JULY/AUGUST 2005

Maine medicine

MAINE MEDICAL ASSOCIATION

In this issue...

Top Four Federal Physicians Come to Maine to Tout Medicare Part D Prescription Drug Benefit

The top four physicians in the federal government came to Scarborough, Maine on July 13 to promote the new Medicare prescription drug benefit which begins on Jan. 1, 2006. Mark McClellan, M.D., CMS Administrator, Surgeon General Richard Carmona, M.D., CDC Director Julie Gerberding, M.D., and Elias Zerhouni, M.D., Director of the National Institutes of Health spoke to a group assembled at the Southern Maine Agency on Aging. MMA staff participated in the event.

The "Four docs" bus tour, as it is dubbed by CMS, aims to raise awareness of the voluntary drug benefit which Medicare recipients can begin to enroll in Nov. 15.

Because the various carriers of the benefit in Maine haven't been announced, the program was short on details but certainly the considerable fire-power from Washington drew attention. New York Times health reporter Robert Pear was among those attending, leading to a feature piece on the front page of the Sunday New York Times.

The drug benefit will be available to about 240,000 Medicare enrollees in Maine.

At a meeting with stakeholder groups prior to the public session, MMA EVP Gordon Smith asked Dr. McClellan for his assistance in urging Congress to include benzodiazepines on the Medicare formulary. As this class of medication, used by many seniors, was excluded from the coverage originally, it will take an act of Congress to provide coverage. McClellan noted in response to the question that it is hoped that state Medicaid drug programs will continue to offer benzodiazepines and that federal matching funds will continue to be paid to the states for them.

From top clockwise: *Surgeon General Richard Carmona, M.D. with MMA EVP Gordon Smith; DHHS Commissioner Jack Nicholas with CMS Administrator Mark McClellan, M.D. and CDC Director Julie Gerberding, M.D.; Mark McClellan, M.D.*

Governor Announces Full-Scale Review and Redesign of Office of MaineCare Services

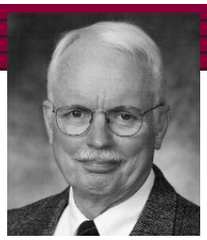
On July 13, Governor Baldacci held a press briefing to announce that he has ordered a full-scale review and redesign of the Office of MaineCare Services [formerly known as the Bureau of Medical Services (BMS)]. The Governor acknowledged that in looking at the MECMS situation, the Department had uncovered deeper structural weaknesses at MaineCare, many of which had existed for decades.

At a Provider Advisory Committee meeting held on July 14, Commissioner Jack Nicholas and Deputy Commissioner John Michael Hall noted that even if the MECMS problems are fixed, the cultural problems would remain without fundamental and system-wide change.

"Through conversations with providers, MaineCare staff, and other stakeholders, we have learned that the circumstances that gave rise to the premature deployment of MECMS are symptomatic of profound, longstanding issues at BMS that, if left unaddressed, will inevitably foster similar crises

continued on page 2

President's Corner



Lawrence B. Mutty, M.D., President, MMA

The Sine Qua Non of Quality Patient Care:

"Getting to Know You" is a Broadway Show tune from the "King and I". It bears an important message for physicians as we contemplate the essential requirement, the sine qua non, of quality care. That essential is adequate time. Time is required in order for the doctor to get to know his or her patient. Time is needed to learn about the biological, psychological, social and spiritual context within which the illness developed, treatment is conducted and rehabilitation expected. Time is necessary for the physician to share necessary clinical information with other members of the health care team; to referral physicians, the nurse, the pharmacist or other helping professionals and, as appropriate, to talk with family members.

However, now more than ever, there are powerful forces pressing down on the physician that are inimical to spending the necessary time with the patient. Pressures mount from government payers, insurance companies and employers to see more patients for less and less time, to reduce the numbers of support staff, to overbook the schedule.

Technology is properly touted as increasing the accuracy and efficiency of recording and disseminating information. However, cookie cutter software computer programs tend to submerge the individuation of the patient. A certain irreducible minimum of person to person time with the patient is required in order to build the essential foundation of trust. In the last analysis, it is the physician who must define, for any given interaction, the necessary minimum time.

Too often now, especially in the case of specialist physicians, the encounter with a new patient is not that between a kindly disposed and trusted friend and a neighbor. Rather it is more like two strangers warily circling one another as potential adversaries in a court of law.

If you were to have the privilege that I enjoyed this past year of visiting the free clinics in Ellsworth, Rockland, Brunswick, Portland and Biddeford, you would learn of the enormous satisfaction experienced by the many physicians and nurses who volunteer their precious time to serve in these clinics. These doctors and nurses speak of the joy of practicing medicine the way they always believed it should be. In such clinics, free of the duress of third party payers of all species, they can devote all the time necessary to fully understand their patients and to communicate with the others on the treatment team and with families. This dedication of time is rewarded with commensurate gratitude, love even, by patients and their kin. I submit, it is no mere coincidence that lawsuits against free clinics are such an extreme rarity.

Bear in mind that the Maine Medical Association, the American Medical Association and your specialty society are your principal allies as you wrestle with those gathering thieves of time. The cost cutters may attempt to turn you into some kind of production line automaton, deprived of the time and satisfaction of a medical practice that can be truly said to offer quality. Please keep your memberships up to date. Together we are stronger!

Any thoughts, comments or questions can be directed to me, Lawrence Mutty, M.D., by calling 207-326-4637, faxing 207-326-8352, or emailing lmutty@verizon.net.

Upcoming Specialty Society Meetings

SEPTEMBER 9 - 11, 2005 *Harborside Hotel & Marina - Bar Harbor, ME*

(The following Specialty Societies will be holding meetings in conjunction with MMA's Annual Session taking place at the Harborside Hotel and Marina in Bar Harbor, ME)

Maine Society of Anesthesiologists Meeting
Contact: Anna Bragdon 207-441-5989 or msainfo@adelphia.net

Maine Society of Orthopedic Surgeons Annual Meeting
MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

Maine Association of Psychiatric Physicians, Executive Council Meeting
MMA Contact: Warene Eldridge 207-622-7743 or weldridge@mainemed.com

Maine Urological Association Meeting
MMA Contact: Warene Eldridge 207-622-3374 or weldridge@mainemed.com

SEPTEMBER 23, 2005 *Harborside Hotel & Marina - Bar Harbor, ME*

Maine Society of Eye Physicians and Surgeons Fall Business Meeting
(To be held in conjunction with the 4th Annual Downeast Ophthalmology Symposium) 10:30am – 12:30pm
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

SEPTEMBER 23 - 25, 2005 *Harborside Hotel & Marina - Bar Harbor, ME*

4th Annual Downeast Ophthalmology Symposium
(Presented by the Maine Society of Eye Physicians and Surgeons)
MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

OCTOBER 7 - 9, 2005 *Bar Harbor Regency - Bar Harbor, ME*

Maine Chapter, American College of Physicians Annual Scientific Meeting
MMA Contact: Warene Eldridge 207-622-3374 or weldridge@mainemed.com

MMA Welcomes Our Newest Corporate Affiliate:

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Redesign of Office of MaineCare Services...continued from page 1

in the future," Mike Hall said in a statement released to the media.

Deloitte Consulting has been engaged by the state to work on the Transformation Project, the name given the effort by DHHS. Each Deloitte staff member will have a particular focus and expertise: claims management, provider relations, business processes, organizational leadership and development and customer service. Beginning in July, they will evaluate the current organization, map decision processes, determine where staff are deployed and assess effectiveness and capacity to meet the myriad demands that are made on the Bureau.

The Department will begin receiving input from providers in early September, initiating a discussion of the agency's core mission and priorities as part of designing the new structure and work methods. Providers will be asked what works well, but also what aspects of their interactions with MaineCare are inefficient or burdensome, and distract them from focusing on patient care. "We cannot eliminate every piece of documentation or paperwork, but we can work on subtracting those that have little real utility and then streamlining others so that transactions with MaineCare more closely resemble the routine transactions your members have with other insurance carriers," Mike Hall stated.

The Governor noted in his press conference that the Bureau had lost the confidence of providers, recipients and the public. The objective of the Project is to restore that confidence.

The MaineCare program provides coverage for more than 300,000 Maine people. It represents over 20% of the state's general fund.

WellPoint/Anthem Settles Class-Action Lawsuit with Physicians for Nearly $200 Million

Health plan company WellPoint (which owns Anthem Blue Cross and Blue Shield of Maine) will pay $198 million to settle allegations brought in a class-action lawsuit by 18 state medical associations on behalf of 700,000 physicians. The associations accused the company of underpaying for physician services and allowing hospitals to bill WellPoint members for services the company should have paid. Under the settlement agreement, WellPoint will pay $135 million to physicians, contribute $5 million to set up a foundation to promote quality health care and improve health care delivery to the uninsured, and pay up to $58 million in legal fees. WellPoint serves 28.2 million members and operates Blue Cross and Blue Shield HMOs and other health plans in 13 states. For more information, visit www.Wellpoint.com. As we have in the Aetna and Cigna settlements, MMA will continue to provide members with information on the settlements and the opportunities to participate.

Save the Date of Wednesday, September 28th for Technology Program

The Maine Chapter of MGMA (Medical Group Management Association) and the Maine Medical Association team up in September to present a technology program designed for physicians and office staff interested in exploring how to improve their practice through technology. While much of the day will feature information on Electronic Medical Records (EMR), information will also be available on e-prescribing and other technological advances. The program will be held on Wednesday, Sept. 28 at the Augusta Civic Center.

With several federal and state initiatives pushing practices to adopt more aggressive strategies for using technology to improve data collection and enhance quality improvement efforts, medical practices in Maine have an acute need for assistance in the technology area.

The Sept. 28 program is intended to be very "hands-on" and to assist practices in a very practical way. Vendors who have successfully implemented projects in Maine will be invited to present and demonstrate their products. Plenary sessions on the topics of vendor-selection and the roll of technology in Pay for Performance will be included. Physicians, vendors and practice managers who have successfully implemented a project will present in a panel format and discuss what they would do differently if they had the chance to do it again.

Registration materials are enclosed but members or staff (or vendors) wishing to get a head start on this program can contact Chandra Leister at 622-3374 or via e-mail at cleister@mainemed.com.

Angus King Named Vice-Chair of Federal Medicaid Advisory Commission

On Friday, July 8, HHS Secretary Mike Leavitt announced the membership of the advisory commission charged with identifying reforms necessary to stabilize and strengthen the Medicaid program. Former Maine Governor Angus King will serve as vice-chair of the commission, which will be chaired by former Tennessee Governor Don Sundquist. The commission is made up of 13 voting members and 15 non-voting members.

Consisting of health policy leaders from both sides of the aisle, state health department officials, public policy organizations, individuals with disabilities and others with special expertise, the commission will submit its first report to Secretary Leavitt by Sept. 1. Through the FY 2006 budget agreement, HHS agreed to create this commission to develop proposals on the future of the Medicaid program.

The commission must submit two reports to Secretary Leavitt. By Sept. 1, the commission will outline recommendations for Medicaid to achieve $10 billion in reductions in spending growth during the next five years as well as ways to begin meaningful long-term enhancements that can better serve beneficiaries. The commission, for its first report, also will consider potential performance goals for Medicaid as a basis of longer-term recommendations.

The second report, due Dec. 31, 2006, will provide recommendations to help ensure the long-term sustainability of Medicaid. The proposal will address key issues such as:

- How to expand coverage to more Americans while still being fiscally responsible
- Ways to provide long-term care to those who need it;
- A review of eligibility, benefits design, and delivery; and
- Improved quality of care, choice and beneficiary satisfaction.

The Reuters news agency reported on July 9 that leaders of both political parties were invited to appoint four nonvoting members to the commission, but that Democrats refused to do so, charging that the panel will be one-sided.

The escalating cost of the Medicaid program is a recurring issue in Washington and in state capitals across the country. In Maine, the average annual growth in Medicaid spending was 8.6% from l994 through l999 and 12.1% from l999 through 2004. The program cost approximately $2 billion to operate in fiscal year 2004 with nearly two-thirds of the funds coming from the federal government. The program serves about 275,000 Mainers currently.

A full copy of the commission's charter is available at **http://www.cms.hhs.gov/faca/mc/default.asp.**

The HHS press release listing all members of the commission is available at **http://www.hhs.gov/news.**

Maine's Unused Pharmaceutical Return Program Gaining Momentum as National Model

By W. Bogan Brooks, M.D., DFAPA, Damariscotta, Maine

In the United States, there has not been a safe way for patients to dispose of unused prescription medication; and the accumulation of unused prescription medication has been dangerous. Some people have died from accidental poisoning, while others have died by purposeful ingestion. Drug abusers have diverted unused controlled substances for illicit purposes. Americans have flushed unused pharmaceuticals down the toilet and polluted our environment.

In response to this public health and safety problem, the Maine Association of Psychiatric Physicians in collaboration with the Maine Medical Association and other interested parties supported a bill that was passed in 2003 by the 121st Maine Legislature entitled: "An Act to Encourage the Proper Disposal of Unused Pharmaceuticals." This bill allows Mainers to safely dispose of their unused prescription medication by mailing unused pharmaceuticals in a prepaid envelope to the Maine Drug Enforcement Agency for destruction. The Maine Drug Return Implementation Group, which was charged with the task of making recommendations to the Legislature for the implementation of the Unused Pharmaceutical Return Program, gave its report to the Legislature in January 2005.

As options for funding the prescription drug return program in Maine are currently being explored, several groups across the country have expressed an interest in Maine's innovative program. List-serves regarding this serious public health problem have been set up and Maine's Unused Pharmaceutical Return Program appears to be gaining momentum as a national model. At its convention in March of 2005, the United States Pharmacopeia passed a resolution to work with appropriate constituencies to develop programs to promote safe medication use and disposal. In May of 2005, the Assembly of the American Psychiatric Association endorsed an action paper that encourages state legislatures and the federal government to adopt programs for the proper disposal of unused pharmaceuticals.

At a time when Maine is trying to find a way to save $56 million in pharmaceutical costs for the coming biennium, Maine's Unused Pharmaceutical Return Program represents a potential savings to Maine's Medicaid program. Here is how it works. Since every returned prescription medication represents a wasted health care expenditure, a careful analysis of which medications are not taken by patients may provide important clues about ways to eliminate wasted health care dollars. It is this potential in Medicaid savings for cash strapped legislatures across the country that makes Maine's Unused Pharmaceutical Return Program such an attractive model for improving public health and safety.

UPCOMING AT MMA

AUGUST 15, 2005
9:00am – 3:00pm
Governor's Council on Physical Fitness, Sports, Health and Wellness

AUGUST 16, 2005
5:30pm
Committee on Membership and Member Benefits

AUGUST 17, 2005
1:00pm – 3:00pm
Maine Health Alliance/Maine Health

AUGUST 24, 2005
Noon – 2:30pm
Maine Health Information Center

AUGUST 31, 2005
4:00pm – 6:00pm
Public Health Committee

SEPTEMBER 2, 2005
9:00am – Noon
First Friday CME Seminar

SEPTEMBER 9 -11, 2005
152nd Annual Session at Harborside Hotel and Marina, Bar Harbor

SEPTEMBER 15, 2005
All Day
Governor's Council

SEPTEMBER 21, 2005
6:00pm
Payor Liaison Committee

SEPTEMBER 22, 2005
10:30am
RPC (Maine Association of Psychiatric Physicians)

SEPTEMBER 28, 2005
All Day
Technology Conference, Augusta Civic Center

OCTOBER 4, 2005
5:30pm
Committee on Membership and Member Benefits

OCTOBER 5, 2005
6:00pm
Maine Chapter, American Academy of Pediatrics

OCTOBER 6, 2005
12:30pm – 4:30pm
Home Care Alliance

OCTOBER 7, 2005
9:00am – Noon
First Friday CME Seminar

OCTOBER 12, 2005
4:00pm – 6:00pm
Public Health Committee

THE CODING CENTER

Jana Purrell, CPC

Why are they looking at me???

Some of you may have recently been chosen--in most cases, being chosen can be a good thing. However, if CMS (Centers for Medicare & Medicaid Services) sends you a letter referencing the PCA program—indeed you have been chosen……for a probe review!

The PCA (Progressive Corrective Action) initiative was created by CMS to be used to conduct Medical Reviews. CMS as the Medicare contractor for ME, NH, VT, and MA is required to conduct probe reviews to evaluate potential billing problems. If you receive a letter requesting between 20-40 claims, you may have been selected for a Medical Review Probe. Chances are this occurred as a result of data analysis which has identified potential problems with your utilization trends. This data analysis may be a general review of a particular code or it may be a response to a complaint or report. You will be asked to provide any medical documentation related to the claims in question. Some things to keep in mind when sending the requested documentation:

- Usually you will have 30 days to submit documentation—read the letter carefully and follow the instructions
- Contact the PCA coordinator if you are not going to meet the time frame outlined. Be sure to respond to the request, don't ignore it
- Send only the documentation for the dates/claims in question—you don't want to send more than they asked for
- Documentation for all of the services billed on the claim in question should be sent—consult requests, injection services, diagnostic tests, etc
- Any forms that are referenced (medication list, problem list, history form) should be included

Once the probe has taken place, any problem discovered will be classified as minor, moderate or major based on the number of claims paid in error, the dollar amount paid incorrectly, and your past billing history. In all cases, the carrier will provide education on the appropriate billing procedures and request a refund of any money paid on claims in error. Depending on the degree of the problem, further review may take place—random review to see that the problem has been corrected; some level of prepayment review until the provider has proven they have corrected their billing procedures; or if it has been determined as a major problem, a comprehensive prepayment review and/or random sampling of other services, payment suspension, and/or referral to the Benefit Integrity Department.

Are there things you can do to avoid a Probe Review? Absolutely! As mentioned, a review can occur because of analysis of your claims data. You are being compared to your peers. Be sure that you and/or your group is enrolled under the correct specialty and locality. If you are enrolled incorrectly you could be compared to a group of peers whose practice patterns may be significantly different. Confirm that your personal and group designations are correct with all your payors. Keep in mind that just because your name showed up on the list, doesn't mean you have done anything wrong—depending on your specialty, locality, patient mix, it may make perfect sense that your billing pattern is different from your peers.

Other problem areas that have been identified on Medical Review that you can avoid are:

- Documentation of E/M service does not support code selected
- Chief complaint or reason for the encounter (which is required to establish medical necessity) is missing or not clear
- HPI was not documented at the required level for the code billed
- ROS is missing or not documented
- Conflicting dates of service between the date on the documentation and the date of service submitted on the claim
- Document was illegible—only the portion that was legible was used to determine the appropriate level of service
- No examination of patient documented—required on consults, admits, new patients if not coding based on time
- E/M service billed actually was documented as a routine non-covered service
- Provider rendering the service is missing or unclear
- If forms completed by patient and/or staff are used, the physician must note this information was reviewed—just having the form in the chart isn't enough
- Information regarding the decision making is vague or not documented

Being aware of the common areas of concern, being thorough and complete in your documentation of services, and conducting periodic internal reviews and audits will help you be confident in your billing procedures.

Additional information regarding audit services, what information to send if an audit is requested and general documentation guidelines can be found on our website at www.thecodingcenter.org

Update on other billing/coding info:

- Medicare Part B Outreach and Education department is available to meet with billing staff on-site to discuss claims issues, questions about remittance advice issues and general billing questions. Contact Thelma Woods at thelma.woods@eds.com or call 1-781-741-3492
- To take a look at new ICD9 codes that will go into effect October 1, 2005 go to **http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines**

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MMA Initiates "First Fridays" Educational Programs

"First Fridays" is a new series of educational seminars presented by MMA on socio-economic issues, CME and practice management. The seminars will be held the first Friday morning of each month, from 9:00a.m. to noon at the MMA offices in the Frank O. Stred Building in Manchester. The first program is Sept. 2 on the subject of Minors' Rights to Health Care; Consent and Privacy Issues.

The **Sept. 2** program is co-sponsored by the Maine Chapter of the American Academy of Pediatrics and features healthcare attorneys Kenneth Lehman, Andrew MacLean and Gordon Smith discussing some of the more complex and sensitive issues of caring for minors. While anyone is welcome, the program will be of particular interest to staff in a pediatric or family practice setting and an additional mailing of program materials will be sent to such practices.

The **Oct. 7** program is entitled, "Preventing Prescription Drug Abuse" and will include a description of the information available to practices through the new state Prescription Drug Monitoring Program. MDEA Director Roy McKinney will also provide an update on the current status of prescription drug abuse in Maine.

On **Nov. 4,** speakers will present on The Medicare Modernization Act, particularly emphasizing the Part D drug benefit which begins on Jan. 1, 2006. Seniors will be asking physicians about the program and this educational effort is intended to assist office staff and physicians in responding to these questions. CMS officials will be included in the presentations.

Closing out the 2005 series on **Dec. 2** will be "The Best of the 2005 Physician Survival Seminar." MMA has imposed on the most highly rated speakers from our May and June programs and asked them to present again on Dec. 2. This will give those practices in the central Maine area an opportunity to benefit from the best of the earlier programs if staff had not been able to attend the Bangor or Portland programs.

The fee per program is $60 per attendee which includes a light breakfast and all course materials. Registration materials are included in this issue of Maine Medicine but interested persons may also contact Chandra Leister at MMA for a registration flyer or additional information (622-3374 or cleister@mainemed.com).

MMA members and their staffs are encouraged to make suggestions for future topics for this series of programs. Send your suggestions to Gordon Smith at gsmith@mainemed.com.

Help on the Way with MaineCare Prior Authorizations

The MaineCare prior authorization process continues to be a significant administrative hassle for MMA members and their staffs. Due to MMA and Maine Osteopathic Association efforts, aided significantly by the MaineCare Advisory Committee, the legislature enacted a Resolve, Chapter 113, entitled *"Resolve, To Increase the Quality of Care and Reduce Administrative Burdens in the Pharmacy Prior Approval Process."* The Resolve has nine paragraphs detailing improvements to be made in the PA process. The Resolve reads as follows:

- The department shall specify on the preferred drug list and on the prior authorization form the number, titration if required, and classes of preferred drugs that must be determined to be clinically inappropriate or ineffective before the department will permit the use of a nonpreferred drug.
- In the next changes to the MaineCare Benefits Manual, but no later than January 15, 2006, the department shall adopt a provision to articulate the current standards for off-label drug use of prescription drugs for children.
- The department shall change the prior authorization forms to provide examples of clinical conditions and functional limitations that could support a waiver of prior authorization.
- By Jan. 2006, the department shall amend its rules regarding prior authorization to include the criteria for approving special exception overrides. The department shall arrange to modify the message screen to include a reminder that overrides may be available. The message format must comply with National Council for Prescription Drug Programs standards.
- By Oct. 1, 2005, the department shall minimize the burden on providers of submitting duplicative medical records on behalf of a MaineCare member. In order to reduce the submission of duplicate information, the department shall work to provide notice to providers of the types of documentation required and to create a prior authorization file for each member.
- The department shall provide prompt notice of changes to the preferred drug list through postings on its website, its group electronic mailings regarding pharmacy issues and notices to provider organizations.
- The department shall arrange to allow submission of the prior authorization form and other required documentation as an e-mail attachment when such submissions are feasible.
- By January 15, 2006, the department shall amend its rules regarding the drug utilization review committee under the MaineCare Benefits Manual, Chapter ll, section 80.01-13 to establish conflict-of-interest standards for members of the committee.
- The department shall consult with the MaineCare Advisory Committee on the design of future studies related to pharmacy prior authorization, including a survey of MaineCare members. The department shall report to the Joint Standing Committee on Health and Human Services by Feb. 1, 2006 on its progress in implementing this subsection.

Saving Lives By Increasing Colorectal Cancer Screening Rates In Maine: A Health Systems Approach

By Robert Werner, MBA, Health Professional Account Manager, American Cancer Society

The American Cancer Society (ACS) is joining forces with the Maine Medical Association in working to reduce the number of deaths due to colorectal cancer by bringing increased emphasis and attention to the importance of colorectal cancer screening. Colorectal cancer is the second leading cause of cancer death in the United States, accounting for an estimated 56,290 deaths in 2005. In Maine, approximately 800 colorectal cancer cases will be diagnosed during 2005, and approximately 310 people will die from the disease.

Colon cancer almost always starts with the growth of a polyp on the lining of the colon or rectum. Colorectal cancer screening can save lives by detecting the polyp before it becomes cancerous – removing the polyp *prevents* cancer. Patients diagnosed at an advanced state of colorectal cancer have a projected five-year survival rate of 7 percent while early detection leads to a survival rate of 92 percent. ***Increasing screening rates is the key strategy for decreasing the number of lives lost to colorectal cancer – if all Americans 50 and older were screened for colorectal cancer, the death rate would be cut in half, saving approximately 30,000 lives per year!***

ACS and the Maine Medical Association are collaborating on a pilot project in Somerset County to directly engage those physicians that play the most critical role in the delivery of cancer prevention messages and early detection advice to their patients – primary care providers. ***89 percent of patients in a recent study conducted by ACS indicated that they were more likely to get a colorectal cancer test if "my doctor told me to."*** ACS will distribute Continuing Medical Education (CME), patient education materials and other helpful tools to assist physicians in implementing effective colorectal cancer screening programs in their practices.

In addition, partnerships with health plans, hospitals, and community health centers will enhance collaboration between ACS and primary care providers within health systems regarding the promotion of best practice models and tools that will encourage the wider adoption of proven colorectal cancer screening strategies. The new HEDIS measure adopted by NCQA will require health plans to publicly report their colorectal cancer screening rates in 2006, providing an additional incentive for health systems to work with their contracted providers to improve screening rates among individual practices.

Maine ranks 8th in the nation in the percentage of adults aged 50 and older who have had a recent colorectal cancer screening test, with 57% receiving either a Fecal Occult Blood Test (FOBT) in the preceding year or a sigmoidoscopy or colonoscopy within the preceding five years, compared to a screening rate of approximately 40% for the United States. ***The American Cancer Society goal for 2015 is to increase colorectal cancer screening rates from the current national average of approximately 40 percent to 75 percent for people aged 50 and older.***

Building collaborative relationships with organizations such as the Maine Medical Association will assist ACS in fulfilling its mission of eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research, education, advocacy, and service.

For more information about the colorectal cancer screening project, contact Robert Werner of the American Cancer Society at (603) 471-4138 or via e-mail at rob.werner@cancer.org.

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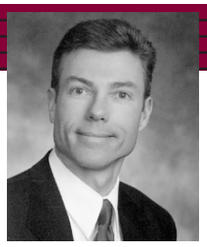
LEGISLATIVE UPDATE



Andrew MacLean, Esq.

122nd Maine Legislature Adjourns First Session in Mid-June

The MMA scores wins with its legislative agenda - MaineCare physician fee increase, incremental improvement in medical liability laws, extension of provision allocating portion of Capital Investment Fund to non-hospital projects, and preservation of access to medically-necessary breast reduction and varicose vein surgery. Thanks to all members who participated in the MMA's legislative advocacy activities!

Following a hectic final week of work, the 122nd Maine Legislature adjourned its 2005 session early in the morning of Saturday, June 18, 2005. The Legislature succeeded in enacting a package of new spending cuts and revenue increases to replace a borrowing scheme in the Part I biennial budget that had been strongly criticized by many and the subject of a people's veto campaign organized by the Republican minority. See the description of L.D. 1691 below. The Legislature considered a tax reform proposal, but deferred final votes on the package and consideration of a bond package until later in the year. The Legislature now is scheduled to return to Augusta on July 29, 2005 to consider an $83 million bond package negotiated by legislative leaders.

You can read the Governor's traditional sine die remarks on the web at: http://www.maine.gov/tools/whatsnew/index.php?topic=Portal+News&id=7632&v=article-2004.

The MMA accomplished something with each of its four legislative proposals in the 122nd Maine Legislature:

- **MaineCare Reimbursement Rates.** The clearest win of the session for the MMA and organized medicine generally is the $3 million General Fund increase in MaineCare reimbursement rates in the "Part I" biennial budget for 2006-2007 (L.D. 468). With the federal match, this initiative will infuse between $8 and $9 million in the physician fee schedule. This increase of 10-15% will bring Maine's rates up from approximately 40% of Medicare rates to approximately 53% of Medicare rates. The MMA was able to accomplish this, despite a late session proposal to delay implementation by one year in the borrowing replacement plan, with the strong support of the Baldacci Administration and the Maine Hospital Association.
- **Medical Liability Reform.** While the MMA and its allies in the *Coalition for Health Care Access & Liability Reform* were unable to find the votes to pass a cap on non-economic damages in medical negligence actions, the group did succeed in enacting "I'm sorry" legislation (L.D. 1378), a provision the Bureau of Insurance estimates could save between 3.5% and 5.9% in total claim costs, and in obtaining a commitment from the Maine Trial Lawyers' Association to discuss other initiatives to improve the medical liability climate in Maine that may be presented to the Judiciary Committee in 2006.
- **Fairness in the CON program.** With the agreement of the MHA, the MMA and the Maine Ambulatory Surgical Center Coalition extended the sunset from 2007 to 2008 on the provision of the Capital Investment Fund statute setting aside 12.5% for non-hospital projects (L.D. 742). Many physicians believe this provision is critical to ensuring that non-hospital projects receive fair consideration in the CON review process.
- **Access to Medically-Necessary Breast Reduction and Varicose Vein Surgery.** With the help of Plastic & Hand Surgical Associates and the American Society of Plastic Surgeons, the MMA responded to a move by CIGNA to eliminate coverage for these services by enacting legislation to require health insurance carriers to offer coverage for these services through a policy rider (L.D. 596).

The MMA also is pleased to have worked through the Maine Coalition on Smoking OR Health to double Maine's cigarette excise tax from $1 per pack to $2 per pack. The MCSOH's advocacy for a $1.50 increase in the tax provided strong support for the increase ultimately adopted by the Legislature. The current Chair of the MCSOH is the MMA's Public Health Committee Chair, Jo Linder, M.D. and the MMA thanks Jo for her leadership on this issue.

On the day before adjournment, Friday, June 17, 2005, the Legislature enacted L.D. 1691, *An Act to Eliminate Pension Cost Reduction Bonding and Provide Replacement Budgeting Measures,* a party-line majority report from the Appropriations Committee. The votes on enactment were 74-72 in the House and 19-14 in the Senate. Working with the Maine Hospital Association, the MMA succeeded in persuading both the Appropriations Committee Democrats and Republicans to reject a proposal to delay the $3 million MaineCare physician fee increase until the second year of the biennium and a second proposal to fund the first year of the increase by cutting reimbursement to "provider-based" physician practices.

The report of the Committee's majority Democrats surpassed the $250 million goal in achieving $256,386,760 in cuts or new revenue over the biennium ($107,990,558 in 2006 and $148,396,202 in 2007). The Committee's minority Republicans recommended cuts totaling $252,108,035 over the two years.

The majority report includes a $1 per pack increase in the cigarette excise tax effective September 16, 2005 and an increase in the tax on smokeless tobacco effective October 1, 2005. These tax changes yield new revenue of $53,148,108 in FY 2006 and $72,609,461 in FY 2007.

Savings in the DHHS section of the budget, of particular interest to physicians, include:

- $600,000 in each year through elimination of the foster care clothing allowance;
- $1.5 million in the second year by continuing current suspension of new enrollments in the MaineCare non-categorical adults waiver less than 101% of the FPL;
- $10,431,749 in the second year through managed behavioral health care services;
- $5 million over the two years from the Fund for a Healthy Maine; of particular concern is $1.6 million in cuts to the tobacco prevention and cessation programs in the second year;
- Approximately $213,000 in each year by the elimination of funding for hospital specialty clinics at EMMC, CMMC, and MMC;
- $211,378 in each year by restructuring the maternal and child health program;
- $250,000 in the first year by reducing the nursing home COLA;
- Approximately $1.6 million in the first year by paying hospital payment lawsuit settlements before September 30, 2005; and
- $1,125,000 in each year from the Dirigo Health Agency.

The bill also takes $5 million in the first year from the Department of Professional & Financial Regulation, a department funded totally by dedicated revenue. This amount includes reserve funds from all of the licensing boards, including the physician licensing boards. This action will result in the BOLM losing approximately $130,000. Such a "sweep" of these dedicated accounts has happened one other time in the recent past.

The MMA staff, Legislative Committee members, and specialty society representatives were involved in shaping many other pieces of health care legislation among more than 300 monitored by the MMA.

You can view the list of committee assignments on the web at: **http://janus.state.me.us/house/jtcomlst.htm.** The primary committees having jurisdiction over health care matters are the Joint Standing Committees on Health & Human Services, Insurance & Financial Services, Business, Research & Economic Development, and Judiciary.

You can find your House member on the web at: **http://janus.state.me.us/house/townlist.htm.** *You can find your Senator on the web at:* **http://www.state.me.us/legis/senate/senators/index.htm.** Please take the time to introduce yourself to your two legislators.

During the legislative session, the MMA publishes, by e-mail, a weekly legislative update called "Political Pulse." To subscribe, go to www.mainemed.com and visit the Legislative & Regulatory Advocacy section of the site. *You will find more information about the 122nd Maine Legislature on the web at:* **http://janus.state.me.us/legis.**

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

Ethics Note: Occupational Health, Independent Medical Examinations, and Employer-Requested Medical Examinations

Physicians performing medical examinations in the occupational health setting or in the workers' compensation system have obligations both to the patient and to the business or government agency requesting the examination. The AMA *Code of Medical Ethics* describes the obligations to the patient in these situations as those of a "limited physician-patient relationship" in Opinion 10.03, *Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations.* You can view the ethics opinions on the AMA web site at **http://www.ama-assn.org/apps/pf_online/pf_online.** Go to "Ethical Opinions" and then "E-10.00, Opinions on the Physician-Patient Relationship." The Maine Workers' Compensation Act, 39-A M.R.S.A. §101 *et seq.*, further describes the parameters of the employer-requested examination at §207 and of the independent medical examination at §312. You can find the Maine Workers' Compensation Act on the web at: **http://janus.state.me.us/legis/statutes/39-A/title39-Ach0sec0.html.** A common question about these two medical examinations under the Act is whether the employee/patient is entitled to a copy of the report. Both §207 and §312 clearly state that the employee/patient is entitled to a copy of the examination report from the physician performing the examination.

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!

Maine medicine

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