JULY/AUGUST/SEPTEMBER 2012

Maine medicine

MAINE MEDICAL ASSOCIATION

IN THIS ISSUE

Join Your Colleagues at the 159th Annual Session

The Maine Medical Association will hold its 159th Annual Session in Bar Harbor, Sept. 7-9, 2012. The theme of the educational program is *Caring for our Elders* and features geriatrician and best-selling author Dennis McCullough, M.D. Program Chair Janis Petzel, M.D. has put together an outstanding CME program featuring over eight hours of category one credit. Program faculty appear on the right. The program begins at 1:00pm Friday, Sept. 7 at the Jackson Laboratory. The Saturday afternoon and Sunday morning programs will be held at the Bar Harbor Club adjacent to the Harborside Hotel and Marina. The Sunday morning program, which follows the annual running of the Edmund Hardy, M.D. Road Race, features presentations by physicians practicing in different settings, highlighting their perspectives on the advantages and disadvantages of each.

At the Saturday morning business meeting, the new MMA website will be introduced for the first time, resolutions will be considered and presentations will be made by Medical Mutual President Terrance Sheehan, M.D. and Harvard Pilgrim Health Care Chief Medical Officer Michael Sherman, M.D., MBA. Members who graduated from Medical School in 1962 will be presented with 50-year pins.

On Saturday evening, President Nancy M. Cummings, M.D. will present the President's Medallion to Dieter Kreckel, M.D. Dr. Kreckel practices family medicine in Rumford and is part of the faculty at the Central Maine Medical Center Family Practice Residency Program. He is a former President of the Maine Academy of Family Physicians.

The flyer with complete programming information and registration information is included with this issue of *Maine Medicine*. Members and guests may also register on-line at www.mainemed.com. We hope to see many of you in Bar Harbor on September 7th!

Janis B. Petzel, MD, DFAPA, Program Committee Chair

Daniel Onion, MD, MPH

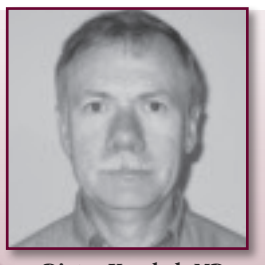
Lisa Clarcq, DO

Jennifer McConnell, MD

Amy Madden, MD

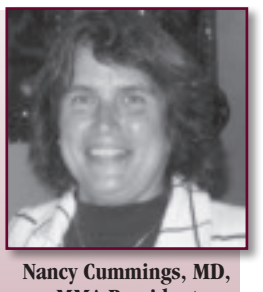
David Harrison, PhD

Dennis McCullough, MD



Dieter Kreckel, MD, MMA President-Elect

Jeffrey Dunn, MD, MBA, FACS



Nancy Cummings, MD, MMA President

Allan Teel, MD

Laurel Coleman, MD

U.S. Supreme Court Upholds Affordable Care Act

On a fateful Thursday, June 28th, the United States Supreme Court upheld the Affordable Care Act, agreeing that the requirement for nearly all Americans to purchase health insurance is allowed under the taxing authority provided to the federal government under the Constitution. The 5 to 4 decision, authored by Chief Justice John Roberts, brought to a legal conclusion a two year legal battle that has left the ACA largely intact, but certainly battered and bruised. The State of Maine had been one of 26 states which had challenged the law in a federal lawsuit. Predictably, Democrats were quick to praise the decision and Republicans were stunned and disappointed. Governor LePage led the way calling the decision a *massive overreach by the federal government*.

While the legal case is closed, there is still uncertainty about the future of the law given the pledge by Republicans to repeal the law if they are in the majority in the Congress after November. But under the current rules of the Senate, it would take 60 votes to repeal the law and the President, if re-elected would certainly veto the attempt. But portions of the law could be rendered ineffective by de-funding them. In addition, the Court held that the federal government could not withhold federal funds to states which refuse to expand the Medicaid program, thereby also creating uncertainty. And that language has also led to Governor LePage and Commissioner Mary Mayhew stating that they will not seek a federal waiver prior to terminating MaineCare coverage for approximately 23,000 Mainers, rather they will simply submit a plan amendment to DHHS. But that plan amendment also requires federal approval, which Secretary Kathleen Sebelius is unlikely to approve. The MaineCare cuts were part of the budget bill enacted by the Republican-controlled legislature in June.

The impact of the court decision in Maine is significant. Among other things, it means that the state will have to either resume planning for the health insurance exchange planned for 2014, or accept that the federal government will establish and run the exchange. The exchanges, similar to the connector in Massachusetts, are expected to make it easier for individuals and small businesses to purchase health insurance. Medicaid may be expanded, but that is no longer a certainty given the language in the court decision that prohibits the federal government from withholding funds from states which reject the expansion.

The individual mandate in the law is likely to have the most lasting impact. Starting in 2014, most Americans will be required to be insured or pay a penalty. There will be federal subsidies to help people who can't afford coverage. In fact, individuals with income under 400% of the federal poverty level will be eligible for subsidies. The mandate, along with the Medicaid expansion, is expected to bring about 30 million currently uninsured Americans into the health insurance marketplace. An estimated 26 million people will remain without coverage once the law is fully implemented. This number could be higher, depending on whether any states refuse the Medicaid expansion.

MMA will continue to provide timely information on the law and its implementation to members and their office staff. The Association has supported the notion of an individual mandate since the publication of its White Paper on Health System Reform in 2003 and will continue to advocate for improved coverage, while at the same time working to change those provisions in the law that need to be changed.

SAVE THE DATES

MMA FIRST FRIDAYS EDUCATION SEMINARS

Register for these seminars at www.mainemed.com

All seminars take place at the MMA Headquarters in Manchester, Maine with Registration and Breakfast at 8:30am and the Session from 9:00am – 12:00pm.

September 7, 2012
Risk Management Seminar - Handling Patient Complaints (Medical Mutual Insurance Company of Maine)

October 5, 2012
Physician Compensation, Recruitment and Retention - Employment Contracts

November 2, 2012
Annual Compliance Seminar - Plans for small practices, coding, etc.

December 7, 2012
All You Wanted to Know About the Affordable Care Act and more

The programs are also available off-site/on-line through Webex. Contact the MMA office at 622-3374 for more information.

Thank You

A special thank you to the following physicians who served as volunteers on prelitigation screening panels from January thru June 2012. Physicians willing to volunteer may contact the MMA EVP Gordon Smith at 622-3374 ext: 212 or via email at gsmith@mainemed.com.

Timber Gorman, MD
Peter Hunag, MD
Charles Markowicz, MD
Phil Peverada, MD
Ed Ringel, MD
Craig Thompson, MD

Nancy Cummings, M.D.
President, MMA

President's Corner

The Supreme Court's ruling renewed my faith in our political system. Like many of you, I am tired of decisions that are being made based on the party that proposed the idea instead of the content or value of the proposal. The current US health care system is broken and not sustainable. The ACA while not a perfect bill can be seen as a start, much like Social Security when that bill was introduced. As a physician and the mother of two children I am concerned about what the health care system will look like for them. No matter what your political affiliation, as a parent, when you look at your children you ponder their futures. What will their career opportunities be, where will they live, how will they live, will they stop constantly fighting with each other? To find out the answer to any of those questions first and foremost they have to have a future that includes quality health care. Fiscally and ethically as a society, we need a system that centers on preventative care, maintaining peoples' health rather than treating illness. It is much easier to prevent than cure and, for the bean counters out there, much less expensive. One of the strong points of the ACA is it's support of prevention.

The individual mandate was the keystone to the bill and the most contentious element. Those that opposed it claimed it infringed on individual freedom and the government did not have right to require individuals to purchase health insurance. Do we not have to purchase auto insurance to drive or pay a toll to use the turnpike? Individual freedom at the "cost of the many" is too big a price to pay. As Paul Krugman states in his *New York Times* article, *Real Winners*, published June 28, 2012, which I highly recommend reading: "this is a compassionate law and should be seen as a start". What parent would not want coverage for their child if they suddenly came down with an unexpected illness or injury. They not only have the worry associated with their medical woes but also the worry of how to pay for it.

As a physician I have the honor and privilege of being given a window into my patients' lives. Practicing in rural Maine, I see folks delay pain-relieving procedures because of cost. Some are forced to make the choice between food and their medications. While the ACA does not fix all of this, it does provide many positives for the citizens of our state. Since 2011, Maine has received $10 million dollars in grants from the Prevention and Public Health fund that the bill created. Additionally 187,251 people with Medicare and 226,000 with private insurance received free preventative service coverage, and almost 12,000 people with Medicare received discounts on brand name prescription drugs when they hit the "donut hole" in 2011. And finally, over 7,000 young adults who would otherwise be without insurance, gained coverage through their parents' health plans.

In T. R. Reid's book, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*, an individual from Sweden asks incredulously, and I am paraphrasing here, in America if a person has the misfortune to lose their job and thus their income you then take away their health insurance? I ask, are we a compassionate society or one based on Darwinian principles? I prefer to think of America as the land of opportunity for all and that should include health care for all, and certainly not healthcare dependent on one's socioeconomic status into which they were born. Is this idealistic? Yes, it is. Is it possible? It may be.

I can be reached at 207-778-9001 or president@mainemed.com. I hope to see many of you at the Annual Meeting, September 7-9 in Bar Harbor.

Gordon H. Smith, Esq.

Notes from the EVP

During the last few years, my family and I have had the good fortune to be able to rent a cottage on Popham Beach during the first week of July. It has become an important family tradition and this year the weather cooperated, adult children and spouses and close friends visited and we all disconnected from the frantic pace of our professional lives. I hope you all get to do the same during this (so far) excellent summer, weather-wise.

Summer vacation for my family always includes morning jogs, walks on the beach, competitive ping pong at night and a good book or two. This year we all tried a new sport: paddle boarding (you should all try it). No work, no TV (no Red Sox!) and no golf. By the time July rolls around, I have generally accumulated a wide variety of books to read, enough so that an entire year of vacation weeks would probably not get me through them all. So I get to pick one or two from the pile. This year I took *Great by Choice*, by Jim Collins and Morten Hansen and *My Mother, Your Mother, Embracing Slow Medicine*, by Dartmouth geriatrician and family physician Dennis McCullough, M.D. Dr. McCullough is the keynote speaker at the MMA Annual Meeting in September so I thought it would be wise to get familiar with his writings. I enjoyed the book and am very much looking forward to meeting Dr. McCullough this Fall. The rest of my article this issue will discuss the themes of *Great by Choice*.

Jim Collins is, as many of you know, one of the best known management consultants in the country. He is the author or coauthor of six books including the best sellers *Good to Great* and *Built to Last*. He began his research and teaching career on the faculty at Stanford Graduate School of Business and now operates a management laboratory in Boulder, Colorado, where he conducts research, teaches, and consults with executives from the corporate and social sectors.

Collin's new work focuses on the question, *Why do some companies thrive in uncertainty, even chaos, and others do not?* Based on nine years of research, Collins and his colleague Morten Hansen, enumerate the principles for building a truly great enterprise in unpredictable, tumultuous, and fast-moving times. Looking for companies that had outperformed their rivals consistently, the authors chose Amgen, Biomet, Intel, Microsoft, Progressive Insurance, Southwest Airlines and Stryker as the "great" companies. While it is not possible to adequately present the work in this short article, I can at least re-state the characteristics that separated these companies from their rivals.

Fanatical discipline, empirical creativity and productive paranoia were the three behaviors that, over a long period of time, seemed to separate the winners from the losers. As health care is certainly in a tumultuous period, I believe there is something to be learned from these businesses and their long time behaviors. There is a lot of empirical business research presented in the book and it is not an easy read. I would rather read a Tess Gerritsen novel but have to wait for her next release in the Fall (*Last to Die*, Jacob tells me). But there are some take-aways from Collin's work that I think the MMA Board can consider at its next planning retreat in January. Foremost among these is the notion that any organization needs to experiment with firing bullets and following up successful bullets with cannonballs. This is similar to the concept explored in *Built to Last* of trying a lot of stuff and keeping what works. In other words, do not bet the farm on an unproven approach, but once you have tipped your toe into the water and it isn't bitten off, be brazen enough to go deeper into the water.

The Maine Medical Association is in a constant state of change, as is the health care system that our members practice in daily. I believe we can borrow some lessons from the business world to help us thrive in the current uncertainties and at times, chaos.

I always welcome your responses and other thoughts. I hope I will see many of you at the Annual Session, Sept. 7-9 in Bar Harbor!

The Popham Cottage (above) is old but has everything needed for a great vacation. The photo at left is the view from the cottage.

Maine Medical Association Health Care Reform Literature Available

The Maine Medical Association is happy to provide physician offices with materials about "What does National Health Reform mean for ME and You?" at no charge. You can view a sample at: http://www.mainemed.com/healthsystem/HealthReforme.pdf These brochures are great to have in waiting areas and patient exam rooms. The Affordable Care Act (ACA) can be confusing and difficult to understand. In plain language, the brochure outlines benefits for:

- Young Adults (under age 26)
- People with No Insurance
- Refugees, Asylees & Immigrants
- People with Medicare
- Everyone with Insurance

Other materials such as posters, flyers and business cards are also available at no charge. To order, please contact Jessa Barnard, jbarnard@mainemed.com, 207-622-3374 x 211.

Upcoming Specialty Society Meetings

SEPTEMBER 8, 2012 – 2:00PM *Harborside Hotel & Marina – Bar Harbor, ME*
Maine Society of Anesthesiologists Fall Business Meeting
(To be held in conjunction with the MMA Annual Session)
Contact: Anna Bragdon 441-5989 or mesahq@gmail.com

SEPTEMBER 12, 2012 *MMA Headquarters – Manchester, ME*
Maine Chapter American College of Emergency Physicians
Fall Business Meeting
Contact: Maureen Elwell 622-3374 x219 or melwell@mainemed.com

SEPTEMBER 14-16, 2012 *Point Lookout – Northport, ME*
Maine Chapter of the American College of Physicians Annual Chapter Meeting
Contact: Warene Eldridge 207-215-7118 or warene54@yahoo.com

SEPTEMBER 28, 2012 *Harborside Hotel & Marina – Bar Harbor, ME*
Maine Society of Eye Physicians and Surgeons Fall Business Meeting
(To be held in conjunction with the 11th Annual Downeast Ophthalmology Symposium)
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

SEPTEMBER 28-30, 2012 *Harborside Hotel & Marina – Bar Harbor, ME*
11th 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

SEPTEMBER 29, 2012 *Marriott at Sable Oaks – South Portland, ME*
Maine Society of Orthopedic Surgeons Annual Educational Sessions
Contact: Warene Eldridge 207-215-7118 or warene54@yahoo.com

NOVEMBER 2, 2012 *Hampton Inn – Waterville, ME*
Maine Association of Psychiatric Physicians General Membership Meeting
MMA Contact: Dianna Poulin 207-622-3374 ext: 223 or dpoulin@mainemed.com

NOVEMBER 3, 2012 *MaineHealth – 110 Free Street, Portland, ME*
Maine AAP Fall Educational Conference
Contact: Leslie Goode 207-782-0856 or ldgoode@aap.net

Common Sense Compliance

Is it Audit Preparation, or Just Good Practice?

By Stacey Mondschein Katz

You may have heard that the Office of Civil Rights (OCR) recently published its protocol and findings for the first 20 HIPAA/HITECH audits conducted by KPMG. The auditors' extensive request includes the covered entity's documented security risk analysis, its security, privacy and breach notification policies, proof of training and attendance, complaint log and process, organizational chart, hiring list, and more. Is your practice ready to provide the requested documents within 10 days of the demand letter?

Even if you are not selected for the next round(s) of audits, there is plenty to motivate you toward compliance: Meaningful Use dollars, a potential prosecution by the State Attorney General, looming enforcement penalties, and more. None of this is going away, regardless of changing details in the upcoming (final) Omnibus HITECH rule.

Although the to-do list is long, and this article is brief, you can certainly get started. Using HIPAA as your practice guide, you may want to start by naming your privacy and security official(s) to oversee your processes. Then ask: Where can your organization's protected health information (PHI) and electronic PHI (ePHI) be found? On paper files, on portable devices, in the office, in the car? Once answers to those foundational questions have been documented, next identify and document your protections.

The HIPAA Security Rule requires administrative safeguards (such as policies, procedures, and training), physical protections (such as door, window and cabinet locks, weather protections, surge protectors), and technical safeguards (such as firewalls, anti-virus software, encryption, and strong passwords, for starters.) What do you have in place?

HIPAA Security Rule policy requirements are extensive, including policies on acceptable workstation use, password protection, contingency and emergency plans to ensure access to ePHI in the event of a disaster, a policy on sanctions and for terminating access immediately when workforce members (including students or residents) leave your employ, and a breach notification process. Even before the audit program, these documents made sense for securing and ensuring the integrity of PHI.

A regularly educated workforce is essential, and the first line of defense against any breach of PHI. Document attendance at your annual training, and put privacy or security topics on your meeting agendas, being sure to document this additional "training" in your minutes.

You must regularly audit access to your electronic record and document your review. You might also consider what I call a "walk-through"; observing your office practices on a regular basis. Keep a file of your findings and fixes to show your good faith compliance efforts. "Walk-throughs" also offer an opportunity to commend workforce members for a job well done.

Make sure your authorization form is HIPAA and state-law compliant, and POST your current Notice of Privacy Practices *conspicuously* in your office. See that you have written processes in place for patient complaints, requests to access, copy and amend the paper or electronic record, and to request restrictions on the sharing of PHI. These are basic patient rights. Deficiencies in these types of HIPAA Privacy Rule requirements were a regular audit finding.

The regulators require far more, but this will get you started. Weaving a culture of compliance throughout your practice need not be overly burdensome when performed in a logical, patient-focused, and systematic way.

Stacey Mondschein Katz, Esq. *is the founder and president of SMK Consulting Services, LLC, a healthcare compliance and education company. She may be reached at stacey@smkconsultingservices.com or through her website at www.smkconsultingservices.com.*

Invite a Physician to Join MMA

Encourage your colleagues to become an MMA member and take advantage of the benefits of membership.

Contact Lisa in the MMA Membership Department at 622-3374 ext 221 or email lmartin@mainemed.com.

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

Save the Date:

MMA's 159th Annual Session
September 7-9, 2012
at the Harborside Hotel in Bar Harbor

Andrew MacLean, Esq.

Legislative Update

125th Maine Legislature Adjourns; Attention Turns to Summer/Fall Political Campaigns

The 125th Maine Legislature completed the work of its Second Regular Session on May 31, 2012 with enactment of the third FY 2012-2013 supplemental budget (L.D. 1746; P.L. 2011, Chapter 657) of the session and adjourned sine die. *The 125th Legislature is not expected to return to Augusta this year. The MMA staff has prepared a comprehensive summary of the health care legislation considered by the outgoing legislature that is now available in printed form from the MMA office and is available on the MMA web site, www.mainemed.com. The MMA staff and the trustees of the Maine Physicians Action Fund (MPAF), a political action committee affiliated with the MMA, are focusing on the key political races to be decided on Election Day, Tuesday, November 6, 2012. In addition to the Presidential race, these include a U.S. Senate seat, both Congressional seats, and all 186 seats in the 126th Maine Legislature.*

Because the Republican-controlled legislature decided to take little action on implementing the *Affordable Care Act* (ACA) until the U.S. Supreme Court ruled on its constitutionality, a series of three supplemental state budgets for FY 2012-2013 topped the agenda in the health policy debate during the Second Regular Session of the 125th Legislature. State budget debates always implicate health care delivery in Maine because of the proportion of the budget devoted to health care and social service programs, but the implications were even greater for these programs during this session because Governor LePage proposed substantial restructuring of the MaineCare program in his budget recommendations. The three budget bills enacted during this session are:

- **L.D. 1816 (P.L. 2011, Chapter 477):** http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280043806
- **L.D. 1903 (P.L. 2011, Chapter 655):** http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280044292; and
- **L.D. 1746 (P.L. 2011, Chapter 657):** http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280043557.

The first two budgets passed by bipartisan, two-thirds majorities. The third budget bill containing the most controversial provisions suggested by the Governor passed by a simple majority of Republican votes, meaning that it is not effective until August 30, 2012, 90 days after adjournment of the session. You will find a summary of L.D. 1746 prepared by the non-partisan legislative staff in the Office of Fiscal & Program Review on the web at: http://www.maine.gov/legis/ofpr/session_information/125th/LD1746_enactedsumm.pdf. Some of the key provisions of L.D. 1746 include:

- Part C. Transfers $25 million from General Fund unappropriated surplus at the end of FY 2013 for hospital settlements
- Part E. Eliminates transfer of up to $2.5 million of slot machine revenue to the *Fund for a Healthy Maine* in FY 2013
- Part H. Continues MaineCare funding for Critical Access Hospitals at 109% of cost; repeals requirement of a move to DRG/APC reimbursement
- Part O. Limits MaineCare coverage of opioid drugs
- Part S. Effective 1/1/13, limits MaineCare reimbursement for methadone treatment for addiction to 24 months with additional reimbursement available with prior authorization
- Part T. Establishes the *MaineCare Redesign Task Force* to find $5 million in General Fund savings in FY 2012-2013
- Part U. Requires DHHS to prepare a "global Medicaid waiver" for the 126th Legislature
- Part Z. Effective 10/1/12, reduces MaineCare eligibility for a parent or caretaker of an eligible child from 133% to 100% of the federal poverty level (FPL)
- Part AA. Eliminates the Office of Substance Abuse (OSA) as a separate DHHS office
- Part BB. Eliminates the Office of Elder & Adult Services as a separate DHHS office
- Part CC. Eliminates the Office of Adults with Cognitive & Physical Disability Services as a separate DHHS office
- Part DD. Eliminates the Office of Adult Mental Health Services as a separate DHHS office
- Part EE. Eliminates the Office of Advocacy and directs DHHS to pursue a private contractor for such services
- Part FF. Directs the Commissioner to restructure DHHS to improve and streamline services
- Part GG. Directs DHHS to submit a Medicaid State Plan Amendment (SPA) effective 10/1/12 to eliminate MaineCare coverage for individuals 19 or 20 years of age with income </= 150% of the FPL
- Part HH. Reduces eligibility for the elderly low-cost drug program from 185% to 175% of the FPL and for the Medicare savings program
- Eliminates MaineCare funding for 3 STD screening clinics in Portland, Lewiston, and Bangor
- Eliminates MaineCare funding for smoking cessation products
- Eliminates MaineCare funding for ambulatory surgical facility services
- Cuts many programs funded by the Fund for a Healthy Maine, including Head Start, Child Care Subsidy, Healthy Maine Partnerships, School-based Health Centers, and family planning

The Insurance & Financial Services Committee carried over two bills to establish an insurance exchange in Maine (L.D.s 1497 and 1498), but the Committee never could agree to pass out an exchange bill. Instead, it recommended, and the full legislature enacted, L.D. 1497 as a bill to set standards for those acting as navigators in an exchange. With the U.S. Supreme Court's decision upholding the constitutionality of the ACA on June 28th, Governor LePage and the leadership of the 126th Legislature will have to make some decisions about ACA implementation in late 2012 and early 2013.

During the two-year cycle of each Maine legislature, the MMA Legislative Committee tracks more than 300 bills of interest to the physician community and the MMA staff prepares a comprehensive summary of the outcome of legislative action on these bills. The summary for the 125th Legislature is now available and the MMA staff is available to present a legislative update to your practice or specialty society.

Through this summer and fall, the MMA staff is monitoring or participating in legislative and/or executive branch working groups on MaineCare redesign (L.D. 1746), mammography (L.D. 1886), MaineCare coverage of suboxone (L.D. 1816), MaineCare coverage of opioids (L.D. 1746), prescription drug abuse (Governor's Executive Order 2012-002), and community paramedicine (L.D. 1837).

The 2012 election campaigns are in full swing as the General Election Day approaches. At the top of the ticket of Maine races is the race for the U.S. Senate seat being vacated by Senator Olympia J. Snowe among former Governor Angus King (I), Secretary of State Charlie Summers (R), State Senator Cynthia Dill (D), and two lesser known independent candidates. You can find a list of candidates for the general election on the web at: http://www.maine.gov/sos/cec/elec/upcoming.html. The Maine Physicians Action Fund (MPAF), MMA's affiliated political action committee (PAC), encourages you to get to know the candidates, particularly your state legislative candidates. MPAF Trustees draw your attention in particular to the following physician candidates for the 126th Maine Legislature:

- Geoffrey M. Gratwick, M.D., a Democratic challenger to Senator Nichi S. Farnum in Senate District 32, Penobscot County;
- Ann E. Dorney, M.D., a Democrat in House District 86, Madison, Norridgewock, and Solon, running against Republican Edward R. Goff, IV;
- Jane P. Pringle, M.D., a Democrat in House District 111, a part of Windham, running against Republican Stuart A. Pennels in an open race; and
- Linda F. Sanborn, M.D., a Democrat incumbent in House District 130, part of Gorham, running against Republican Matthew L. Mattingly.

If you have not yet done so, your MPAF Trustees urge you to join them in helping to elect state legislative candidates who are sensitive to issues of concern to Maine physicians: https://www.mainemed.com/mpaf/application.php. In addition to these candidates, the November general election ballot will include one citizen-initiated referendum on same sex marriage and four bond questions.

During the legislative session, the MMA staff provides links to bills for review and comment, updates on the legislature's work, and calls-to-action through our weekly electronic newsletter, *Maine Medicine Weekly Update*. Also, the MMA Legislative Committee holds a weekly conference call to review bills and brief members on legislative action every Tuesday night at 8:00 p.m. for any interested physician or physician staff member. The conference call information is published each week in the *Maine Medicine Weekly Update*.

To find more information about the MMA's advocacy activities, visit the Legislative & Regulatory Advocacy section of the MMA web site, www.mainemed.com/legislation/index.php. 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://www.maine.gov/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.

Report on L.D. 1818 Work Group: Resolve, To Evaluate the All-payor Claims Database

The L.D. 1818 Work Group met on July 19th in Augusta and as part of its "Voice of the Customer" initiative heard presentations from Frank Johnson, formerly the Director of the State Employee Health Commission and Gordon Smith, Executive Vice President of MMA. The Group was charged by the legislature with reviewing and evaluating the current structures of and relationships among the Maine Health Data Organization, the Maine Health Data Processing Center and OnPoint Health Data in order to evaluate the timeliness and effectiveness of the data received. The Work Group was established primarily because of concerns regarding the timeliness and efficiency of the data derived from the all payor claims data base (APCD).

MMA's representative to the Group is Josh Cutler, M.D., former Director of the Maine Quality Forum. Our representative to the MHDO is Neil Korsen, M.D. Cutler co-chairs the Work Group with Colin McHugh who directs provider networking at Anthem Blue Cross Blue Shield (Maine).

In remarks offered on behalf of MMA, Mr. Smith made the following points:

- The database needs to be owned by the state but controlled by a group of stakeholders, as exists now through the Maine Health Data Organization.
- It is an appropriate time to review the make-up of the Board of the MHDO, given that the organization was created nearly twenty years ago and several board positions have been established by the legislature since that time.
- If significant changes need to be made in the organizations involved or in the processes followed, then keep what is working and be careful not to throw out the baby with the bathwater.
- Physicians support the distribution of accurate data on a timely basis and recognize the increasing value of such data as new payment models emerge.
- That the transparency and public reportability of such data is dependent upon the ability of physicians to review the data for accuracy and the need for specialty societies to review the data to ensure that the public is not inadvertently mislead.
- As the data is a public resource, the costs of the operation of the organizations and processes should be public funds.

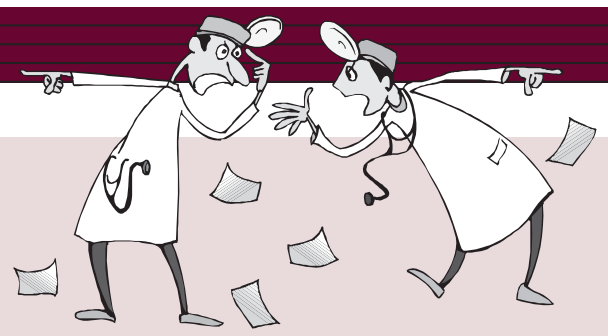
The Group meets again on August 9 in Portland and August 16 in Augusta. Materials for the group are now posted on the OSC web site at http://www.maine.gov/hit/ld_1818/index.html.

L.D. 1886 Work Group re Imaging and Breast Density Holds Initial Meeting

Work Group Chairs Sheila Pinette, D.O. and John Benson, M.D., FACR convened the L.D. 1886 group which met for the first time at the offices of the Maine Medical Association on July 19. The Work Group is to review and report on strategies to improve the dialogue between patients and physicians regarding breast density and breast imaging options. The Group is reviewing the current standards for breast imaging standards, the federal Mammography Quality Standards Act and breast imaging results protocols and will recommend strategies to improve the dialogue between patients and physicians regarding breast density and breast imaging options.

The Work Group is charged with submitting its report with recommendations to the HHS Committee of the Legislature by Dec. 7, 2012. The Group is staffed with resources from the Maine Center for Disease Control and Prevention.

Medical Mutual Insurance Company of Maine Risk Management Practice Tip: *Managing the Angry Patient*



Patients and their families may present as angry, rude and inappropriate for many different reasons. A patient and his family may have faced changes in their economic status. The patient may be concerned of his pending diagnosis and the change it may make in his lifestyle. He may be tired, frustrated and be caring for elderly parents or a compromised child. Communication breakdown may have occurred between the office employees and the patient.

When a patient or family member approaches office staff or a provider in an angry manner, the following may help in defusing the issue and in deciding how to document the conversation:

- Pick a safe location in the non-public section of the office. Alert your staff to standby in case assistance is needed or the police need to be called. Never be the first in the room with the angry patient controlling the exit.
  - To avoid claims of "false imprisonment," the patient/family member must enter the room cooperatively and feel they can leave at will.
- Set the controls for the discussion. State that their language/behavior is unacceptable. "I realize you are angry, please lower your voice and I will discuss your concerns." Remember, you do not own their anger. The goal is to gain control of the conversation while you investigate the patient's voiced concerns.
- If you reach an agreement, review what both parties have agreed to, i.e., "the patient will follow-up with scheduled appointments for diabetic control...He will meet with the dietitian prior to our next appointment on...He verbalizes understanding that this is all very difficult and new to him."
- As appropriate, create a simple document describing the behavior and the actions the patient has agreed upon and have the patient sign it. Ask the patient to verbally repeat the agreement. Place the agreement in the record and provide a copy to the patient.
- In documenting this discussion, consider the following:
  - Describe the inappropriate behavior factually.
  - If the patient or family member makes rude, threatening, or inflammatory statements, include them in quotation marks.
  - It is not necessary to record expletives such as vulgar language. If vulgar language is used, the following documentation may be made, "While using vulgar language, the patient stated he would not put up with..."
- Separate the judgment of the behavior from the judgment of the individual.
  - The individual receiving the message must recognize that it is his behavior that is the problem not his person or dignity.
  - If the behavior persists, state the consequences clearly and calmly, even to the point of calling for the police.
  - If the behavior escalates and the threat of physical harm exists:
    - Exit the room.
    - Implement the plan for contacting the police.

After investigation and depending on the nature of the patient's concern, an apology may be appropriate as well as changes in office processes or staff behavior.

Medical Mutual Insurance Company of Maine's "Practice Tips" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.

Barbara Slager, M.D., President of Coastal Women's Healthcare with Rick Hoover from the CMS regional office.

Southern Maine Women's Health Practice Honored for Use of Health Information Technology

Coastal Women's Healthcare has received **national recognition for their use of health information technology** to improve patient care. The practice was honored by the federal Centers for Medicare and Medicaid Services (CMS) at a ceremony held May 10th at the practice in Scarborough.

The Maine Regional Extension Center (MEREC), operated by HealthInfoNet, organized the ceremony to recognize Coastal Women's Healthcare for their successful transition from paper to electronic health records (EHR) and for meeting rigorous standards required under new federal CMS "meaningful use" guidelines. They were further recognized as the first independent women's health practice to connect with Maine's health information exchange (HIE), operated by HealthInfoNet.

"When Coastal Women's Healthcare asked us to help them meet meaningful use, we were surprised at how advanced they already were," said Todd Rogow, Director of IT and the MEREC at HealthInfoNet. "As an independent practice, Coastal Women's Healthcare's use of technology to support patient care is exceptional."

Beverly Neugebauer, Executive Director at Coastal Women's Healthcare said they've always been ahead of the curve. "While our providers' exceptional care of their patients is clearly our priority, the added element of new, secure technology helps us improve patient care while also increasing patient convenience." She adds, "For example, electronic medical records have helped us ensure our patients are getting the best quality care, while our online patient portal makes it easy for our patients to complete necessary medical history forms, access their lab results or request appointments."

Barbara Slager, MD, president of Coastal Women's Healthcare, agrees that going electronic leads to higher quality care and patient satisfaction. "Patients now realize their chart is continuously up-to-date, organized and accessible. Now we can spend more time talking about their current problem, screening recommendations and lifestyle modification."

Slager explains that the HIE goes one step further, allowing her to see tests and procedures done at other facilities, which helps her better coordinate her patients' care and reduce duplication. "For example, if a patient has heavy periods and had a blood count done through their primary care doctor, I can pull up her latest numbers and recommend appropriate therapy. Eventually, I will be able to see her pelvic ultrasound too, including the actual images. This reduces redundant care, an important factor in current health care costs."

In attendance at the ceremony were officials from CMS, representatives of Maine's Congressional delegation, the Maine Medical Association and other Maine health care leaders. "I'm thrilled to represent CMS in honoring this exceptional practice," said Rick Hoover from the CMS regional office. "At CMS we believe the use of health information technology will reduce costs and improve patient outcomes. We're seeing an example of that right here in Scarborough, Maine."

How Can a Young Doctor Afford to Buy Your Practice?

By Herbert K. Daroff, J.D., CFP®, Baystate Financial Planning, hdaroff@baystatefinancialplanning.com

It's time to retire. You have some retirement savings, but you were hoping to add the value of your medical practice to your nest egg.

Of course, you may be fortunate enough to sell your practice to a hospital or large medical practice, just in time to retire. If not, then in order to maximize the net after tax value of your practice, if sold to a younger doctor, you need to recognize that you are both an owner and an employee of your practice.

- Every dollar that the practice allocates to you as an owner (EMPLOYER) is a very tax INefficient dollar. It is either paid to you as a non-deductible expense, or the value attributed to you is included in your taxable estate.
- The same dollar allocated to you by the same practice, but this time as EMPLOYEE is a very tax Efficient dollar. It is either pay to you as a tax deductible expense, or the value can be excluded from your taxable estate.

If you start the planning for the ownership and management succession of your practice at least 10-years* in advance of retirement, then you can take advantage of one of the most tax efficient, cost effective, BUT much maligned planning techniques, the defined benefit pension (qualified) plan.

I started my career in financial services in June 1973. For the first 10 years, all I did was create defined benefit pension plans. For the next 20 years (from 1983 to 2003), all I did was terminate defined benefit pension plans. Since 2003, we have seen a resurgence of defined benefit pension plans, especially in professional practices (i.e., doctors, lawyers, accountants, etc.) that are in tax pass through entities (P.C.s taxed as S-Corporations, or LLP/LLCs).

Here's how it works. Younger doctor joins your practice with plans to succeed you in ownership and management. However, he or she does not have the funds to buy you out and with significant student loans still outstanding, may never have adequate funds. As long as the defined benefit plan contribution allocates to you at least as much as you would net from taking that amount as compensation, net after taxes, then the strategy will work.

- For example, a $100,000 plan contribution would have to allocate at least $60,000 to you, which is the same amount as you would net after income taxes if you took that $100,000 as compensation and paid $40,000 in state and federal income taxes (40% bracket), netting $60,000 after taxes.

Typically, you are the oldest, highest paid, employee with the most years of service to the practice. However, if you have many other employees who are of similar age to you, this strategy may not work.

*If you start the process much closer to retirement, then we need to use non-qualified deferred compensation.

With either a qualified or non-qualified retirement plan, you can accept a LOWER purchase price (EMPLOYER benefit dollars), which when added to your EMPLOYEE benefit dollars, provides you with a higher net after tax result.

- I want to buy your practice for $1,000,000. Let's assume that I will pay you $100,000/year for 10 years. I need to earn $166,666/year in order to net after taxes (40% state and federal income tax bracket, assumed) the $100,000 that I pay to you. Assuming that you have zero cost basis in your practice, you lose $20,000 (20% state and federal capital gains tax bracket, assumed) and net $80,000/year for 10 years.
- BUYER needs to earn $1,666,666 so that SELLER can net $800,000
- Who's the big winner in that transaction? The IRS and State Department of Revenue. They collect $866,666 in taxes from you and me.
- Instead, I agree to pay you $1,333,333 in retirement income (qualified or non-qualified). You net the same $800,000 after taxes, but I save $333,333. Alternatively, I agree to pay you $1,666,666 in retirement income. You net $1,000,000. You net $200,000 more.
- Or, we split the tax savings between us.

MaineCare Gathers Input on Opioid Benefit Redesign

Kevin Flanigan, MD, Medical Director of MaineCare Services, convened an advisory committee in July to provide input on how to implement the changes to MaineCare opioid coverage and other pain management issues contained in the supplemental budget that was passed by the legislature in May. As a reminder, a summary of the provisions in the budget can be found on the MMA website at **http://www.mainemed.com/spotlight/2012/FY13_DHHSbudget_SummaryofFinal.pdf**, and include limits on prescriptions of opioid medication for acute pain, requirements for patients to participate in alternative interventions before receiving prescriptions for chronic pain, prior authorizations before patients with certain diagnoses can receive opioid medications, and generating reports for prescribers showing how their prescribing patterns compare to their peers.

The first advisory committee meeting was well attended, including a number of physicians and MMA staff. The committee largely discussed its process for reviewing draft recommendations and began to discuss in more detail the issue of generating reports with prescribing data. The group will meet regularly to discuss each of the elements in the budget proposal and Dr. Flanigan plans to present a draft policy to MaineCare administration this fall. The policy will have to go through formal rulemaking and Dr. Flanigan did not give a final effective date for the changes. The advisory committee has scheduled its next meetings for August (dates have been changed so watch the Update for specifics).

The policies and rules will not be finalized prior to the effective date of the legislative proposals so watch these updates to learn about how the MaineCare staff will handle these issues during the transition.

Dr. Flanigan also has convened a working group to advise MaineCare on the criteria to be utilized in implementing the two year limit on suboxone. Physician participants include Drs. Mark Publicker, David Moltz, Noah Nesin, and Louisa Barnhardt.

Both work groups are continually monitored by MMA staff.

UPCOMING AT MMA

August 8
4:00pm – 6:00pm
MMA Public Health Committee

August 9
1:00pm – 3:00pm
OSC HIT Steering Committee

August 15
9:00am – 11:00am
Patient Centered Medical Home - Conveners

11:00am – 1:00pm
Patient Centered Medical Home - Working Group

1:00pm – 4:00pm
Aligning Forces for Quality, Patient Family Leadership Team

August 16
6:00pm – 8:00pm
Maine Association of Psychiatric Physicians Executive Committee

August 22
11:30am – 2:00pm
MMA Senior Section

August 30
10:00am – 12:00pm
Maine Health Management Coalition

September 5
8:30am – 12:00pm
Maine Health Management Coalition

1:00pm – 2:00pm
Aligning Forces for Quality, Executive Leadership Team

2:00pm – 3:00pm
Quality Counts, Board

September 7
8:30am – 12:00pm
First Fridays Seminar: Risk Management

September 7 – 9
MMA Annual Session in Bar Harbor

September 10
4:00pm – 7:00pm
Medical Professionals Health Program Committee

September 13
1:00pm – 3:00pm
OSC HIT Steering Committee

September 19
9:00am – 11:00am
Coalition for the Advancement of Primary Care

11:00am – 1:00pm
Patient Centered Medical Home, Working Group

1:00pm – 4:00pm
Aligning Forces for Quality, Patient Family Leadership Team

September 20
8:30am – 4:00pm
Pathways to Excellence (Maine Health Management Coalition)

6:00pm – 8:00pm
Maine Association of Psychiatric Physicians Executive Committee

continued on next page


Stephen D. Sears, M.D.

From the State Epidemiologist

By Stephen D. Sears, M.D., M.P.H., State Epidemiologist, Maine Center for Disease Control and Prevention

TB – What's old? What's new?

It has been 130 years since Robert Koch announced the discovery of Mycobacterium tuberculosis, the bacterium that causes tuberculosis (TB). Despite being over a century old, TB is still very much with us in Maine. In 2011, Maine had 9 active cases of Tuberculosis. As of July 1, 2012, Maine has had 13 active Tuberculosis cases. These cases range from under five to over 65 years old, 6 males and 7 females and 53.9% were foreign born. Despite a majority being in Cumberland County, the cases span five counties and over 330 miles.

Worldwide, tuberculosis remains the second greatest killer of a single infectious agent. One third of the world's population is infected with tuberculosis. There are around nine million new cases each year causing nearly 2 million deaths. In the United States, the number of reported TB cases has been steadily declining since 1992 and is currently 3.4 cases per 100,000 persons (10,251 in 2011). Recently, there has been a new topic in global TB news - Extensively Drug-Resistant TB (XDR-TB). XDR-TB is resistant to almost all TB drugs. Previously, the most resistant cases known were Multidrug-Resistant (MDR-TB), which is when the organism is resistant to at least isoniazid and rifampin, the two most potent TB drugs. Maine has not yet seen a case of Multidrug-Resistant TB (MDR-TB), or Extensively Drug-Resistant TB (XDR-TB), but with the global world becoming more connected each day it is a possibility.

What's new in diagnostics? For over a century the Tuberculin Skin Test (TST), formerly called PPD, has been used to screen for tuberculosis. Several years ago, the Interferon-Gamma Release Assays (IGRAs) was developed as a blood test to measure how the immune system reacts to the TB bacteria. Recently, its usage has increased and studies suggest IGRAs are as effective as TSTs to screen for TB. A major benefit of IGRAs, unlike a TST, is that it will not be positive from BCG so people who are vaccinated with BCG can receive an IGRA test and if it is positive it is from the TB germ and not the vaccination.

How about prophylaxis for TB? Well, for the first time in years there is a new regimen recommended for Latent TB Infection (LTBI). This regimen was published in the MMWR on December 9, 2011. This regimen includes medications previously used to treat TB yet in a much shorter time period. Rifapentine and Isoniazid are given once weekly for 12 weeks by directly observed therapy (DOT). The key part of this regimen is that health care professional must directly observe the client taking the medications. This happens on a weekly basis and gives the provider an opportunity to check for any adverse effects or symptoms. This regimen is still very new and DOT can present some logistical challenges so currently the State of Maine is only offering this regimen in select situations.

Even though TB cases are still low in Maine, LTBI is common and it is important that tuberculosis remain on your radar. Each year, Maine has around 450 people on LTBI treatment. Latent TB is diagnosed through a TST or IGRA and indicates that the person was exposed to the TB germ but it is not currently active and they are not infectious. A person with LTBI has an estimated 10% chance of developing active and potentially infectious TB over their lifetime. It is essential for the control of TB to screen for and treat individuals with LTBI to reduce their personal risk as well as the public risk of Tuberculosis.

So, TB cases are down but it is still with us. New testing methods, lab diagnostic techniques and treatment regimens have made improvements in the care of Tuberculosis, however much more effort is still needed in order to eliminate the disease. We must do our individual and collective part to diagnose and treat not only active but also Latent TB so that everyone can live in a world free of tuberculosis. Contact the Maine CDC disease reporting line at 1-800-521-0821 with any questions or to report a case of active Tuberculosis.


Jessa Barnard, J.D.,

Public Health Spotlight

By Jessa Barnard, J.D., Director of Public Health Policy, MMA

Is it Time for a Sugar-Sweetened Beverage Tax in Maine?

After an unsuccessful attempt in 2006, the American Medical Association House of Delegates adopted a policy on the taxation of sugar-sweetened beverages (SSB's) at their June meeting in Chicago. While not a full endorsement of a tax on soda and other sugary drinks, the new policy states that addressing the growing obesity epidemic will require a multifaceted approach and a key component is "consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programming could be financed." The policy goes on to state that if taxes are implemented, the revenue should be earmarked for obesity prevention or treatment efforts.

The AMA Council on Science and Public Health submitted a thorough review of the research in support of the new AMA policy. You can read the full report here: http://www.ama-assn.org/assets/meeting/2012a/a12-refcomm-d.pdf. Among their conclusions was that the intake of SSBs is strongly associated with increased body weight and cardiometabolic conditions, including high blood pressure, increased triglyceride levels and total cholesterol, type 2 diabetes and coronary heart disease. It is inversely associated with consumption of milk, calcium, fruit, dietary fiber and overall dietary quality. Reducing intake of SSBs is a simple way to reduce intake of added sugars without compromising the nutrient adequacy of a person's diet, the report found.

The majority of states do currently tax sugar-sweetened sodas, typically in the form of a sales tax. However, the taxes are at a level that has had little to no impact on rates of overweight and obesity.

"The AMA report states that overall, a higher, penny per ounce SSB excise tax could reduce SSB consumption by 10-25%, the prevalence of overweight and obesity by 5% in children and adults, diabetes incidence by 2.6% and reduce medical costs by $17 billion over ten years."

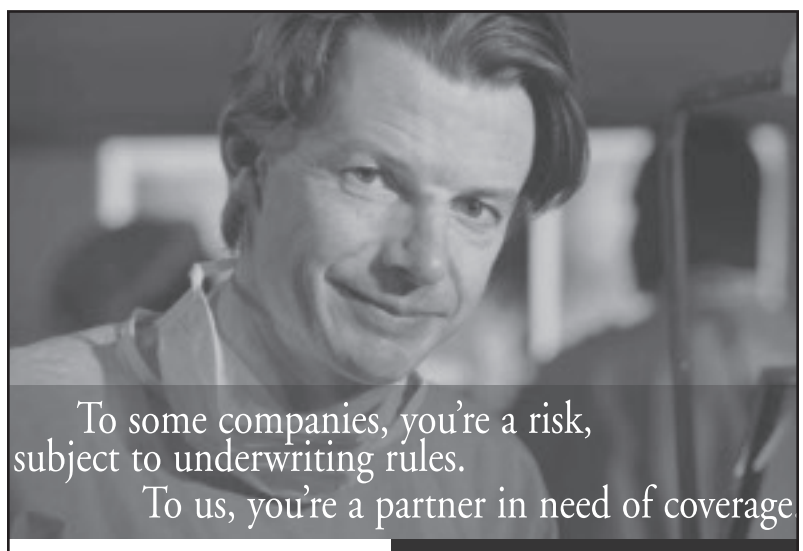
The revenues would have an even greater impact on population health and medical costs if they were used for obesity prevention or other health promotion. Current national polling data show that when the funds are channeled for this purpose, nearly 2/3 of voters support such a tax.

As many of the readers of this article will recall, Maine was one of the first states to attempt a beverage tax. It was complicated by including a tax on beer, wine and liquor along with a soda tax and by dedicating the proceeds to expanded coverage through the Dirigo program. The tax was repealed by a voter referendum after the beverage industry dedicated large amounts of money to the campaign.

Has the time come for Maine to reconsider a tax on sugar-sweetened beverages (SBBs) as an important public health intervention? It won't be easy. SSB tax proposals were considered in eleven states in 2011 and none passed. The beverage industry remains a strong opponent of such efforts and there are challenging policy questions such as how to address juices and sweetened milk. However, as the evidence grows that such taxes could be an important tool in reducing the obesity epidemic, they become harder to ignore.

Weigh in with your thoughts as the MMA Public Health Committee considers whether a resolution supporting a SSB tax should be presented to the MMA membership at the Annual Session in September. For more information or to share your opinion, contact Jessa Barnard at jbarnard@mainemed.com.

Visit the MMA website at: www.mainemed.com



Committee on Loan and Trust Administration Report

The MMEF Committee on Loan and Trust Administration meets every year to approve loan applications from medical students from Maine to the Maine Medical Education Foundation. Mark Bolduc, MD of Waterville chairs the committee.

This year the committee met on June 7, 2012 at the Frank O. Stred building in Manchester. Participating in this meeting were: Dr. Bolduc, Dr. Barus, Dr. Forbush, Dr. Gerritsen, Dr. Pringle, Heidi Lukas, Andrew MacLean, Diane McMahon, Gordon Smith, and Angela Westoff, MOA Executive Director.

The MMEF Loan and Trust Committee reviewed applications from 42 MD candidates and 10 DO candidates with approximately $282,000 approved in loan amounts. Below is a listing of students for whom loans were approved. The primary requirement for eligibility is that the student be a Maine resident. Note that two of the students were approved pending further documentation regarding residency.

MMEF LOAN RECIPIENTS	MEDICAL SCHOOL
Joseph Anderson	University of New England
Nicole Barbee	Tufts Maine Track
Clayton Barnes	Tufts Maine Track
Bethany Bartley	Tufts University School of Medicine
Ashley Beaulieu	University of New England
Peter Beaulieu	University of New England
Abhijit Bhattacharyya	Tufts Maine Track
Tiffany Bombard	Albany Medical College
Erica Brown	Tufts Maine Track
Christopher Buttarazzi	Tufts Maine Track
Matthew Buttarazzi	Tufts Maine Track
Joseph Canarie	Dartmouth Medical School
Stephanie Corriveau	University of New England
Malcolm Creighton-Smith	Tufts University School of Medicine
Brienne Cressey	Tufts University School of Medicine
Molly Gail Curtis	Tufts Maine Track
Anne Cutler	Tufts Maine Track
Jessica Dietz	Tufts Maine Track
William Douglas	University of New England
Albert Emery	University of Vermont
Erik Steven Fisher	Weill Cornell Medical College
Brian Fulmer	Tufts Maine Track
Brandon Giberson	University of New England
Gregory Goldstein	Tufts Maine Track
John Howe	Loma Linda University School of Medicine
Caitlin Hynes	Tufts Maine Track
Zahraa Ibrahem	Windsor School of Medicine
Nathaniel Johnson	Tufts Maine Track
Geoffrey Kendall	Tufts Maine Track
Jennifer Kendall	Wake Forest Univ. School of Medicine
Allison Dawna Labbe	Tufts University School of Medicine
William Laplante	Tufts Maine Track
Mathieu Larochelle	University of Vermont
Joseph Mack	Tufts Maine Track
Megan Jean McCullough	Tufts Maine Track
Adam O'Brien	University of New England
Patrycja Olszynski	Tufts University School of Medicine
Danielle O'Rourke-Suchoff	Case Western Reserve School of Medicine
Molly Peverada	Kentucky College of Osteopathic Medicine
Kelly Pitts	Tufts Maine Track
Glen Poisson	Avalon University School of Medicine
Bethany Roy	Tufts Maine Track
Zachary Schwamb	Kansas City University of Medicine and Bioscience
Michael Sighinolfi	Tufts University School of Medicine
Matthew Sonagere	University of New England
Marya Spurling	Tufts University School of Medicine
Jacob Stevens	Dartmouth Medical School
Caleb Swanberg	Tufts Maine Track
Holly Thro	Tufts Maine Track
Heidi Walls	Tufts Maine Track
Clinton Weiss	Tufts Maine Track
Benjamin Wooden	Mount Sinai School of Medicine

Payment Reform

Harold Miller, Executive Director of the Center for Healthcare Quality and Payment Reform.

On June 27th, MMA presented a forum on payment reform featuring Harold Miller of the Center for Healthcare Quality and Payment Reform. The Forum was presented through the generous support of the Maine Health Management Coalition and was co-sponsored by the Maine Osteopathic Association and Quality Counts. The evening featured a lively discussion between the physician audience and Mr. Miller on topics ranging from bundled payments to Accountable Care Organizations.

UPCOMING AT MMA

September 26
8:00am – 2:00pm
Hanley Center for Health Leadership Behavioral Health IT Integration

October 3
8:30am – 12:00pm
Maine Health Management Coalition

1:00pm – 2:00pm
Aligning Forces for Quality, Executive Leadership Team

2:00pm – 3:00pm
Quality Counts, Executive Committee

3:30pm – 5:00pm
Behavior Health Committee

October 5
8:30am – 12:00pm
First Fridays Seminar

October 10
4:00pm – 6:00pm
MMA Public Health Committee

October 11
1:00pm – 3:00pm
OSC HIT Steering Committee

4:00pm-8:00pm
Peer Review Boot Camp

October 16
6:00pm – 9:00pm
ME Chapter American Academy of Pediatrics

October 17
9:00am – 11:00am
Patient Centered Medical Home - Conveners

11:00am – 1:00pm
Patient Centered Medical Home - Working Group

1:00pm – 4:00pm
Aligning Forces for Quality, Patient Family Leadership Team

October 18
8:30am – 4:00pm
Pathways to Excellence (Maine Health Management Coalition)

6:00pm – 8:00pm
Maine Association of Psychiatric Physicians Executive Committee

October 24
11:30am – 2:00pm
MMA Senior Section

November 2
8:30am – 12:00pm
First Fridays Seminar

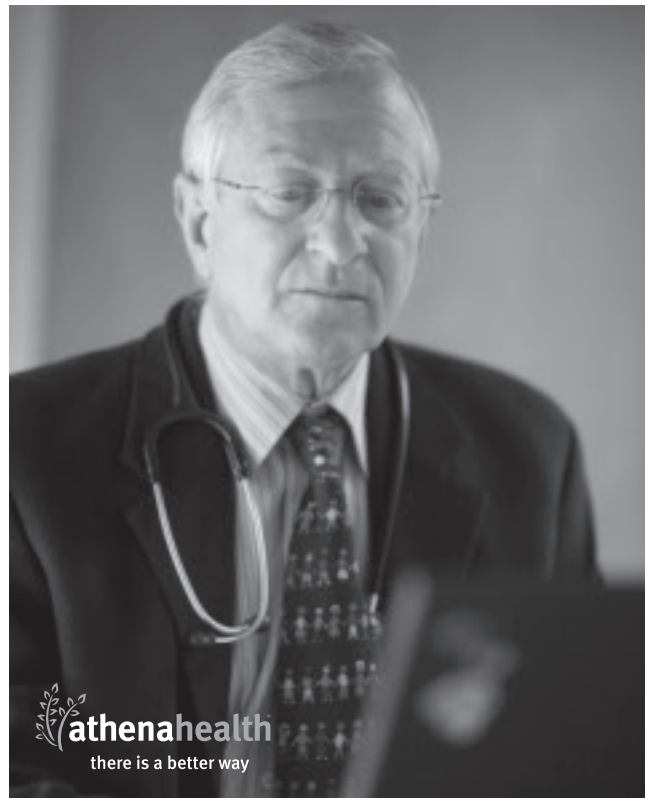
November 7
8:30am – 12:00pm
Maine Health Management Coalition

1:00pm – 2:00pm
Aligning Forces for Quality, Executive Leadership Team

2:00pm – 3:00pm
Quality Counts, Board

***All MMA Committee Meetings are now being offered through WEBEX*

Maine medicine
Maine Medical Association
30 Association Drive • P.O. Box 190
Manchester, ME 04351



Visit us on the web at **www.mainemed.com**

Save the Date: MMA's 159th Annual Session
September 7-9, 2012 at the Harborside Hotel in Bar Harbor