Office of Affordable Health Care

2023 Public Hearing Comment Solicitation – **Payers and Providers**

*Written comments are due by midnight on Friday October 6th, 2023.*

*Comments may be emailed to* *meg.garratt-reed@maine.gov**, and should be attached as a word document or PDF. Please note that comments are not confidential and will be posted publicly.*

Submitter Information

Organization: Jean Antonucci MD

Individual submitter’s name: same

Title: same

Comments

1. Please identify and briefly describe the top (2-3) concerns of your organization in reducing health care cost growth and promoting affordability of health care for consumers.

I am unclear whether my original response was heard so I’ve done it again on the forms.

I am a primary care physician, working in rural Maine for 32 yrs.

Some qualifications/background: my MIPs score was 98% before I was exempt for being in a tiny practice. I did that horrible PCMH 3 times and was a level three .

Small practices do excellent work but it is s primary care overall that needs support; employed doctors are so hidden, so shielded, from what goes on ,they don’t know how to speak up and they are also afraid to.

I now work one day a week for a large system. I work in Pittsfield doing MAT, gave a talk at the AAFP a year ago on” 45 minutes learning to begin with Suboxone”. No one has taken me up on giving the talk more locally because primary care can’t do one more thing, but I’m available because I work only part time now as I’m semi-retired.

There are a few things we need to do to reduce costs.(I seem to have some trouble with formatting here…☺ )

-- The hospitals are a big problem; we have four separate systems with a lot of power over processes -- they increase costs in the small independent practices because they’re basically unfriendly to us. Small practices are efficient and cost less. I closed mine 2 1/2 years ago, as MaineHealth made life so difficult. I couldn’t accomplish anything for patients (scheduling tests or getting labs picked up became onerous, involving signing on to a complex field to get the urine picked up or faxing and waiting while the test ordered was evaluated for payment ,whereas previously it was scheduled and I could inform the patient right then and there), and some systems will not see patients in at some areas unless the PCP is employed by them. These policies waste time and reduce access for our primary care patients.

 -We need one sign-on or a unified EMR and hospitals need to, or someone statewide needs to, make this happen so that practices can facilitate getting their orders into the systems and sharing info.

-We need what the NASEM report said- a statewide healthcare czar and probably not some of the people who have been in leader ship roles in the last 15 years .Various “leaders” with no training in primary care inflicted PCMH on us without evidence, causing many to avoid or leave the programs like Health Homes.We need to make primary care a good job again and make it possible for us to do it. We have several small sterling practices in the state but fewer and fewer as I’m sure you know.

-Another problem that needs to be addressed is that, unless it has changed since I closed my practice, the HMOs require referrals to consultants -that sounds good on the surface, but the patients are not always in our offices: example- Mary has a mass in her breast, and I send her to the surgeon for a referral- fine, but the surgeon sends her to oncology and radiation oncology .Primary care has to stop what they’re doing and get their staff or themselves to write referrals. This is humiliating to us to get consultants paid. XRT is one of the highest paid fields there is, but on my dime I have to stop seeing patients and reduce access for my patients to get them paid- same for ophthalmology, which I cannot gatekeep or when someone’s in the ER with a serious fracture, someone needs to stand up and speak about that. I have written to the legislative committee at Maine Medical Association about this, but it doesn’t seem to rise to the level where any action is taken though MMA is a great organization.

PCPs can make more money and see more patients without any infusion of cash if administrative burdens are streamlined.

Vaccines are also a burden- now that the former head of vaccine program is gone. Things may be easier but vaccines only come in sealed boxes of 10 and it is a huge burden of management to order them and return them. It’s almost impossible to share them /you can’t get three doses of something at a time in a state that’s older and older and series of three polio shots shouldn’t cause us to get 10 and then apply for permission to return it and get a label and so forth.

 I’m hope I’m educating you to know about these things. These all connect to money- the more you support real primary care ,not the fads and waste of getting more team members to shovel the waste, the better you can do on costs

The prices are not under anyone’s control and this is the biggest issue. Hospitals putting everyone in $15,000 beds ….

These other ideas above are all actionable really, and without costing anyone money to put into the system, reducing administrative burden for primary care, get us to earn more money  and makes us happier with less of this paperwork garbage we can serve more people and keep them out of the ER.

Here are some final ideas.

We desperately need dentistry and psychiatry, and every year the southern Maine programs are producing new psychiatrists and dentists. So where are they? They’re not in the communities my patients can get to, (untreated mental illness including substance abuse costs society. Untreated dental issues cause pain, unnecessary PCP and ER visits) .We need a van with a hygienist and a dentist to visit towns for a week. This is what they do in Alaska- they load up on a plane. I’ve been to Alaska - they fly out to every village for a week once a year.

In addition, we need psychiatrists to do consult service through telehealth throughout the state, patients of any physician to be able to come to some health center and have a visit with the psychiatrist enabled. It shouldn’t be that patients of private Dr. John can’t be seen as it happened in Farmington because the primary care doctor had to employed by the hospital system

 That’s what’s going on

 I’m more than happy to come to Augusta and talk to you

Of the concerns described in question one, are there characteristics specific to Maine (geographically, economically, demographically) that contribute to the significance of the issue here?

- Hospitals have a lot of power and not are not interested in cooperating to improve care Also the HMO problem mentioned above wastes precious PCP time

1. Please identify and briefly describe the top strategies your organization is pursuing to address these concerns, as well as metrics for success and any results observed.

-I ran my own practice for 16 yrs. Saw every patient the day they called and on time had a MIPS score of 98% PCMH level 3 x 3 See remarks re PTAC above

With as much specificity as possible, please identify and describe the top state health policy changes your organization would recommend to support your efforts to address those concerns.

-Listed above Czar, single sign on, reduced power of hospitals to restrict access to their specialist.

Please share any additional comments.