



Commission to Study Primary Care Medical Practice

Date: September 27, 2007
To: Members, Commission to Study Primary Care Medical Practice
From: Elizabeth Cooper, Legislative Analyst
RE: Meeting Summary – September 14, 2007

The following is a summary of my notes from the Commission's first meeting. I have also included webpage links to information provided at the meeting. You have most of this in hard copy form in your notebooks. Hard copies of the information received after the conclusion of the first meeting will be available at our **next meeting on October 26, 2007**.

INTRODUCTION/STUDY OVERVIEW

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. The Commission reviewed the content of their notebooks, which include a list of Commission members, Commission's charge, the agenda and other background material. (See <http://www.maine.gov/legis/opla> for this information.)

OVERVIEW OF PRIMARY CARE PRACTICE IN MAINE

Department of Health and Human Services (DHHS) - Tony Marple (Director, Office of MaineCare Services) and Dr. Rod Prior (Medical Director, Office of MaineCare Services) presented some information on the current state of primary care medical practice in Maine. Some highlights from the information they provided follows.

They discussed the evolution of the primary care system indicating that there is a national trend of more physicians working in employed positions rather than in self-employed practices. Many factors are related to this including the need to increase access to care, technology costs, reimbursement rates, methods of billing, business operations and recruitment. They reviewed information provided in the Commission members notebooks including an update on the Muskie School study; tables showing primary care practices by county; a narrative covering physician employment patterns; geographic distribution of MaineCare recipients; and regulations and licensing requirements related to providing a safety-net for access. (See <http://www.maine.gov/legis/opla/primcare914mats.pdf> to download pdf files of September 14th meeting materials that include this information.) Additionally, DHHS representatives suggested that funding for data and analysis from the Maine Health Information Center (MHIC) could provide more in-depth information on the current state of primary care medical practice in Maine.

MaineCare reimbursement rates for all physician services are based on a Resource Based Relative Value Scale (RBRVS) fee for service for physician owned and hospital affiliated practices and as

a percentage of cost for hospital operated (also known as Provider Based Entities) practices. Federally Qualified Health Centers (FQHCs) are paid at a higher fee table than that of private physicians, and Rural Health Centers (RHCs) are reimbursed at cost. Generally speaking, private and hospital affiliated practices are paid at significantly lower rates than hospital based practices, FQHCs or RHCs.

The Resource-Based Relative Value Scale (RBRVS), which MaineCare uses for paying private physicians was established in 1992 by the federal government for payments to Medicare. (Learn more about the RBRVS system at: <http://www.ama-assn.org/ama/pub/category/16392.html>. Also, see summary of MMA testimony below.) According to Dr. Prior, the current commercial insurance RVRBS rate for a primary care visit in Maine is approximately \$50; Medicare pays approximately \$38 and MaineCare (Medicaid) at 53% of the Medicare reimbursement pays approximately \$20 for the same service. A cash paying patient would pay approximately \$70 to \$75 for the same visit. Funding has been provided in the State budget to increase physicians' MaineCare reimbursement in two biennial budgets passed by the 122nd and 123rd Legislatures. PL 2005, chapter 12 and PL 2007, chapter 240 (the biennial budget laws) include \$3,000,000 each for increasing physician reimbursement rates.

PANEL DISCUSSION - CHALLENGES FOR PRIMARY CARE MEDICAL PRACTICES

Maine Hospital Association (MHA) – Mary Mayhew (Vice President of Government Affairs and Communications) presented oral testimony regarding primary care practice in hospitals. Highlights of the testimony and answers to questions from the Commission are summarized below. For complete testimony and follow-up information provided by MHA, go to: <http://www.maine.gov/legis/opla/mhaprestoprimacare.pdf>.

Ms. Mayhew provided testimony on some of the reasons hospitals began employing physicians and recruitment challenges as well as reasons some physicians choose to be employed by hospitals. She discussed the differences between Provider Based Entities (PBE) and 501c3 physician practices owned by hospitals that are not certified as PBEs. The Commission discussed recruiting challenges and requested information on the number of net new physicians practicing in Maine as a result of hospital employment.

The Commission members discussed the financial aspects of hospitals owning primary care practices and the influence of hospitals on referral patterns of the primary care physicians. A Commission member noted that hospitals do not dictate how a physician practices medicine, but communication patterns are different in a group setting. Also, the hospital is governed by a board and medical staff members are represented on board. Ms. Mayhew indicated that policies are in place related referral practices and primary care physicians affiliated with hospitals are not required to make all referrals within the hospital network.

Commission members discussed the need for patients/consumers to have choice in the model of primary care practice they want. There was also discussion about hospitalists, who provide primary care-type services during in-patient stays. Ms. Mayhew indicated that hospitals are currently recruiting 14 hospitalists and provided more information, which can be found at the end of the MHA testimony at web address above.

Maine Primary Care Association (MPCA) - Kevin Lewis (Executive Director of MPCA), Dawn Cook (Chief Executive Officer of Health Access Network), Noah Nesin, MD (Medical Director for Health Access Network) and Reverend Robert Carlson (President, Penobscot Community Health Care) presented information on the Federally Qualified Health Centers

(FQHCs), and other primary care networks organized to provide access and a safety net for primary care.

They discussed the transition of primary care from a disease based model to a preventative health model that includes community wellness. They discussed FQHCs, Rural Health Centers (RHCs) and Community Health Centers. Some health centers are referred to as FQHC “look-a-likes” as they provide similar services and are eligible for grant funding, but do not receive a specific type of grant funding known as a 330 grant. Additional information on these organizations, including maps of primary care providers in Maine can be found in the background information at: <http://www.maine.gov/legis/opla/primcarebackinfo.pdf>. A report on primary care access provided by the MPCA prior to the meeting can be found in the meeting materials at: <http://www.maine.gov/legis/opla/primcare914mats.pdf>.

Health Access Network, a 501c3 non-profit organization, was established after doctors from solo-practices found it hard to stay in business. Similarly, the impetus for the creation of Penobscot Community Health Care, was a response to the reduced access to primary care as private physicians limited MaineCare patients due to low reimbursement rates. The model of primary medical care encompassed by these community based organizations and networks provide services that primary care physicians typically can not provide alone such as nutrition education, disease management education, social work and mental health services. Additional materials can be found at: <http://www.maine.gov/legis/opla/primcareassocpresent.pdf>.

Maine Academy of Family Physicians (MAFP) – Paul Pelletier, M.D. provided testimony and Deborah Halbach (Executive Director) provided a packet of information in response to pre-meeting questions that were sent to all panelist. (See <http://www.maine.gov/legis/opla/primcare914mats.pdf> for questions.)

Dr. Pelletier talked about the low pay of primary care physicians, administrative burdens for solo and small office practitioners and the low rate of students entering the primary care field. He talked about the primary care emphasis found at the University of New England. He indicated that improvement in the MaineCare reimbursement rates and prior authorization process would help primary care practice in Maine.

Deborah Halbach provided an overview of the information in the packet she provided on behalf of the Academy. The packet includes: maps of the geographic disbursement of Maine physicians and health professional shortage areas; charts of state comparisons of Medicaid reimbursement and a link to an article on Medicaid pay issues; a study on the economic impact of family physicians in Maine; a comparison of state medical malpractice laws, information on educating, training and recruiting family physicians, and information on what other states are doing related to primary care practice. The complete packet can be found at: <http://www.maine.gov/legis/opla/MaineAFPpresent.pdf>.

Maine Medical Association (MMA) – Gordon H Smith, Esq. (Executive Vice President) and Andrew MacLean, Esq. (Deputy Executive Vice President and General Counsel) provided testimony and information.

Gordon Smith indicated that MMA represents employed and self-employed physicians. He indicated that while MMA would like for patients to be able to choose from both models, those choices are not always available in all counties in Maine. He pointed out that recent state budgets have included funding for increasing physician reimbursement through MaineCare. Regarding recruitment, he noted that Maine can’t pay what other states pay doctors and that issues such as medical malpractice, overhead costs and quality of life issues influence doctor’s decisions to be

employed or self-employed. He provided an outline entitled “Legal Implications for Physicians of Hospital Employment,” which starts on page 2 of the information that can be found at: <http://www.maine.gov/legis/opla/MMApresent.pdf>.

Andrew MacLean provided an overview of the Resource Based Relative Value Scale (RBRVS) system noting that it has components for overhead, medical malpractice and cost of services. (Learn more about RBRVS system at: <http://www.ama-assn.org/ama/pub/category/16392.html>. Also, see summary of DHHS testimony above.) He discussed conversion rates as the RBRVS system is applied to commercial insurance and MaineCare. He provided a table that shows how the RBRVS system is procedure-oriented and undervalues the cognitive factors used by primary care physicians in their work with patients. (See page 1 of the information found at: <http://www.maine.gov/legis/opla/MMApresent.pdf>.) He pointed out that under the RBRVS system Anthem’s reimbursement for a procedure to remove a skin lesion is \$269 while a primary care office visit for an established patient is only \$168; the reimbursement of that same office visit through MaineCare is only \$115.

Maine Osteopathic Association (MOA) – Louis A. Hanson, DO provided testimony as a member and past president of MOA. He owns a solo family practice and has 1 full-time employee and a part-time employee. He noted that it is harder to stay in practice with increased administrative burdens and narrowing margins of financial reimbursement.

Before the Baldacci administration included funds for increases in MaineCare reimbursement in recent budgets, physicians in Maine went 21 years without an increased rate of reimbursement from MaineCare. Dr. Hanson discussed the difficulty of dealing with increased scrutiny from the federal Drug Enforcement Administration (DEA) related to prescribing medication as well as the administrative burdens imposed by out of state managers of care for approval of insurance claims, patient confidentiality requirements, prior authorization procedures and requirements of continuing education as a solo practitioner. He also mentioned the increased “call” burden, which he currently shares with 5 other doctors in the area.

Panel Discussion Q & A

The Commission chairs opened up the meeting for questions and answers between the Commission members and the panelists. One Commission member suggested that universal health care would address many of the issues and several panelists indicated that they support universal health care. Another Commission member indicated that there could be concern if the government were in charge of a single payor system noting the already low MaineCare reimbursement rates and lack of increased reimbursement for over 20 years. And another Commission member used MeCMS as an example of reluctance to support government operated universal care.

There was a discussion of FQHCs and FQHC look-a-likes. The MPCA indicated that there is only one “look-a-like” left and that look-a-likes get the same FQHC reimbursement rates but do not receive the 330 grant provided to FQHCs. The 330 grant provides approximately 16% of the total revenue provided to FQHCs. A Commission member requested information on the total number of providers that are retained by moving to a FQHC and the number of new doctors recruited to FQHCs. Members of the MPCA indicated that 10 new doctors (including dentists) were recruited through the Health Access Network and the Penobscot Community Health Care recruited 10 new dentist, 1 new pediatrician and 2 new primary care doctors that were not currently in practice in Maine. Members of the MAFP indicated that there 2 new FQHCs in

northern Aroostook County with 1 new private practice and 3 internists. In parts of Maine, all the independent practices are gone as the system has moved to hospital employed physicians.

A Commission member asked about competition between private practice, hospitals and FQHCs and what the legislature might do to provide more choice for patients. The MMA indicated that competition exists in the more populated areas of the state, but in the rural areas there is little competition. The Commission and panelists discussed the impact of federal funds, the ability to factor payor mix into RBRVS rates and effects of cost shifting due to low MaineCare reimbursement.

Some solutions suggested by panelists were to increase MaineCare co-payments and develop a physician incentive payment program that would encourage private primary care physicians to accept more MaineCare recipients. There was discussion of how to further increase MaineCare reimbursement to physicians as well as how to reduce emergency room visits and redirect the savings to primary care. Related to education and training, there was discussion of loan repayment programs such as the repayment option through the Finance Authority of Maine (FAME) for graduates going into practice in underserved areas as well as the positions held in the Dartmouth medical program for Maine graduates and the need to increase High School Proficiency Assessment (HSPA) scores in Maine. FAME will be meeting September 27th and there was a suggestion that an update from that meeting would be helpful. On November 14-16, the MPCA is holding a conference that will include a discussion of recruitment.

Public Comment/Testimony - One person testified during the comment period expressing disappointment that advance practice nurses were not involved in the Commission's work. Testimony included information on the value of advance practices nurse practitioners, the difficulties of credentialing, call duty and reimbursement as well as factors that discourage nurse practitioners from becoming independent. The Commission members indicated that they as very interested in the perspective of advance practices nurses as well as other mid-level care providers such as physicians assistance. Persons representing those professional have already been invited to participate in panel discussions at the next meeting on October 26, 2007.

Commission Discussion/Planning

The Commission discussed plans for future meetings and expressed interest in information on the following items: Maine Health Information Center data; University of New England medical programs and the needs of residents to remain in Maine; mid-level practitioners including Advance Practice Nurses and Physician Assistants; the impact of insurance (both health insurance and mal-practice) on primary care; rate negotiation for providers, HMOS and PPOs; information from licensure boards and on education loan programs through FAME. The Commission adjourned at approximately 4:00 p.m.