Commission to Study Primary Care Medical Practice

DRAFT NOTES

Date: November 2, 2007

To: Members, Commission to Study Primary Care Medical Practice

From: Elizabeth Cooper, Legislative Analyst

RE: Meeting Summary – October 26, 2007

The following is a summary of my notes from the Commission's second meeting.

Opening Remarks - The chairs of the Commission (Senator Lisa Marrache´ and Representative Gary Connor) opened the meeting shortly after 10:00 a.m. and the Commission members introduced themselves.

Presentation - Department of Health and Human Services - Dr. Rod Prior (Medical Director, Office of MaineCare Services) provided information from the MaineCare Primary Care Case Management program. In his presentation he noted, among other things, that MaineCare members served by Federal Qualified Health Centers (FQHCs) have increased more than other provider types. The MaineCare Primary Care Case Management program has improved primary care access for MaineCare members. Doctors that participate in this program receive a small monthly patient management fee and a small annual incentive fee based on certain measures of quality of care. Physicians practicing in federally qualified health centers, rural health centers, and hospital-based practices generally receive better reimbursement from Medicare and Medicaid than do physicians in private practice. In general there is more access to primary care physicians for new MaineCare members in poorer and more rural areas than in the more affluent and more urban areas, largely because of the larger presence of federally qualified health centers, rural health centers, and hospital-based practices in those areas. See page 1 of the presentation materials. There was also discussion of the group of Rockport doctors that decided to discontinue serving MaineCare patients. Related articles beginning on page 15 of the presentation materials were distributed to Commission members at the meeting.

Panel Discussion - Business Climate, Malpractice, Insurance and Rate Negotiations - Terrence J. Sheehan, M.D., President and Chief Executive Officer of Medical Mutual Insurance Company of Maine, opened the panel discussion with a presentation on medical malpractice. He noted that in recent years the experience has been good with rates stabilizing in 2005 and 2006 and a 7 percent dividend for physicians in 2006. There was a discussion of the review panels that make recommendations for malpractice cases. See presentation materials starting on page 24 of this summary. Additional information (starting on page 28) on malpractice was provided by the Bureau of Insurance and a list of malpractice related bills that were carried over by the Joint Standing Committee on Judiciary are on page 30.

Martha Ridge of Anthem Blue Cross and Blue Shield, presented information from the private insurer's perspective. She noted that 99 percent of Anthem members have a primary care physician within 30 miles and described quality incentive programs that are in place. Anthem reimbursement rates are about 130% of the Medicare reimbursement rate. Anthem works with primary care physicians on practice management and has a tiered pay-for-performance program called AQI Primary Care Quality Incentive Program. The program rewards performance by paying up to an additional 6 percent for primary care services based on industry standard measures of quality, including clinical outcomes, patient safety and administrative processes that enhance patient care. More information on the program can be found beginning on page 31 of the presentation materials.

Douglas J. Jorgensen, D.O., C.P.C., Jorgensen Consulting, L.L.C., talked about the need for billing optimization for physicians noting that while Maine is ranked #3 in the nation for quality, the State's MaineCare reimbursement is quite low in comparison to other states. He expressed concern about the government practice of taking "overpayment" of past Medicaid and Medicare expenditures automatically without due process. He expressed the belief that competition and capitalism in

medication will drive costs down. Some of the barriers to private practice for primary care physicians include the difficulty of negotiating contracts, restrictive covenants that hospitals put into employed physicians contracts, administrative burden and low reimbursement rates.

Mark Souders, Director of Payer & Employer Contracting, Kennebec Regional Health Alliance and MaineGeneral Health, talked about reimbursement rates noting that private pay rates are better in general than the rest of the country. Public payment rates are lower and payment rate increases do not keep up with the growing costs of technology and administrative burdens. Federal Trade Commission regulations also affect rate negotiations and give the advantage to larger insurers. Pay for performance programs are good, but sometimes the cost of the technology doctors need to participate in the program is more than what they would receive from the incentive payments. Pre-certification and pre-authorization processes are overly burdensome.

Panel Discussion - Challenges for Primary Care Physicians in Maine - Kevin S. Flanigan, M.D. provided testimony about his experience as a private practice physician and the factors such as reimbursement methodology, management models and administrative issues that impact a physician's decision about which practice model to use. Dr. Flanigan identified three significant threats to the future of private primary care practice: 1) inadequate public sector reimbursement rates, 2) burdensome administrative practices and 3) micromanagement of medical care delivery. He gave examples of other states' increases of Medicaid reimbursement and noted that other states pay higher management fees. He recommended specific changes to the MaineCare card for ease of identifying a member's eligibility category and changes to prior authorization processes. Dr. Flanigan's written testimony begins on page 43 of the presentation materials.

John H. Irwin, D.O. talked about his experience starting a now defunct diagnostic clinic and an endoscopy center that provides services at costs that are substantially lower than what hospitals charge. He noted the difficulty in staying open as hospitals in the area bought up practices reducing competition. He indicated that the Certificate of Need program and other regulations make it difficult to provide care. There was discussion of referral patterns and the influence of practice owners (such as hospitals) on employed physician referrals. There was limited discussion of the federal Stark rules, which are named for California Rep. Pete Stark, the author of the 1993 legislation upon which the current Medicare and Medicaid regulations are based. Commission members touched on how a single payor system might factor into the discussions.

Jeffrey M. Lovitz, M.D. talked about the challenges physicians face today. New physicians going into practice often have debt and other barriers to starting their own practice. In response to questions from Commission members, Dr. Lovitz stated that philosophically he favors a single payor system. However, the implementation of such a system concerns him. He suggested that MaineCare should be expanded to include state employees. There was significant discussion by the Commission members about the business factors, loan repayment, incentive plans and payor mix that influence a physician's choice of practice.

Maine Dartmouth Family Practice Residency – Present and former residents, Timothy Pieh, M.D., Amy Madden, M.D. and Kelley J. Harmon, D.O. talked about factors that influence physician decisions about practice location and type. Many physicians come into the work force with a large amount of debt. While loan forgiveness programs are available, many students are unaware that they exist. When recruiting employed physicians, debt repayment is often an incentive offered to young doctors. Seats in medical schools, loan forgiveness programs and opportunities for Maine residencies should be expanded. Doctors often stay in the area where they complete their residency. Other incentives such as housing may help lure physicians to underserved areas. If not for high debt, business start-up cost, the administrative burden and quality of life issues, these young physicians said they would prefer a private practice where they could be directly involved in the practice decisions.

Presentation - Patient Centered Medical Home - Jeffrey Jan Aalberg, M.D. provided information on the concept of the patient-centered medical home. The concept is based on seven principals that include a relationship with a personal physician who leads a team that is collectively responsible for all the patients health needs. The concept is an attempt to reconfigure primary care by using a chronic care model and increasing focus on outcomes with appropriate resources to support it. He provided examples of the current model of care and how certain aspects would change. The medical home provides comprehensive care by a physician-directed team treating the whole patient through all stages of life with coordinated, integrated, quality care that has enhanced access and a payment structure that recognized the added value to the patient. See Dr. Aalberg's presentation starting on page 60. More information on the patient-centered medical home model provided by Commission member David Peterson can be found starting on page 94 of the presentation materials.

Panel Discussion - Future of Primary Care and Regional Issues - Cathy Bradley, F.N.P., E. Victoria Grover, PA-C, Partners of Full Circle Health Care, talked about the role mid-level practitioners play in providing primary care. They encouraged the support of nurse practitioners and physician assistants to fill the void of primary care in rural areas of Maine. The women talked about the formation of their practice and some of the challenges they faced. Reimbursement rates are still too low and their practice is not open to new MaineCare patients.

Jacquelyn Cawley, D.O., Interim Dean/VP Health Services of University of New England's College of Osteopathic Medicine, provided information about the osteopathic medicine program. She indicated that of the 2000 students that were part of the first graduating class, 350 are still in Maine. The average debt for students completing medical school is around $200,000. While the number of students choosing primary care as their field is declining, over 50% of the students are still choosing primary care. However, more students are choosing out-of-state residencies due to the challenges of reimbursement for teaching physicians and limited in-state residencies with an osteopathic focus.

Hugh F. Harwood, M.D. talked about his experience working in a variety of practice settings. In the 1990s, Dr. Harwood had a solo practice. Larger group practices formed as health maintenance organizations changed the practice landscape. Dr. Harwood moved to a hospital setting and helped to develop a primary care practice at the hospital. He believes the entrepreneurial spirit and medicine go together quite well because clinical aspects drive decisions in the solo practice model.

Virginia Ann La Noce, F.N.P., NP, owns a solo practice called Family Medicine. She testified that the current structure and rate of reimbursement under MaineCare negatively impact her practice. She presented ideas for reform including allowing MaineCare billing for "no shows," MaineCare payment of co-pays and deductibles as a secondary insurer and simplification of MaineCare paperwork. She encouraged the Commission to take steps that would address these issues and look at incentives to get nurse practitioners into private practice. Her written testimony can be found on page 104 of the presentation materials.

Jud Knox, President and Chief Executive Officer of York Hospital, talked about the need for the hospital to hire primary care physicians as the area lost solo practices. York Hospital competes with the New Hampshire market in which 90% of primary care practices are owned by hospitals. While he believes low reimbursement rates are related to the shift to employed primary care positions, he does not believe it is the driving factor. He indicated that life-style issues are a big factor in a physician's decision to become employed. It's a trade off between autonomy and stability. He suggested that in addressing issues of the eroding primary care base, the Commission should look at medical homes, increased use of mid-level practitioners and physician income guarantees. While he contends that hospitals do not control employed-physician referral patterns, he acknowledged that as an administrator he wants to know if there are reasons why referrals are not being made to specialists at his hospital.

Jeffrey Landfair, M.D. came to Maine due to quality of life issues. He believes that factors influencing a primary care physician's decisions on location and type of practice include lifestyle,

ability to pay-off or have educational debt relief, administrative burden issues and whether or not a doctor wants to deal with the business aspects of a practice. He talked about his recent experience in seeking employment and noted that many hospitals as well as group practices offer repayment of debt. He believes that it is important for physicians to have a variety of practice choices.

There was discussion among the Commission members and panelists about income guarantees with one Commission member noting that these are more difficult due to Stark 1 and Stark 2. There was a suggestion of funding of pilots to explore different models of primary care practice, creating more residency slots that match the needs of UNE students and providing more autonomy for physician assistants.

Public Comment Period - Comments were provided on MaineCare reimbursement, addressing the restrictive covenants that hospitals have in physician contracts, allowing physician assistants to practice independently, influence of hospitals on referral patterns, addressing the differences in what nurse practitioners can do in a hospital setting versus an independent setting and recognizing the fact the health care system that has evolved over time is more expensive than other systems. One of the people commenting requested that "the Commission…ask the Provider Advisory Group to provide suggestions for improving the business climate for primary care as they have been instrumental in the improvement of MaineCare and the group consists of most capable innovative people in the healthcare industry. He also indicated that "several examples of MaineCare not paying PCPs legitimate claims were given…" and he request that the Commission "…recommend MaineCare stop this practice."

Last Meeting: December 7, 2007

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