MAY/JUNE 2008

Maine medicine

MAINE MEDICAL ASSOCIATION

IN THIS ISSUE

MMA Hosts Successful 1st Congressional District Candidate Forum

On Tuesday, May 13, 2008, MMA Legislative Committee Chair Katherine S. Pope, M.D. welcomed 7 of the 8 candidates hoping to replace Congressman Tom Allen (D) in Maine's 1st Congressional District and nearly 50 physicians, MMA staff, and friends to a candidate forum held at the MMA offices in Manchester. According to the assembled candidates, this was the 30th time they have all appeared together during this primary campaign that ends June 10th.

The candidates who participated were Republicans Dean Scontras and Charlie Summers and Democrats Michael Brennan, Adam Cote, Steve Meister, M.D., Chellie Pingree, and Ethan Strimling. Democrat Mark Lawrence was unable to attend. Following a brief reception, each candidate made a 5-minute opening statement. Then, the forum broke for a 20-minute intermission that provided an opportunity for the candidates to mingle with the physicians and guests. During the last hour of the forum, each candidate was asked to spend 5 minutes on the following: *Discuss 3 steps you would take to improve the health care system of the U.S.*

Norma Dreyfus, M.D., Charles Grimes, M.D., John Makin, M.D., Adam Cote and candidate and MMA member Steve Meister, M.D.

Candidate Charles Summers and MMA Legislative Committee Chair Katherine Pope, M.D.

The candidate presentations on health care reflected long-recognized differences in the two major political parties' platforms on health care, with the Republicans favoring free-market approaches to improving health care access and health insurance coverage, such as insurance market reforms and changes in the tax treatment of health insurance premiums for the self-employed, and 3 Democrats (Candidates Brennan, Pingree, and Strimling) favoring some form of single payer system in which the government guarantees coverage for all. Democrats Adam Cote and Steve Meister, M.D. preferred a "pluralistic" or "hybrid" approach to improving access and coverage. All candidates seemed to acknowledge the power of health information technology to improve our health care system and appeared willing to help the medical community to access that technology. The candidates also outlined their views on the war in Iraq and the economy, including our current energy crisis.

Members and guests listen to the candidates.

Dervilla McCann, M.D., Sam Solish, M.D., candidate Adam Cote.

Reporter Susan Cover identified the forum as perhaps the only one of the campaign's forums to focus on health care in a front-page article in the Kennebec Journal on Wednesday, May 14, 2008.

The candidate forum was the fourth "issue-oriented" forum conducted by the MMA Legislative Committee in 2007 and 2008 in an effort by Dr. Pope to promote interaction between MMA members and key policymakers and, frankly, to make Legislative Committee meetings more interesting! The previous forums featured guests from the Maine legislature and executive agencies and addressed the Dirigo Health Program, the MaineCare program, and the state budget process. The Legislative Committee plans to sponsor similar events with the 124th Maine Legislature in 2009.

HealthInfoNet Demonstration Phase Now Well Under Way

HealthInfoNet's 24-month demonstration phase is off to a solid start following the project's late February kick-off. The demonstration phase includes participation by Maine's four largest health care delivery systems, an independent rural hospital, a private group practice and the Maine Center for Disease Control and Prevention. These organizations account for fifty-two percent of annual inpatient discharges and more than forty percent of annual outpatient visits across Maine. Information to be exchanged during the demonstration phase include person demographics, lab results, diagnostic imaging study reports, prescription medication profiles, allergies, transcribed diagnostic study reports, and patient visit history. Work is currently underway to develop the interfaces and map the clinical content from each provider organization that will enable the first exchange of clinical data to begin in late October of 2008. HealthInfoNet and its participating organizations are working with 3M Health Systems and its subcontractors Orion Health and Connectria to accomplish delivery of the technical infrastructure that will enable the realization of the statewide exchange.

Stakeholder Process Aimed At Creating Statewide Health IT Fund

Maine Governor John Baldacci and the Maine Legislature have established an intensive multi-stakeholder planning process aimed at accelerating adoption of electronic clinical systems through the creation of a new statewide Health IT Fund. Maine's recently released State Health Plan has identified the development of electronic systems as a statewide priority.

A "Resolve" approved by the Governor and the Legislature directs HealthInfoNet (Maine's health information exchange or HIE) and the Maine Quality Forum to coordinate the planning process (Note article above regarding HealthInfoNet). Representatives from 20 organizations (including MMA) identified in the Resolve have been invited to conduct a thorough review of the development of electronic health information exchanges or HIE's across the nation. Beginning in late May and continuing through the end of this year, the process will then examine Return on Investment projections associated with greater information-sharing and explore a range of possible funding options.

The Resolve calls for the stakeholders to use this research to develop a set of recommendations for establishing and financing a new statewide quality improvement and technology fund. This fund would initially contribute to HealthInfoNet's establishment and sustainability, and then help make it possible for health care providers with limited financial resources to obtain electronic medical record and other electronic clinical systems that support improved patient care and coordination of care across the State. Recommendations developed by the group will be presented to the Legislature's Health and Human Services Committee in December. Legislation based on these recommendations may then be introduced following a review by the Committee.

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Maine Health Care Advance Directives

The Maine Health Care Advance Directives document is available on MMA's website.

Go to www.mainemed.com, click on "*Patient Resources,*" then click on *"Health Care Advance Directives."*

Subscribe to MMA's *Maine Medicine* Weekly Update

Each Monday, *Maine Medicine* Weekly Update keeps physicians and practice managers in the loop with breaking news – by fax or email only. It's a free member benefit – call 622-3374 to subscribe.

William Strassberg, M.D., President, MMA

President's Corner

Make a Difference

I just returned from Boston and the Massachusetts Medical Society Annual Meeting. It was striking to be reminded how issues facing physicians and physician societies in these (and most other) states are so similar. While I was so graciously hosted by the officers and members of the MMS, I was also fortunate to share in their educational sessions which surrounded leadership in medicine and the need for physicians to accept this challenge and maintain our position as the principal advocates for the profession of medicine, medical care in the United States, and our patients.

I was reminded that concerns about our profession and its place in the health care arena was a primary topic of discussion by physicians across our country, and that physician leadership and engagement will be critical to make positive changes. In meetings and recent publications, the same issues that are the very cornerstones of our Maine Medical Association Professionalism Program, including the industrialization of medicine, loss of physician respect and autonomy, industry relations, and the need to take leadership in the patient safety movement have all been prominent. B. Dale Magee M.D., President of the MMS noted:

> "As the crisis in the cost and quality of health care heats up, most are looking to us for guidance. In a rapidly changing environment, how can we meet those challenges?...Can one doctor make a difference, or must we all wait for the system to change? Knowledge, experience, collaboration, and persuasion – these are our tools…"

Panel discussions noted that health care coverage for Americans was a critical issue before medicine today. Questions were raised: Is health care coverage a basic social need or is it a commodity to be bought and sold on the free market like other goods and services?

Meanwhile, home in Maine, four groups have announced efforts to repeal recent tax increases that the legislature passed to help pay for the Dirigo Health program. They include levies on beer, wine, soda and other soft drinks, and a 1.8 percent surcharge on paid insurance claims. Another proposal would repeal the entire law revamping the state-run Dirigo program. You can bet that one of the primary topics at the MMA June 4th Executive Committee meeting will be to discuss how much the MMA should be involved with the opposition campaign to the People's Veto. We are the experts, and we must be heard. These policy issues are local as well as national. Your voice, and the voice of your association can make a difference nationally, and here in Maine.

The industrialization of medicine was cited by speaker Peter Budetti M.D., J.D., who noted that the "commoditization" of health care away from a personalized physician/patient relationship toward competing commercial products has resulted in monumentally vested interests in health care. These include pharmaceutical companies, health care payors, medical device manufacturers, and, some would argue, organized medicine. Our relationship with these industry groups remains an issue of great public interest, and is one of the themes of our Professionalism Program. The resultant loss of physician autonomy is a second theme associated with these changes.

Quality improvement and measures are other topical issues, and were also discussed at the MMS meeting. Meaningful measures that align with improvements in patient health and outcomes are to where we must drive the system. Society must participate as improvements in overall health also requires that patients recognize their role as responsible members of the health care team. Physicians are best situated to lead this team via persuasion, collaboration, and by example. The MMA 17th Annual Practice Education Seminar will be held on May 28th and I will moderate a panel discussion on: Transparency and Accountability: A Summary of Projects in Maine. The day long seminar is another way physicians can keep abreast of these and other best practice issues in Maine, bring them home to their community - and make a difference to our patients.

Quality also brings us to the third and final prong of the Professionalism Initiatives in Maine: patient safety. Also a focus of the MMS, the Maine Initiative notes that patient safety today is a systems issue. Medical errors are not due to carelessness or lack of trying hard enough – they are associated with faulty systems, processes, and conditions that lead people to make mistakes. The Maine Medical Association Patient Safety Initiative focuses on the need to change the "culture" of patient safety. It is important to change the mindset of physicians (and others) that we are individually responsible for not making mistakes. The system must be viewed as a whole, medical error assessment must be altered to systems wide review and improvement, and the culture of blame and individual shame must end for real and positive change to occur. Doctors and their patients are at the nexus of care, and the time is ripe for physicians to assume a leading role in this movement. The Physician Quality Committee is hoping to create a page on the MMA website where patient safety groups are catalogued and linked, safety tools are available for review and implementation, and where patient safety education is available. We are your association and, with your help, we can make a difference. As always, I am available at baybones@midcoast.com.

MMA wants to hear from you!

Issues or concerns you would like to see addressed by the MMA:

_____

_____

_____

Please provide your name and telephone number or e-mail address so that we may contact you if clarification or further information is needed.

Name: _____

Telephone: _____

E-mail: _____

Return to MMA via fax at 207-622-3332. *Thank You*

Upcoming at MMA

JUNE 4	1:00pm – 2:00pm 2:00pm – 5:00pm 5:00pm	Operations Committee Executive Committee Budget and Investment Committee
JUNE 5	12:00pm – 4:30pm	Home Care & Hospice Alliance of Maine
JUNE 6	9:00am – Noon	"First Fridays" Educational Program: Risk Management Update 2008
JUNE 10	8:30am – 4:00pm	Aligning Forces for Quality Steering Committee
JUNE 18	7:00pm – 9:00pm	Payor Liaison Committee
JUNE 19	8:00am – 3:30pm 4:00pm – 6:00pm	Pathways to Excellence Committee on Physician Quality
JULY 2	12:30pm – 2:00pm 2:00pm – 5:00pm	Aligning Forces for Quality Quality Counts!
JULY 8	5:00pm – 8:30pm	Maine Chapter, American Academy of Pediatrics Board Meeting
JULY14	6:00pm – 8:30pm	Medical Professionals Health Program
JULY 23	2:00pm – 5:00pm	Executive Committee (at Dr. Strassberg's house)
AUGUST 1	9:00am – Noon	"First Fridays" Educational Program: Rediscovering the Care in Health Care
AUGUST 27	4:00pm – 6:00pm	Committee on Public Health

▲ *On March 15, Maine physicians converged on the Woodlands in Falmouth for an event honoring U.S. Maine Senator Susan Collins. The event was hosted by Stuart Gilbert, MD of Falmouth and MMA EVP Gordon Smith, both seen above with the Senator.*

Upcoming Specialty Society Meetings

JUNE 6-8, 2008 *Harborside Hotel & Marina - Bar Harbor, ME*
Maine Chapter of the American College of Surgeons 2008 Annual Scientific Meeting
Contact: Joel Lafleur, MD, FACS 207-596-5723 or jlafleurmd@gmail.com

JUNE 26, 2008 *Lobster Bake on Cabbage Island*
Maine Chapter, American College of Emergency Physicians Meeting
5:00pm – 8:30pm
Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

SEPTEMBER 4-7, 2008 *Samoset Resort, Rockport, ME*
The following Specialty Societies will be holding meetings in conjunction with MMA's Annual Session taking place at the Samoset Resort in Rockport, Maine:

Maine Society of Orthopedic Surgeons Annual Fall Education Sessions (Sept. 5-6)
MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

Maine Association of Psychiatric Physicians (Sept. 6)
MMA Contact: Warene Eldridge 207-622-7743 or weldridge@mainemed.com

Maine Urological Association (Sept. 6)
MMA Contact: Kellie Miller 207-622-3374 ext. 229 or kmiller@mainemed.com

SEPTEMBER 19, 2008 *Harborside Hotel & Marina - Bar Harbor, ME*
Maine Society of Eye Physicians and Surgeons Fall Business Meeting
(To be held in conjunction with the 7th Annual Downeast Ophthalmology Symposium)
10:30am – 12:00pm
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

SEPTEMBER 19-21, 2008 *Harborside Hotel & Marina - Bar Harbor, ME*
7th Annual Downeast Ophthalmology Symposium
(Presented by the Maine Society of Eye Physicians and Surgeons)
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

OCTOBER 17-19, 2008 *Harborside Hotel & Marina – Bar Harbor, ME*
Maine Chapter of the American College of Physicians 2008 Annual Scientific Meeting
MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

MMA Welcomes Our Newest Corporate Affiliate:

Maine Air National Guard

We appreciate their support!

THANKS TO SUSTAINING MEMBERS

Thank you to the following individuals and practices who have shown their support for the MMA's long-term growth by renewing at an additional sustaining membership level.

Charles Crans, MD

Jo Linder, MD

Tamas Peredy, MD

David Simmons, MD

Coastal Women's Healthcare

Mid Coast Hospital

Northeast Cardiology Associates

Penobscot Community Health Center

New MMA Committee Appointments

Jenie Smith, M.D., *Executive Committee*

Demystifying Medicare Advantage

By Bill Hall, Generations Advantage Marketing Manager, Martin's Point Health Care

You've probably heard the names of some new health plans in the last year or two: Today's Option, Secure Horizons, SmartValue Plus, Generations Advantage Prime … What are all these health plans and where did they come from? These plans, along with many others, are Medicare Advantage plans – a new way for Medicare beneficiaries in Maine to get their Medicare benefits.

What is a Medicare Advantage Plan? Medicare Advantage (MA) plans are health plans created by Medicare and run by private companies. They are not supplement plans and they do not replace Medicare. MA plans cover all of the benefits of Medicare Parts A and B, and often include Part D coverage and additional benefits as well. All of the benefits are administered through the MA organization, not through Medicare. MA plans generally charge a much lower premium than supplement plans and members pay co-payments or co-insurance for services received.

How do MA plans differ from supplement plans and original Medicare? Medicare Advantage plans work differently than Original Medicare or supplement plans.

- With Original Medicare, when a beneficiary receives services, they present their Medicare card. The provider bills Medicare and the beneficiary pays the remaining costs.
- With a supplement plan, the provider bills Medicare and then bills the supplement plan for the remaining costs.
- With a Medicare Advantage plan, the member pays a copayment at the time of service and the provider *bills the MA plan, not Medicare* for the service. The MA plan, in turn, collects a capitation rate from Medicare for each member they serve.

What are the different types of Medicare Advantage plans? Managed Care Plans, or HMOs, have a network of contracted doctors, hospitals, and other health care providers and usually require that members coordinate their care through a Primary Care Provider. Members pay predetermined co-payments or co-insurance for services. These plans often provide additional benefits not covered by Medicare.

Private fee-for-service plans don't have a network of health care providers. Some doctors and hospitals do not accept insurance from private fee-for-service plans. It's the member's responsibility to verify with their doctors and hospitals that they will accept the member's MA plan. Like managed care plans, co-payments and co-insurance apply for services.

PPOs or Preferred Provider Organizations have a network of doctors but offer some coverage for members who choose to go outside of the network, usually at a higher cost for the member. In general, no referrals are needed to see a specialist with PPOs.

When are the enrollment periods for MA plans? Medicare beneficiaries can sign up for Medicare Advantage plans only during certain enrollment periods. The Annual Election Period runs from November 15 to December 31. The Open Enrollment Period runs from January 1 to March 31. Special Enrollment Periods exist when members can change plans based on certain conditions – for example if they disenroll from a group plan, or if they move into or out of a plan's service area. For individuals who turn 65 during the year, they can join an MA plan as soon as they are eligible for Medicare Part A and have enrolled in Medicare Part B.

Questions? Ask Martin's Point: Martin's Point offers the only Maine-based, not-for-profit Medicare Advantage plans in Maine. We launched our Generations Advantage plan in 2007, and expanded our offerings as well as our service area in 2008. We currently offer three MA plans to beneficiaries in eight Maine counties. As a local resource, we are happy to answer any questions you have about Medicare Advantage plans. We can be reached, toll-free, at 1-866-544-7504.

Classified Ads

Medical Director Sought

Mercy Hospital in Portland is seeking a Medical Director for Mercy Primary Care. At Mercy Hospital and at our locations throughout greater Portland, you'll find more than the latest technology and highly skilled doctors, nurses, physician assistants, therapists and support staff. You'll also experience the special approach we take to healthcare, recognizing each patient as a whole person-body, mind and spirit. FMI please contact Ed de Oliveira @ 207-553-6092 or via email deoliveirae@mercyme.com. www.mercyhospital.org

Wanted

Physician artists to exhibit at MMA Annual meeting at the Samoset Resort in Rockport, Maine from September 4-7, 2008. Call Norm Rosenbaum, MD at 207-885-5219.

If you would like to know how your classified ad can appear in the next issue of ***Maine Medicine***, contact Shirley Goggin at 445-2260 or sgoggin@mainemed.com

With Sincere Appreciation!

The short-session of the 123rd Legislative Session is now behind us. On behalf of the MMA, we would like to acknowledge all members who assisted in the legislative process to advocate for patients and fellow physicians during the session. The Association shows its appreciation by recognizing those physicians for taking time out of their busy schedules to make valuable contributions. Testimony at public hearings or participation in the Doctor of the Day Program or Physicians' Day at the Legislature are all essential elements of MMA's role in promoting a good practice environment for physicians in the State of Maine and quality healthcare for Maine Citizens.

We have done our very best to check our files and our memories and apologize for anyone missed in this list.

LEGISLATIVE TESTIMONY

Jay Bosco, MD
Frank Bragg, MD
Don Burgess, MD
Ned Claxton, MD
Russ DeJong, MD
David Dixon, MD
Norma Dreyfus, MD
Kevin Flanigan, MD
Elisabeth Fowlie Mock, MD
Lani Graham, MD
Jo Linder, MD
Larry Losey, MD
Dora Anne Mills, MD, MPH
Jay Naliboff, MD
Noah Nesin, MD
Paul Pelletier, MD
Jim Raczek, MD

DOCTOR OF THE DAY

Jeffrey Bensen, MD
Carla Burkley, MD
David Dumont, MD
Steve Feder, DO
Richard Flowerdew, MD
Maroulla Gleaton, MD
Dan Hale, MD
David Howes, MD
Brian Jumper, MD
Lisa Letourneau, MD
Jo Linder, MD
Peter McGuire, MD
Carol Saunders, MD
David Seltzer, MD
Nevalee Seltzer, MD
Key Stage, MD
Daniel Summers, MD
James VanKirk, MD
Peter Wilkinson, DO
Jeffrey Young, MD

Jana Purrell, CPC

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

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

What makes a service "prolonged?"

I have recently been receiving calls related to the "prolonged services" codes 99354—99357. I have seen audits recently by several payors (non-Medicare) related to the use of these codes and The Center for Medicare and Medicaid Services (CMS) issued a revision to their policy on the use of these codes in April, 2008. There are prolonged services codes for both "face-to-face patient contact" and "non-face-to-face contact," however since the latter codes are generally not reimbursed by payors and are not commonly used, I will concentrate on the "face-to-face" services here.

Codes 99354—99357 are used when a physician or qualified non-physician provider (NPP) provides prolonged service face-to-face with the patient that is beyond the usual time (outlined in CPT) in either the outpatient or inpatient setting. The service must be reported in addition to the Evaluation and Management (E/M) service provided.

Codes 99354 (outpatient) or 99356 (inpatient) report the direct face-to-face patient contact that require one hour beyond the usual service and are payable when they are billed on the same day by the same provider. Codes 99355 (outpatient) or 99357 (inpatient) report each additional 30 minutes above and beyond the first hour.

To report the prolonged service, the following must occur:

- *Time involved must exceed the typical time of the E/M service by at least 30 minutes. (Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the E/M code)*
- *Only direct face-to-face between the physician or NPP counts—in the office setting the time with office staff or time the patient is waiting does not count; in the hospital setting, time spent reviewing charts, discussion of patient with staff, waiting for test results without face-to-face contact with the patient does not count*
- *Time does not need to be continuous. The codes are for the total duration of face-to-face time spent on a given date by the same provider*

The documentation for the prolonged service must support the medical necessity of the E/M service plus the prolonged service, that the physician or NPP personally furnished the face-to-face time with the patient, and the start and end times of the visit should be documented along with the date of service.

Remember, the prolonged services codes must be billed with the appropriate E/M code. The companion E/M codes for 99354 are:

- Office or Other Outpatient visit codes (99201 - 99205, 99212 – 99215)
- Office or Other Outpatient Consultation codes (99241 – 99245)
- Domiciliary, Rest Home, or Custodial Care codes (99324 – 99328, 99334 – 99337)
- Home Services codes (99341 - 99345, 99347 – 99350)

The companion E/M codes for 99356 are:

- Initial Hospital Care and Subsequent Hospital Care codes (99221 - 99223, 99231 – 99233)
- Inpatient Consultation codes (99251 – 99255)
- Nursing Facility Services codes (99304 -99318)

New threshold tables have been designed to assist in the reporting of the prolonged services—(complete tables in the article listed below). **Example:**

Code	Typical Time for Code	Typical Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99201	10	40	85
99202	20	50	95

The other important clarification that CMS has issued relates to the use of the prolonged services codes when associated with an E/M service based on counseling and/or coordination of care (time-based coding).

If the level of E/M service is based on time (i.e. greater than 50% of the face-to-face visit (office), or floor time (hospital) was spent in counseling and/or coordination of care)—the prolonged services may only be reported with the highest code level in that family of codes (i.e. 99205, 99215, 99245, 99223, 99233, 99255, etc).

Examples of Billable Prolonged Services:

1. A physician performed a visit that met the definition of visit code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills code 99213 and 1 unit of code 99354 (first hour).
2. A nurse practitioner spends 75 minutes with an established patient discussing the results of recent diagnostic testing, prognosis and options. The NP bills code 99215 (40 min) and 1 unit of 99354 (additional 35 min)

Examples of NonBillable Prolonged Services:

1. A physician performed a visit that met the definition of visit code 99212 and the total duration of the face-to-face contact (including the visit) was 35 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.
2. A physician assistant provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The PA cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354. The physician must bill the highest level code in the code family (99215 = 40 minutes; the additional 20 minutes is non-billable as it does not meet the threshold time of at least 30 minutes)

You can find the recent Medlearn article (#MM5972) published by CMS at http://www.cms.hhs.gov/MLNMattersArticles/2008MMAN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=8&sortOrder=descending&itemID=CMS1209905&intNumPerPage=10

As always, please contact The Coding Center at 888-889-6597 or checkout our newly designed website at www.thecodingcenter.org if you have questions or need assistance with your coding needs.

CDC Takes Steps to Increase Awareness of the Choking Game

A deadly game played mostly by adolescent boys has officials at the Centers for Disease Control and Prevention (CDC) so concerned that physicians and parents are urged to look for warning signs of the activity.

A new CDC study found "the choking game" has claimed 82 lives since 1995. About 87 percent of the deaths were among boys 11-16 years old, with the average age being 13.

The game involves intentionally trying to choke oneself or another in an effort to obtain a brief euphoric state or "high." Death or serious injury can result if strangulation is prolonged.

The CDC also found that most of the deaths occurred when a child engaged in the activity alone. Most parents were unaware of the choking game prior to their child's death.

"This report is an important first step in identifying the choking game as a public health problem," said Ileana Arias, Ph.D., director of CDC's Injury Center. "More research is needed to identify risk factors that may contribute to kids playing the choking game and to determine what may help to reduce this type of behavior."

Read more at www.cdc.gov/ncipc/duip/research/choking_game.htm.

Signs that a child may be engaging in the choking game include:

- Discussion of the game – including other terms used for the game. (For a list of terms, see web site referenced above.)
- Bloodshot eyes
- Marks on the neck
- Severe headaches
- Disorientation after spending time alone
- Ropes, scarves and belts tied to bedroom furniture or doorknobs or found knotted on the floor
- Unexplained presence of things like dog leashes, choke collars and bungee cords

Public Health Spotlight

Kellie Miller, Director of Public Health Policy

2008-09 STATE HEALTH PLAN RELEASED BY THE GOVERNOR

This spring the 2008-09 State Health Plan was officially released by the Governor. The Plan is organized in three major categories representing the components that need to occur in Maine:

I. **Improving Health** - building a system that supports every person getting and staying healthy;
II. **Assuring Best Practices/Less Variation** in care delivery, making sure that every health care consumer receives the right care at the right time; and
III. **Efficiency and Effectiveness** - eliminating redundant or ineffective systems and treatments so that every consumer gets the quality and services needed at the lowest possible cost.

One of the MMA's Public Health Committee's Priority Initiatives - "The need to ensure that Maine has an increased Childhood and Adult Immunization Rate," has been specifically written into the plan (page 37), and sets a goal to achieve a 90% immunization rate. As Maine's consolidated statewide public health infrastructure emerges, the plan indicates that it is important that it doesn't operate in a silo, and that our public health systems should work hand in hand with our health care delivery system. This issue has emerged recently as an important public health topic, given the on-going reductions in federal funding for vaccines relative to their cost, as well as increasing the numbers of effective vaccines for both children and adults. The Public Health District Coordinating Councils (DDC's), will conduct (as outlined in the plan) an assessment of adult and childhood immunization needs in each district, using data from Maine CDC/DHHS, in hopes to achieve the goal of 90% by the end of 2009.

The Plan also accentuates an investment in Prevention (page 10), and points out the need to ensure the health of the environment, reduce dependency on chemicals containing toxins and references the MMA's Public Health Committee's priority initiative in this arena (however, referred to as the Public Affairs Committee).

The MMA's Public Health Committee will be working to move these prevention efforts forward and will work in concert with the development of the District Coordinating Councils throughout the state. To access a copy of the 2008-09 State Health Plan, go to: http://www.maine.gov/statehealthplan or contact Kellie Miller, Director of Public Health Policy, at kmiller@mainemed.com or 207.622.3374, ext. 229.

HEALTHY FAMILIES – HEALTHY YOU!

The problem of obesity has been widely reported in the media, as have the impacts of obesity on individual health and on the health care system. In recent years, many health experts have researched and published on the issue.

Studies have predicted that by the year 2050, obesity will shorten life expectancy in the U.S. by two to five years. Popular magazines with diet and weight loss tips abound, and state and federal governments have programs focused on obesity. Physicians are beginning to receive education and guidelines for treating overweight and obese patients. Yet the weight problem continues to plague children and adults.

This year the ***MMA's Public Health Committee***, is collaborating with the Harvard School of Public Health, the New England Coalition for Health Promotion and Disease Prevention for the Regional Governor's Conference, and the Maine Center for Public Health to assess the status of the New England states on a number of factors associated with overweight and obesity. A set of indicators have been researched and created that illustrate the condition of populations within each state and the prevalence (or lack) or enabling factors that encourage or discourage people to eat well and stay fit. There are many efforts underway to address this crisis but more are needed, and it will be difficult to devise successful strategies unless we keep track of current and changing conditions – not only of the health status of our population, but also of the "environmental factors" that facilitate or hinder people's ability to make healthy choices. One key sphere that they would like to investigate is physician practices. The MMA will soon disseminate an on-line survey, ***"Healthy Weight Trends Report Survey"*** to its members in primary care specialties to help guide future policy and action. To link to this survey, go to: http://www.surveymonkey.com/s.aspx?sm=CFjSMcW7kfFXzvwheUYFOQ_3d_3d.

LANDMARK LEGISLATION PASSED PROTECTING CHILDREN'S HEALTH

■ **L.D. 2012, *An Act to Protect Children in Vehicles from Secondhand Smoke into Public Law, Chapter 591.***

Gov. John Baldacci signed into law a ban on smoking in any vehicle when children under 16 are present. The new law gives Maine one of the toughest restrictions in the nation against exposing minors to secondhand smoke in vehicles. Bangor pediatric dentist and children's health advocate Dr. Jonathan Shenkin, is the primary architect of the Bangor ordinance and an energetic supporter of the state legislation.

Gordon Smith, Esq. Executive Vice President stated, *"The Maine Medical Association representing physicians in Maine proudly supported this legislation because of its direct and positive impact on the health of Maine children. As Maine continues its quest to become the healthiest state in the nation, we must begin with our infants and children who are often placed in harm's way and cannot speak for themselves."*

■ **L.D. 2048, *An Act to Protect Children's Health and the Environment from Toxic Chemicals in Toys and Children's Products***

Protecting children's health and the environment from toxic chemicals passed by an overwhelming majority at the statehouse. As one of the MMA's Public Health Committee's three public health policy initiatives, many of the committee members were actively involved in supporting this bill. By bringing together the environmental proponents and the medical community/public health proponents, Maine was poised to sign into law, one of the most comprehensive chemical policy framework ever enacted, which reflects a new paradigm that rejects risk assessment and embraces the availability of safer alternatives as the basis for restricting the use of inherently hazardous chemicals.

The Public Health Committee meets throughout the year with the next regularly scheduled meeting to occur August 27, 2008, from 4-6pm at the Maine Medical Association. All meetings are accessible via conference call or videoconference at the MaineHealth Board Room location in Portland. For more information on PHC meeting activities, contact MMA staff, Kellie Miller at kmiller@mainemed.com or 207-622-3374, ext 229. (All meeting agendas and minutes are posted on the MMA website: www.mainemed.com.)

Physicians' Foundation Sending Survey to Every Primary Care Doctor in America

By Philip Miller, The Physicians' Foundation for Systems Excellence

National Group Seeks to Give Physicians a Voice

What is the state of primary care practice in America today? Can primary care physicians continue to provide patient care in the face of rising costs, reimbursement cuts, and pervasive government regulations? What do primary care doctors themselves have to say about the direction of medical practice in America?

The Physicians' Foundation for Health Systems Excellence (PFHSE), a not-for-profit group composed of medical societies and physician leaders, is seeking answers to these questions by undertaking one of the most ambitious physician surveys ever attempted. Beginning in May 2008, PFHSE will send over 300,000 surveys to primary care physicians and selected medical specialists throughout the country. The survey will be sent to virtually every active primary care physician nationwide, and to specialists in small, independent practices.

"We have heard from the pundits about the state of medical care in the United States," notes Louis Goodman, Ph.D. president of PFHSE and executive vice president of the Texas Medical Association. "It's time we heard what physicians have to say."

According to Dr. Goodman, the survey asks primary care physicians about the state of their practices and whether or not they can maintain patient care services in light of regulatory and financial burdens. The key question posed by the survey, Dr. Goodman observes, is can doctors meet the needs of patients under current practice conditions?

"If the survey indicates that medical practice itself is in jeopardy, that urgent message needs to be heard by policy makers and the public," states Walker Ray, M.D., vice president of PFHSE and former president of the Medical Association of Georgia.

PFHSE has partnered with national physician search and consulting firm Merritt, Hawkins & Associates to develop and mail the survey. Tim Norbeck, executive director of PFHSE and longtime former executive director of the Connecticut State Medical Society, notes that physicians around the country will soon be receiving the survey and he urges them to participate.

"This is a critical chance for doctors to have their voices heard," Mr. Norbeck says. "The more physicians who participate, the more persuasive their voices will be.

About PFHSE

The Physicians' Foundation for Health Systems Excellence is a national grant making foundation dedicated to improving the quality of the medical practice environment. PFHSE was established in 2004 as part of a settlement in a class action lawsuit involving physicians and medical societies against the managed care industry. Its board is comprised of physician leaders and medical society members from around the country. For additional information, access www.physiciansfoundations.org.

Video Addresses Chronic Illnesses in Elderly, Minority Patients

The AMA offers a new online program that can help your elderly and minority patients manage their chronic illnesses.

As part of the Educating Physicians on Controversies and Challenges in Health series, the program presents self-management as a key strategy for improving the health of patients with chronic conditions.

It also demonstrates how you can help patients take a more active role in their own health care.

View the 10-minute video presentation, "Self Management Strategies for Vulnerable Populations," and others in the series at www.ama-assn.org/ama/pub/category/15369.html.

Updated Sentinel Event Statistics

As of December 31, 2007, The Joint Commission's sentinel event statistics have been updated on the Joint Commission website, www.jointcommission.org. Since the sentinel event database was implemented in January 1995, the Joint Commission has received 4,817 reports of sentinel events. A total of 4,945 patients were affected by these events, with 3,478 or 70 percent, resulting in patient death. The 10 most frequently reported sentinel events were:

■ Wrong-site surgery	625
■ Suicide	596
■ Operative/post-operative complication	568
■ Medication error	446
■ Delay in treatment	360
■ Patient fall	81
■ Assault, rape or homicide	177
■ Patient death or injury in restraints	176
■ Perinatal death or loss of function	143
■ Unintended retention of foreign body*	141

* Added to reviewable events in June 2005; data represents events reviewed since June 2005.

Questions regarding this information should be directed to Anita Giuntoli at agiuntoli@jointcommission.org.

Medicare Recovery Audit Contractors (RACs)

The Medicare Modernization Act (MMA) of 2003 required the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project using recovery audit contractors (RACs) to identify underpayments and overpayments and to recoup overpayments for the Medicare Fee-For-Service Program. The demonstration began in 2005 and ended March 27, 2008. The demonstration was completed in New York, California and Florida. The Tax Relief and Health Care Act of 2006 made CMS' use of recovery audit contractors permanent and requires CMS to expand nationwide by January 1, 2010.

CMS is planning a gradual transition for the permanent program. The nation will be divided into four regions. Each region will have a RAC who CMS will task with reviewing provider and physician claims to determine if they were billed and paid accurately. CMS has not yet announced the RACs but anticipates an announcement in mid/late spring.

CMS has committed to working closely with the physicians and associations to ensure physicians are educated about the RAC program. CMS has a website where additional information can be found including an expansion map and past status reports. The status reports include the impact on physicians during the demonstration, lessons learned and sample physician claim types where overpayments were found. The CMS website is www.cms.hhs.gov/rac.

Andrew MacLean, Esq.

Legislative Update

123rd Maine Legislature Completes Work and Adjourns in Mid-April

The 123rd Maine Legislature brought its second session to a close on Friday, April 18, 2008, concluding a session including definitive action on Dirigo Health Program legislation, successful efforts to close a substantial gap in the biennial budget while maintaining a MaineCare physician fee increase, and enactment of several public health bills of interest to physicians. The MMA leadership believes it was a successful session with a MaineCare fee increase coming effective July 1, 2008, defeat of lay midwifery licensing, and enactment of an alternative funding method for the Dirigo Health Program among the highlights.

Following a final flourish of activity on the Dirigo Health Program, school and jail consolidation, bridge repair and maintenance, and driver's license security, the 123rd Maine Legislature adjourned *sine die* late in the evening of Friday, April 18, 2008. Practically, *sine die* means this legislature has adjourned for the final time. Members of this legislature now are either enjoying their retirement or planning their re-election campaigns. Technically, *sine die* means adjournment without a definite date and time to return.

The State FY 2008-2009 supplemental budget (L.D. 2289) that closed a gap in the biennial budget of approximately $200 million also maintained a General Fund increase of $3 million in the MaineCare fee schedule. This new funding will increase MaineCare physician reimbursement rates from approximately 53% of Medicare rates to approximately 62% of Medicare rates, effective August 1, 2008 rather than July 1, 2008 because of rulemaking procedural requirements.

As you have seen in the press, the legislature enacted and the Governor signed an amended version of L.D. 2247, *An Act to Continue Maine's Leadership in Covering the Uninsured*, the bill intended to provide a sustainable and stable source of funding for the Dirigo Health Program and to make some modest changes to the regulation of health insurance in Maine. The new funding for Dirigo replaces the controversial "savings offset payment" (SOP) with a 1.8% "health access surcharge," a combination of alcohol and soft drink taxes, and some money from the Fund for a Healthy Maine. The $0.50 per pack increase in the cigarette excise tax proposed in the original version of L.D. 2247 simply could not achieve sufficient support in the Senate to assure passage.

The MMA continues to believe that the Dirigo Health Program has been a positive contribution to our health care system and our pluralistic approach to covering the uninsured. For physicians, remember that the DirigoChoice health insurance product pays market rates for medical services. From a quality improvement and public health perspective, the Maine Quality Forum, under the direction of Josh Cutler, M.D. advised by a panel of providers and other health care experts, is at the forefront of the patient safety and quality improvement movement in Maine. The MMA will defend the Program through a "people's veto" initiative for L.D. 2247, if necessary.

During the next to final week of the session, the Maine Senate rejected the majority committee report on L.D. 2253, *An Act to License Certified Professional Midwives* that would have licensed so-called "lay" midwives in Maine and provided them with a scope of practice and educational standards determined principally by the midwives' national organization. The Senate voted 24 to 11 against acceptance of the licensing proposal and instead accepted the minority committee report that rejects licensing but allows access to a limited list of medications for use during home births. The House initially had accepted the licensing proposal by a 30-vote margin, but later "receded and concurred" with the Senate action. The MMA and other medical organizations opposed licensing of the lay midwives, arguing that licensing would lead to confusion with certified nurse midwives (CNMs) and would wrongly suggest the State's endorsement of the safety of home births.

The legislature's action on L.D. 2253 ends for 2008 the effort by lay midwives to seek increased legitimacy in Maine through licensing. The effort in Maine was part of a national effort through which lay midwives have gained licensure in 24 states, including New Hampshire and Vermont. Despite a state agency "sunrise review" report recommending against licensure, a bare majority (7 members) of the Business, Research & Economic Development Committee voted to proceed with licensing through the Board of Complementary Health Care Providers that currently licenses naturopathic doctors and acupuncturists.

The grassroots lobbying on L.D. 2253 was intense with several Senators reporting dozens of calls and contacts by midwives and women who had given birth at home. The MMA's efforts were complemented by the work of the Maine Section of ACOG, the Maine Academy of Family Physicians, the Maine Chapter of the AAP, the Maine Chapter of ACEP, the Maine Association of Psychiatric Physicians, the Maine Osteopathic Association, and the Maine Association of Nurse Practitioners. Supportive grants from the AMA's Scope of Practice Partnership and the Maine Section of ACOG helped the lobbying effort considerably.

One of the bills endorsed by the MMA Public Health Committee was the subject of considerable legislative debate and press coverage in the final weeks of the session. L.D. 2048, *An Act to Protect Children's Health and the Environment from Toxic Chemicals in Toys and Children's Products* was a 9-4 "ought to pass as amended" report from the Natural Resources Committee. The bill authorizes the DEP in concurrence with the Director of the Maine CDC to include on a list of chemicals of high concern chemicals identified by specific entities. Prior to designating priority chemicals, the DEP is required to consult with affected industries, independent experts, and other interested parties. It authorizes the BEP to adopt rules restricting the sale of children's products containing priority chemicals if safer alternatives are available. It authorizes the DEP to designate mercury or a mercury compound as a priority chemical for the purpose of adopting rules to prohibit the sale of a mercury-added product that is not currently regulated.

The MMA's summary of all legislation tracked during the 123rd Maine Legislature will be available this summer.

You can find joint standing committee assignments on the web at:

- http://janus.state.me.us/house/jtcomlst.htm.

You can find your Senator and Representative on the web at:

- http://janus.state.me.us/house/townlist.htm.

To find more information about the MMA's advocacy activities, go to www.mainemed.com and visit the Legislative & Regulatory Advocacy section of the site. You will find more information about the Maine Legislature, including schedules, committee assignments, legislator contact information, audio coverage of legislative work, and newly enacted laws on the web at: http://janus.state.me.us/legis/.

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.

SAVE THE DATE

September 4th-7th, 2008

MMA's 155th Annual Session
at the Samoset Resort - Rockport, Maine

See insert in this issue for more information. For room reservations at the Samoset Resort, call 1-800-341-1650.

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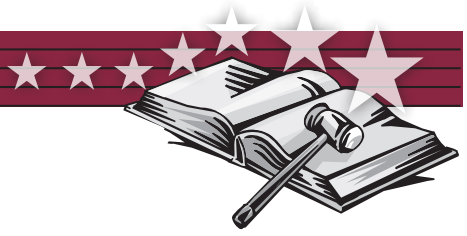

Gordon Smith, MMA EVP

Notes from the E VP

With the additional space now available in our bi-monthly publication, I think it is time to institute a regular column from the Executive Vice President. Similar to the President's Corner and Mr. MacLean's and Ms. Purrell's articles, this column will give me a regular opportunity to communicate with members and other readers as well. In a voluntary membership association, you can never communicate too much, and I look forward to being able to share my personal thoughts on what is going on within MMA and in the broader world of medicine in Maine. It is a busy time and a time of great change.

Inconsistent with my reputation, I will limit these columns to six hundred words. I will try not to repeat the material we prepare every Monday in Maine Medicine, published only electronically. If you are not receiving that publication, entitled *Maine Medicine Weekly Update,* just send me an e-mail and we will add you to the list. It is the best way to learn what is going on each week. My e-mail address is at the conclusion of this column.

If you are wondering how much content you can get into an article of six hundred words, I am already over one hundred fifty. It goes fast.

By the time you read this, we will be in the sixth month of MMA's 155th year and looking ahead to the Annual Meeting in September (Sept. 4-7, 2008 at the Samoset). It has been quite a successful year to date, with most of our programs and projects achieving some measure of success and with the budget tracking well. We have had five "First Fridays" presentations, a successful Practice Education Seminar (17th Annual), the Corporate Affiliate Breakfast and completed another busy legislative session. In addition, the Voluntary Practice Assessment Initiative (funded by the Maine Quality Forum), the Chronic Pain Project (funded by the Board of Licensure in Medicine) and the educational series on the Prescription Monitoring Program (funded by the Office of Substance Abuse) all are achieving their objectives. Virtually all of the committees are active and the Physician Health Program (recently renamed the Medical Professionals Health Program) and the Coding Center are not only meeting their objectives but exceeding them. None of this would be possible without a hard-working, loyal and dedicated staff. We are fortunate to have them.

The legislative session was dominated by budget issues, but there was still plenty of focus on public health issues and the lay midwifery issue. We are glad to have it done until January. Now our focus will be on the political aspects of the process as every house and senate district will be subject to the election process of Nov. 4.

Finally, the 28 member-strong Executive Committee continues to think strategically and exert appropriate governance in MMA's work without micro-managing. The staff appreciates their time, support and approach. Much of its focus has been on developing the elements of the Professionalism Initiative proposed by Dr. Strassberg and described in his regular columns for this publication. Focusing attention on quality improvement/patient safety, relationships with industry and accountability, it is a worthwhile endeavor in these changing and stressful times. The Committee on Physician Quality and the newly rejuvenated Committee on Ethics and Discipline are moving the Initiative ahead.

Please let me hear from you if you have any concerns or ideas about what MMA is doing (gsmith@mainemed.com or 622-3374 ext. 212). We appreciate the feedback, and will give it every consideration. My 600 words are done.

Dirigo Health Update *(as reported by the Dirigo Health Agency for February 2008)*

Due to funding constraints, the Dirigo Health Agency capped individual enrollment in DirigoChoice on August 1, 2007, and small group enrollment on September 1, 2007. This chart compares the current enrollment in DirigoChoice to the enrollment at its highest level, immediately preceding the implementation of the caps.

Enrollment:	**August 1, 2007**	**February 1, 2008**	**Change over 6 months**
Number enrolled	15,113	13,681	-1,432

Enrollment Distribution by Group:	**August 1, 2007**	**February 1, 2008**	**Change over 6 months**
Small Group	23%	24%	+1%
Sole Proprietors	28%	28%	0%
Individual	49%	48%	-1%

Subsidy Distribution:	**August 1, 2007**	**February 1, 2008**	**Change over 6 months**
Group A (100% subsidy)	1%	Not reported	---
Group B (80% subsidy)	52%	52%	0%
Group C (60% subsidy)	15%	15%	0%
Group D (40% subsidy)	10%	10%	0%
Group E (20% subsidy)	5%	5%	0%
Group F (no subsidy)	17%	18%	+1%

Subsidy Costs as a Percentage of Premium*:	**2005**	**2006**	**2007**	**2008 to date**
DHA Subsidy	49%	53%	54%	56%
Employer/Enrollee contribution	51%	47%	46%	44%

* = *Represents the subsidy costs spread across all enrollees*

Costs of Coverage (Year to Date):	
Dirigo Subsidies	$6,978,401.61
Employer/Enrollee contribution	$5,490,627.69
Total	$12,469,036.30

Disparate Parties Agree on Standards to Measure M.D. Performance

Physician groups, health insurers and organizations representing consumers, labor and employers have reached an agreement about guidelines to measure physician performance. Those endorsing the new principles call it the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs.

"Efforts by health insurers to rate physicians must not be driven solely by costs and economics," said Nancy Nielson, M.D., AMA president elect. "The primary goal of these programs must be to promote quality care using meaningful measures."

Organizations working on the charter met with AMA leadership and made many changes to the original draft to address the original draft to address AMA concerns. The final document goes beyond voluntary "criteria" and requires:

- An independent audit of health insurer's programs
- Reporting of cost/efficiency information to patients only with quality information
- Clear context information on data limitations for patients and encouragement to talk with physicians about the information
- Engaging physicians in program design
- Provision of clear prior notice to physicians reported and opportunity to appeal

"Instead of tiered and narrow networks, the AMA believes that providing valid data to physicians and patients will better improve the quality and efficiency of care," said Dr. Neilson.

She noted that additional work must be done to accurately and fairly evaluate the work of individual physicians, but sees the Patient Charter as "an important step in the right direction."

To read more about the standards, see http://healthcaredisclosure.org/docs/files/PatientCharter040108.pdf.

Endorsers of the Patient Charter Include:

American Medical Association
American Academy of Family Physicians
American College of Physicians
AARP
Aetna
AFL-CIO
America's Health Insurance Plans
Cigna
Leapfrog Group
National Business Coalition on Health
UnitedHealth
Wellpoint

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