MARCH/APRIL 2006

Maine medicine

MAINE MEDICAL ASSOCIATION

In this issue...

SavetheDate

2006

MMA Annual Session

September 8-10, 2006

Fairmont Algonquin, St. Andrews, New Brunswick, Canada

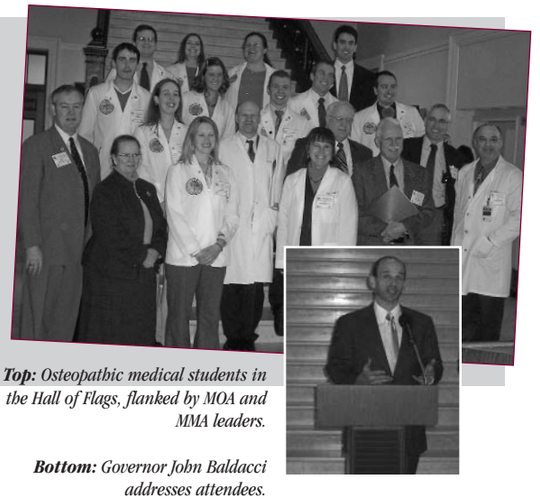
See insert inside containing educational programming.

2006 Physician's Day at the Legislature a Success

For the first time in a so-called short legislative session, dozens of physicians and medical students attended a Physician's Day at the Legislature on March 2 organized by the Maine Medical Association and the Maine Osteopathic Association. In addition to sharing breakfast and lunch with legislators, attendees heard from Governor John Baldacci and from four-term State Representative Thomas Shields, M.D. (a former MMA President) and three-term state representative Lisa Marraché, M.D. While Dr. Shields is term-limited and can not stand for re-election, Dr. Marraché is seeking to move up to the State Senate.

Several issues of interest to physicians were pending before legislative committees on March 2nd, including Dirigo Health reforms, Certificate of Need and Advanced Directives. Several physicians testified on the bills.

In addition to meeting with various legislative leaders, attendees were greeted by MMA President Jacob Gerritsen, M.D., who also served as Physician of the Day, and Thomas DeLuca, D.O., President of the Maine Osteopathic Association.



Top: *Osteopathic medical students in the Hall of Flags, flanked by MOA and MMA leaders.*

Bottom: *Governor John Baldacci addresses attendees.*

MMA President Jacob Gerritsen, M.D., President-Elect Kevin Flanigan, M.D., and EVP Gordon Smith met in Washington with (from top) U.S. Senator Susan Collins, Rep. Thomas Allen, and Senator Olympia Snowe.

MMA in Washington to Advocate for Medicare Payment Reform

MMA representatives were in Washington D.C. in mid-March attending the AMA Advocacy Conference and meeting with all four members of the Maine Congressional delegation. Congressmen Allen and Michaud, and Senators Snowe and Collins were all very generous with their time. Governor Baldaccci also spoke at the conference, participating in a panel, including three presentations on improving access to care. Following his talk, the Governor met for over an hour with MMA President Jacob Gerritsen, President-elect Kevin Flanigan and EVP Gordon Smith. The discussion focused on the problems at MaineCare and on the pending changes in the Dirigo Health Program.

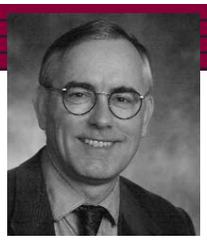
In the meetings with the federal representatives, MMA highlighted the Medicare payment problem, noting the 5% reduction in fees expected again in 2007. MMA representatives asked for a positive 2.8% update, as recommended by the well respected MedPAC Commission. If the sustainable growth rate formula is not fixed, the 5% reduction in 2007 would be the first in a series of cuts which would add up to 34% by 2015!

"Physicians can not be expected to make the improvements in health information technology that the government and others are demanding, if their reimbursement drops by a third," noted Dr. Gerritsen. "Under the current system, physicians are not covering the costs of doing business."

In Maine alone, the 2007 cut would mean a loss of $13 million to physicians. The over-all loss from 2007 through 2015 would exceed $800 million, again, just in Maine.

On March 16, following the AMA Conference, the U.S. Senate passed S. Cong. Resolution 83, the Fiscal Year 2007 Budget Resolution, by a vote of 51-49. Attached to the Resolution was an amendment sponsored by Sen. Kay Bailey Hutchison (R-Tx) that would create a deficit neutral "reserve fund to ensure that physicians will receive an appropriate reimbursement rate under Medicare instead of a scheduled cut which would threaten the adequate provision of care for seniors and disabled citizens." While the amendment does not have the force of law, it does put the entire U.S. Senate on record in support of a favorable solution. The AMA supported the amendment, which was adopted by unanimous consent. The Amendment was co-sponsored by five other Senators, including Senator Susan Collins.

President's Corner



Jacob Gerritsen, M.D., President, MMA

Who are you? Who makes up the MMA membership? It turns out that detailed answers to those questions were pretty much unknown until this past January when the MMA Member Demographics Taskforce, led by yours truly and ably assisted by our Director of Finance, Heidi Lukas, engaged in some major number crunching of three different databases never before combined, and came up with some of the following highlights:

There are 3463 actively practicing physicians in Maine and of those 1650 are MMA members.

Sex: 77% of us are male and 23% are female (73% of all Maine doctors are male).

Age: 54% of us are over 50; 32% are between 40 and 50 and 13% between 30 and 40. For all Maine doctors the numbers are 50, 32 and 18%.

Type of Practice:

20% of us are in solo private practice; 23% work for a hospital and 44% for a private group. For all Maine doctors the numbers are: 23, 23 and 37%.

The numbers about solo practice are sobering and one conclusion, bolstered by just looking around us, is that solo primary care practice is down and on the way out.

It's not hard to see why.

As I write this article the Resident Matching Program results have just been announced: in primary care, only 56% of matches in Internal Medicine and even more sobering, only 41% of Family Practice slots were filled by US medical school grads.

US medical students are increasingly opting out of primary care.

Malpractice rates are up and Medicare rates are frozen for this year. Your MMA and nationally, the AMA, is spending a disproportionate amount of time, energy and resources to avert the scheduled 4.4% Medicare payment cut scheduled to take effect in 9 months; President-elect Kevin Flanigan, EVP Gordon Smith and I recently returned from our annual trek to Washington D.C. to plead the case for Maine physicians and patients to our congressional representatives.

MaineCare is headed for a meltdown with no electronic crossover payments for 14 months with almost a fourth of Mainers on the program, while at the same time we are supposed to be investing in Information Technology to be able to respond to the requests coming from all sides documenting the quality of medicine we practice, prodded by report cards posted on the internet.

The numbers about **solo practice** are *sobering* and one conclusion, bolstered by just looking around us, is that solo primary care practice **is down and on the way out.**

This decline of primary care and solo practice is not in the public interest. Patients need and want a variety of venues to get their care and choice is important. It is also true that care given in an institutional setting is not necessarily the most cost-effective.

At the same time that our population is aging (the fastest growing segment of the population is the 85 year old and over group) and increasingly needs comprehensive longitudinal primary care, our medical students are shunning primary care because it is unattractive, with its low reimbursement and low status reflecting that.

A prominent member of our MMA Executive Committee reports that his income has dropped every year for the last 7 years. Why should we care? Because few will want to replicate his experience.

The way care is compensated lags behind the trends in health care. These are moving towards chronic disease management and health promotion/support to enable people to live healthier lifestyles and prevent disease.

Insurers, both commercial and governmental, try to reduce payments for medical care whenever possible. If more patients are to be seen, visits must be shorter, and problems simple and discrete. Indeed, the coding system rewards us for seeing new patients with acute problems. Geriatric patients are optimally treated using the interdisciplinary care model which is not covered by insurance. We did not go to school for decades at tremendous expense, to work on a production line. That is what primary care has become. "Productivity" — patients per hour, not improved health — has become critical, whether we work for ourselves or others.

Yet there are increasingly many patients with complex, chronic illnesses who need our help. If we are paid the same for everyone, we cannot afford to see them. The solution? First, we need to be compensated for work done without the patient present, as are other professionals. Second, insurers should pay more for complex cases and less for easy ones. A rethinking of our system of health insurance is needed.

I know that many of us love taking care of our patients, despite our profession being under attack, and that we would do it all over again anyway. What holds the health care system together is that for many of us it's not about what we can get out of it, which would make it a job, but what we can contribute, which makes what we do a true profession.

Your comments are always welcome and can be directed to jacobg@adelphia.net or 207-236-6070.

MMA Welcomes New Staff Member

Jessica Violette began working for the Maine Medical Association in Mid-October 2005 in a temporary position, and began working full-time in January 2006. Jessica is the MMA staff assistant, Coding Center Coordinator, and Conference Room scheduler. Jessica participates in various projects generated by staff to keep her busy while still managing the Coding Center and answering incoming phone calls.

Jessica is a native of the State of Maine, residing in the small town of Chelsea with her fiancé Jake. Jessica loves the outdoors and is an avid horseback rider who loves to trail ride and thoroughly enjoys competing in Team Penning, where she pens cows on her beloved horse Soldier, in the Central Maine area and at fairs. Jessica had planned to attend Unity College, majoring in Adventure Therapy, but later decided that joining the workforce was for her. Jessica is self-described as a "people pleaser" which makes everyone around her work with ease. Jessica is also training to become a Medical Transcriptionist in hopes to further her career in the medical field.

Upcoming Specialty Society Meetings

MAY 5, 2006 *Harraseeket Inn – Freeport, ME*
Maine Society of Eye Physicians and Surgeons Spring Meeting
MMA Contact: Shirley Goggin at 207-445-2260 or sgoggin@mainemed.com

MAY 6, 2006 *Harraseeket Inn, Freeport, ME*
Topics in Gastroenterology for Primary Care
MMA Contact: Gail Begin at 207-622-3374 Ext: 210 or gbegin@mainemed.com

MAY 6-7, 2006 *Samoset Resort, Rockport, ME*
Maine Chapter, American Academy of Pediatrics Spring Conference: Pediatric Potpourii
Topics include: *Pediatric Hot Topics, Pediatric Check-up, Newborn Screening, Asthma, Atopic Dermatitis, Calcium Intake Guidelines, Pediatric Consent, Immunizations Review, as well as sessions on Coding and EMR.*
Contact: Aubrie Entwood at 207-685-9358 or agridleyentwood@aap.net

MAY 12, 2006 *Eastland Hotel, Portland, ME*
Maine Association of Psychiatric Physicians & Consultation Project Teen Suicide: Understanding and Responding to the Tragedy in Our Communities **1:00–5:00pm**

Maine Association of Psychiatric Physicians General Membership Meeting **6:00pm**
Advocacy in Psychiatry – David Fassler, MD
MMA Contact: Warene Eldridge 207-622-7743 or weldridge@mainemed.com

JUNE 2 – 4, 2006 *Asticou Inn, Northeast Harbor, ME*
Maine Chapter, American College of Surgeons Meeting
Contact: Joel LaFleur, M.D. at 207-596-6636 or jlafleur@penbaysurgery.com

MMA/MOA Work Together on MaineCare/MECMS

The Maine Medical Association and the Maine Osteopathic Association have worked diligently for more than a year on the MaineCare/MECMS problem. Both organizations sit on the Governor's Provider Advisory Committee which meets once every two weeks. We have tried to work with the Office of MaineCare Services and continue to meet with the people trying to fix the claims management system. It has, at times, been frustrating for all concerned, as the system has obviously not functioned as intended and has not yet reached full functionality and stabilization. As a result, Maine remains the only state Medicaid program that is not HIPAA complaint, hundreds of physicians have not been paid the Part B cross-over claims, and the program is so low on funds that the weekly check run has been capped. As of this writing, over 200,000 claims are still in suspension.

Many physician practices have reached the breaking point with the program. It was one thing to be paid fees so low that they did not even cover the cost of providing the care, but it is another thing entirely not to be paid at all. Here are some of the questions physicians are asking:

Who picked this vendor and had it ever built such a system before?

Who will ultimately bear financial responsibility for the $20 plus million fiasco?

When will it be fixed?

Why would anyone flick the switch on the new system without a back-up system in place?

Was the system pilot tested before full implementation? Were dummy files created and tested?

When will it be fixed?

Will the so-called Transformation project, intended to improve provider relations within the Office of MaineCare Services (OMS), represent anything more than a cosmetic make-over?

When will the OMS have a permanent Director, a position that has been filled on an acting or interim basis since Governor Baldacci was elected?

The day to day processing of fresh claims is gradually getting better, but all too often, when one item is fixed, it breaks something different along the way. For instance, anesthesia claims, once processed and paid correctly, have not processed correctly for the last two months or more.

The Baldacci administration asked for $4 million in the Supplemental budget to reimburse providers for some of the costs associated with the delay in claims payment. Unfortunately, the Appropriations Committee reduced that amount to $1 million, but most members indicated they would consider more once costs are better established. The legislature has generally been receptive to our advocacy on the issue so the committee action was disappointing.

Every Monday, MMA has updated members and practice managers on the status of the system in the pages of the e-publication entitled *Maine Medicine Weekly Update.* If you and your staff are not receiving the publication, please call Lauren at 622-3374 (ext. 223) or send an e-mail to her at lmier@mainemed.com and request to be added to the distribution list.

MMA and MOA recently met with the Governor to discuss the continuing problems and drafted some op-ed articles that you will begin to see in the media.

The two associations will consider more aggressive action if the problems continue, including, but not limited to, filing complaints with the federal CMS (which is paying for most of the new system), litigation, legislation and direct political action. Good intentions are not enough. The system needs to be fixed. Now.

John C. Dalco, M.D. (1934-2006)

First Director of Physician Health Program

The Maine Medical Association was saddened to learn of the death of John C. Dalco, M.D. on Feb. 8, 2006 at the age of 72. Dr. Dalco was the first Director of MMA's Physician Health Program and served in that capacity for some 15 years before retiring and passing on the torch to David Simmons, M.D. who had served as Assistant Director of the program during the last two year's of Dr. Dalco's directorship.

It is not an overstatement to say that Dr. Dalco founded the Physician Health Program in Maine and made it a model for the country. He was a frequent lecturer across the country on physician health and addiction issues and was active in the Federation of State Physician Health Programs. He was a member of the AMA, the Massachusetts Medical Society, MMA and the American Society of Addiction Medicine. He also practiced as an internist in Scituate, MA for 35 years.

In his years serving Maine physicians, John helped dozens of physicians with their recovery from addiction and he will be sadly missed. Our condolences to his wife of 40 years, Claire, and his son, John C. Dalco, Jr. and his wife Theresa. Contributions in John's name may be made to the American Cancer Society, 30 Speen St., Framingham, MA 01701.

Condolences may be sent to Claire Dalco at 7 Rocky Hill Circle, Scituate, MA 02066. The MMA Committee on Physician Health will determine an appropriate way to recognize Dr. Dalco's contribution to the program and members will be informed of what that recognition will be.

Annual Practice Education Program June 21 in Bangor

The Association will present its 15th Annual Medical Practice Education Program in Bangor, Maine on Wednesday, June 21 from 8:30am to 4:00pm. The program will be held at the Spectacular Event Center. This popular program gives MMA a single chance annually to bring to the attention of physicians and practice managers, the trends in medicine in the state, and the changes in law and regulation that need to be kept in mind in achieving compliance. This year's program is co-sponsored by the Maine Health Alliance.

Among the topics this year are quality improvement, Pay 4 Performance, Dirigo Health, improving reimbursement (including enforcing payor contracts), MHINT (now called HealthInfoNet), updates from MaineCare and Medicare, and obligations under the Americans with Disabilities Act. The annual legislative and regulatory update will be presented by Andrew MacLean and Mr. Smith will review the new Physician's Guide to Maine Law 2006. More detailed information is located in the insert included in this issue of *Maine Medicine*. The insert includes registration material, as well. Questions can be addressed to Gail Begin at 622-3374 (ext. 10) or gbegin@mainemed.com.

UPCOMING AT MMA

APRIL 19, 2006
2:00pm – 4:00pm
HealthInfoNet

APRIL 20, 2006
11:30am – 4:45pm
Committee on Continuing Medical Education and Accreditation

5:00pm
Maine Association of Psychiatric Physicians, Executive Committee Meeting

APRIL 24, 2006
3:00pm
HealthInfoNet; Technology Committee

APRIL 26, 2006
2:00pm
MMA Executive Committee

5:00pm
MMA Budget and Investment Committee

MAY 2, 2006
1:00pm – 3:00pm
"Stop Stroke"

MAY 5, 2006
9:00am – 1:00pm
"First Fridays" CME Program: "Improving Quality in Your Office Practice/Using Physician Specific Data"

MAY 8, 2006
5:30pm – 9:00pm
Committee on Physician Health

MAY 17, 2006
2:00pm – 4:00pm
HealthInfoNet

MAY 18, 2006
9:30am – 4:00pm
Home Care Alliance

MAY 24, 2006
4:00pm – 6:00pm
Public Health Committee

MAY 29, 2006
Office Closed for Memorial Day Holiday

JUNE 2, 2006
9:00am – Noon
"First Fridays" CME Program: "Common Coding Errors"

JUNE 7, 2006
2:00pm
MMA Executive Committee

The Coding Center by Jana Purrell, CPC, Coding/Reimbursement Specialist

Jana Purrell, CPC

Maine Medical Association/NH Medical Society/VT Medical Society Tel: 888-889-6597 Fax: 207-787-2377 jpurrell@thecodingcenter.org

Consultations

Just when you thought you understood the rules for documenting consults—they change it! In an attempt to make it easier, the American Medical Association (AMA) Current Procedural Terminology (CPT) deleted the Follow-up Consult codes (99261-99263) and the Confirmatory Consult codes (99271-99274) effective January 1, 2006.

Here at the Coding Center, we often get asked how to code and document consultation services. The Centers for Medicare and Medicaid Services (CMS) recently published a Medlearn article regarding these changes including clarifications and reminders. Below are highlights and examples. For the complete article, go to:
http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4215.pdf

E/M services following an initial consultation service and second opinion evaluations:

- Essentially, follow-up services to an initial consultation in the facility setting will be billed using codes 99231-99233 in the hospital and 99307-99310 in the nursing facility setting. Reminder that only one initial consult (99251-99255) can be billed per consultant, per patient, per admission. Example: Dr. Jones asked to consult on patient with abdominal pain on 2/5/06; he documents the initial consult and makes recommendations for treatment to Dr. White, the attending physician. Dr. White asks Dr. Jones to come back and see the patient on 2/8/06 because the patient is still complaining of abdominal pain. The visit on 2/8/06 by Dr. Jones would be billed as a subsequent hospital visit (99231-99233).
- Second opinion services will be coded based on who is asking for the opinion. If a healthcare provider is asking, the appropriate initial consult code would be used in the facility setting (99251-99255) and in the office/outpatient setting (99241-99245).
- If the second opinion request does not meet the consultation requirements (i.e. request is coming from the patient), use the Subsequent Hospital Care codes for the inpatient setting (99231-99233) and Subsequent NF Care codes for the NF setting (99307-99310). In the office setting, the appropriate office/outpatient code would be billed (99212-99215 or 99201-99205). Remember a written report is not required by Medicare to be sent to a physician when a second opinion has been requested by the patient and/or family. Also modifier - 32 (mandated services) is not recognized as a payment modifier by Medicare.

Reminders for when to use the consultation codes include:

- A consultation service requires a request from an appropriate source (i.e. healthcare provider), an evaluation and a written report.
- Diagnostic and/or therapeutic services may be initiated at the initial consultation.
- An NPP may request and/or perform a consultation service within the scope of practice and state licensure requirements and when the requirements for physician participation and physician supervision are met.
- Ongoing management of the patient following the initial consultation service is reported using the subsequent care visit codes depending on the setting and type of service.
- In an office or outpatient setting, if an additional request for a consultation, regarding the same or a new problem with the same patient, is received from the same or another physician and documented, the Office/Outpatient Consultation codes may be reported again.
- Medicare will pay for a consultation if a physician or qualified NPP in a group practice requests a consultation from another physician or qualified NPP in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting professional's knowledge. However, a consultation should not be reported on every patient as a routine practice between physicians and qualified NPPs within a group practice.
- A preoperative consultation at the request of a surgeon is payable if the service is medically necessary and not routine screening (some 3rd party payors will not pay for a "consult" by a primary care physician on their own patient—in this case bill as established patient visit (99212-99215).
- Physicians or qualified NPPs who had been treating the patient preoperatively or who had not seen the patient for a pre-operative consultation and are asked to assume management of an aspect of the patient's care postoperatively, must report subsequent hospital care codes for the inpatient hospital setting, subsequent NF care codes in the SNF/NF setting or the appropriate office or other outpatient visit codes in these settings. In this case, the surgeon is not asking the physician or qualified NPP for their advice or opinion.

Consultation documentation reminders:

- Include a written request for a consultation in the requesting physician or qualified NPP's plan of care—this is not new—documentation in both the requesting provider's notes and in the consulting provider's notes ensures that both parties understand the intent of the request—consultation versus referral.
- A consultation request may be verbal; however, the verbal interaction identifying the request and reason for a consult must be documented in the patient's medical record by the requesting physician or qualified NPP and also by the consultant physician or qualified NPP in the patient's medical record—can be a booking slip detailing a phone request, faxed form from requesting party, or an actual letter.
- The reason for the consultation service must be documented by the consultant in the patient's medical record—chief complaint, nature of presenting problem.
- The consultant's written report may be part of a common medical record or in a separate letter to the requesting physician or qualified NPP—if sending a copy of the office note, be sure to send with a cover letter to ensure the requirement of "written documentation" is met. Do not just use "cc" at the bottom of the note.

AMA Physician Quality Reporting Initiative

During the Budget Reconciliation process last year, the AMA was repeatedly pressed by key Congressional and administration leaders to demonstrate a commitment to work with policymakers on physician quality reporting initiatives. Physician concerns about the initial CMS Physician Voluntary Reporting Program proposal were interpreted on Capitol Hill as a sign of opposition to quality reporting. Congressional leaders and the Bush Administration were less inclined to address payment cuts triggered by the SGR formula if there was insufficient progress on the quality front.

In mid-December, the AMA outlined a number of steps it agreed to take to work with CMS and Congress on quality and physician payment issues. During a subsequent meeting with Congressional leaders, the AMA Board Chair signed a joint working agreement that contained these items the AMA previously had committed to pursue:

- In 2006, physician groups will work with CMS to reach agreement on a starter set of evidence-based quality measures for a broad group of specialties for review by a consensus-building process. The AMA is working through the Physician Consortium for Performance Improvement to refine a starter set of evidence based quality measures for the CMS voluntary program.
- By the end of 2006, physician groups will have developed a total of approximately 140 physician performance measures covering 34 clinical areas.
- In 2006, physician groups will work with CMS to develop the most accurate and efficient method for physicians to report quality data to CMS.
- During 2006, physician groups will develop with CMS and three Congressional committees to implement additional reforms to address payment and quality objectives.
- In 2007, physicians would report voluntarily to CMS on at least 3 to 5 quality measures per physician. Physicians that report measures should receive an additional quality update to offset administrative costs.
- By the end of 2007, physician groups will have developed performance measures to cover a majority of Medicare spending for physician services.

In February, the agreement was the focus of an article in the *New York Times* which led to quite a bit of comment.

The AMA has stated that it welcomes the involvement and collaboration of other physician groups in quality reporting activities but did not commit any individual state or national specialty society to the activities outlined in the agreement with Congressional leaders.

The details of a pay for performance program and additional payments for quality reporting will have to be negotiated in subsequent legislation and regulations.

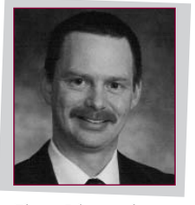
visit us online: www.mainemedicine.com

Focus On Maine's Medical Liability Laws: Statute of Limitations

In each of the next several issues of *Maine Medicine*, the MMA will highlight an aspect of Maine law governing legal actions for medical malpractice, part of the common law "tort" of "negligence." Black's Law Dictionary (5th Edition) defines "tort" as "a private or civil wrong or injury, other than a breach of contract, for which the court will provide a remedy in the form of an action for damages." Each action for negligence requires the existence of a legal duty from the defendant to the plaintiff, breach of that duty, and damage as a proximate result of that breach. The *Statute of limitations for health care providers and health care practitioners*, 24 M.R.S.A. §2902, provides that actions for medical negligence must be brought within 3 years from occurrence for adults. For minors, the action must be brought within 6 years from occurrence or 3 years from the age of majority whichever is shorter. The limitation of actions involving a foreign object is measured from discovery of the object. Compared to other states, the Maine statute of limitations for medical malpractice is very favorable to the health care practitioner because the general civil statute of limitations is 6 years from occurrence and because of the absence of a "discovery rule." Most other states' statute of limitations for medical malpractice permit the period of litigation exposure to be expanded by measuring the period from the time the negligent act or omission is or should have been discovered, rather than from the occurrence of the negligent act or omission.

You can find 24 M.R.S.A. §2902 on the web at: http://janus.state.me.us/legis/statutes/24/title24sec2902.html.

A Message From Your President-Elect



I write to you today to tell you of what I have learned recently and how that will impact how your MMA works with you. In February, Gordon Smith our Executive VP and I went to an Association Leadership conference in San Diego where it was actually colder one day then it was in Maine. The program was sponsored by the well-respected American Society of Medical Association Executives. There I learned very important things about how organizations go from good to GREAT. This leap is accomplished by first recognizing the difference between features offered by the association such as our staff, our corporate affiliates and the discounts offered to members by them, as well as their support of many of our efforts, and our CME programs, and benefits which are what the members actually receive when using some or all of the features. To this end, it behooves us the leadership, to ensure that the current and future features meet our members needs and are used to benefit every member. The second and more important lesson learned in San Diego is that successful communication is a two-way street. If an organization is to become great in the eyes of its members, they have to have a sense of participation and a sense that this participation is welcome and accepted. So far I have attempted to communicate to you, not with you, by submitting these letters to *Maine Medicine*. I will now invite you to engage in the communication with me and the rest of your leaders by calling or inviting us to your meetings, whether they be hospital medical staff, county society or group practice meetings. It is only through this dialogue that this organization can truly be what we want it to be. So please join with me and help keep this organization strong and vibrant and successful in its endeavors to better serve you and your patients needs. You may also communicate with me via e-mail to flanmansvpc@pol.net.

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Legislative Update

Andrew MacLean, Esq.

122nd Maine Legislature Eyes Mid-April Adjournment

2006 is an election year with the Governor's office and all 186 legislative seats up for grabs. Accordingly, partisanship and political maneuvering have influenced many issues on the agenda during the Second Regular Session of the 122nd Maine Legislature, particularly three bills (L.D.s 1845, 1935, and 1945) relating to the Dirigo Health Program and health care reform in Maine.

Supplemental Budget

At the beginning of the fourth week in March, the Appropriations Committee is finalizing negotiations on the Governor's supplemental budget proposal for the State Fiscal Year 2006-2007 biennium, L.D. 1968. The key issues for the physician community in the supplemental budget concern the MaineCare claims management (MECMS) system and the Maine Tobacco Helpline. The State's recovery of "interim payments" to providers because of the MECMS transition problems is linked to the State's ability to pay MaineCare claims in the fourth quarter of SFY 2006 ending June 30, 2006. Despite the MMA and other provider organizations urging the Appropriations Committee to accept the strong majority recommendation of the Health & Human Services Committee to include the Baldacci Administration's proposed $4 million in FY 2007 to reimburse providers for interest costs incurred as a result of MECMS payment delays, the committee voted 12 to 1 on March 20 to reduce the amount to $1 million. Also, the MMA and other public health advocates in the Maine Coalition on Smoking OR Health are lobbying the Committee to include $250,000 in supplemental funding for the Maine Tobacco Helpline in each year of the biennium. The helpline has witnessed a significant increase in demand for services since the $1 per pack cigarette tax increase enacted by the Legislature in 2005.

Dirigo Health Program/Health Care Reform

As expected, the Dirigo Health Program has emerged as a leading issue in the 2006 gubernatorial race and the principal health care issue in the current legislative session. The Legislature has three bills before it dealing with these issues: L.D. 1935, *An Act to Protect Health Insurance Consumers*, sponsored by Senator John Martin (D-Aroostook), L.D. 1845, *An Act to Increase Access to Health Insurance Products*, sponsored by Representative Mark Bryant (D-Windham), and L.D. 1945, *An Act to Establish a High-Risk Health Insurance Pool*, sponsored by Assistant House Republican Leader Josh Tardy (R-Newport).

L.D. 1935 would prohibit Anthem or any other carrier providing the DirigoChoice product from passing on to premium payers the cost of the "savings offset payment" (SOP), the principal funding mechanism for the Dirigo Health Program. The Governor's Office of Health Policy & Finance supports the bill and is negotiating the bill with the three principal organizations opposing the bill, the Maine Association of Health Plans, the Maine State Chamber of Commerce, and the Maine Hospital Association. These three organizations have developed an alternative funding proposal for the Dirigo Health Program that is available on the MHA website, http://www.themha.org/advocacy/Dirigo%20Proposal%20_Final%2003-09-06_.pdf. The MMA has expressed concern that passage of L.D. 1935 could adversely affect Anthem's provider payment updates.

L.D. 1845 would amend the governance of the Dirigo Health Program and would permit the State to provide the DirigoChoice product through a self-insured plan. You can read the Governor's March 15, 2006 comments on this proposal on the web at: http://www.maine.gov/tools/whatsnew/index.php?topic=Portal+News&id=14526&v=article-2004.

L.D. 1945 would amend regulation of the individual health insurance market in Maine and would change Maine's community rating rules in addition to creating a high-risk health insurance pool. L.D. 1945 represents the Republicans' alternative to Dirigo and their health care reform proposal. The Insurance & Financial Services Committee split along party lines on L.D. 1945 with majority Democrats opposing the plan.

Other Bills of Interest

The following bills are highlights of bills being tracked by the MMA Legislative Committee, chaired by Katherine S. Pope, M.D.:

L.D. 1420, *An Act to Establish a Maternal & Infant Death Review Panel* (enacted, P.L. 2005, Chapter 467; MMA supported)

L.D. 1947, *An Act to Protect Children from the Onset of Autism* (deals with thimerosal in vaccines; majority "ought not to pass" report from the HHS Committee awaiting floor debate; MMA opposes)

L.D. 1976, *Resolve, Regarding Legislative Review of Portions of Chapter 120: Release of Data to the Public, a Major Substantive Rule of the Maine Health Data Organization* (deals with release of physician identifiable data to the public; unanimous "ought to pass" report from the HHS Committee awaiting floor action; MMA supports in part)

L.D. 1814, *Resolve, to Establish the Work Group to Review and Recommend Improvements for the Certificate of Need Program* (establishes a new work group to make recommendations on a series of CON issues by November 1, 2006; unanimous "ought to pass as amended" report from the HHS Committee awaiting floor action; MMA supports final version)

L.D. 1927, *Resolve, to Collect Information About Employer-Based Health Insurance* (prompted by concern about large employers, such as Wal Mart, not bearing their "fair share" of employees' health care costs; unanimous "ought to pass as amended" report from the HHS Committeee awaiting floor action; MMA supports)

You can view the text of these bills or check their status on the web at: http://janus.state.me.us/legis/LawMakerWeb/search.asp.

During the legislative session, the MMA publishes a weekly e-mail legislative update called *Political Pulse*. To subscribe, go to www.mainemed.com and visit the Legislative & Regulatory Advocacy section of the site. You will find more information about the 122nd Maine Legislature, including schedules, committee assignments, legislator contact information, and audio coverage of legislative work, on the web at: http://janus.state.me.us/legis/. The MMA's Interim Summary of Health Care Legislation from the 2005 session of the legislature is available on the web at www.mainemed.com or from the MMA office.

The MMA welcomes your participation in our legislative advocacy activities. For more information, please contact Andrew MacLean, Deputy Executive Vice President, at amaclean@mainemed.com.

Maine medicine

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