on Physician Health

We have all been made aware of problems in the state from the abuse of oxycontin, which has brought us national recognition. The Board of Licensure is watching for cases of inappropriate prescribing and abuse of prescription writing.

This is a big problem in our state and in others. Opiates and other abusable drugs command high prices on the streets of all our cities and towns. We have to become aware of our prescribing practices around these drugs and continually learn and assess our use of these medications in our patients.

The classes of drugs that are abusable are: opiates, stimulants, sedative hypnotics (benzodiazepines, barbiturates), and hallucinogens (Marinol, marijuana). All of us know about opiate abuse and are under greater pressures to prescribe them for chronic pain and end of life pain management. Remember that all opiates and opiate like drugs including propoxyphene and tramadol are potentially abusable and addictive.

With the onset of new awareness and treatment for problems such is ADHD many old and new forms of prescribable stimulants are available and are being diverted in schools and colleges in Maine. Less abusable forms are out on the market, such as Concerta, are not as easily crushed and inhaled or injected. Adolescent use of prescription drugs has risen markedly in the past few years becoming a major issue in this age group. The Maine Association of Prevention Providers has literature for families to help raise awareness.

The sedative hypnotics are the class that most concerns me. I often see known alcoholics and addicts being prescribed these for "sleep and anxiety." These drugs are abusable in their own rights but are contraindicated in this population until other alternatives are exhausted and then require close monitoring and follow-up to insure there is not the development of cross addiction and\or a relapse of the patient on to their original drug of abuse. Maine has a high percentage of prescriptions written for benzodiazepines and there is a workgroup of doctors trying to look at this problem within the state.

The hallucinogens are a more recent class to become available in the state. This is in the form of Marinol and more recently the law allowing limited marijuana use for selected medical conditions. There are situations where marijuana use may be an option but remember that its use impairs cognitive and motor abilities and is the drug most associated with automobile accidents in the United States.

The State through the Office of Substance Abuse will soon be initiating a monitoring system through pharmacy records to give feedback to physicians about their patients' use or misuse and each physician's prescribing practices. This is an opportunity to use the information generated to look at how you prescribe and adjust your use of these medications and improve the health of your patients and the state as a whole.

Leaving No Stone Unturned

(How "Little Gifts" Can Increase your Estate Tax "Exemption")

By Bruce R. Johnson, Esquire and Janet C. McCaa, Esquire, Johnson & McCaa LLC

Sometimes there really *are* simple solutions to complex problems. The owner of a taxable estate may have become weary of useful but lengthy and complex legal documents named with acronyms -- ILITs, GRATs, GRUTs, FLIPs, QPRTs and the like.

But there's also a very simple *partial* solution to the problem of reducing the value of an estate to manageable proportions. This technique -- dubbed the "Nonmarital Spousal Gift Trust" by the lawyer who has done the most to publicize it[1] -- can significantly increase the $3 million estate tax exemption available to a married couple in 2004. Before looking at the arithmetic, let's look at the structure and the mechanics of an "NSG" trust.

It relies on the humble "annual exclusion." An annual exclusion gift is worth $11,000 or less (indexed for inflation), and escapes the tax because Congress determined that some gifts are too small to tax. "Too small" is defined by law as $11,000 or less.

Let's apply this "small gift" concept to a real life situation. Elaine Estateowner is 40. Her estate might be modest or substantial, as long as it is potentially taxable. The small gift concept works well in each situation.

Implementation begins with Elaine's creating a purely discretionary *Crummey* trust for her husband, Ed. "Purely discretionary" means that the trustee alone decides what is distributed from the trust and when. A *Crummey* trust qualifies for the $11,000 annual exclusion from gift tax by granting the trust beneficiary (Ed, in this case) a limited withdrawal right for thirty days after each contribution is made to the trust. (Mr. Crummey -- his real name -- was the first taxpayer successfully to litigate the use of this technique.)

The rules regarding *Crummey* powers may cause a portion of the trust to be included in Ed's estate when he dies, which would defeat a principal purpose of the trust. Thus, Elaine may choose to reduce her gifts to avoid the impact of those rules. The initial reduced amount would be $5,000 annually, which could begin to increase around year 12. If she gave the maximum nontaxable amount each year to the NSG trust and it earned 8% after tax, after eighteen years the restrictive *Crummey* rules would no longer apply. Elaine could begin giving the full $11,000 in year 19.

Ed can do the same thing for Elaine. The terms of the two trusts should be materially different so that IRS can't "look through" the trusts and ignore them.

One way to achieve the 8% after-tax return in an NSG trust is to structure it as a "grantor trust," which simply means that Elaine, as the trust creator, pays its income tax. Grantor trust status is optional (meaning that Elaine can also structure the trust so that it pays its own income tax). If grantor trust status is chosen, the effect on trust growth is potentially powerful.

One secret to the success of an NSG trust lies in the fact that the estate owner who creates it does not claim a tax break which she normally could claim. That tax break is the "marital deduction." Interspousal gifts are easily and routinely made on a tax-free basis, but there's a future cost for today's tax-free status. The gift property will later be included in the taxable estate of the donee spouse.

By deliberately not qualifying her gifts to the NSG trust for the marital deduction, Elaine potentially excludes them from both her estate and Ed's estate. If Ed makes NSG gifts to Elaine, if the trusts earn 8% net and if Elaine and Ed both live their actuarial life expectancies, each NSG trust will be worth $1 million dollars. That total of $2 million in the NSG trusts would be in addition to the $3 million in "regular" exemptions which Elaine and Ed enjoy this year.

An annual exclusion gift program involving NSG trusts is very flexible. Gifts can consist of assets as simple as cash or as complex as closely-held business interests which qualify for valuation discounts. In addition, gifts can be made annually or only as frequently as the donor spouse feels comfortable in making them. Finally, the terms of the trust can cause benefits to the donee spouse to end upon divorce, remarriage or any other event defined by the donor spouse.

Two tendencies historically have relegated interspousal annual exclusion gifts to a "hiding place" under a rock, as it were. The first is the tendency of planners to think only in terms of "downstream" gifts to members of the second and subsequent generations. The second is the tendency of estate owners to think that you just can't accomplish much overall when you're doing it only $5,000 or $10,000 at a time.

Now you know enough to overcome those tendencies. Leave no stone unturned.

Johnson & McCaa LLC, a law firm in Portland, Maine, focuses its practice on business succession and estate planning, probate and trust administration, business law, tax-exempt organizations, probate litigation and alternate dispute resolution.

[1] Roy M. Adams, of the New York office of Kirkland & Ellis, on whose article in the April, 1999, issue of **Trusts & Estates** this paper relies.

2004 Rural Medical Access Program Application

Rural Medical Access Program Background:

The Rural Medical Access Program promotes obstetrical and prenatal care in federally designated underserved areas of Maine through assistance with insurance premiums for eligible obstetricians and family or general practice physicians. To be eligible for this program, physicians must be practicing in Maine as of May 1, 2004 and have malpractice insurance for prenatal care and/or obstetrical services.

Eligibility is determined in two categories:

1. Physicians whose practices are located in federally designated underserved areas, who practice at least 50% of the time in underserved areas, and whose practice includes at least 10% MaineCare clients.
2. Physicians whose practices are not located in federally designated underserved areas but are located in Primary Care Analysis Areas of under 20,000 population and at least 50% of the visits are patients from federally designated underserved areas and/or MaineCare.

The 2004 application for the Maine Rural Access Program is now available. These applications must be completed and returned to the Office of Rural Health and Primary Care by May 3, 2004. Late applications cannot be accepted. Subsidies for payment of liability insurance premiums from between $5,000 and $10,000 are available to qualified applicants. Please contact Matthew Chandler for an application.

Matthew Chandler, Program Manager
Office of Rural Health
#11 SHS, 161 Capitol Street
Augusta, ME 04333-0011
Tel: 207-287-5524

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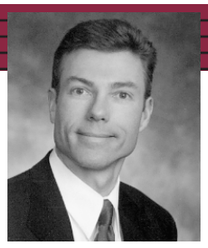
LEGISLATIVE UPDATE



Andrew MacLean, Esq.

With Only Weeks Remaining in the Session, Legislators are Wrestling With Governor Baldacci's SFY 2005 Supplemental Budget, L.D. 1919 - Approximately $80 Million In Medicaid Savings Sought

On March 15th, more than 1000 people turned out for a joint Appropriations/Health & Human Services Committee public hearing at the Augusta Civic Center to oppose MaineCare cuts in the Governor's second supplemental budget of the session. Also, the Legislature has received Governor Baldacci's plan to combine the Department of Human Services and the Department of Behavioral & Developmental Services, L.D. 1913, a bill that will occupy the time of the Health & Human Services Committee through the rest of the session.

Members of the 121st Maine Legislature are approaching "crunch time" in their work this session. Because of partisan disagreement over the first supplemental budget, tempers are short - - yet legislators face some of the most difficult work of the session remaining before they can adjourn on or before April 21, 2004. By late March, most bills have moved from committees to the floor of the House and Senate to await debate and final disposition.

The State's fiscal problems have cast a shadow on all activities at the State House this session. Difficult supplemental budget negotiations have been necessary to address deficits of more than $100 million in each of FY 2004 and FY 2005, and the projected "structural gap" for the FY 2006-07 biennium is $934.1 billion. This "structural gap," the difference between anticipated revenue and the cost of current services trended forward, is almost one fifth of the state's annual budget.

The Governor's SFY 05 supplemental budget proposal included the following principal elements:

- $22 million in savings from redesigning the Medicaid benefit framework as "MaineCare Basic" - - the proposed redesign included the elimination of 15 services such as dental, podiatry, and various types of therapy and stricter controls on utilization
- $7.3 million in savings from reductions in hospital reimbursement as a result of an expanded hospital "tax and match" concept
- $11 million in savings from the mental health services budget
- $4.4 million in savings from the mental retardation services budget
- $12 million in savings from the long-term care services budget
- $14.4 million in savings from the pharmacy budget

Following the public hearing and work sessions during the week of March 15th, the H&HS Committee recommended that the Appropriations Committee reject almost half of the Governor's proposed savings including most of the MH/MR savings, the elimination of services in MaineCare Basic, and $900,000 in savings to be achieved by reducing the reimbursement for "provider-based" physician practices (hospital-owned practices) to private practice rates. Some confusion arose about the MMA's position on the proposed physician reimbursement cuts, but the MMA did oppose the cut, suggesting instead that efforts to standardize reimbursement rates for provider-based and private physician practices should focus on increasing private practice rates. The Baldacci Administration withdrew this proposal during an Appropriations Committee work session on Monday, March 22nd.

As of March 22nd, the Senate still had not taken up a bill expanding the scope of practice of acupuncturists to include various techniques known as "oriental medicine" (L.D. 263 - MMA opposes). Legislators supporting the bill are concerned that they do not have the votes to pass the bill. A bill presenting a scope of practice threat to psychiatrists has come to a successful conclusion. On March 22nd, the full legislature accepted the H&HS Committee's unanimous "ought-not-to-pass" recommendation on L.D. 1713, *Resolve, to Establish the Commission to Study Access to Prescription Medication for Persons with Mental Illness.* Instead, the Committee has written a letter to state mental health officials asking them to conduct a departmental study of issues identified through the Committee's work on the bill. The scope of the study does not include expanding prescriptive authority to individuals without medical training such as psychologists.

On Wednesday, March 24th, the H&HS Committee conducted a public hearing on L.D. 1913, *An Act to Establish the Department of Health & Human Services,* the DHS/DBDS merger bill. You can read the text of the bill by using the "Bill Status Search" function on the Legislature's web site described below. You can find the gubernatorial task force recommendations online at http://www.maine.gov/governor/baldacci/news/events/dhsbds/dhsbds_unification_council.htm.

In state health policy personnel action, Superintendent of Insurance Alessandro A. Iuppa won confirmation by the Senate for a second five-year term during the week of March 15th and the H&HS Committee held a confirmation hearing on March 30th for John "Jack" Nicholas, a former State Budget Officer, nominated by Governor Baldacci to be Commissioner of the new Department of Health & Human Services.

Finally, medical liability reform recently has been on the agenda of the U.S. Senate in Washington, D.C. On Tuesday, February 24, 2004, the Senate voted 48-45, 12 votes short of the 60 votes required for cloture, in favor of S. 2061, the *Healthy Mothers and Healthy Babies Access to Care Act.* Both Senator Snowe and Senator Collins voted in favor of the bill. The MMA expects the Senate Republican leadership to schedule additional medical liability reform votes between now and the November elections.

During the legislative session, the MMA publishes, by e-mail, a weekly legislative update called "Political Pulse." To subscribe, go to www.mainemed.com and visit the Legislative and Regulatory Advocacy section of the site.

You will find more information about the 121st Maine Legislature on the web at http://janus.state.me.us/legis. You can review bill or amendment text and check the status of any bill at this site by going to "Session Information" and "Bill Status Search." To review the complete list of legislative committee assignments, go to http://janus.state.me.us/house/commlist.doc.

The MMA welcomes your participation in our legislative advocacy activities. For more information, contact Andrew MacLean, General Counsel & Director of Governmental Affairs at amaclean@mainemed.com.

Ethics Note: Do-Not-Resuscitate Orders and Advance Health Care Directives

The medical community recently has concentrated on improving end-of-life care. DNR orders and advance health care directives are important tools for ensuring that an individual's end-of-life care meets their needs and wishes. The Maine Legislature has addressed advance directives by enacting in the Probate Code the *Uniform Health Care Decisions Act,* 18-A M.R.S.A. §5-801, *et seq.* You can find this statute online at http://janus.state.me.us/legis/statutes/18-A/title18-Asec5-801.html. You can view a model advance directive form at http://janus.state.me.us/legis/statutes/18-A/title18-Asec5-804.html. Several years ago, the Maine Hospital Association, the MMA, and others created a model form that is available at many health care facilities or the MMA office. The AMA Code of Medical Ethics includes two opinions on these subjects: Opinion 2.22, Do-Not-Resuscitate Orders and Opinion 2.225, Optimal Use of Orders-Not-to-Intervene and Advance Directives. You can view the ethics opinions on the AMA web site at http://www.ama-assn.org/apps/pf_online/pf_online. Go to "Ethical Opinions" and then "E-2.00, Opinions on Social Policy Issues."

Public Health Corner

May is National Stroke Awareness Month. In Maine, 827 stroke deaths occurred in 2000; the age-adjusted death rate was 56.6/100,000 population. For more information on strokes and risk screening, go to www.strokeassociation.org.

Save the Date

Committee on Continuing Medical Education & Accreditation (CCMEA) Annual Meeting

THURSDAY, APRIL 29TH

2:00pm – 4:00pm	CME Committee Meeting @ MMA Office in Manchester
4:30pm – 7:00pm	CME Annual Dinner Meeting @ Senator Inn in Augusta
4:15pm-5:00pm	Social
5:00pm-6:00pm	Speaker
6:00pm – 6:15pm	CME Award
6:15pm – 7:30pm	Dinner

For more information, contact Gail Begin at 622-3374 or gbegin@mainemed.com.

SAVE THE DATE

FRIDAY, MAY 21ST

Maine Medical Association's Annual Corporate Affiliate Breakfast

7:30am - 9:00am – Harraseeket Inn - Freeport, ME

Speaker: Robert McAfee, M.D.

Maine medicine

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