



Commission to Study Primary Care Medical Practice

**Presentation Materials
from**

Meeting of October 26, 2007

Presentation Notes

MaineCare Presentation to Commission to Study Primary Care Medical Practice October 28, 2007

Slide 1: shows the percentage of total MaineCare members served on at least one occasion by provider class during fiscal years 2000, 2002, 2004, and 2006. Hospital outpatient encounters include all hospital outpatient services including emergency room, clinic, laboratory, radiology, and therapy services. Physician services include both specialist and primary care physicians.

The following slides come from the MaineCare Primary Care Case Management program wherein MaineCare members select or are assigned a primary care physician. Approximately 200,000 MaineCare members are enrolled in this program. Members who have both Medicare and MaineCare coverage, institutionalized members, and members in certain Waiver programs such as the HIV Waiver are excluded from the PCCM program. As part of this program, primary care physicians enroll to become part of the program. Enrolled providers are paid a small monthly management fee and usually receive an annual incentive payment based upon their performance on certain quality metrics.

As part of the PCCM program, enrolled providers **may** list themselves as open or not open to accepting new MaineCare members. The following slides are derived from data kept for that program

Slide 2 shows the number of MaineCare members enrolled in PCCM and served by physicians in various practice settings.

Slide 3 shows, by county, the percentage of primary care practices open to new MaineCare patients as a percentage of total PCCM practices.

Slide 4 shows a history over the past 2 years of the percent of PCCM practices open to new members by practice setting – federally qualified health center (FQHC), hospital-based, Indian Health Service (HIS), physician-based, and rural health center (RHC). The physician-based group includes practices which are affiliated with but not owned by a hospital. These affiliations are generally via an umbrella corporation which owns both hospital(s) and physician practice(s). These hospital-affiliated practices are paid by MaineCare using the same professional fee schedule as applied to private physician practices.

Slide 5 shows a history over the past 2 years of the overall percent of PCCM practices open to new MaineCare members by county.

Slide 6 shows the number of physician practice months of practices enrolled in PCCM by county and type of practice over a 2-year period.

Slide 7 shows the number of physician practice months of practices enrolled in PCCM and open to new MaineCare members by county and type of practice over a 2-year period..

Slide 8 shows the number of practice months of practices enrolled in PCCM and open to new MaineCare PCCM members relative to the number of MaineCare members in the county enrolled in PCCM. This is perhaps the best measure of primary care physicians to MaineCare members without a PCP.

Slide 9 shows by county the percentage of MaineCare members enrolled in PCCM whose primary care provider practices in a county different from the member's residence county. This slide suggests that analysis of physician supply and demand must take into account the member's choice of where they receive their care.

Slide 10 comes from a survey of hospital-employed physicians done by Maine hospitals as part of their state licensure process. It shows the specialty distribution of hospital-employed physicians in Maine. The point of the slide is to show that hospitals employ a broad range of physician specialties.

The following slides are derived from the MaineCare claims database. The analysis was done by Cathy McGuire of the Muskie School as part of their study of primary care physician utilization by Medicaid in New Hampshire and Maine

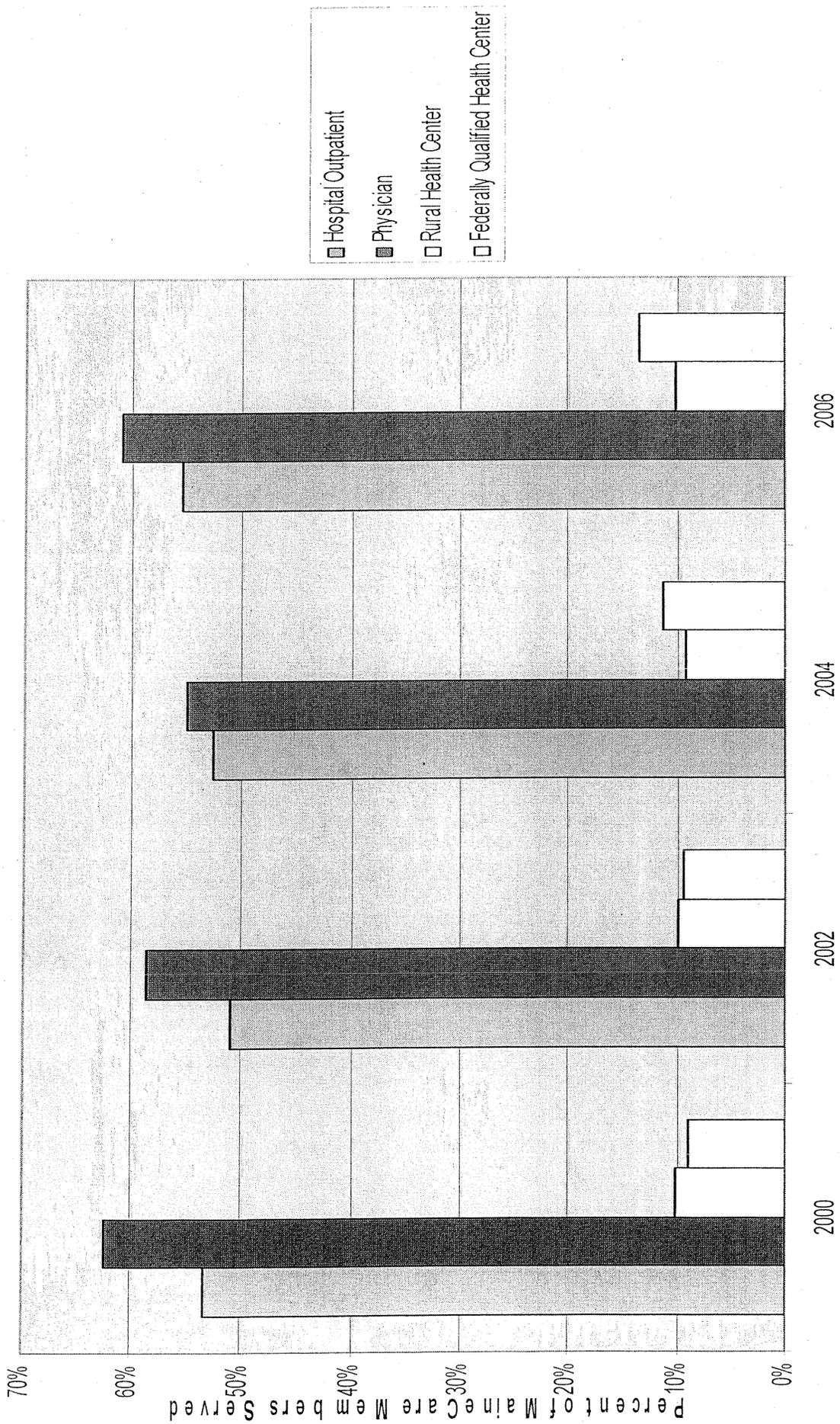
Slide 11 shows the per-member-per-year payments by MaineCare for each of 4 years in 5 categories: hospital outpatient, physician services, Indian Health Service, federally qualified health center, and rural health center. Hospital outpatient services include emergency department, clinic, laboratory, radiology, and therapy services. Physician services include all physician specialties and all services billed via a professional claim form including services provided in hospital-affiliated practices.

Slide 12 shows the average per-claim MaineCare cost for outpatient professional claims. Hospital claims were identified as those including a (physician) professional service charge and excluding emergency department visits. Primary care and specialist physician visits cannot be differentiated. Physician claims were limited to office visits by the specialties of family practice, internal medicine, pediatrics, and ob/gyn. Non-hospital claims include those which do not include a face-to-face physician encounter such as laboratory or radiology visits.

The costs in the various categories are difficult to interpret, as both unit pricing and the services included in a claim vary markedly among hospital claims, private physician claims, and health center claims.

Roderick E Prior, M.D. Medical Director for MaineCare

Percent of Members Served By Provider Type



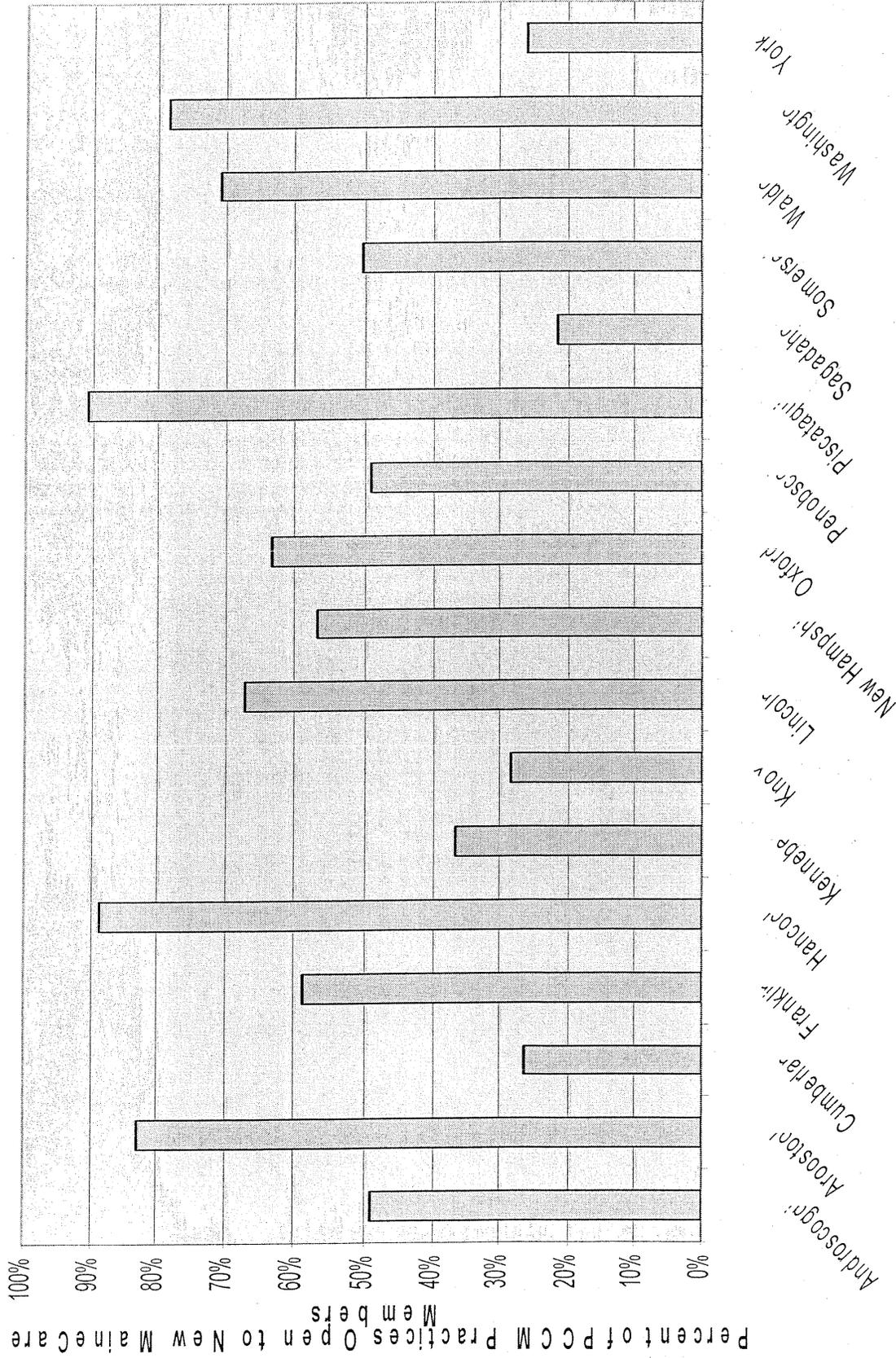
MaineCare Users of Primary Care Services



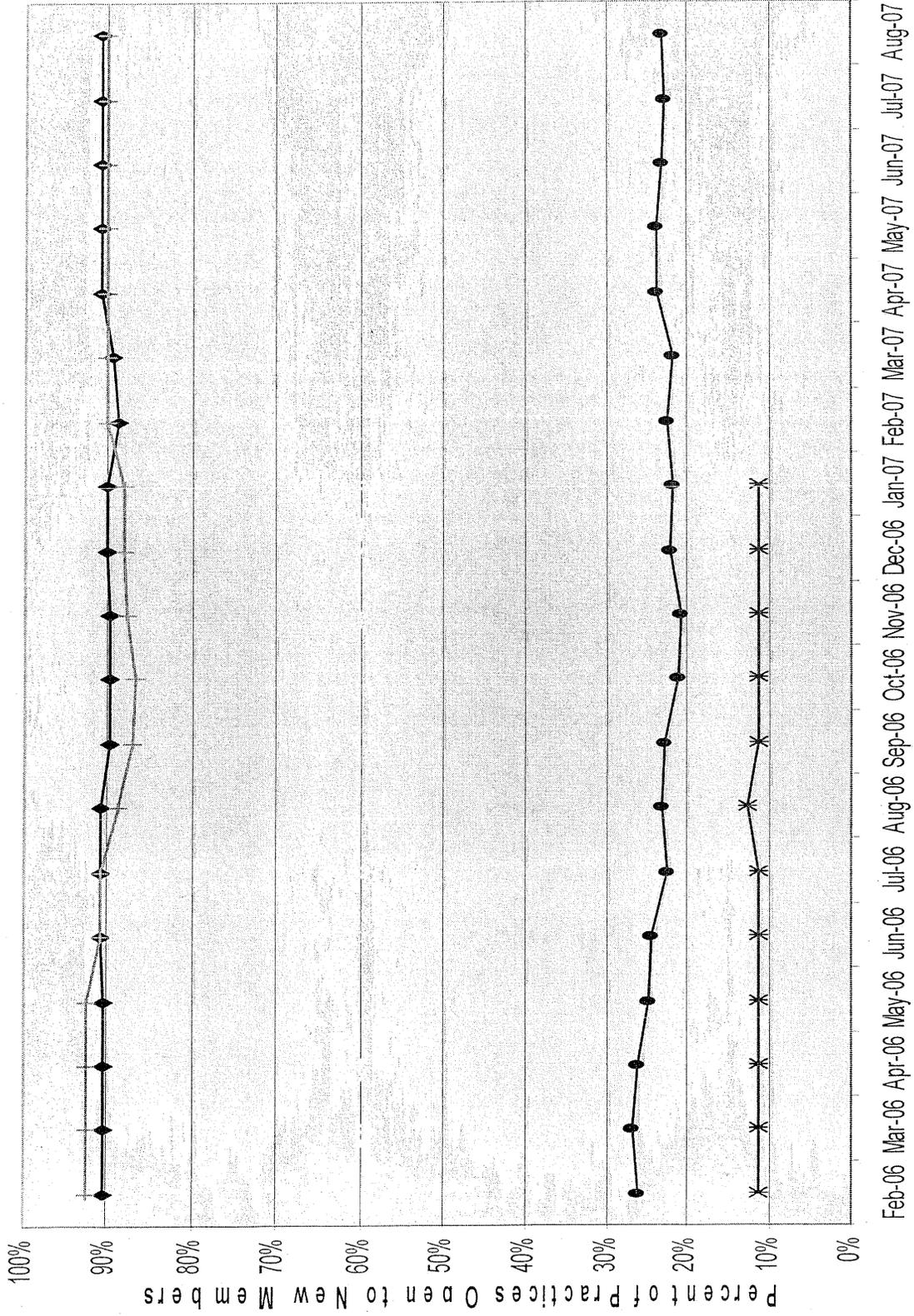
10/30/2007

Practice Affiliation

Open Practice Percentages By County



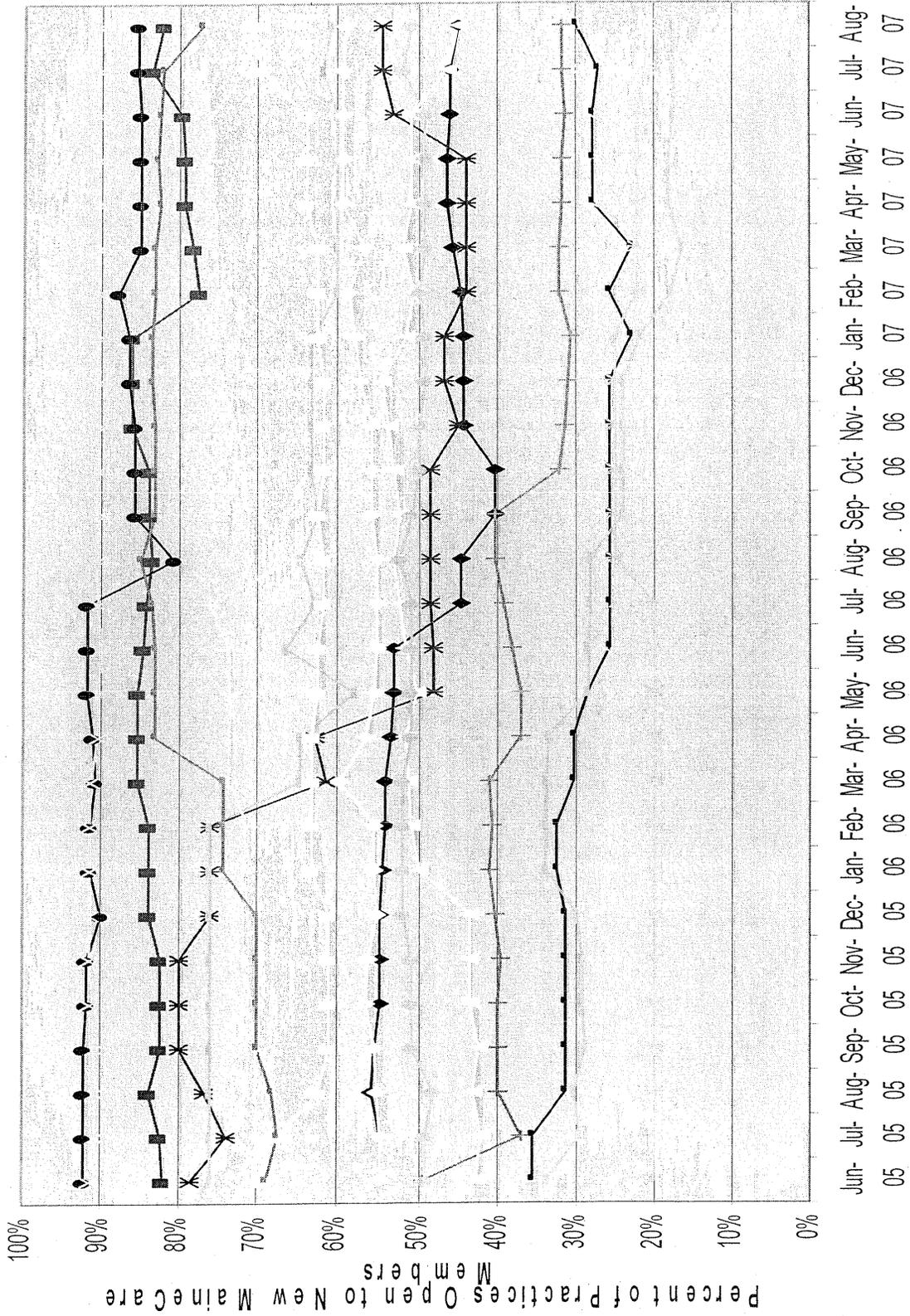
Percent of Practices Open to New MaineCare Members



10/30/2007

Month and Year

Percent Open Practices By Month

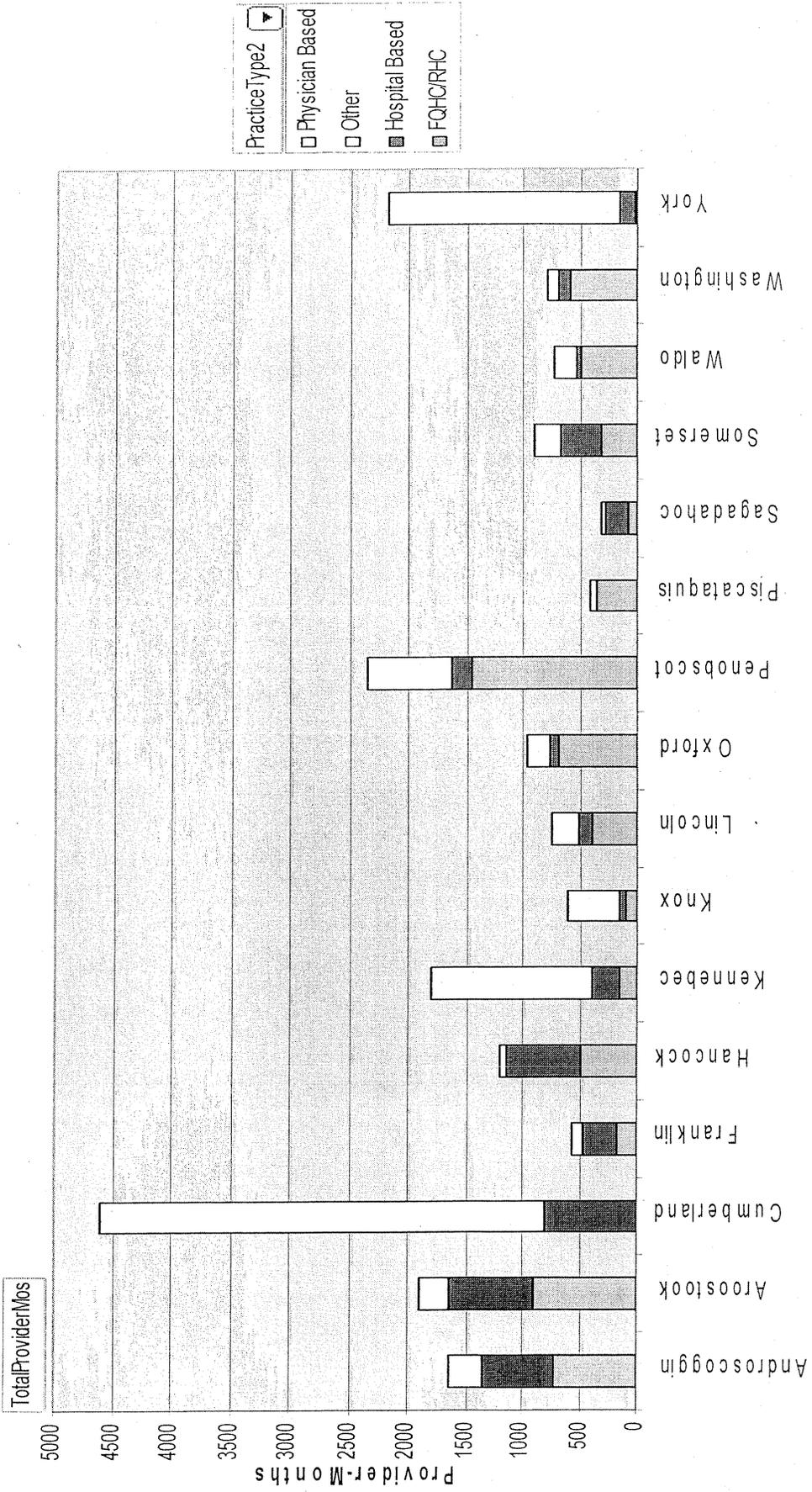


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Month and Year

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Total Provider Months by Practice Type

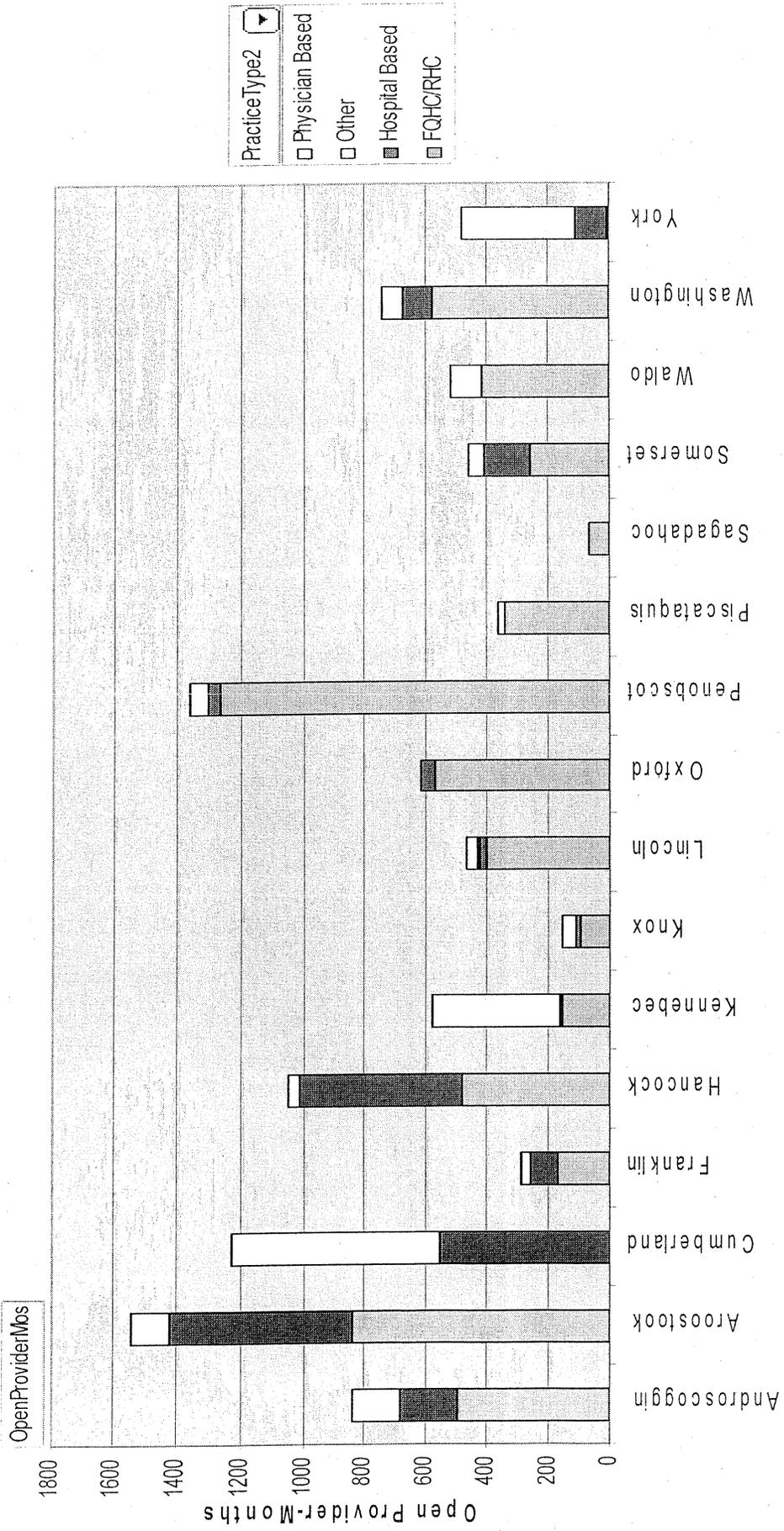


County
County Name

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Open Provider Months By Provider Type



County

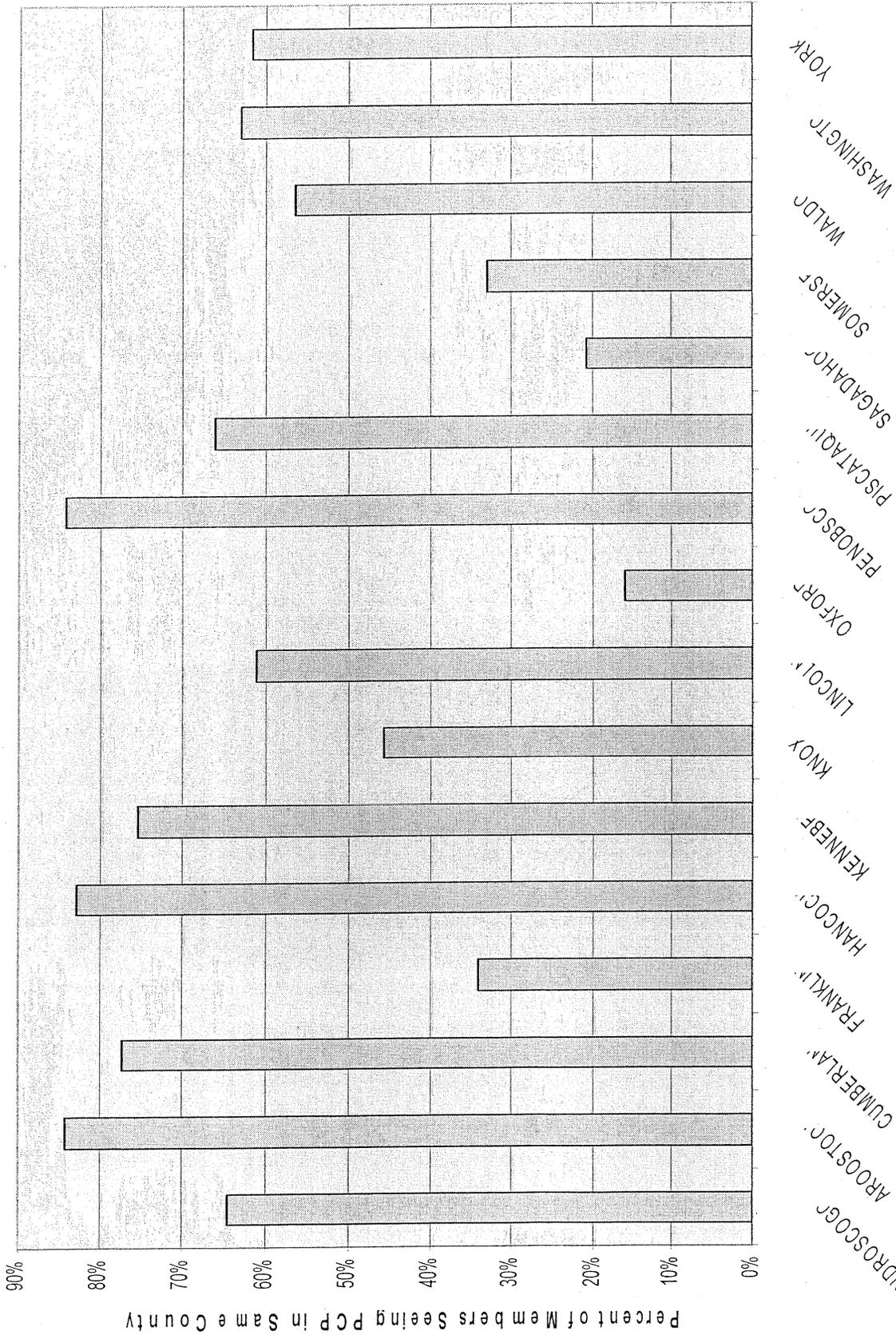
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Relative Physician New-Member Availability Per Member

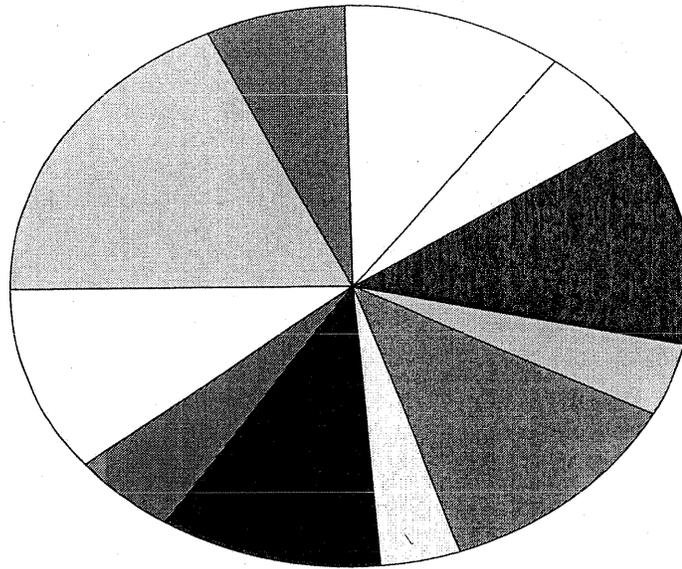


Percent of Members who See a PCP in the Same County



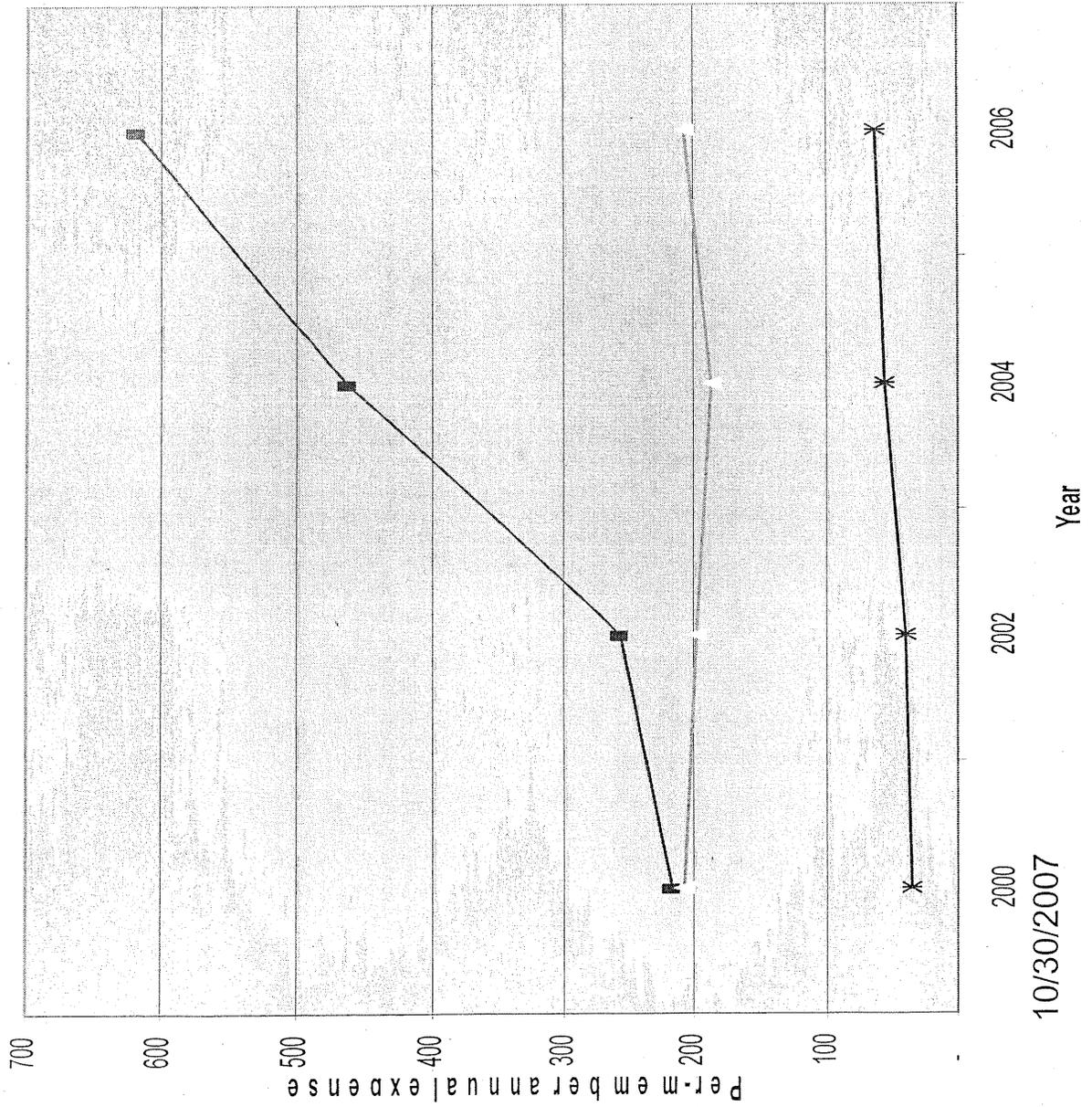
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Hospital Affiliated Physicians By Specialty



- Family Practice
- Pediatrics
- Internal Medicine
- Obstetrics & Gynecology
- Medical Specialty
- Psychiatry
- Surgery
- Anesthesiology
- Emergency Medicine
- Hospital Medicine
- Other

Outpatient MaineCare Per-Member Expenses By Provider Type

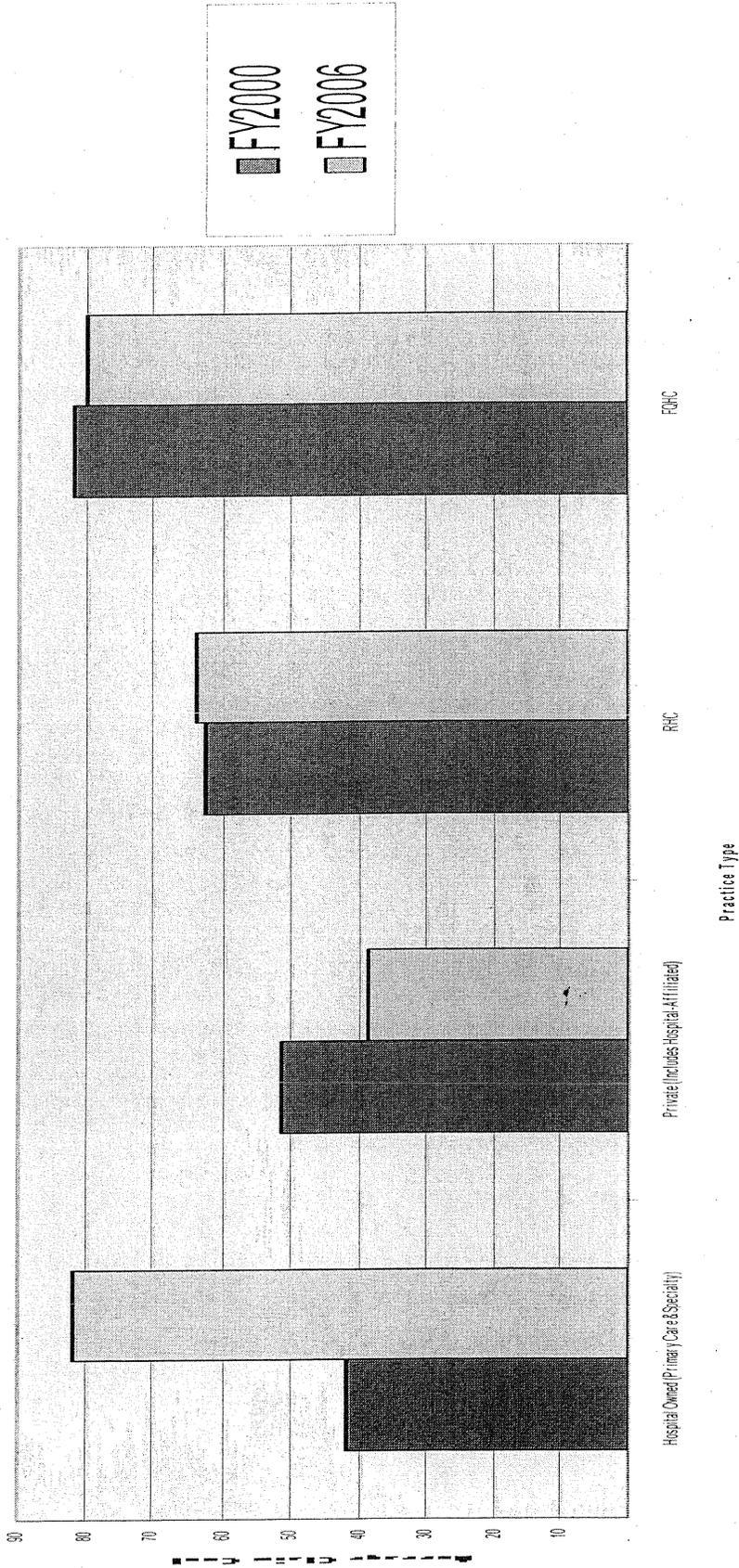


Note: Hospital expenses include ER, laboratory, radiology, and therapy services as well as physician and clinic services.

Physician services include all physicians, not only primary care physicians.



Average Cost Per MaineCare Claim
for Physician-Related Outpatient Services





Local MaineCare rejection symptomizes bigger ills

By Lynda Clancy
VillageSoup/Knox County Times Reporter

ROCKPORT (Oct 18): A bold move made last month by a group of Rockport doctors to discontinue serving MaineCare patients is making waves locally and in Augusta, where the state's Bureau of Medical Services has taken notice.

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But as Midcoast Medicine's financial manager Chris McIntosh said, what happened in his office is a symptom of a larger nationwide crisis illustrated by fewer physicians entering family practice.

It also looms at a time when Maine is urging its citizens to adopt healthier lifestyles, when Gov. John Baldacci wants to make Maine the healthiest state in the nation, and when government has made longtime efforts to provide health care to citizens who can't afford it.

Currently, MaineCare is actively recruiting existing physicians from Damariscotta to Belfast to help take on the 400 or so patients who must find new health care in the Midcoast, said Bureau of Medical Services spokesman John A. Martins. He said the number of MaineCare providers in Maine has increased from 1,340 in 2006 to 1,462 in 2007. "We are concerned when any members can't find service," he said.

The decision of four doctors at Midcoast Medicine in Rockport Village to disenroll from Medicaid, otherwise known as MaineCare, followed six months of discussion and the loss of two doctors, said McIntosh.

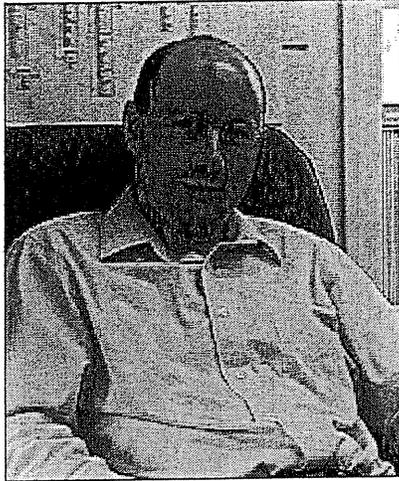
"We agonized over it for quite a while," he said, with the office first slimming its office staff and eliminating raises.

Midcoast Medicine is a busy office with roots long in Camden and Rockport; its founding doctors, McKim and Linda Petersen, have practiced in the area for 30 years, taking over the practice from Dr. Cox. Yet low reimbursement by the state to cover visits of MaineCare patients prompted the doctors to trim Midcoast Medicine's patient roster by approximately 800 names.

The reasons are simple: A typical office visit costs \$76, but MaineCare reimburses the doctors just \$24, said McIntosh. Private insurance companies, on the other hand, will reimburse the doctors at 90 percent of the cost.

Why the low reimbursement to family doctors in private practice is a question that no one seems able to answer, although plenty have raised it. The funding pie may be just so small, and doctors in private practice, who are busy tending to patients, lack a strong voice before MaineCare.

Erick Steele, a physician and writer, cited in the July 2007 issue of the Maine Policy Review,



Chris McIntosh, Midcoast Medicine's office manager. (Lynda Clancy)

published by the Margaret Chase Smith Policy Center at the University of Maine, the "difficult relationship" between MaineCare and the health provider community.

"MaineCare is one reason many Maine physicians have become employed by hospitals, because hospitals can guarantee their salaries and often get better reimbursement for MaineCare patients' services than do private physicians," he wrote. "The private practice of medicine is dead or dying in parts of Maine as a result of reimbursement and other problems."

Midcoast Medicine says no more

In a letter sent Sept. 28 from Midcoast Medicine to approximately 800 MaineCare patients, the doctors wrote: "The recent loss of two of our physicians, in part due to extremely low

reimbursement from MaineCare, has made it impossible to continue to accept MaineCare as an insurer. We simply cannot continue to offer our services below our cost to produce them."

The letter continued: "Consequently, I will no longer be able to provide medical care to you. Therefore you should place yourself under the care of another physician."

Through the efforts of Waterville doctor and Maine Sen. Lisa Marrache, the Legislature last year established a Commission to Study Primary Care Medical Practice. The commission will:

- identify the causes of the loss of independent ownership of primary care medical practices due to financial, regulatory or business-related reasons;
- seek input from independent primary care physicians on payer mix, reimbursement and Medicaid regulatory changes and the effects of such factors on the ability of independent primary

In reality, McIntosh said, Midcoast Medicine's MaineCare patients number approximately 350 to 400. The other 400 represent one-time visits, "a patient they saw four years ago with a sore throat," he said.

The doctors urged patients to quickly find another doctor, and provided a list of resources for the patients, including Penobscot Bay Medical Center, Waldo County General Hospital, Miles Memorial Hospital, rural health clinics in Waldoboro, Damariscotta and Belfast, and the Mid-Coast Mental Health Center.

At the same time, there is diminished availability of family doctors, and it goes beyond Medicaid reimbursements. Midcoast Medicine is actively recruiting new doctors, as is Penobscot Bay Medical Center.

According to the American Academy of Family Physicians, the number of primary care doctors has decreased partly because of rising liability premiums and an increase in administrative paperwork, not to mention the high cost of education itself and the debt load a new doctor might carry.

The academy cited a Medical Group Management Association study, which found that "on average, a 10-physician practice spent more than \$247,500 per year on administrative costs."

McIntosh described the administrative requirements from MaineCare -- more forms to complete, more justifications demanded of doctors about why they might prescribe a certain drug over a generic drug, and delayed payments for various reasons. Midcoast Medicine is still waiting for \$4,000 in reimbursements from 2005 from MaineCare.

"We almost need a full-time person to process the forms," he said. "We're literally

care physicians to practice medicine in Maine;

- seek to determine the effect of hospital control of primary care medical offices or primary care physicians on health-care costs, access to health care and medical treatment of Maine's citizens; and
- review how comparable states manage physician-hospital relationships with respect to health-care costs, patient advocacy and access to health care.

The commission is to report back to the Joint Standing Committee on Health and Human Services before Dec. 5.

losing money."

MaineCare generous to patients

But there have been efforts to redirect MaineCare. The Maine Medical Association noted among its legislative successes in 2005-06 the \$3 million general fund increase in MaineCare reimbursement for physicians, which, with federal matching funds, increased to \$8.3 million.

That took MaineCare rates up to approximately 53 percent of Medicare rates, although McIntosh said little actually trickled down to family doctors in private practice.

John A. Martins, a spokesman for Maine's Bureau of Health, which oversees MaineCare, said the family doctor reimbursement has been a historical challenge, one that Baldacci has tried to mitigate, "and is looking to do in 2009."

While Medicare is administered federally, Medicaid, or MaineCare, is a joint state/federal program, with almost 65 percent of its funds deriving from federal coffers, a ratio based on socioeconomic factors. Poorer states, such as Mississippi, get 75 percent funding from Washington; wealthier states, such as Connecticut, receive about 50 percent in federal money.

"Maine has historically had a generous Medicaid package," said Andrew MacLean, deputy executive director at the Maine Medical Association. "The state has unfettered control of how that money is expended."

That generosity extends to approximately 145,000 Maine residents this year, and reflects a collective state effort to cover its poor.

The Maine Policy Review described MaineCare's share of the general fund increasing from 1.4 percent in 1997 to 22.8 percent in 2006. MaineCare, according to Paul Saucier in the Review, "is a phenomenally complex program" and bears characteristics that make it "a very difficult program to understand and administer."

To cope, family doctors have used a "payer-mix" approach to their patient base to ensure income, capping the number of MaineCare patients they will see.

But that doesn't cover their rising expenses anymore, according to McIntosh, expenses that include the costs of equipment, office space, personnel and liability insurance.

Midcoast Medicine believes its practice shrunk from six doctors to four in part because of the low reimbursement. Being a private practice, there are no additional subsidies, and providing care is not a sustainable model, said McIntosh.

"We didn't do this to pick a political fight," he said. "We are trying to meet community demands as best we can."

That political fight, if there is to be one for the family doctor in private practice, will take place at the Statehouse.

"Few in the provider community believe that MaineCare simply does not want to pay its bills, or enjoys its status as a problematic payer," said Steele in the Maine Policy Review. "Most of MaineCare's problems reflect tight state budgets, rapidly increasing health-care costs, and our society's failure to have developed a universal insurance model at a national level. We have gotten into this mess in part because Maine's state government is trying to solve large social problems with limited solutions and limited dollars."

Ironically, the most comforting, and forgiving, words to McIntosh and the doctors came in the form of a note from a

MaineCare patient after she received the letter. While sad about being forced to find a new doctor, she understood the circumstances. "I admire anyone who is willing to take on MaineCare," she said. "I feel badly you have not been paid adequately for all your wonderful service."

Related Links:

- [American Academy of Family Physicians.](#)
 - [MaineCare.](#)
 - [Midcoast Medicine.](#)
 - [The Future of MaineCare in Maine Policy Review.](#)
 - [www.mainemed.com.](http://www.mainemed.com)
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Close

Print

PenBay Healthcare scrambles to fill doctor gap

By **Stephen Betts**

(Created: Friday, October 5, 2007 12:30 PM EDT)

ROCKPORT — The decision by a private medical practice to drop patients covered by the MaineCare program has left Pen Bay Healthcare scrambling to meet the needs of hundreds of low-income people.

The decision by Midcoast Medicine of Rockport comes as the region already was experiencing an acute shortage of primary care physicians, particularly for those people covered by MaineCare.

The decision by Midcoast Medicine was a difficult one, said the practice's manager Chris McIntosh. But the decision had to be made, he said, because the low reimbursement by the state was making it impossible to recruit or retain physicians.

"They've been agonizing over this for six months," McIntosh said.

Letters were sent out to 815 patients, informing them of Midcoast Medicine's decision. McIntosh said, however, that the number is misleading because it included many people who were only seen once in the past few years. He said about half are patients who are regularly seen by one of the staff members in the practice.

State law requires that doctors provide 30-day notices to patients. Midcoast Medicine gave its patients 60 days notice, informing them that they would continue to provide care through Nov. 30. The letters are dated Sept. 28.

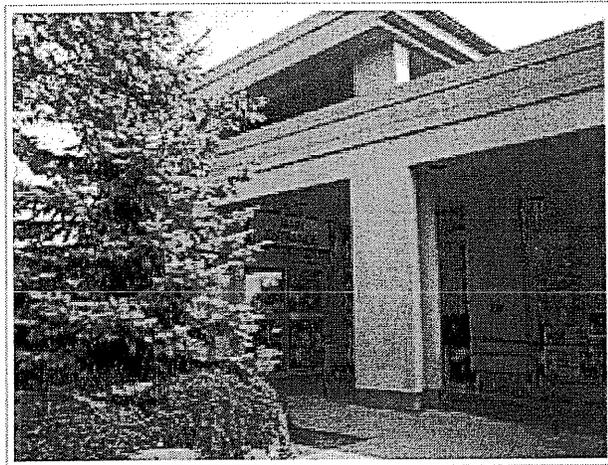
Pen Bay Healthcare, the parent corporation that oversees Penobscot Bay Medical Center, has recruitment and retention of primary care physicians as one of its top priorities, said Christopher Burke, director of marketing and communications for Pen Bay Healthcare. A meeting was held Thursday to discuss options.

One of the options being considered is to create clinics, called primary care centers, that will treat routine medical problems.

"We're prepared to invest in the clinics," Burke said.

PenBay Healthcare is in talks with retired physicians to see if they will staff these clinics. He said many physicians who are retired did not want to work full-time, but are willing to work a certain number of hours to staff the clinics, along with physician assistants and nurse practitioners.

Pen Bay also is working to recruit primary care physicians and some specialty doctors, he said. The shortage of primary care physicians is not an issue limited to the Midcoast, Burke said, with shortages throughout the state and country. There are 300 primary care physician vacancies



statewide, he added.

Pen Bay has been in the forefront of trying to deal with the shortage during the past 10 years, he said, by placing more physicians on the staff. Half of doctors in the region are employed by Pen Bay Healthcare. In addition, the hiring of physician assistants and nurse practitioners is another trend in which Pen Bay has been a leader, he said.

While the national average during the past 12 years for turnover of doctors is 6.3 percent, the rate is 1.8 percent at Pen Bay, Burke said.

The shortage of primary care physicians has many reasons, as many doctors go into specialty practices that pay more.

McIntosh said that the physicians at Midcoast Medicine looked at everything to keep its MaineCare patients, but in the end, it was not financially feasible. He said that the reimbursement for services by MaineCare is far below what it costs to provide the care and well below what private insurance companies pay.

For example, the charge for a routine office visit is \$76. Private insurance companies will pay about 80 to 90 percent of those charges, with the remainder written off by the practice. MaineCare, however, only pays \$29. For more involved visits, the charge is \$120 and MaineCare pays less than \$43.

McIntosh said that he expects that Midcoast Medicine will not be the last private practice to drop patients with MaineCare.

In addition to the low reimbursement, the amount of paperwork simply to get paid by the state is far more than what is required from private insurance companies. The state also is often slow in paying. McIntosh said some claims owed to the practice by MaineCare dating back to 2005.

The MaineCare officials also are unresponsive to the concerns voiced about their reimbursement, he added.

Midcoast Medicine has been working with Pen Bay and other practices to try to find other doctors to cover their patients. He said a rural health clinic in Waldoboro accepts patients.

A check of the Pen Bay Physicians Referral Hotline finds no doctors listed who will accept adult MaineCare patients. Two pediatricians, Drs. William Stephenson and Emery Howard, are accepting patients ages birth to 18 years old who are covered by MaineCare, while Drs. Alison Faulkingham and Susan McKinley are accepting infants.

One doctor not listed on the Pen Bay hotline, but who says he is accepting MaineCare patients is Dr. Edward Harshman of Thomaston.

Harshman said he accepts MaineCare patients as long as they do not require opiates or other controlled substances and have not enrolled in a managed-care plan that requires them to choose a primary-care physician.

The Thomaston doctor commented after a story published in The Courier-Gazette on Aug. 25 concerning the primary care physician shortage.

"I have a very commodious and comfortable suite of offices with ample parking in a residential neighborhood and am accepting new patients. I do not accept Medicare, but I accept most other insurance and self-pay," Harshman said in an e-mail.

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Penobscot Bay Medical Center ramps up recruiting, clinic plans

By Holly S. Anderson

VillageSoup/Knox County Times Senior Reporter

ROCKPORT (Oct 18): Following news of Midcoast Medicine's decision to cease caring for patients who are covered by MaineCare, Penobscot Bay Medical Center in Rockport has been working harder than ever to fill some vacancies in its staffing roles, while at the same time putting plans for as many as three urgent care clinics into high gear.

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Chris Burke, PBMC's director of marketing and communications, said that Midcoast Medicine's recent decision to drop its MaineCare patients puts a strain on an already tight market for new physicians and physicians accepting new patients.

"I'm not making any kind of judgment about what they did, it's simply that this exacerbates and increases the challenges we are facing right now," said Burke.

Burke said the hospital is also keeping lines of communication open with Midcoast Medicine to ensure the community's health is taken care of.

"We ultimately view ourselves as responsible for the health and well-being of our community," Burke said. "We are already aggressively working to bring new physicians to the Midcoast and over the last two years, we've brought 27 new physicians into the area."

Recruiting and retaining physicians, said Burke, is a big problem because fewer and fewer doctors are entering the primary care field.

Burke said that trend is a result of high education costs and decreasing reimbursements to doctors, as well as the rise in the numbers of midlevel practitioners. Midlevel practitioners, said Burke, include physician assistants and nurse practitioners.

Another factor, added Burke, is the demographic that 50 percent of medical school graduates are women, many of whom ultimately like to work part time early in their careers to raise families.

In Maine, Burke said, there are 250 to 300 physician openings.

"But it's not just a regional issue or a Maine issue, it's a national issue and everyone is competing for these doctors," said Burke. "We recently had a number of doctors leave, including some that retired, some on maternity leave and some for other hospitals. We also have some that suffered personal tragedies and throughout all this, the number of MaineCare patients has increased."

In response to all of these issues, especially in the short term, Burke said, PBMC is working diligently to open as

many as three urgent care or primary care clinics in the coming weeks.

"It's all very preliminary, but the clinics would be the thing between a doctor and an emergency room," Burke said. "For example, when you have a cold that just won't get better, you can't always get in to see your doctor right away so you would go to the clinic instead of the emergency room."

Burke said it's a model that the Midcoast is not accustomed to, but it's a familiar model in larger urban areas.

"We'll need to work closely with the community to ensure it is a physician-directed and physician-led plan," said Burke. "And it's a plan that is weeks into the future now, not months."

Burke added that preliminary indications are that a clinic would be open for a certain number of hours in Rockland, a certain number of hours on the hospital campus and a certain number of hours in another Rockport facility.

Close

Print

Hospital and doctors pledge medical care for children dropped by Rockport practice

(Created: Monday, October 22, 2007 10:03 AM EDT)

ROCKPORT — The decision by a Rockport medical practice to no longer serve its state insured patients has led to a promise by the local hospital authorities to guarantee medical coverage for all children in Knox County.

Mid Coast Medicine of Rockport announced recently that it will no longer provide medical services to any patient insured through the state's MaineCare program, saying the level of reimbursement provided by the state insurance program is not sufficient to pay its bills.

On Friday, Oct. 19, Penobscot Bay Medical Center announced its intention to guarantee health coverage for all the children dropped by the Rockport practice, and all others in the county too, as follows:

STATEMENT

Local pediatricians, led by Dr. William Stephenson, chair, Pediatric Department, PBMC, have pledged to work together with PBMC to provide care for all children in the community, 24 hours a day, every day of the year. This collaboration is taking place in the wake of the recent decision of Mid Coast Medicine to release their MaineCare patients.

"As pediatricians, we recognize the need for all children in Knox County to have a medical home," said Dr. Dana Goldsmith, for 20 years a practicing pediatrician and now Vice President, Medical Affairs, PBMC. "Although their practices are already full, these dedicated pediatricians have come together and decided to open their doors — on a rotating basis — to children in need of medical care."

"Practicing pediatrics in a small community carries special rewards," said Stephenson. "Our patients are our friends, neighbors and children's friends. As pediatricians, we recognize the need for all children in Knox County to have access to excellent care. We are dedicated to providing that for the babies, children and adolescents in the community."

Last summer, Dr. Stephenson, was impressed with the incredible generosity of the people in the Midcoast community. "When my house was destroyed by fire, followed several weeks later by the sudden, tragic death of Dr. Sayat's husband, the community rose to the occasion with their concern, support and kindness," said Stephenson. "This response from our friends and neighbors was greatly appreciated and reminds me of how much people care for each other in this area."

Details of this program are currently being coordinated and will soon be made available via local newspapers and the Penobscot Bay Medical Center website: <http://pbmc.org>.

COMMISSION TO STUDY PRIMARY CARE MEDICAL PRACTICE IN MAINE

One of the issues confronting physicians is the ever-increasing cost of medical professional liability insurance. There have been three “crises” over the past three decades where the cost and availability of insurance have created a threat to physician access. Premium costs in Maine reached a historical high point in 2005, having increased significantly from 2001. Rates during this time increased 50% to 75% for primary care specialties after having stable rates for the previous eight years. The rate changes were necessitated by the increasing cost of defending and paying for claims. These rates apply to all physicians, whether they are in private practice or employed by hospitals.

The filed rates are offset in most instances by credits for how long physicians are insured by an insurance carrier and by the number of consecutive years without a significant claims payment. In addition, large groups and hospitals are experience rated and can benefit from favorable claims experience. Some hospitals can also lower rates by taking on additional risks such as significant deductibles. Of course, these same advantages can be more than offset by an unfavorable claims experience.

Claims-made policies increase in a step-wise fashion reaching maturity by the fifth year.

An example is as follows with the percentages applying to the fifth-year rate:

Year 1: 30%, Year 2: 60%, Year 3: 80%, Year 4: 90%, and Year 5: 100%.

Part-time physicians receive considerable discounts and physicians in their first-year of practice receive a 50% discount to help mitigate their expenses.

Rates stabilized in 2005 and 2006 and Medical Mutual declared a 7% dividend in 2006 to Maine physicians. This bit of good news was caused by significant decreases in the claims frequency the past several years and a moderation of severity. If this trend continues, physicians will benefit by continued dividends and/or rate decreases.

My company is a mutual company which works closely with our physicians and hospitals, particularly in the areas of patient safety and risk management. Our policy is to return premiums in excess of the cost of doing business back to our policyholders. Maine physicians' premium costs are in the lowest quartile nationally which is a tribute to their high quality care and their attention to patient safety and the physician-patient relationship.

I do not know what degree the cost of medical professional liability insurance plays in a physician's decision to become a hospital employee. I do know that the current cost is considerable and has adversely affected physicians' income. When this is combined with other economic factors such as reimbursements and additional overhead costs, the decision is easily understood.

MEDICAL MUTUAL INSURANCE CO. OF ME's 2007 Rates (\$1 million per occurrence and \$3 million in aggregate) and Discounts filed with Maine Bureau of Insurance are as follows:

PEDIATRICS FAMILY/GENERAL PRACTICE					
YEAR	1	2	3	4	5
Premium	\$2,625	\$5,149	\$7,555	\$8,457	\$9,113

FAMILY/GENERAL PRACTICE W/OBSTETRICS					
YEAR	1	2	3	4	5
Premium	\$5,249	\$10,298	\$15,109	\$16,904	\$18,226

INTERNAL MEDICINE					
YEAR	1	2	3	4	5
Premium	\$3,149	\$6,179	\$9,066	\$10,148	\$10,936

OBSTETRICS/GYNECOLOGY					
YEAR	1	2	3	4	5
Premium	\$14,435	\$28,319	\$41,551	\$46,513	\$50,122

FROM 07/01/1993 TO 10/01/01 RATES WERE AS FOLLOWS:

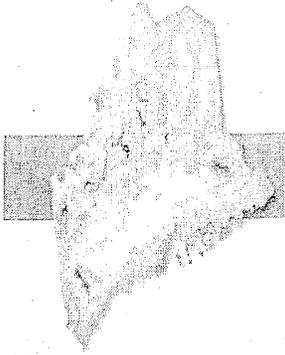
PEDIATRICS/INTERNAL MEDICINE FAMILY/GENERAL PRACTICE					
YEAR	1	2	3	4	5
Premium	\$1,765	\$3,673	\$5,166	\$5,843	\$6,192

FAMILY/GENERAL PRACTICE W/OBSTETRICS					
YEAR	1	2	3	4	5
Premium	\$2,869	\$5,620	\$8,240	\$9,226	\$9,939

OBSTETRICS/GYNECOLOGY					
YEAR	1	2	3	4	5
Premium	\$9,173	\$17,908	\$26,405	\$29,528	\$31,843

PREMIUM DISCOUNTS (CREDITS) ARE AS FOLLOWS:

1. One per cent (1%) credit for each consecutive year where there is no indemnity payment greater than \$15,000. This is capped at 15%.
2. Consecutive years with MMIC: 1% credit, capped at 10%
3. First-year in practice: 50% credit
4. Part-time practice (25 hours or less, including call time): 40% credit



MAINE DEPARTMENT OF

**Professional
& Financial
Regulation**

A Report to the Joint Standing Committee on
Insurance and Financial Services of the
122nd Maine Legislature

Medical Malpractice Insurance in Maine

Submitted by the Bureau of Insurance,
Department of Professional and Financial Regulation
March 30, 2005

Executive Summary

In 2003, the Legislature enacted the Dirigo Health Act (P.L. 2003, c. 469), which required the Superintendent of Insurance to submit to the Legislature a report regarding medical malpractice lawsuits in Maine, the cost and availability of medical malpractice insurance, and the impact on the cost of such insurance of a cap on non-economic damages of \$250,000. Significant findings of this report include:

- Maine's current premium rates are generally less than half of the national average and among the 10 lowest states in the nation.
- Maine's medical malpractice insurance market is extremely concentrated, suggesting a lack of competition and a potential lack of coverage availability for healthcare providers, however stakeholders interviewed for the report did not view this market concentration as a major problem.
- Neither Maine's level of annual rate changes nor the estimated severity trends of Medical Mutual Insurance Company of Maine (MMIC) in the last several years exhibit the pattern of dramatic inflation shown in other states.
- Nationwide loss and defense expense to premium ratios increased from 80% in the early 1990s to over 120% in 2001-2002. Maine's five year average of 90% of premium is significantly lower than the national average of 113%.
- A \$250,000 cap on non-economic damages could reduce expected loss and allocated loss adjustment expense by 15%-22%. A non-economic damage cap of \$350,000 could produce reductions of 12%-17%, while a \$500,000 cap has estimated reductions of 8%-12%.
- Effectively implemented "I'm sorry" programs are estimated to generate a 3.5% - 5.9% savings in total claim costs and potentially an increase in actual indemnity payments received by patients after attorney fees.

**Bills Related to Medical Malpractice Laws
Carried Over in the Judiciary Joint Standing Committee
to the 2nd Session of the 123rd Legislature**

L.D. 367 - An Act To Protect Emergency Room Personnel from Civil Liability - Sponsored by Representative W. MacDonald

This bill protects from legal liability in a civil action an emergency room health care practitioner who examines a patient requesting a prescription for a scheduled drug and denies the prescription for the scheduled drug to the patient.

L.D. 469 - An Act To Disseminate "Lessons Learned" from Medical Injury Claims - Sponsored by Senator Peter Bowman

This bill requires the Board of Licensure in Medicine each year to analyze and create a report of all claims of medical injury filed in the State in the preceding year to determine cause and to suggest possible means of prevention of reoccurrence. The report will not include names of any of the parties in any claim and must be sent out to all surgeons and physicians practicing medicine in Maine and to the Legislature by March 1st of each year.

L.D. 608 - An Act To Extend the Statute of Limitations for Certain Medical Malpractice Cases - Sponsored by Senator Margaret Rotundo

This bill changes the statute of limitations for medical malpractice from beginning when the act or omission happens to beginning when the harm is discovered by the plaintiff.

L.D. 684 - An Act To Permit Medical Providers an Opportunity To Express Regret for a Medical Error - Sponsored by Senator Peter Mills

This bill makes a one-time General Fund appropriation of \$75,000 in fiscal year 2007-08 for the Commissioner of Health and Human Services to issue grants to develop communication programs and procure information technology products to assist health care providers in disclosing medical errors and to improve patient safety. This bill also makes privileged and immune from discovery an expression of regret or apology or an explanation of how a medical error occurred made by a health care provider if it is provided within 14 days of when the provider knew or should have known of the consequences of the error. This bill further establishes the Medical Error Disclosure and Compensation Program, which creates a system that allows health care providers, facilities and medical malpractice insurers to disclose medical errors and negotiate compensation with the subject patient without the threat of litigation, and directs the Commissioner of Health and Human Services to create a patient safety database.

L.D. 857 - Resolve, To Create A Medical Malpractice Study Group - Sponsored by Senator Lisa Marraché

This resolve proposes to form a medical malpractice study group to determine ways to limit liability for physicians.

L.D. 1271 - An Act To Establish Health Care Practitioner Immunity for Consulting Physicians in Critical Specialties or Subspecialties - Sponsored by Representative Robert Walker

This bill provides limited immunity protection to a specialty or subspecialty consulting physician who provides volunteer, unpaid consultation services to a treating physician in the physician's area of expertise.

In 2005, Anthem Blue Cross and Blue Shield introduced the AQI Primary Care Quality Incentive Program for eligible participating primary care providers throughout the Northeast region (Connecticut, Maine and New Hampshire.) We are pleased to be able to continue this program in 2007. This program rewards performance for primary care services based on industry standard measures of quality, including clinical outcomes, patient safety and administrative processes that enhance patient care.

The AQI Primary Care Quality Incentive Program is just one component of the Anthem Quality Insights suite of innovative, quality recognition and health improvement programs that are designed to help address some of the most pervasive and costly health concerns. Anthem Quality Insights is redefining the relationship that health care providers traditionally have had with insurers by creating a mutually beneficial, patient-focused collaboration that is right for today's health care environment.

The 2007 Primary Care Quality Incentive Program will reward eligible physicians and providers who render primary care services to our members. It is just one more example of how we are working to fulfill our mission of improving the lives of the people we serve and the health of our communities. We are committed to applying the resources of our company to help prevent disease and disability; to helping our members achieve their personal health goals; and to leading the way in improving the quality and affordability of health care delivery.

What are the goals of the Quality Incentive Program?

This Program was developed to foster positive, collaborative relationships with our participating physicians and providers that will enable us to promote improved health outcomes through an emphasis on quality primary care services.

Who is eligible for the Program?

- Participating providers who specialize in Internal Medicine, Family Practice or Pediatrics, and who are designated as a PCP as their primary specialty
- Eligible physicians who are providing services to members of Anthem Blue Cross and Blue Shield commercial plans and products (HMO, POS, PPO, and Traditional/Indemnity) in Connecticut, Maine or New Hampshire
- For those providers who are part of a multi-specialty group, participation in this program is limited to those providers in the group who are in the specialties listed above. Scoring and any compensation increases will be limited to those primary care providers who are eligible to participate in the program.
- Physician/provider groups that are part of individually negotiated contracts, such as PHOs and other entities, may not be eligible for the program at this time.

Who is eligible for the Program? (con't)

- A physician/provider group is defined as an organization at the Tax ID level. A group may include one or more practitioners. A “large” group is four or more practitioners. A “small” group is one to three practitioners.
- A provider group must have a minimum number of Anthem Blue Cross and Blue Shield members for each component, as outlined in the chart below, to be eligible for points related to that component of the program. This helps to ensure that we will be able to effectively and fairly assess the group.

Component	Minimum Number of Unique Anthem Members required for Eligibility
Process Measures Diabetes, Asthma, CVC, Childhood & Adolescent Well Care, Appropriate Testing for Children with Pharyngitis	25 members (large group) or 15 members (small group), in total, for all Process Measures combined (members are counted only once)
Pharmacy Generic Utilization	1 member with prescription drug coverage administered by Wellpoint NextRx
Technology EMR/EHR, e-Rx, Electronic Disease/ Patient Registry	1 member
Clinical Outcomes Childhood & Adolescent Immunizations, Diabetes, CVC	25 members (large group) or 15 members (small group) in total for all eligible outcomes measures combined.* (members are counted only once)

* A group must have at least five members eligible for a particular measure in order for that measure to be included in the eligibility count and scoring of the clinical outcomes component.

What period of time does the program cover?

The measurement period for the program is January 1, 2007 through December 31, 2007.

What do practices need to know about the AQI Web Portal?

Data submission by providers will be accepted through the AQI Web Portal, which is online at anthem.com through Anthem Online Provider Services (AOPS). Providers must enroll free of charge with AOPS for access to the AQI portal. Enrollment forms are available through AOPS. The portal allows provider offices to submit and receive information about the program. In addition, it offers Web-based tools to help practices maintain or increase the quality of care provided to their patients and to optimize their incentive opportunity. If you have any questions, please contact your Network Relations Consultant or e-mail us at: ppmne@anthem.com.

When will my performance results be available?

Final performance results will be available on the Web Portal to providers in June 2008. You will have until June 15, 2008 to review and comment on your final results. If you have any questions please contact your Network Relations Consultant or e-mail us at: ppmne@anthem.com.

What are the measures used in the Program?

The program includes a combination of Chronic Disease and Preventive Measures, both process and outcomes based, and measures focused on technology and pharmacy utilization. Additional information about the measures follows.

How were the measures developed?

We used a variety of resources, including focus groups, research, and data analysis in the development of these measures. The Process Measures are similar to the National Quality Forum (NQF) NQF Endorsed™ National Voluntary Consensus Standards and HEDIS® Professional members include the American College of Cardiology, American College of Obstetricians and Gynecologists, American Heart Association, American Medical Association, and Physician Consortium for Performance Improvements, Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA). The Health Plan Employer Data and Information Set reporting, HEDIS® reporting is the standard for data collection and performance measurement of managed care.

NQF Endorsed™ is a registered trademark of the National Quality Forum.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Diabetes

Rationale

The American Diabetes Association estimates that 20.8 million people in the United States have diabetes. The rate of diabetes related complications can be significantly reduced with appropriate care. Direct and indirect costs of diabetes in the U.S. are estimated to be over \$132 billion a year.

Measures

- **Dilated Retinal Exam (DRE)**
Members with diabetes, age 18 to 75, who had an eye exam with an eye care professional during the measurement year or the year prior to the measurement year.
- **HbA1c Test**
Members with diabetes age 18 to 75, who received 2 HbA1c tests, at least 3 months apart, during the measurement year.
- **LDL-C Test:**
Members with diabetes, age 18 to 75, who received an LDL-C test during the measurement year.

Asthma

Rationale

According to the American Lung Association, asthma affected approximately 30 million Americans in 2003. Asthma ranks within the top ten prevalent conditions causing limitation of activity. The annual economic cost to our nation is around \$16.1 billion.

Measure

- **Appropriate Medication Use**
Members with persistent asthma, age 2 to 56, who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the measurement year.

Cardiovascular Conditions (CVC)

Rationale

According to the American Heart Association, cardiovascular disease is the leading cause of death in America. The estimated cost of cardiovascular diseases and stroke in the United States for 2006 is estimated at \$403.1 billion. Cardiovascular conditions include coronary artery disease (CAD) and ischemic vascular disease (IVD).

Measure

- **LDL-C Test**
Members with CVC, age 18 to 75, who received one LDL-C test in the measurement year.

Childhood & Adolescent Well Care Visits

Rationale

The American Medical Association and the American Academy of Pediatrics stress the need for annual well care visits for young children and adolescents. During a child's life, the periodic assessment of physical, social and emotional health status is of great importance.

Measures

- **Well Child Visits**

Members, age 3 to 5, who received a well care visit during the measurement year.

- **Adolescent Well Care Visits**

Members, age 11 to 18, who received a well care visit during the measurement year.

Appropriate testing for children with Pharyngitis

Rationale

According to the Centers for Disease Control, antibiotic resistance is a serious and growing concern worldwide. Smart use of antibiotics, including strep testing, is the key to controlling the spread of antibiotic resistance.

Measure

Members, age 2-18, who were diagnosed with pharyngitis or tonsillitis, prescribed an antibiotic, and received a group A streptococcus test for an episode in the measurement year.

Diabetes (DM)

Rationale

Glycemic control is a quality indicator that measures how well a person with diabetes is maintaining appropriate blood sugar levels. It is estimated that improved glycemic control over a three-year period could significantly

improve diabetic patients' health and reduce the number of hospital admissions and doctor visits. Maintaining appropriate LDL levels can also have a positive impact on the health of individuals with diabetes.

Measures

- **HbA1c Levels below 7**

Members with diabetes, age 18 to 75, who had an HbA1c level below 7 during the measurement year.

- **HbA1c Levels above 9**

Members with diabetes, age 18 to 75, who had an HbA1c level above 9 during the measurement year. [Note: This measure requires performance at or below target.]

- **LDL-C Levels below 100**

Members with diabetes, age 18 to 75, who had an LDL-C level below 100 during the measurement year.

- **LDL-C Levels below 130**

Members with diabetes, age 18 to 75, who had an LDL-C level below 130 during the measurement year.

Cardiovascular Disease (CVC)

Rationale

Maintaining appropriate LDL-C and blood pressure levels can lead to improved morbidity and mortality rates for individuals with cardiovascular conditions including coronary artery disease and ischemic vascular disease.

Measures

- **LDL-C levels**
Members with CVC, age 18 to 75, who had an LDL-C level below 100 during the measurement year.
- **Blood Pressure**
Members with CVC, age 18 to 75, who had a blood pressure reading below 140/90 during the measurement year.

Depression Screening for Chronic Diseases

Rationale

Depression is one of the most common complications of chronic illness. It is estimated that up to one-third of individuals with a serious medical condition experience symptoms of depression. According to the Cleveland Clinic, the rate for depression occurring with other medical illnesses is quite high: Heart attack: 40-65%, Coronary artery disease (without heart attack): 18-20% and diabetes: 25%. Although available therapies alleviate symptoms in over 80 percent of those treated, less than half of people with depression get the help they need as reported by the National Institute of Mental Health.

Measure

- **Depression Screening**
Members with CVC and/or diabetes, age 18 to 75, who were screened for depression and/or depression follow up visit during the measurement year.

Childhood & Adolescent Immunizations

Rationale

Vaccines prevent disease in the people who receive them, and protect those who come in contact with unvaccinated individuals. Vaccine-preventable diseases have a costly impact, resulting in doctors' visits, hospitalizations and premature deaths. Although these diseases aren't as common in the U.S. as they used to be, they do still occur and can lead to pneumonia, choking, brain damage, heart and liver problems and blindness in children who are not immune.

Measures

- **Childhood Immunizations: 4 DTPs, 3 Polios, 1 MMR, 3 Hep Bs, 3 Hibs, 1 VZV**
Members who turned 2 during the measurement year and received all immunizations listed above.
- **Adolescent Immunizations: 2nd dose MMR, 3 Hep Bs, 1 VZV**
Members who turned 13 during the measurement year and received all immunizations listed above.

What data is required from practices for Clinical Outcomes Measures?

Immunization and test dates we have on file in our claim system will be pre-populated on the AQI Web Portal. Supplemental data must be submitted by the group, on the AQI Web Portal, **no later than February 15, 2008**. To be considered in the final scoring of the Clinical Outcomes component, the following information is required:

- **Dates of service for**
 - Immunizations
 - Depression Screenings
- **Dates of service and tests results for:**
 - Blood pressures (CVC)-only one date of service and result is required
 - HbA1c (DM)- only one date of service and result is required
 - LDL-C (DM and CVC)- only one date of service and result is required
- **The latest tests in 2007 should be used.**

Physician Recognition Programs

Individual providers that have current Physician Recognition Program certification** during the measurement year will be eligible to have their members with diabetes and/or CVC marked as compliant for the clinical outcome measures with no need to submit supplemental data. Individual providers must attest to current certification.

**Eligible Physician Recognition Certification Programs

- Bridges to Excellence (BtE)- Diabetes Care link - www.bridgestoexcellence.org/
- Bridges to Excellence (BtE)- Cardiac Care link - www.bridgestoexcellence.org/
- National Committee for Quality Assurance (NCQA)- Diabetes Physician Recognition Program (DPRP) - www.ncqa.org/
- National Committee for Quality Assurance (NCQA)- Heart/Stroke Physician Recognition Program - www.ncqa.org/

TECHNOLOGY MEASURES

Rationale

Technology services can reduce errors, improve clinical quality and promote administrative and cost efficiencies in provider offices.

Measures

A physician/group can earn points if at least one or more of the physicians under the group's Tax ID are utilizing one or more of the following technologies to the extent described:

- **Electronic Medical Record (EMR) or Electronic Health Record (EHR):** Implemented and in use prior to January 1, 2008, that is used to manage patient documentation for at least some of your patients on a regular basis.

· **Electronic Prescription (e-Rx):**

Implemented and in use prior to January 1, 2008. The practice must be using this tool to generate prescriptions in place of handwritten prescriptions. It is not required that the product electronically submits prescriptions directly to the pharmacy.

· **Electronic Disease/Patient Registry:**

Implemented and in use prior to January 1, 2008. The system must be able to produce lists of patients with chronic diseases/conditions, such as diabetes, and must be able to produce patient lists that can be used for patient recalls, follow ups, and other purposes.

· **Use of the AQI Web Portal:**

The practice has registered for access to the AQI Web Portal. We recommend the use of the portal to review member rosters and to provide outcome data.

What information is required from practices for the Technology Component?

The Technology Component will be scored based on a survey available on the AQI Web Portal. Surveys must be completed via the AQI Web Portal by February 15, 2008 to be considered for technology related points.

Generic Drug Utilization

Rationale

In addition to cost savings, studies have shown that patient compliance is greater with generic prescriptions.

Measure

· **Generic Drug Utilization:**

Generic drugs prescribing rate, during the measurement period. Points will be rewarded if the provider's/group's rate is higher than the state-wide network rate for the same specialty or an improvement in the group's performance compared to his/her/its previous year's generic prescribing rate*. For multi-specialty groups, the statewide network rate will be determined by a weighting methodology, based on the number of scripts written by each primary care specialty type in the group.

When and how is the quality incentive paid?

- The 2007 Quality Incentive Program will reward qualifying physicians and providers through an adjustment to fee schedule-based payments over the period July 1, 2008 through June 30, 2009.

* Points will be awarded for only one of these criteria.

- Providers/groups that meet or exceed the Plan threshold goal, but do not meet the Plan target goal, will be eligible to receive a 2% fee schedule-based increase (provided they satisfy the threshold number of members required).
- Providers/groups that meet or exceed the Plan target goal, but do not meet the Plan maximum goal, will be eligible to receive a 4% fee schedule-based increase (provided they satisfy the threshold number of members required).
- Providers/groups that meet or exceed the Plan maximum goal will be eligible to receive a 6% fee schedule-based increase (provided they satisfy the threshold number of members required).
- Providers/groups that do not meet the Plan threshold goal will not be eligible for the incentive reward.
- For PCPs in a group practice, the eligibility criteria and performance results of all PCPs in the group will be aggregated at the Tax ID level.

fee schedule increase will apply only to the primary care providers in the group.

How can I find out more about the Quality Improvement Program targets and scoring?

Updates or additional information, including the program targets and point structure will be made available on the AQI Web Portal.

Who do I contact with Questions?

If you have any questions about the Anthem Blue Cross and Blue Shield 2007 Quality Incentive Program, please contact your Network Relations Consultant or e-mail us at: ppmne@anthem.com.

Total Points Achieved	Adjustment to Fee Schedule
50-59	2%
60-79	4%
80-100	6%

The above rewards are non-cumulative. In other words, a provider/group cannot qualify for more than one fee schedule increase. In a multi-specialty group, any

How are the measurements scored?

Each provider/group will be scored on their aggregate points*. The maximum achievable points is 100. The chart below depicts the maximum achievable points for each component.

Program Component:	Points
Chronic Disease & Preventive (Process)	40
Chronic Disease (Outcomes)	10
Pharmacy: Generic Drug Utilization	25
Technology (Structure): EMR/EHR, e-Rx, Electronic Disease Registry	20
Use of the AQI Web Portal	5
Maximum Points Available	100

* For providers that are part of a multi-specialty group, please note that only those providers in the group that have been designated as primary care providers by Anthem Blue Cross and Blue Shield will be included in this program. Scoring and any compensation increases will be limited to those physicians and providers who are eligible to participate in the program.

Component	Goals and Scoring	Maximum Possible Points
Process Measures		
Requires a minimum of 25 members (large groups) or 15 members (small groups) eligible for all Process Measures combined.		
Asthma Medication Use Diabetes · DRE · HBA1C · LDL-C Cardiovascular Conditions · LDL-C Childhood Well Visits Adolescent Well Visits Appropriate Testing for Pharyngitis	Threshold Goal Total Process Measures score between 50% and 55%	20
	Target Goal Total Process Measures score between 56% and 69%	30
		40
	Maximum Goal Total Process Measures score greater than or equal to 70%	40
Pharmacy Measure		
Applies only to members with pharmacy coverage through NextRx.		
Generic Utilization Percentage difference between Group and Network Rates	Below the Comparison Network Rate , but showed improvement of greater than or equal to 1% to 1.99% over their previous year's rate.	5
	Below the Comparison Network Rate , but showed improvement of greater than or equal to 2% over their previous year's rate.	10
	Threshold Goal Equal to the Comparison Network Rate and up to 1.99% above the Comparison Network Rate.	15
	Target Goal Generic Rate between 2% and 2.99% above Comparison Network Rate	20
	Maximum Goal Generic Rate greater than or equal to 3% above Comparison Network Rate	25
		25
Technology Measures		
Applies only to technology in use by at least one provider under the Group's Tax ID.		
EMR/EHR Electronic RX Electronic Patient/Disease Registry	1 Technology	10
	2 Technologies	15
	3 Technologies	20
		20
Use of AQI Web Portal	Registered User of AQI Web Portal	5
		5

Clinical Outcomes

Requires a minimum of 25 members (large groups) or 15 members (small groups) eligible for all Outcomes Measures combined. A group must have at least 5 members eligible for a particular measure, in order for that measure to be included in the scoring for the Clinical Outcomes

Outcome	Measures	Goals Scoring
Immunizations		
• Childhood Combo	81.73%	
• Adolescent Combo	72.26%	
Diabetes		
• HbA1c below 7	>40%	
• HbA1c above 9	<20%	
• LDL-C below 100	>36%	
• LDL-C below 130	>63%	
Cardiovascular Conditions (CVC)		
• Blood Pressure < 140/90	75%	
• LDL-C < 100	50%	
Depression Screening for Chronic Diseases	10%	
TOTAL POINTS		100

The maximum possible points for the Clinical Outcomes component will be 10. Available points for each of the individual outcome measures will vary based on the combination of measures for which a Group is eligible. Refer to the AQI Web Portal for further details on the scoring scenarios.

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TESTIMONY OF KEVIN S. FLANIGAN, M.D.

REGARDING

CHALLENGES FOR PRIMARY CARE PHYSICIANS IN MAINE

Commission to Study Primary Care Medical Practice
Room 209, Cross State Office Building
Friday, October 26, 2007, 11:30 a.m.

Good morning Senator Marrache, Representative Connor, & Members of the Commission to Study Primary Care Medical Practice. As you know, I am Kevin Flanigan and I am a Board Certified Pediatrician specializing in the care of infants, toddlers, children, and adolescents. I also am a Board Certified Internist specializing in the care of adult patients. I would like to thank you for the opportunity to speak before you today.

As I begin my remarks, I would like to say that I am keenly aware of the dual role I play today as both a member of this Commission and as a speaker before you. I understand that when I sit with you as a member of this Commission I do so as a representative of a state association of physicians. However, as a speaker today, I am a primary care physician in private practice that is in dire need of your help if I am to continue to be available to the members of my rural community for years to come.

As a "Med/Peds" physician in Pittsfield, Maine, I deliver primary care to the patients of central Maine. While I am not the only physician in the area, I am the only pediatrician between Waterville and Bangor. My practice also is the only private practice left in the area. When I moved to Pittsfield I was one of four private practices in an area that was also served by two Rural Health Clinics. Now, ten years later the local hospital runs three primary care practices and one general surgery practice. A second hospital has

taken over one of the original satellite office sites. A Federally-Qualified Health Center has opened in the area. Only one of the original Rural Health Clinics remains independently run.

As you have heard before, this shift from a majority of fee-based reimbursement practice business models to one of cost-based reimbursement practice business models has not produced an appreciable increase in the number of practicing physicians. It has, however, stabilized the number of local practicing physicians.

With that backdrop, I would like to discuss why I believe this shift is happening and perhaps offer some suggestions as to how private practice can be preserved as a viable business model for rural primary care physicians and the patients they serve. When discussing the business of medicine one must realize that there are three major factors that contribute to a physician's decision about which practice model to choose. The first factor is the *reimbursement methodology* with its impact on an office's ability to invest in itself and to offer a competitive pay scale for all of its employees. The second factor is the *management model* of that business including oversight of its finances, facility and equipment, employees, and now management of its medical data. The third factor is the *administrative issues* related to the delivery of medical care today.

When I look at the financing of medical services in Maine, I do not see a pretty picture. Total physician office reimbursement simply is not adequate to meet health care system stakeholders' expectations of a physician practice today. This financial strain begins with the fact that Maine has the highest per capita Medicaid enrollment of any state in the nation. Add to that the fact that Maine also has the second highest ratio of Medicare recipients in the nation. This means that 60% of my patients receive their

medical insurance through government programs. This is a great accomplishment for the state and a real benefit for the people of Maine as long as physicians are able to continue to accept this type of coverage without being financially ruined. Right now, the northern half of Maine receives a reimbursement rate that is 33% less than the national average while in other parts of New England private practice physicians are paid as much as 33% more than the national average! Moreover, MaineCare is reimbursing private practice physicians at approximately 53% of Medicare rates. Specifically, this means that while cost-based reimbursement practice models are receiving between \$75 and \$125 per visit regardless of level of complexity, I may receive as little as \$34 from Medicare or worse yet \$19.85 from MaineCare. Generally speaking, in my practice it costs approximately \$78 to see a patient in the office. This is a rough estimate arrived at by dividing the total number of visits into the total amount of money spent running the practice. For the last six months MaineCare has paid me an average of \$43 per visit. This means that for every MaineCare patient I see I lose \$25. It would cost my practice less to meet each MaineCare patient at the door and give him or her a \$20 bill and direct them to seek care elsewhere.

These low reimbursement rates from both state and federal government are compounded by the fact that this state has the highest per capita Medicaid enrollment and the second highest Medicare ratio in the nation. As a consequence of the role of these government programs in our health care system, there is not enough private insurance money to allow Maine's private medical practices to compete on a national scale for recruitment or retention of physicians. This lack of physicians then complicates the

picture even more when you consider the fact that with fewer and fewer doctors available those remaining have more and more work to do!

In addition to this increased medical care workload, any doctor who remains in private practice has to maintain a certain degree of oversight and management activity in the practice. These unpaid work hours have to come from somewhere. A physician cannot see fewer patients during the work day as that would drop revenue. Therefore, a physician's personal time begins to suffer. When I began recruiting for a partner nearly seven years ago I would try to explain to candidates that their share of the work would only be half of what I do now - what a great deal! In fact when a formal practice manager is a luxury and not a necessity then the administrative workload and its responsibilities are more than new physicians are willing to assume or feel capable of handling. In reality, many physicians want to participate in the governance of their practice. They do not, however, want that commitment to interfere with or detract from their real purpose - providing medical care to their patients.

In addition to these business responsibilities, physicians today face an ever-increasing number of mandates to provide quality data. I recognize that this data is being compiled and that if I do not oversee my own data then there is a great chance that the data used to assess me may be modestly inaccurate or simply wrong. Even with an electronic medical record, however, this process of data collection and analysis is time consuming and difficult. Physicians also will question the value derived from the data. For example, in Medicare our internal cost estimate is between \$9,000 and \$10,000 to compile and transmit the information requested in order to qualify for the recently announced 1.5% bonus. For my practice that bonus would be a mere \$4,000-\$6,000 -

not much of an incentive to collect and report this data. Yet if I do not participate in this program, I may have to spend even more time and money showing that the data used to assess my practice is inaccurate and needs to be corrected. Anthem presents a second example of the problems with these quality initiatives. Presently, one of Anthem's products has me labeled as meeting all of its quality criteria thereby allowing me to receive the maximum 6% "pay-for-performance" increase in reimbursement. Yet as third party administrator for the state employee insurance plan, Anthem uses a different set of criteria derived from the *Pathways-to-Excellence* (PTE) program. Because I do not yet participate in this initiative, I am not listed as a preferred provider and patients must pay extra to continue seeing me as their primary care physician.

With this system of uncertain, performance-based fee increases and flat Medicare reimbursement, I look at the end of the fiscal year budget and asks how am I to increase revenue in order to meet next year's increases in the cost of delivering care to my patients. Where will the money come from to pay merit increases to my staff? Where will the money come from to cover my increasing insurance costs such as liability insurance, health insurance, and workers compensation insurance? Will I have to take yet another pay cut similar to those I took in four of my first seven years of independent private practice?

The third and final component of medical care delivery that I wish to highlight today is something I call "medical care management." This is the process that requires physicians to seek prior authorization for the care they believe is necessary to appropriately manage their patient. The process a physician's staff might have to go through in order to receive permission for a patient to have a test or study done can be

nothing short of absurd. There may be limits on who is allowed to do this test and where it must be done. If the order is for medicines, then the absurdity defies all logic. Last week, I received a denial for a diabetic medicine stating that the criteria for a patient to receive this medicine included that the patient be diabetic, over age 18, have failed one or more of three other medications, take this new medicine in conjunction with one of the previously failed medications, and that the patient be insured by this insurer. Well, because this is a Medicare Part D prescription plan and the letter identified the patient by date of birth, it is obvious that the patient is over age 65. The patient had in fact taken and failed to achieve diabetic control on the medicines that the insurer had been paying for the past nine months and would obviously still be on some of these medicines as we started the new one. After 18 minutes on the phone, I received a fax authorizing the patient to receive this prescription until 2039. Unfortunately, next month I will have to increase the dose per the medication protocol and will likely have to recertify this patient for this new dose.

In caring for MaineCare patients these same problems are present but worse. There is an ever shrinking absolute number of brand name prescription drugs a patient can take without requiring a prior authorization. Once that limit has been reached, an additional brand name only medication can only be added if a prior authorization is approved. This concept of limiting cost by redirecting towards generics is fine, but what does one do when the only drug in the category that is covered is a brand name drug and the patient already is on the maximum number of branded drugs? And, what is a physician to do when not all of the strengths of a particular medication are covered? For example, when a medication comes in three strengths and only the high and low strengths

are covered, why should I have to complete a time consuming and costly prior authorization process? If this is a mandated cost saving measure, then why can't an automatic adjustment occur?

In summary, I see three significant threats to the future of the private practice of primary care medicine. The first is inadequate reimbursement by the government programs, the second is burdensome administrative practice management, and the third is micromanagement of medical care delivery. Reimbursement for a majority of the medical care that is delivered in this state is inadequate. Private practices cannot control medical practice management costs sufficiently to compete with a business that is receiving 3 to 5 times the reimbursement that private practice physicians receive. And, private practices cannot offer the same level of administrative and medical management services when revenue is less than what others are receiving.

Some options to address these threats include following the state of Montana's example and set MaineCare reimbursement rates at 81% of private insurance rates or North Carolina's example and pay the same rate as Medicare. Other states have elected to include a management fee for primary care physicians equal to ten times what Maine is paying right now. By increasing reimbursement, the State would allow private practice physicians to more effectively recruit new physicians to the area, retain current physicians, and cover the cost of the administrative tasks that are presently having to be done during off hours for little or no pay. I recognize that the Department of Health & Human Services budget is a significant portion of the overall state budget, but please remember that MaineCare payments for physician services are less than 3% of MaineCare payments to providers overall. Paying this critical segment of the MaineCare

provider network something closer to the cost of providing the medical services will not break the state budget!

The medical management process absolutely must be simplified. A patient's MaineCare card must identify their category of eligibility and the services for which they qualify. The prescription prior authorization process must have some automatic overrides, such as allowing the pharmacist to dispense two pills of one strength to match the ordered strength rather than have to delay the patient's care while a new script is written or a prior authorization is sought. Patients limited to four brand name drugs should not be required to change a current medication when a new medication is added that is available only as a brand name drug and is the only formulary drug available in that category.

In conclusion, I have described several areas in which this Commission can make recommendations that will have a major effect on whether or not the private practice of primary care medicine can survive in Maine. I do not share the pessimism expressed by Gordon Smith, who is the ultimate optimist, at a previous Commission meeting. I do realize that many physicians today would rather be employed. I also know that there are now and will always be patients who would prefer to receive their care from a privately practicing physician, and that there will always be a group of dinosaurs such as myself who are willing to meet that need. The number of us available to these patients depends upon how easy or difficult it is to deliver that care and how financially risky it is to practice in that business model.

Finally, I have attached an article entitled, *Finances driving physicians out of solo practice* from the September 10, 2007 issue of American Medical News and one entitled,

Local MaineCare rejection epitomizes bigger ills from the October 18, 2007 issue of Village Soup. Thank you for your consideration of my remarks and I would be happy to answer any questions you may have.

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THE NEWSPAPER FOR AMERICA'S PHYSICIANS

BUSINESS

Finances driving physicians out of solo practice

The business of medicine has doctors moving into large groups or employed situations, studies find.

By Bob Cook, AMNews staff. Sept. 10, 2007.

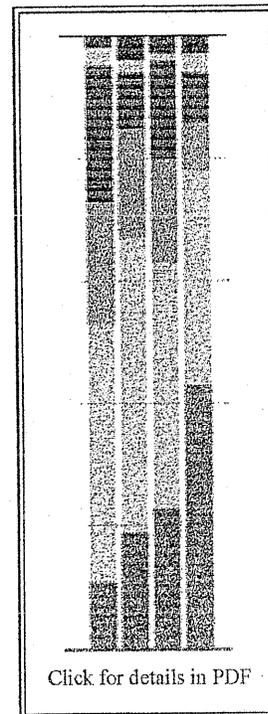
The "herding cats" metaphor long used to describe the difficulty of organizing physicians into large groups appears to be on its way out.

A survey released in August by the Center for Studying Health System Change found a marked increase in the percentage of doctors joining large, single-specialty groups, as well as entering employed situations. The survey, covering 1996 to 2005, also found a marked decrease in the percentage of physicians in solo or two-doctor practices, as well as a large drop in the percentage of doctors who have an ownership stake in their practices. The finding was especially apparent among older physicians.

The CSHSC did not ask physicians why they worked where they did. But the center and other observers say financial pressures and the desire for work-life balance is driving physicians to the relative security of an employed or large-group situation. That way, they can keep semi-regular hours, have less responsibility for the business side of medicine, and possibly gain greater leverage in contract talks with health plans.

Observers say this trend is not going away anytime soon and might well reflect a growing cultural change among physicians.

As further evidence, the national physician search firm Merritt, Hawkins & Associates revealed in July a large increase between 2006 and 2007 in the number of hospitals retaining the firm to find physicians to employ, while also showing a large decrease in solo practice spots to fill.



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"Physicians are like anybody else -- they like their individual freedom, but they also like to feed their family," said William Jesse, MD, president and CEO of the Medical Group Management Assn. It released its own report in August showing physicians in most specialties had salaries that were not keeping up with inflation, even though productivity increased.

Family physician Eric Holmberg, MD, left an employed position in public health to open his

own solo practice in Petaluma, Calif., 3½ years ago. Since then, five internists have shut down their practices, with no one replacing them. Dr. Holmberg, 56, says he might have to follow their lead.

He has tried for two years to hire a second physician, with no takers. The high cost of living and the low reimbursement in northern California, as well as the long hours and constant call, make solo practice difficult to maintain, he said. He said he might have to close shop and go back to being an employee or join a large group, even though he prefers staying in practice for himself and his patients.

"How long do I see this going? I'm not sure I can answer that easily," Dr. Holmberg said. "I go through declines in energy periodically when the workload gets to be excessive. I feel at those times that I will wait until my lease expires and call it quits. And then, two weeks later things may feel less weighty.

"I made a commitment to my family that something would be different by the end of this year. I'm not sure I have the confidence I might have felt earlier in the year."

The CSHSC found the proportion of one- and two-physician practices declined from 40.7% in 1996-97 to 32.5% in 2004-05. While the primary care rate of 36% was stable, the proportion of specialists in such practices fell to 26.1% from 38.1%. Meanwhile, the percentage of doctors in single-specialty groups of six to 50 doctors increased to 17.6% in 2004-05 from 13.1% in 1996-97. The center said those numbers reflect consolidation among specialists. Dermatology was the only specialty in which a majority (61.6%) remained in solo or two-doctor practices.

Financial pressure is driving these trends, said Joy H. Grossman, PhD, a CSHSC senior researcher and co-author of the report. In informal conversations with the doctors, many had the perception that a bigger practice could absolve them of the everyday business pressures and possibly help with reimbursement negotiations.

Dr. Grossman said the desire for greater work-life balance also has been brought up as a factor for fewer doctors in solo practice -- and not just younger doctors. During the period studied, physicians were less likely to have an ownership stake in their practices, down to 54.4% in 2004-05 from 61.6% in 1996-97. Physicians 40 and younger experienced a 3.5 percentage point decrease (28.3% to 24.8%). But doctors 51 and older represent the steepest decline: down 12.7 percentage points, from 51.5% in 1996-97 to 38.8% in 2004-05.

Daniel Wild, MD, 58, a Buffalo, N.Y., orthopedic surgeon, isn't reflected in those numbers. It was only in July he started working under the banner of the multispecialty Buffalo Medical Group after selling his solo practice.

Dr. Wild said his practice was financially sound. But he's planning to retire in about 10 years, so he was reluctant to make a major investment in electronic medical records. Also, he sold the building in which his practice was located, which left him facing relocation costs.

Most orthopedic surgeons in Buffalo have merged in large single-specialty groups, Dr. Wild said. But he opted for the multispecialty group, which hadn't had an orthopedic surgeon in about a decade. He said the structure allows the independence he had as a solo physician but without the business headaches.

"I'm glad not to be a landlord," he said. "I'm glad not to have to worry if the electricity goes out on my sign, or if the snowplow guy doesn't come."

Multispecialty practices actually declined (30.9% to 27.5%) over the period the center studied, which Dr. Grossman attributed to changing financial incentives.

In 1996-97, it was thought the multispecialty model might win out because of the HMO gatekeeper model. But the model waned as patients moved to more open PPO networks, and many of the groups formed during that time broke up.

Many of the primary care physicians in those groups moved to solo or small practices and stayed there, as reflected in the overall lack of decline in those numbers, the center said.

However, there are signs primary care doctors are increasingly having to question their future in solo practice. Merritt Hawkins' survey of its clients' job-search requests found the number of positions based in hospitals nearly doubled from 2006 to 2007, from 654 to 1,297. Meanwhile, the number of requests to fill solo slots and partnerships were nearly halved.

Merritt Hawkins spokesman Phil Miller said these numbers also reflect physicians' preferences.

"The first wave [in the mid-1990s] was selling the doctors on being employees. You remember the whole herding cats thing," Miller said.

"Today, you have a lot of doctors, a lot of them specialists, who actually are coming to the hospital and saying, 'I'm sick of dealing with malpractice, I'm sick of fighting for reimbursement, I'm sick of dealing with a fractious staff -- just hire me.' "

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ADDITIONAL INFORMATION:

Where physicians are heading

More physicians are joining larger, single-specialty groups or other salaried settings.

Practice setting	1996-97	2004-05
1-2 physicians	40.7%	32.5%
3-5 physicians	12.2%	9.8%
6-50 physicians	15.9%	21.8%
Single-specialty, 6-50 physicians	13.1%	17.6%
Multispecialty	30.9%	27.5%
Other*	31.2%	36.0%

* Includes physicians employed by medical schools, HMOs, hospitals (including office-based practices), community health centers, freestanding clinics and other settings, and independent contractors.

Source: Center for Studying Health System Change Telephone survey of 6,600 physicians

(2004-05) and 12,000 physicians (1996-97). The sample was drawn from the American Medical Association and the American Osteopathic Assns. master files and included active, nonfederal, office- and hospital-based physicians who spent at least 20 hours a week in direct patient care.

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Hospital recruitment soaring

A survey released in July by the national search firm Merritt, Hawkins & Associates finds a marked increase in recruiting by hospitals, much of it at the expense of smaller groups. The firm says it's not just places that employ physicians looking for doctors -- it's also doctors seeking work at places that employ physicians. The findings show trends highlighted in a Center for Studying Health System Change survey covering 1996-2005 are not abating.



Source: Merritt, Hawkins & Associates 14th annual review of search and consulting assignments conducted on behalf of its own clients

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Center for Studying Health System Change report on physician practice patterns (www.hschange.com/CONTENT/941)

"2007 Review of Physician and CRNA Recruiting Incentives," Merritt, Hawkins & Associate, in pdf (www.merrithawkins.com/pdf/2007_review_of_physician_and_crna_recruiting_incentives.pdf)

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Local MaineCare rejection symptomizes bigger ills

By Lynda Clancy
VillageSoup/Knox County Times Reporter

ROCKPORT (Oct 18): A bold move made last month by a group of Rockport doctors to discontinue serving MaineCare patients is making waves locally and in Augusta, where the state's Bureau of Medical Services has taken notice.

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But as Midcoast Medicine's financial manager Chris McIntosh said, what happened in his office is a symptom of a larger nationwide crisis illustrated by fewer physicians entering family practice.

It also looms at a time when Maine is urging its citizens to adopt healthier lifestyles, when Gov. John Baldacci wants to make Maine the healthiest state in the nation, and when government has made longtime efforts to provide health care to citizens who can't afford it.

Currently, MaineCare is actively recruiting existing physicians from Damariscotta to Belfast to help take on the 400 or so patients who must find new health care in the Midcoast, said Bureau of Medical Services spokesman John A. Martins. He said the number of MaineCare providers in Maine has increased from 1,340 in 2006 to 1,462 in 2007. "We are concerned when any members can't find service," he said.

The decision of four doctors at Midcoast Medicine in Rockport Village to disenroll from Medicaid, otherwise known as MaineCare, followed six months of discussion and the loss of two doctors, said McIntosh.

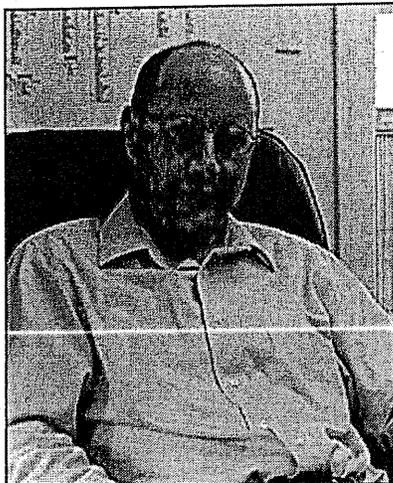
"We agonized over it for quite a while," he said, with the office first slimming its office staff and eliminating raises.

Midcoast Medicine is a busy office with roots long in Camden and Rockport; its founding doctors, McKim and Linda Petersen, have practiced in the area for 30 years, taking over the practice from Dr. Cox. Yet low reimbursement by the state to cover visits of MaineCare patients prompted the doctors to trim Midcoast Medicine's patient roster by approximately 800 names.

The reasons are simple: A typical office visit costs \$76, but MaineCare reimburses the doctors just \$24, said McIntosh. Private insurance companies, on the other hand, will reimburse the doctors at 90 percent of the cost.

Why the low reimbursement to family doctors in private practice is a question that no one seems able to answer, although plenty have raised it. The funding pie may be just so small, and doctors in private practice, who are busy tending to patients, lack a strong voice before MaineCare.

Erick Steele, a physician and writer, cited in the July 2007 issue of the Maine Policy Review,



Chris McIntosh, Midcoast
Medicine's office manager.
(Lynda Clancy)

published by the Margaret Chase Smith Policy Center at the University of Maine, the "difficult relationship" between MaineCare and the health provider community.

"MaineCare is one reason many Maine physicians have become employed by hospitals, because hospitals can guarantee their salaries and often get better reimbursement for MaineCare patients' services than do private physicians," he wrote. "The private practice of medicine is dead or dying in parts of Maine as a result of reimbursement and other problems."

Midcoast Medicine says no more

In a letter sent Sept. 28 from Midcoast Medicine to approximately 800 MaineCare patients, the doctors wrote: "The recent loss of two of our physicians, in part due to extremely low

reimbursement from MaineCare, has made it impossible to continue to accept MaineCare as an insurer. We simply cannot continue to offer our services below our cost to produce them."

The letter continued: "Consequently, I will no longer be able to provide medical care to you. Therefore you should place yourself under the care of another physician."

Through the efforts of Waterville doctor and Maine Sen. Lisa Marrache, the Legislature last year established a Commission to Study Primary Care Medical Practice. The commission will:

- identify the causes of the loss of independent ownership of primary care medical practices due to financial, regulatory or business-related reasons;
- seek input from independent primary care physicians on payer mix, reimbursement and Medicaid regulatory changes and the effects of such factors on the ability of independent primary

In reality, McIntosh said, Midcoast Medicine's MaineCare patients number approximately 350 to 400. The other 400 represent one-time visits, "a patient they saw four years ago with a sore throat," he said.

The doctors urged patients to quickly find another doctor, and provided a list of resources for the patients, including Penobscot Bay Medical Center, Waldo County General Hospital, Miles Memorial Hospital, rural health clinics in Waldoboro, Damariscotta and Belfast, and the Mid-Coast Mental Health Center.

At the same time, there is diminished availability of family doctors, and it goes beyond Medicaid reimbursements. Midcoast Medicine is actively recruiting new doctors, as is Penobscot Bay Medical Center.

According to the American Academy of Family Physicians, the number of primary care doctors has decreased partly because of rising liability premiums and an increase in administrative paperwork, not to mention the high cost of education itself and the debt load a new doctor might carry.

The academy cited a Medical Group Management Association study, which found that "on average, a 10-physician practice spent more than \$247,500 per year on administrative costs."

McIntosh described the administrative requirements from MaineCare -- more forms to complete, more justifications demanded of doctors about why they might prescribe a certain drug over a generic drug, and delayed payments for various reasons. Midcoast Medicine is still waiting for \$4,000 in reimbursements from 2005 from MaineCare.

"We almost need a full-time person to process the forms," he said. "We're literally

care physicians to practice medicine in Maine;

- seek to determine the effect of hospital control of primary care medical offices or primary care physicians on health-care costs, access to health care and medical treatment of Maine's citizens; and
- review how comparable states manage physician-hospital relationships with respect to health-care costs, patient advocacy and access to health care.

The commission is to report back to the Joint Standing Committee on Health and Human Services before Dec. 5.

losing money."

MaineCare generous to patients

But there have been efforts to redirect MaineCare. The Maine Medical Association noted among its legislative successes in 2005-06 the \$3 million general fund increase in MaineCare reimbursement for physicians, which, with federal matching funds, increased to \$8.3 million.

That took MaineCare rates up to approximately 53 percent of Medicare rates, although McIntosh said little actually trickled down to family doctors in private practice.

John A. Martins, a spokesman for Maine's Bureau of Health, which oversees MaineCare, said the family doctor reimbursement has been a historical challenge, one that Baldacci has tried to mitigate, "and is looking to do in 2009."

While Medicare is administered federally, Medicaid, or MaineCare, is a joint state/federal program, with almost 65 percent of its funds deriving from federal coffers, a ratio based on socioeconomic factors. Poorer states, such as Mississippi, get 75 percent funding from Washington; wealthier states, such as Connecticut, receive about 50 percent in federal money.

"Maine has historically had a generous Medicaid package," said Andrew MacLean, deputy executive director at the Maine Medical Association. "The state has unfettered control of how that money is expended."

That generosity extends to approximately 145,000 Maine residents this year, and reflects a collective state effort to cover its poor.

The Maine Policy Review described MaineCare's share of the general fund increasing from 1.4 percent in 1997 to 22.8 percent in 2006. MaineCare, according to Paul Saucier in the Review, "is a phenomenally complex program" and bears characteristics that make it "a very difficult program to understand and administer."

To cope, family doctors have used a "payer-mix" approach to their patient base to ensure income, capping the number of MaineCare patients they will see.

But that doesn't cover their rising expenses anymore, according to McIntosh, expenses that include the costs of equipment, office space, personnel and liability insurance.

Midcoast Medicine believes its practice shrunk from six doctors to four in part because of the low reimbursement. Being a private practice, there are no additional subsidies, and providing care is not a sustainable model, said McIntosh.

"We didn't do this to pick a political fight," he said. "We are trying to meet community demands as best we can."

That political fight, if there is to be one for the family doctor in private practice, will take place at the Statehouse.

"Few in the provider community believe that MaineCare simply does not want to pay its bills, or enjoys its status as a problematic payer," said Steele in the Maine Policy Review. "Most of MaineCare's problems reflect tight state budgets, rapidly increasing health-care costs, and our society's failure to have developed a universal insurance model at a national level. We have gotten into this mess in part because Maine's state government is trying to solve large social problems with limited solutions and limited dollars."

Ironically, the most comforting, and forgiving, words to McIntosh and the doctors came in the form of a note from a

MaineCare patient after she received the letter. While sad about being forced to find a new doctor, she understood the circumstances. "I admire anyone who is willing to take on MaineCare," she said. "I feel badly you have not been paid adequately for all your wonderful service."

Related Links:

- [American Academy of Family Physicians.](#)
 - [MaineCare.](#)
 - [Midcoast Medicine.](#)
 - [The Future of MaineCare in Maine Policy Review.](#)
 - [www.mainemed.com.](#)
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