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Final Report
of the Commission to Study
Primary Care Medical Practice

December 2007

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EXECUTIVE SUMMARY

The **Commission to Study Primary Care Medical Practice** ("the Commission") was established by the 123rd Legislature to: examine the causes of the loss of independent ownership of primary care medical practices; assess factors that affect the ability of independent primary care physicians to practice medicine in Maine; determine the impact of hospital control of primary care practices on access, treatment and costs; and review how other states manage hospital-physician relationships. Although the Commission's charge focused on primary care physician practices, the Commission members were keenly aware during their deliberations that it really is "all about the patient." Regardless of the structure of ownership of primary care practices, the rate of physician reimbursement and relationships between hospitals, physicians and other primary care providers, the goal is to ensure that all people in Maine have access to appropriate, quality health care and medical treatment. To that end, the Commission believes these recommendations will dramatically improve the health of Mainers through:

- a patient-centered medical home model that supports a preventative health care system with appropriate reimbursement for primary care;
- a focus on ensuring an adequate, quality supply of primary care providers by encouraging Maine youth to enter the field of primary care, providing clinical opportunities and residencies as well as active recruiting; and
- a commitment to access and quality that meets the health care needs of people of Maine.

The Commission held four meetings that included expert presentations and testimony from physicians, residents, advanced practice nurses, physician assistants and government officials. The meetings included panel discussions with representatives from medical associations, hospitals, federally qualified health centers, community health centers, the insurance industry and leaders in the field of education. In addition, the Commission reviewed research, news articles and newly issued reports. Based on this information, the Commission identified findings in the areas of patient-centered medical homes; MaineCare; education, training and recruitment; and access, quality and technology. They discussed 35 proposals for addressing issues in these areas and, after significant deliberation, developed the following 15 recommendations for improving primary care medical practice in Maine including six recommendations for immediate Legislative action.

RECOMMENDATIONS FOR IMMEDIATE LEGISLATIVE ACTION
(See draft legislation in Appendix C.)

1. Develop a Patient-Centered Medical Home pilot project. Require the Governor's Office of Health Policy and Finance and the Department of Health and Human Services to convene a group of stakeholders to report recommendations to the Joint Standing Committee on Health and Human Services by January 15, 2009, including any necessary legislation, for implementing a multi-payor patient-centered medical

home pilot project. The pilot project will be based on the seven joint principals of the patient-centered medical home and include specific standards for quality, access and integration as well as appropriate reimbursement for physicians.

2. Increase MaineCare reimbursement for primary care. Beginning July 1, 2008, appropriate funds amounting to an additional $5 million in General Funds each year over the previous fiscal year for incremental increases in MaineCare reimbursement for services billed under the evaluation and management (E & M) codes in the physician fee schedule until payments are equal to that of Medicare reimbursement for the same service. Increases under this provision for physicians may not be made by lowering reimbursement for other providers.

3. Identify MaineCare benefit limitations. Require the Department of Human Services Office of MaineCare Services, when an enrolled member has limited benefits under a waiver program, to provide an indication of the limitation on the front of the MaineCare card in order to alert health care providers of the limitation. This would remind providers that they can verify coverage prior to providing or ordering benefits that may be limited. Cards indicating limited benefits would be phased in at the member's annual renewal or when reissued for another reason.

4. Streamline MaineCare paperwork for cost effective prescribers. Require the Department of Health and Human Services, Office of Maine Care Services to implement processes (similar to those that are in place for specialists) that will exempt primary care physicians and other practitioners who demonstrate a history of cost-effective prescribing that meets the needs of patients from certain pre-authorization requirements.

5. Provide flexibility in dispensing prescribed medications. By January 1, 2009, the Maine Board of Pharmacy and the Department of Health and Human Services shall report to the Joint Standing Committee on Health and Human Services on the feasibility of adopting flexible dispensing standards that would allow a pharmacist to dispense the prescribed medication in the prescribed dosage or in a dosage or dosages equivalent to the prescribed dosage. In assessing the feasibility of a flexible dispensing standard, the Board and Department shall consider the impact on patient medication compliance, costs to the health care system and MaineCare as well as other unintended consequences.

OTHER IMPORTANT RECOMMENDATIONS

6. Expand "Opportunity Maine". Expand the Opportunity Maine tax credit program to make medical school more affordable for Maine students by allowing them to claim a state tax credit to pay student loans after they graduate. To be eligible, graduates must work and pay taxes in Maine after they finish medical school.

7. Align MaineCare's Primary Care Case Management (PCCM) fees with the medical home concept. Request that the Department of Health and Human Services to restore MaineCare's PCCM fees to $3 beginning July 1, 2008, and then each fiscal year

thereafter increase the fee to a level that is consistent with the patient-centered medical home model.

8. Evaluate MaineCare's clinical management contract. Request that the Department of Health and Human Services provide a written report to the Joint Standing Committee on Health and Human Services, by January 15, 2009, that evaluates the clinical management contract and includes recommendations for compensating physicians participating in clinical management at a rate that is consistent with the medical home model.

9. Support medical school partnerships and in-state clinical opportunities and residencies. Support Maine Medical Center's development of the Medical School Partnership and request that the Legislature be kept informed of its progress. Support existing partnerships with the University of New England's College of Osteopathic Medicine, Dartmouth Medical School and Vermont College of Medicine as well as clinical opportunities and residencies throughout the state.

10. Increase outreach. Expand the role of Area Health Education Center Programs in recruiting high school students into the primary care medical profession through a comprehensive campaign including funding for staff and a volunteer speakers' bureau with resources to reimburse speakers for expenses. Encourage professional associations to educate their members about programs available to help young people pursue a medical education. Request the Department of Economic and Community Development (DECD) to include a message encouraging physicians to come practice in Maine as part of the State's marketing efforts.

11. Invest in and sustain Finance Authority of Maine (FAME) medical education programs. Recognize the need for on-going funding of the FAME's current medical education program and the health professions loan programs as well as the need to increase awareness regarding the availability of the programs. Request that FAME consider developing a loan repayment program for medical students that is similar to the dental loan repayment program.

12. Maintain a stable medical practice environment. Recognize that a stable medical practice environment facilitates recruitment. Consistent rules and regulations as well as reliable payment sources and systems make an area more attractive for practicing medicine. Malpractice laws that contain costs and provide adequate levels of protection for doctors acting in the best interest of their patients positively impact recruitment efforts in the State. In particular, the Commission recognizes the strides made in recent years to create a stable malpractice environment and the Commission supports efforts to maintain this progress.

13. Support initiatives that increase or preserve access to health care. Recognize the importance of facility-based primary care providers, including hospitals, community health centers and federally qualified health centers (FQHCs), in preserving access in areas where high costs and low MaineCare reimbursement has eroded the independent physician base. Support the valuable role that nurse practitioners and physician assistants play in providing primary care. Request the Joint Standing Committee on Business, Research and Economic Development to review and consider expanding

the scope of work that physicians and nurse practitioners are allowed to perform.[1] Encourage the Health and Human Services Committee to use the Department of Labor report on the work of the health workforce forum to inform policy decisions related to the supply of physicians and other primary care providers.

14. Support quality initiatives. Support the on-going work of the Maine Quality Forum and the standardization of quality measures. Support the Maine Medical Association's voluntary practice assessment initiative and other initiatives to assist physicians in meeting quality standard goals.

15. Support investment in medical information technology. Support the development of interoperable technology initiatives that enhance patient care and clinical management; support quality initiatives and performance measurement; and facilitates the exchange of health information between providers.

In summary the Commission members recognize that the solutions to Maine's primary care challenges will not happen overnight. Some of the Commission's recommendations set the stage for long-term system change, such as the implementation of a full-scale patient-centered medical home model and a focus on education and training that provides incentives for Maine youth to practice medicine in the state. Other recommendations can be implemented in this biennium or the next, such as increased reimbursement from MaineCare and streamlined paperwork. Still other recommendations sustain programs and providers that are maintaining access to primary care, while policy makers continue to make progress on their commitment to quality primary care that meets the health care needs of people of Maine.

[1] According to testimony given on October 26, 2007, advance practice nurses are, by law or rule, allowed to do more in a hospital setting than they are in a private practice setting. Physician assistants testified about the need for more independence in practice similar to nurse practitioners. Although these suggestions are outside the scope of the Commission's charge, members want to recognize the value of the mid-level practitioners in providing access to primary care.

I. INTRODUCTION

Primary care is the cornerstone of preventative health and, as such, has the potential to dramatically improve the health of Americans and to play a significant role in bringing down health costs nationwide. According to the American Academy of Family Physicians "...a reliance on preventative and primary care improves [health] outcomes and lowers costs."[2] Patients who have "...a regular source of preventative and primary care have lower costs per person, lower emergency room utilization, fewer hospital admissions, fewer unnecessary tests and procedures, less illness and injury, higher satisfaction..." and add value for their employers as "...they take fewer sick days and are more productive on the job."[3]

Yet, our current health care reimbursement system undervalues primary care. Private and public insurers use a reimbursement system that is procedure-oriented and fails to take into account the cognitive factors used by primary care providers in their work with patients. For example, the private insurance reimbursement in Maine for a primary care office visit is 37 percent to 81 percent lower than the reimbursement for a procedure to remove a skin lesion.[4] While it is not the sole factor, the Commission found that this chronic under-valuing of preventative care discourages physicians from choosing primary care as their field of practice and, in particular, from opening their own primary care practice.

In Maine, low Medicaid reimbursement rates amplify the problem due to the large percentage of the population in the program. One out of every five people in the state is covered by MaineCare, the State's Medicaid program.[5] Thus, low Medicaid reimbursement rates impact Maine providers to a greater degree than it would if they practiced medicine in other parts of the nation. Moreover, the lower level of reimbursement for self-employed primary care providers compared to facility-based primary care providers exacerbates the erosion of independent primary care practice in Maine and contributes to physicians' decisions to become employed in other practice settings.

Nationally, the supply of primary care physicians has declined in recent years and there is a trend of more physicians working in employed positions.[6] According to Maine Department of Labor, "new physicians are...less likely to enter solo practice and more likely to take salaried jobs."[7] Members of Maine's Legislature have heard that MaineCare reimbursement rates play a big part in doctors' decisions to be employed. Researchers from the Muskie School of Public Service indicated reimbursement was the greatest trigger of conversions during physician interviews conducted as part of a study commissioned by Medicaid programs in Maine and New Hampshire.[8]

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[2] Patient-centered medical home fact sheet accessed on the Academy of Family Physicians website in December 2007 at: www.aafp.org/online/en/home/policy/federal/presidentialrace/factsheets/medicalhome.html.

[3] Ibid.

[4] The Maine Medical Association and the Maine Academy of Family Physicians provided comparison information that based on the Resource Value Rate-Based System (RVRBS) system. See presentation materials at: www.maine.gov/legis/opla/primarycare.htm.

[5] Maine Department of Labor, *Healthcare Occupations Report 2006.*

[6] Muskie School of Public Policy, Institute of Public Health, *Understanding Changes to Physician Practice Arrangements in Maine and New Hampshire.* Executive Summary provided to Commission on November 9, 2007.

[7] Maine Department of Labor, *Healthcare Occupations Report 2006.*

[8] Muskie School of Public Policy, Institute of Public Health, *Understanding Changes to Physician Practice Arrangements in Maine and New Hampshire.* Executive Summary provided to Commission on November 9, 2007.

However, reimbursement alone does not fully explain the many factors that go into a physician's decision about practice type. Factors including business and technology costs; relief from administrative responsibilities and business operations; the security of a salary and physician life-style choices; and in the case of federally qualified health centers, protection under federal tort law all influence practice-type decisions. According to the Maine Medical Association, the trade-off is the loss of ownership and control, an income source that is subject to certain terms of employment and possible limits on professional judgment. Policy implications may include higher costs, through a larger number of employed physicians getting reimbursed at federally qualified health centers (FQHCs) or hospital practices; decreased competition; and limited choices for patients.[9] However, without these facility-based practices, access in Maine would be dramatically reduced. Private practice physicians, with large a Medicaid volume, report that they cannot afford to absorb low Medicaid reimbursement and many limit the number of MaineCare patients that they will see.[10] In some counties there are no independent physicians and many point to high costs and low reimbursement rates.[11]

Fortunately, Maine hospitals, community health centers, federally qualified health centers and mid-level practitioners such as advanced practice nurses and physician assistants have helped to maintain access to primary care. According to the Maine Hospital Association, hospitals in Maine began employing primary care physicians in order to preserve access to primary care services due to the direct link to health status and to ensure that people are not forced to use the emergency room as their only point of entry to the healthcare system. Primary care practices are not big revenue generators for hospitals and, in fact, most of these practices lose money and are subsidized by other revenue centers within the hospital. Likewise, the number of FQHCs, community health centers and mid-level practitioners have grown in recent years and provide access in areas that might otherwise not have primary care.

Maine has succeeded in the health care arena in many areas including the percentage of population with some form of health coverage, high tobacco cessation rates, low rates of teen pregnancy and infant mortality, as well as a strong health care safety net. But a continued under-valuing of primary care could erode the progress the State has made. While recognizing the valuable role of hospitals, community health centers, federally qualified health centers and mid-level practitioners play in providing primary care, the challenges of providing primary care in Maine continue to grow and the State cannot afford to squeeze private practice out of the mix. With fewer medical students choosing to practice primary care, private practices closing their doors to MaineCare patients due to low reimbursement and the need to have a prevention focused healthcare system in mind, the Commission to Study Primary Care Medical practice was created as further described in the background section of this report.

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[9] Information provided by Maine Medical Association on September 14, 2007, in an outline entitled "Legal Implications for Physicians of Hospital Employment," which can be found at www.maine.gov/legis/opla/primarycare.htm

[10] See table on the number of primary care physicians that are open and closed to MaineCare patients, which was provided by Maine Department of Health and Human Services (DHHS) on September 14, 2007, and can be found at www.maine.gov/legis/opla/primarycare.htm.

[11] Muskie School of Public Policy, Institute of Public Health, *Understanding Changes to Physician Practice Arrangements in Maine and New Hampshire.* Executive Summary provided to Commission on November 9, 2007.

II. BACKGROUND

A. Commission Membership and Charge

The Commission was created by a joint order (Senate Paper 732), which charged the Commission with the following.

A. Identify causes of the loss of independent ownership of primary care medical practices due to financial, regulatory or business-related reasons.

B. Seek input from independent primary care physicians (PCP) on payor mix, reimbursement and Medicaid regulatory changes and the effects on their ability to practice medicine in Maine.

C. Determine the effect that hospital control of primary care offices and physicians has on health care costs, access to health care and medical treatment.

D. Review how comparable states manage physician-hospital relationships with respect to health care cost, patient advocacy and access to health care.

E. Report findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health and Human Services by December 5, 2007. The Joint Standing Committee may introduce a bill related to the study.

B. Commission Process

The Commission held four meetings that included expert presentations and testimony from physicians, residents, advanced practice nurses, physician assistants and government officials. The Commission held panel discussions that included representatives from medical associations, hospitals, federally qualified and community health centers, the insurance industry, financing programs and the education community. The first two meetings included a public comment period and the Commission received written comments as well. In addition, the Commission reviewed information from research, news articles and newly issued reports.

The Commission discussed causes of the loss of independent ownership of primary care medical practices including financial, regulatory or business-related reasons. They heard from independent primary care physicians (PCP) on payor-mix, reimbursement and Medicaid regulation and the effects on their ability to practice medicine in Maine. They discussed the effect that hospital control of primary care offices and physicians has on health care costs, access to health care and medical treatment and reviewed information from other states. Based on this information, the Commission identified findings in the areas of patient-centered medical homes, MaineCare, education, training, recruitment, access and quality. Originally, scheduled to report to the Joint Standing Committee on Health and Human Services by December 5, 2007, the Commission received a short extension. At its final meeting on December 7, 2007 the

Commission approved 15 recommendations for addressing challenges to primary care medical practice in Maine.

III. FINDINGS AND RECOMMENDATIONS

Regardless of the structure of ownership of primary care practices, the rate of physician reimbursement and relationships between hospitals and physicians, the Commission members clearly believe the goal of ensuring that all people in Maine have access to appropriate, quality health care and medical treatment is of top importance. With this goal in mind, the Commission found the need to set the stage for long-term system change through a patient-centered medical home model that supports a preventative health care system with appropriate reimbursement for primary care; a focus on ensuring an adequate, quality supply of primary care providers by encouraging Maine youth to enter the field of primary care, providing clinical opportunities and residencies as well as recruiting; and a commitment to access and quality that meets the health care needs of the people of Maine. Findings and recommendations in each of these areas are detailed below.

A. Patient Centered Medical Home

As the Commission wrestled with issues related to primary care medical practice, it became evident that a patient-centered medical home model would be the path to a focus on preventative health. While the concept of a medical home is not new, it has received renewed attention in recent years. In 2006, the American College of Physicians, issued a policy monograph on the advanced medical home that calls for "...a comprehensive public policy initiative that would fundamentally change the way that primary care...services are...delivered to patients."[12] It calls for changes to financing and reimbursement as well as workforce and training policies that support the model.[13] The American Academy of Family Physicians, American College of Physicians, American Academy of Pediatrics and American Osteopathic Association issued joint principals of a patient-centered medical home in February 2007. The principals include a personal physician who leads a medical team that collectively takes responsibility for the ongoing care of patients with a "whole-person" orientation. Under the model, primary care is coordinated and integrated, and quality, safety and access are of the utmost importance. Hallmarks of the patient-centered medical home include planning, evidence-based medicine, clinical decision support tools, accountability, active participation in decision making by the patient and appropriate information technology supporting an environment of continual quality improvement and increased access through means including expanded hours, open scheduling and new options for communication between doctor and patient.[14]

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[12] American College of Physicians, *The Advanced Medical Home: A Patient-Centered Physician-Guided Model of Health Care,* January 22, 2006.
[13] Ibid.
[14] Joint Principals of Patient-Centered Medical Home, February 2007. Check source and add website.

Integral to its success, the model has a payment structure that appropriately recognizes the added value for patients with payments appropriately reflecting the time, knowledge and skills used during a primary care office visit as well as work that that falls outside of a face-to-face visit including administration, research, communication and referrals. Payments also consider the value of services associated with coordination of a patient's medical care; the resources needed for health information technology investment and the savings from reduced hospitalization that results from a prevention-oriented model. The model's payment structure also allows for additional payments for achieving measurable and continuous quality improvement.

Nationally, support for a patient-centered medical home model continues to grow. In May 2007, the American Academy of Family Physicians presented a statement to the U.S. House Ways and Means Subcommittee on Health that called for "...the patient-centered medical home as a component of a Medicare program that offers better health care more efficiently." Moreover, the Commission heard testimony on how the patient-centered medical home could address primary care challenges in Maine as well as how the concept has been applied in other states. Commission members were particularly interested in North Carolina's application of the concept to the Medicaid program. The Commission strongly supports the patient-centered medical home concept and its potential for improving the health outcomes while reducing medical costs. Therefore, the Commission issues the following findings and recommendations.

Findings

The Commission to Study Primary Care Medical Practice finds:

1. The patient-centered medical home concept improves health outcomes and helps shift the health care system to a preventative model and that every person in Maine should have a patient-centered medical home.
2. The patient-centered medical home model must include all payment and reimbursement sources in order to significantly impact the cost of health care in Maine.
3. The application of the patient-centered medical home concept to the Medicaid program has produced savings in other states and better health outcomes for their Medicaid population.
4. Consumers benefit from having a choice of patient-centered medical homes in independent practice, group practice and employed physician practice arrangements.

Recommendations

The Commission to Study Primary Care Medical Practice recommends the following.

1. Develop a pilot project. Require the Governor's Office of Health Policy and Finance and the Department of Health and Human Services to convene a group of stakeholders to report recommendations to the Joint Standing Committee on Health and Human Services by January 15, 2009, including any necessary legislation, for

implementing a multi-payor patient-centered medical home pilot project. The pilot project will be based on the seven joint principals of the patient-centered medical home and include specific standards for quality, access and integration as well as appropriate reimbursement for physicians. (See legislation in Appendix C.)

2. Align MaineCare's Primary Care Case Management (PCCM) fees with the medical home concept. Request that the Department of Health and Human Services to restore MaineCare's PCCM fees to $3 beginning July 1, 2008, and then each fiscal year thereafter increase the fee to a level that is consistent with the patient-centered medical home model.

3. Evaluate MaineCare's clinical management contract. Request that the Department of Health and Human Services provide a written report to the Joint Standing Committee on Health and Human Services by January 15, 2009, that evaluates the clinical management contract and includes recommendations for compensating physicians participating in clinical management at a rate that is consistent with the medical home model.

B. MaineCare

Appropriate reimbursement for the time, knowledge and skills that primary care providers use in their work with patients is key to the success of the patient-centered medical home model. The payment structure for primary care must reflect that value regardless of the payment source. Involvement by MaineCare in increasing payments to physicians is critical as Medicaid reimbursement is a large part of the payments provided to physicians due to the large number of people in Maine covered by the program.

In addition, low MaineCare reimbursement is causing some practices to not accept new Medicaid patients.[15] A representative of a mid-coast doctor's group that recently decided to drop all of their MaineCare patients indicated that they could no longer afford to offer services below cost and "...the decision had to be made...because low reimbursement by the State was making it impossible to recruit or retain physicians."[16] According to testimony from authors of a Muskie School Study commissioned by Maine's Department of Health and Human Services, between the years 2000 and 2006 MaineCare enrollment doubled; yet primary care provider payments per claim declined from $73 to $47 during the same time period.[17] The current commercial insurance rate for a primary care visit in Maine is approximately $50. Medicare pays approximately $38 and MaineCare (Medicaid), at 53% of the Medicare reimbursement, pays approximately $20 for the same service. A cash paying patient would pay approximately $70 to $75 for the same visit.[18] Other MaineCare issues, such as not knowing who has limited benefits

[15] According to MaineCare Primary Care Case Management Statistics provided by the DHHS, over 46 percent of primary care providers enrolled in the program are not accepting new patients.
[16] Article provided to Commission members at October 26, 2007 meeting; article dated 10/5/07 from MaineCoastNOW.com.
[17] Testimony from Muskie School staff during presentation of the Executive Summary of the report entitled *Understanding Changes to Physician Practice Arrangements in Maine and New Hampshire* to the Commission on November 9, 2007.
[18] Testimony from official from Maine Department of Health and Human Services September 14, 2007. Please note that although MaineCare rates are currently 53% of Medicare based on RVRBS, MaineCare reimbursement to providers is not based on RVRBS and reimbursement may not be 53% of Medicare in the future.

before ordering tests or authorizing a treatment regimen that may not be covered as well administrative burdens including pre-authorization and prescription dispensing issues were cited as hindering private primary care practice.

While funding has been provided in the budget to increase physicians' MaineCare reimbursement in two biennial budgets[19] passed by the 122nd and 123rd Legislatures, it still is insufficient to keep pace with the workload associated with MaineCare and the complexity of patients' needs in this most vulnerable population. The Commission recognizes that many factors impact providers' decisions about practice type or whether to practice in Maine. However, Commission members agree that one factor that the Legislature can impact is Medicaid reimbursement. In addition, payment structure is a critical component in the patient-centered medical home model and key to the success of the shift to a preventative health care model in Maine. With this in mind, the Commission issues the following findings and recommendations.

Findings

The Commission to Study Primary Care Medical Practice finds that:

1. Medicaid reimbursement rates through the State's MaineCare program are lower than many other comparable states.
2. Medicaid reimbursement rates have a greater impact on physicians in Maine than they may have in other states due to the large percentage of the population covered by the State's MaineCare program. This is particularly important when considering a patient-centered medical home model in Maine as the impact of the medical home program would be reduced significantly if MaineCare reimbursement did not increase along with other reimbursement rates in an effort to adequately compensate providers for the costs of preventative care.
3. MaineCare reimbursement rates for the work of primary care physicians are inadequate and contribute to the loss of independent ownership of primary care medical practices and affect primary care physicians' ability to practice medicine in Maine.
4. In addition to low reimbursement, MaineCare administrative requirements and restrictions hinder the ability of physicians to practice in Maine and contribute to practices closing their doors to new MaineCare patients and in some cases, not accepting MaineCare patients at all.

Recommendations

The Commission to Study Primary Care Medical Practice recommends the following.

1. Increase reimbursement for primary care. Beginning July 1, 2008, appropriate funds amounting to an additional $5 million in General Funds each year over the previous fiscal year, for incremental increases in MaineCare reimbursement for

[19] PL 2005, chapter 12 and PL 2007, chapter 240 (the biennial budget laws) include $3,000,000 each for increasing physician reimbursement rates.

services billed under the evaluation and management (E & M) codes in the physician fee schedule until payments are equal to that of Medicare reimbursement for the same service. Increases under this provision for physicians may not be made by lowering reimbursement for other providers. (See legislation in Appendix C.)

2. Identify benefit limitations. Require the Department of Human Services Office of MaineCare Services, when an enrolled member has limited benefits under a waiver program, to provide an indication of the limitation on the front of the MaineCare card in order to alert health care providers of the limitation. This would remind providers that they can verify coverage prior to providing or ordering benefits that may be limited. Cards indicating limited benefits would be phased in at the member's annual renewal or when reissued for another reason. (See legislation in Appendix C.)
3. Streamline paperwork for cost effective prescribers. Require the Department of Health and Human Services, Office of Maine Care Services to implement processes (similar to those that are in place for specialists) that will exempt primary care physicians and other practitioners who demonstrate a history of cost-effective prescribing that meets the needs of patients from certain pre-authorization requirements. (See legislation in Appendix C.)
4. Provide flexibility in dispensing prescribed medications. By January 1, 2009, the Maine Board of Pharmacy and the Department of Health and Human Services shall report to the Joint Standing Committee on Health and Human Services on the feasibility of adopting flexible dispensing standards that would allow a pharmacist to dispense the prescribed medication in the prescribed dosage or in a dosage or dosages equivalent to the prescribed dosage. In assessing the feasibility of a flexible dispensing standard, the Board and Department shall consider the impact on patient medication compliance, costs to the health care system and MaineCare as well as other unintended consequences. (See legislation in Appendix C.)

C. Education, Training and Recruitment

During the Commission's hearings and deliberations many people expressed concern about the supply of primary care providers in Maine. Factors impacting supply include an aging workforce; fewer students choosing to go into the medical field and in particular, into primary care; limited clinical opportunities and residencies; competition for attracting doctors in a national marketplace; and the challenges of attracting doctors to rural and remote parts of Maine. This means that as a state we need to not only recruit new physicians to the area, but also to "grow our own" by encouraging Maine youth to enter the field of primary care, providing education, clinical opportunities and residencies in Maine and incentives for young doctors to stay here after completing their training.

While about 79 percent of physicians in Maine are medical doctors or MDs, "…Maine's only medical school – the University of New England's College of Osteopathic Medicine—graduates only doctors of osteopathic medicine or DOs," which means most Maine doctor's go

to school in other states and may not return after years of residing and establishing lives in other places.[20] The good news is that we do have a medical school in Maine and about half of all DOs practice general medicine. According to the Interim Dean of University of New England's College of Osteopathic Medicine, approximately 350 physicians that were part of the first graduating class are still practicing in Maine.

In another effort to "grow our own," the State is helping Maine residents secure entry into medical school. Under the Maine Access to Medical Education Program, the Finance Authority of Maine (FAME) contracts with three medical schools: Dartmouth Medical School, the University of England's College of Osteopathic Medicine, and the University of Vermont's College of Medicine to reserve seats for up to 20 Maine residents. Also, on the horizon is the development of a medical school partnership that has a vision of incorporating teaching affiliates with rotations of varying duration, branch campuses with a full range of clerkships and distinct clinical focus, at least one full year of instruction at a clinical campus, a segmented educational track, a clinical program and an independent, LCME[21] accredited medical school.[22]

But more needs to be done in the short-term to encourage Maine youth to go to medical school and to create opportunities for medical students to complete residencies in Maine. The University of New England's Area Health Education Center (AHEC) program is working to do both. Created in 1985 the AHEC has the goal of increasing the supply of primary care physicians, particularly in underserved areas, through training, distant learning and outreach to youth. Today the Maine AHEC network includes a program office in Biddeford along with three AHEC centers in Bangor, Farmington and Augusta to provide community-based training experiences, provide continuing education and distant learning opportunities, encourage Maine youth to explore health careers and provide public health training. In most states, AHEC receives an appropriation to leverage federal funds with an average appropriation of $2.6 million.[23] Although it receives funding from The University of New England, the Maine Center for Disease Control and Prevention and the Finance Authority of Maine, the AHEC network operates on a small budget without a direct State appropriation and is limited in the outreach that it can provide. With additional funding this program can be strengthened to further "...improve the supply, distribution, quality, and diversity of health professionals, especially primary care providers, in Maine's rural and underserved areas."[24]

"Residency opportunities are especially vital to the supply [of physicians] as...50% or more remain in-state after residency."[25] Although residency opportunities in Maine are relatively limited, with approximately 26 percent of active physicians reporting to have completed his or her residency in Maine,[26] there are five Family Practice Residency Programs in Maine including programs at Maine Medical Center, Central Maine Medical Center, Maine-Dartmouth Residency in Augusta, Eastern Maine Medical Center and the University of New England. Each program

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[20] Maine Department of Labor, *Healthcare Occupations Report 2006.*
[21] Liaison Committee on Medical Education (LCME) is required for schools to receive federal grants for medical education and to participate in federal loan programs.
[22] Program was discussed at the October 26, 2007 meeting of the Commission. However, there was not a formal presentation.
[23] Area Health Education Center (AHEC) handout from Commission meeting on October 26, 2007 meeting.
[24] Ibid.
[25] Maine Department of Labor, *Healthcare Occupations Report 2006.*
[26] Ibid.

has five to ten family practice residents per year and several of these positions are reserved for University of New England students.

Doctors from the Maine Dartmouth Family Practice Residency indicated that debt load is a big concern for young doctors and forgiveness/repayment incentives are big factors in decisions about practice type and location. They also noted that doctors often stay in the area where they complete their residency and suggested that other incentives such as housing may help lure physicians to underserved areas. If not for high debt, business start-up cost, the administrative burden and quality of life issues, these young physicians said they would prefer a private practice where they could be directly involved in the practice decisions.[27]

With high debt load cited as a particular concern by young doctors, programs to address debt burden are imperative. Four programs in Maine, including the National Health Service Corps (NHSC) Loan Repayment Program, the State Loan Repayment Program (SLRP), the Finance Authority of Maine (FAME), and repayment offers by Maine hospitals, are options for those who want to practice primary care in Maine. Most of these programs all require work in certain locations and the NHSC loan repayment program, SLRP, and FAME all offer repayment options for those working in medically underserved areas (as designated by the federal government).

Recruiting challenges include competition in a national market, fewer graduates choosing primary care, the number of doctors in Maine nearing retirement age and specific regional issues. Physician recruitment in rural areas faces particular challenges including "...lower earning potential, longer hours and...a general shift in desired professional setting among physicians and salary levels."[28] Currently, hospitals are actively recruiting 212 physicians with 102 of those recruitments in the field of primary care.[29] The Maine Recruitment Center (MRC), which is a collaborative effort between hospitals and the Maine Hospital Association, has been an important recruiting tool.

In addition, a stable medical practice environment, including consistent rules, regulations and malpractice laws as well reliable payment sources and systems, facilitates recruiting at all levels by making the State more attractive for practicing medicine. In the last year, much focus has been on problems with the State's Medicaid payment system know as MECMS. While the State has worked to correct these problems and has developed a contract for a fiscal agent, providers continue to express concerns. Providers need reliable sources of payment among other business factors to be enticed to establish and maintain practices in Maine. On a positive front, the State's malpractice insurance experience has been good in recent years with rates stabilizing in 2005 and 2006 caused by "significant decreases in the claims frequency...and a moderation of severity."[30] Maine's current malpractice premium rates are "...generally less than half of the national average and among the ten lowest in the nation."[31]

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[27] Testimony of current and former Dartmouth residents on October 26, 2007.
[28] Maine Department of Labor, *Healthcare Occupations Report 2006.*
[29] Testimony provided by Maine Hospital Association on September 14, 2007.
[30] Testimony of President of Medical Mutual Insurance Company on October 26, 2007.
[31] Medical Malpractice report from Insurance Bureau

Recognizing the need to ensure that there are sufficient primary care providers to meet the needs of Maine's patients and foster the development of a patient-centered medical home model, the Commission issues the following findings and recommendations in the areas of education, training and recruitment.

Findings

The Commission to Study Primary Care Medical Practice finds that:

1. The number of college students pursuing medical education in Maine is not sufficient to meet the future demand for primary care.
2. Medical education debt is a concern for young doctors and impacts their decisions on the type of practice arrangement that they choose.
3. The place where a doctor chooses to do his or her residency is often the place where he or she chooses to practice.
4. The number of graduates from medical schools choosing to do residencies in the State of Maine is insufficient to meet the future demand for primary care.

Recommendations

The Commission to Study Primary Care Medical Practice recommends the following.

1. Expand "Opportunity Maine". Expand the Opportunity Maine tax credit program to make medical school more affordable for Maine students by allowing them to claim a state tax credit to pay student loans after they graduate. To be eligible, graduates must work and pay taxes in Maine after they finish medical school.
2. Support medical school partnerships and in-state clinical opportunities and residencies. Support Maine Medical Center's development of the Medical School Partnership and request that the Legislature be kept informed of its progress. Support existing partnerships with the University of New England's College of Osteopathic Medicine, Dartmouth Medical School and Vermont College of Medicine as well as clinical opportunities and residencies throughout the state.
3. Increase outreach. Expand the role of Area Health Education Center Programs in recruiting high school students into the primary care medical profession through a comprehensive campaign including funding for staff and a volunteer speakers' bureau with resources to reimburse speakers for expenses. Encourage professional associations to educate their members about programs available to help young people pursue a medical education. Request the Department of Economic and Community Development (DECD) to include a message encouraging physicians to come practice in Maine as part of the State's marketing efforts.

4. Invest in and sustain Finance Authority of Maine (FAME) medical education programs. Recognize the need for on-going funding of FAME's current medical education program and the health professions loan programs as well as the need to increase awareness regarding the availability of the programs. Request that FAME consider developing a loan repayment program for medical students that is similar to the dental loan repayment program.

5. Maintain a stable medical practice environment. Recognize that a stable medical practice environment facilitates recruitment. Consistent rules and regulations as well reliable payment sources and systems make an area more attractive for practicing medicine. Malpractice laws that contain costs and provide adequate levels of protection for doctors acting in the best interest of their patients positively impact recruitment efforts in the State. In particular, the Commission recognizes the strides made in recent years to create a stable malpractice environment and the Commission supports efforts to maintain this progress.

D. Access, Quality and Technology

Throughout the course of the Commission's work, members and panelist discussed access, quality and technology. Members recognize the important relationship of these areas to the patient-centered medical home model. They also want to build on Maine's strong national reputation for providing access to heath coverage and developing initiatives to provide high quality health care. Technology is also on the forefront with the development of systems for electronic medical records, quality measurement and clinical information sharing.

According to the Maine Economic Growth Council, "in 2005, over 89 percent of people in Maine were covered by health insurance, whereas 84 percent of the U.S. population had coverage."[32] Similar to the U.S. average, about 60 percent of Maine's population under the age of 60 are covered by employer-based health plans. With the availability of employer-based coverage declining nationwide, "Maine has used its Medicaid (MaineCare) program to [make up the difference and]...successfully [reduce] its overall uninsured rate."[33]

While Maine has made great strides in this area, insurance coverage is just part of the access picture. The State Health Plan notes that while access is often thought of as health coverage there are many aspects including the "...affordability, availability, accessibility, acceptability and accommodation" of health care and medical treatment.[34] Although health insurance coverage helps with affordability, access may still be limited by the availability of physicians, limitations on the patients that they see and the ease with which they can be accessed. As independent primary care medical practice has become more difficult in Maine, hospitals, community health centers, federally qualified health centers and mid-level practitioners such as advanced practice nurses and physician assistants have helped to maintain access to primary care.

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[32] Maine Development Foundation. 2007. "Measures of Growth in Focus: Performance Measures and Benchmarks to Achieve a Vibrant and Sustainable Economy for Maine." Augusta: Maine Economic Growth Council, p 27.

[33] Ibid.

[34] Roadmap to Better Health, Maine's State Health Plan 2006/2007, p 92.

According to a report produced by the Maine Health Access Foundation, most states have groups of providers, referred to as "safety net providers" who grant access to health care services to people who have difficulty paying for services in the private sector.[35] In Maine, as in other most rural states, these providers go beyond access issues related to affordability and address access issues such as distance, geography, culture and ethnic issues as well as filling other access gaps. These provider groups include: "critical access hospitals (CAH) and other hospitals, Health Care Access Programs, Federally Qualified Health Centers (FQHC), Indian Health Service clinics, Rural Health Clinics (RHC), primary care residency programs, School Based Health Centers (SBHC), family planning clinics, public health department clinics and free clinics [as well as] privately practicing primary care physicians [who] provide services to people who would otherwise access the safety net."[36]

Maine's 39 non-profit hospitals began employing primary care physicians in order to preserve access to primary care in their communities.[37] Hospitals in Maine employ approximately 42% of the more than 4,500 active physicians licensed in Maine with the majority of these physicians (339) in primary care practices. According to the Department of Health and Human Services, MaineCare members served by Federal Qualified Health Centers (FQHCs) have increased more than other provider types. As poorer, more rural areas increasingly saw independent primary care physicians close their doors, many converted to community health centers and FQHCs. For example, Health Access Network, a 501c3 non-profit organization, was established after doctors from solo-practices found it hard to stay in business. Similarly, the impetus for the creation of Penobscot Community Health Care was a response to the reduced access to primary care as private physicians limited MaineCare patients due to low reimbursement rates. In addition, many communities are using mid-level practitioners play in to fill a void in primary care. During the panel discussions, the Commission heard from a Family Nurse Practitioner and Physician Assistant who provide primary care in northern Maine. These professionals, along with other advanced practice nurses and physician assistants present at the meeting, encouraged the Commission to consider mid-level practitioners as they made recommendations for primary care and to address barriers to mid-level practitioner independent practice.[38]

In addition to access, the Commission is aware of several quality initiatives including efforts through private insurers, non-profits and government. A representative from Anthem Blue Cross and Blue Shield spoke to the Commission about its pay-for-performance program called AQI Primary Care Quality Incentive Program. The program rewards performance by paying up to an additional six percent for primary care services based on industry standard measures of quality, including clinical outcomes, patient safety and administrative processes that enhance patient care.

The Commission also discussed the work of the Maine Quality Forum (MQF), which was established by the Governor and the Legislature to provide consumers with a reliable resource for information about health maintenance, health care and quality of health care services and health

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[35] Maine Health Access Foundation. *Maine Primary Care Safety Net Environmental Scan, Final Report.* February 2006.
[36] Ibid.
[37] Testimony from Maine Hospital Association representative and hospital administrators September 27 and October 26, 2007.
[38] Testimony from mid-level practitioners October 26, 2007.

information. The forum, which includes members representing providers, consumer, employers, private insurers and the State's Medicaid program, is responsible for disseminating research regarding health care quality, evidence-based medicine and patient safety. It is charged with adopting standard measures for quality and performance, coordinating and reporting data, conducting technology assessments, assisting practitioners with the implementation of electronic systems, providing input for the State Health Plan and educating consumers.[39]

Commission members discussed the need to support quality initiatives and encourage providers to take advantage of programs such as the Voluntary Practice Assessment Initiative and the Quality Counts Learning Community, both of which are offered to practice free of charge. They also discussed the need to ensure interoperability and standardize quality measures related "performance incentives." In addition, Commission members expressed concern about the impact that investing in technology for quality initiatives may have on independent primary care practices. In particular, they want to ensure that physicians do not invest in technology that is obsolete in a few years due to changes in quality measurement. Nor do they want to see near-retirement age physicians leaving the field early due to the high cost of technology investment.

In spite of these concerns, the Commission understands that it is vital to achieving the vision of the patient-centered medical home model and encourages support of technology initiatives. In particular, the Commission discussed the work of Health InfoNet, which is an independent non-profit organization, formed to build an electronic health information sharing system that will allow Maine hospitals, physicians and other providers to share patient-specific clinical information. Health InfoNet has received funding of over $2.6 million from business, foundations, grants, insurers and providers.[40] It also received an appropriation in the amount of $265,000 in State fiscal year 2008 and the ability to access capital through the Maine Health and Higher Educational Facilities Authority, (MHHEFA), which provides education institutions and healthcare facilities access to capital markets by issuing bonds and lending the proceeds for financing specific projects.

The Commission recognizes the important relationship of these areas to the patient-centered medical home model, which includes quality, safety and access as key components. The Commission members understand a patient-centered medical home includes planning, evidence-based medicine, clinical decision support tools and accountability as well as appropriate information technology. With this in mind, the Commission issues the following findings and recommendations.

Findings – The Commission to Study Primary Care Medical Practice finds that:

1. Quality, access and technology are critical components of the patient-centered medical home model.
2. Hospitals, community health centers, federally qualified health centers, other safety net providers and mid-level practitioners such as advanced practice nurses and

[39] 24-A MRSA § 6951.
[40] HealthInfoNet Business Plan and Operating Strategy, February 28, 2007

physician assistants have helped to maintain access to primary care as the number of independent primary care physicians has declined.

3. Several quality initiatives including efforts through private insurers, non-profits and government as underway and investment in technology is often required to participate in quality measurement.

Recommendations

1. Support initiatives that increase or preserve access to health care. Recognize the importance of facility-based primary care providers, including hospitals, community health centers and federally qualified health centers (FQHCs), in preserving access in areas where high costs and low MaineCare reimbursement has eroded the independent physician base. Support the valuable role of nurse practitioners and physician assistants play in providing primary care. Request the Joint Standing Committee on Business, Research and Economic Development to review and consider expanding the scope of work that physicians and nurse practitioners are allowed to perform.[41] Encourage the Health and Human Services Committee to use the Department of Labor report on the work of the health workforce forum to inform policy decisions related to the supply of physicians and other primary care providers.
2. Support quality initiatives. Support the on-going work of the Maine Quality Forum and the standardization of quality measures. Support the Maine Medical Association's voluntary practice assessment initiative and other initiatives to assist physicians in meeting quality standard goals.
3. Support investment in medical information technology. Support the development of interoperable technology initiatives that enhance patient care and clinical management; support quality initiatives and performance measurement; and facilitates the exchange of health information between providers.

IV. CONCLUSIONS AND ACKNOWLEDGEMENTS

On December 7, 2007, the Commission completed its work concluding that there is no single answer to Maine's primary care health challenges. However, members agreed that the Commission's work could set the stage for system change that will occur over several years through the development of a patient-centered medical home model, a focus on ensuring a quality supply of primary care providers and a commitment to access and quality that meets the health care needs of people of Maine. The Commission members also believe that short-term action can further these goals by developing a pilot project for a patient-centered medical home that supports a preventative health care system with appropriate reimbursement for primary care. They believe that increased reimbursement from MaineCare is critical to the implementation of such a model and that even outside of the model payments that recognize the value of primary

[41] See footnote #1.

care are long overdue. The members believe that focused efforts on education, training and recruitment are needed to ensure a future supply of primary care physicians. They also recognize that other primary care providers play a vital role in maintain access to primary care in Maine.

The Commission would like to thank all of the physicians, business people, nurse practitioners, physician assistants, association representatives, education leaders, government officials and members of the public who took time out of their busy schedules to come to the Commission hearings and share their thoughts and recommendations for primary care in Maine. The breadth, depth and quality of the information provided through testimony, reports, news articles and statistics greatly informed our work. In addition, the chairs of the Commission would like to express their appreciation to the members who took time to serve on the Commission. Your thoughtful attention to the work of this Commission will help the Legislature take important steps to address some of the challenges to primary care in Maine.

APPENDIX A

Authorizing Joint Order – Senate Paper 732

Authorizing Joint Order – Senate Paper 732

ORDERED, the House concurring, that the Commission to Study Primary Care Medical Practice is established as follows:

1. Commission to Study Primary Care Medical Practice is established. The Commission to Study Primary Care Medical Practice, referred to in this order as "the commission" is established.

2. Membership. The commission consists of the following 13 members, appointed as follows:

A. Three members of the Senate, appointed by the President of the Senate;
B. Five members of the House of Representatives, appointed by the Speaker of the House;
C. Two independent primary care physicians, one of whom is appointed by the President of the Senate and one of whom is appointed by the Speaker of the House;
D. One member of an organization representing hospitals in the State, appointed by the President of the Senate;
E. One member of an organization that has expertise in issues regarding the enhancement of quality of life that provides information, advocacy and service to members of the public, including patients and consumers, appointed by the President of the Senate;
F. One member of an organization representing physicians in the State, appointed by the Speaker of the House.

3. Commission chairs. The first-named Senator is the Senate chair of the commission and the first-named member of the House is the House chair of the commission.

4. Appointments; convening of commission. All appointments must be made no later than 30 days following passage of this order. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been made. When the appointment of all members has been completed, the chairs of the commission shall call and convene the first meeting of the commission.

5. Duties. The commission shall:

A. Identify the causes of the loss of independent ownership of primary care medical practices due to financial, regulatory or business-related reasons;

B. Seek input from independent primary care physicians on payor mix, reimbursement and Medicaid regulatory changes and the effects of such factors on the ability of independent primary care physicians to practice medicine in Maine;

C. 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

D. Review how comparable states manage physician-hospital relationships with respect to health care costs, the report is submitted to implement its recommendations on matters relating to the study.patient advocacy and access to health care.

6. Staff assistance. The Legislative Council shall provide necessary staffing services to the commission.

7. Report. No later than December 5, 2007, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health and Human Services. Pursuant to Joint Rule 353, the commission is not authorized to introduce legislation. Upon receipt of the report required by this section, the Joint Standing Committee on Health and Human Services may, pursuant to Joint Rule 353, introduce a bill during the session to which the report is submitted to implement its recommendations on matters relating to the study.

APPENDIX B
Membership List
Commission to Study Primary Care Medical Practice

COMMISION TO STUDY PRIMARY CARE MEDICAL PRACTICE
Commission Members

Senate Members

Sen. Lisa T. Marrache´, Chair
Sen. Joseph C. Brannigan
Sen. Kevin L. Raye

House Members

Rep. Gary A. Connor, Chair
Rep. Marilyn E. Canavan
Rep. Paulette G. Beaudoin
Rep. Sarah O. Lewin
Rep. Donna W. Finley

Public Members

Ann Woloson, Executive Director
Prescription Policy Choices (representing patients and consumers appointed by Senate)

David A. Peterson, President and CEO
The Aroostook Medical Center (representing Maine Hospital Association appointed by Senate)

John H. Irwin, DO
Medical Service, Internal Medicine (primary care physician appointed by Senate)

Jeffrey Aalberg, MD
Family Practice (primary care physician appointed by House)

Kevin Flanigan, MD
Sebasticook Valley Primary Care (member of physician's organization appointed by House)

APPENDIX C

Draft Legislation

An Act to Implement the Recommendations of the Commission to Study Primary Care Medical Practice

An Act To Implement the Recommendations of the Commission to Study Primary Care Medical Practice

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the patient-centered medical home concept improves health outcomes and has the potential to produce significant cost savings in Maine's health care system;

Whereas, Medicaid reimbursement rates through the State's MaineCare program are lower than many other comparable states and Medicaid reimbursement rates have a greater impact on physicians in Maine than they may have in other states due to the large percentage of the population covered by the State's MaineCare program.

Whereas, MaineCare reimbursement rates for the work of primary care physicians are inadequate and contribute to practices closing their doors to new MaineCare patients and in some cases, not accepting MaineCare patients at all.

Whereas, administrative requirements and restrictions hinder the ability of physicians to practice in Maine

Whereas, In the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Be it enacted by the People of Maine as follows:

Sec. 1. Patient-Centered Medical Home. The Governor's Office of Health Policy and Finance and the Department of Health and Human Services shall convene a group of stakeholders and shall report recommendations to the Joint Standing Committee on Health and Human Services by January 15, 2009, including any necessary legislation, for implementing a multi-payor patient-centered medical home pilot project. The pilot project will be based on the seven joint principals of the patient-centered medical home and include specific standards for quality, access and integration as well as appropriate reimbursement for physicians.

Sec 2A. MaineCare reimbursement for primary care services. Beginning July 1, 2008, appropriate funds for amounting to an additional $5 million in General Funds each year over the previous fiscal year, for incremental increases in MaineCare reimbursement for services billed under the evaluation and management (E & M) codes in the physician fee schedule until payments are equal to that of Medicare reimbursement for the same service. Increases under this provision for physicians may not be made by lowering reimbursement for other providers.

Sec 2B. Appropriations and allocations. The following appropriations and allocations are made.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Medical Care – Payments To Provider Medical Care Services 0147

Initiative: Appropriates funds for increases in MaineCare reimbursement for services bill under the evaluation and management (E & M) codes in the physician fee.

GENERAL FUND	**2008-09**	**2009-10**
All Other	$5,000,000	$10,000,000
General Fund Total	$5,000,000	$10,000,000

FEDERAL FUNDS	**2008-09**	**2009-10**
All Other	$8,627,691	$17,255,383
Federal Funds Total	$8,627,691	$17,255,383

Sec 3. Identify MaineCare benefit limitations. The Department of Human Services Office of MaineCare Services shall, when an enrolled member has limited benefits under a waiver program, provide an indication of the limitation on the front of the MaineCare card in order to alert health care providers of the limitation in order to remind providers that they can verify coverage prior to providing or ordering benefits that may be limited. Cards indicating limited benefits shall be phased in at the member's annual renewal or when reissued for another reason.

Sec 4. Streamline MaineCare procedures for cost effective prescribers. The Department of Health and Human Services, Office of Maine Care Services shall implement processes similar to those that are in place for specialists that will exempt primary care physicians and other practitioners who demonstrate a history of cost-effective prescribing that meets the needs of patients from certain pre-authorization requirements.

Sec 5. Provide flexibility in dispensing prescribed medications. By January 1, 2009, the Maine Board of Pharmacy and the Department of Health and Human Services shall report to the Joint Standing Committee on Health and Human Services on the feasibility of adopting flexible dispensing standards that would allow a pharmacist to dispense the prescribed medication in the prescribed dosage or in a dosage or dosages equivalent to the prescribed dosage. In assessing the feasibility of a flexible dispensing standard, the Board and Department shall consider the impact on patient medication compliance, costs to the health care system and MaineCare as well as other unintended consequences.

SUMMARY

This bill requires the Governor's Office of Health Policy and Finance and the Department of Health and Human Services to report recommendations for implementing a multi-payor patient-centered medical home pilot project to the Joint Standing Committee on Health and Human Services by January 15, 2009. It appropriates funds for incremental increases in MaineCare reimbursement for primary care services. It requires the Department of Human Services Office to identify members with limited benefits under a waiver program on the front of the MaineCare card and to implement processes that will exempt primary care practitioners who demonstrate a history of cost-effective prescribing from certain pre-authorization requirements. It requires the Maine Board of Pharmacy and the Department of Health and Human Services to report on the feasibility of adopting flexible dispensing standards to the Joint Standing Committee on Health and Human Services by January 1, 2009.

APPENDIX D
Task Force Meeting Materials
(Agenda and meeting summaries)

SEPTEMBER 14, 2007

FOCUS: *Gathering Information on Primary Care Practice in Maine*

10:00 a.m. **Introduction/Study Overview**

Opening Remarks
Commission Members' Introductions
Review Charge of Joint Order

10:30 a.m. **Presentation - Overview of Primary Care Practice in Maine**

Overview of Background Packet/Research
Department of Health and Human Services

12:00 p.m. **Lunch Break**

1:00 p.m. **Panel Discussion - Challenges for Primary Care Practices** – *Current state of primary care practices in Maine*

Maine Primary Care Association
Maine Hospital Association
Maine Academy of Family Physicians
Maine Medical Association
Maine Osteopathic Association
Independent Primary Care Physicians
Primary Care Practitioners – Non-Physicians

3:00 p.m. **Public Comment/Testimony**

3:30 p.m. **Commission Discussion**

What we learned
Additional information needed
Next steps

4:00 p.m. **Adjourn**

Commission to Study Primary Care Medical Practice
Meeting Summary – September 14, 2007

INTRODUCTION/STUDY OVERVIEW

The chairs of the Commission (Senator Lisa Marrache´ and Representative Gary Connor) opened the meeting shortly after 10:00 a.m. and the Commission members introduced themselves. The Commission reviewed the content of their notebooks, which include a list of Commission members, Commission's charge, the agenda and other background material. (See http://www.maine.gov/legis/opla for this information.)

OVERVIEW OF PRIMARY CARE PRACTICE IN MAINE

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

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

MaineCare reimbursement rates for all physician services are based on a Resource Based Relative Value Scale (RBRVS) fee for service for physician owned and hospital affiliated practices and as a percentage of cost for hospital operated (also known as Provider Based Entities) practices. Federally Qualified Health Centers (FQHCs) are paid at a higher fee table than that of private physicians, and Rural Health Centers (RHCs) are reimbursed at cost. Generally speaking, private and hospital affiliated practices are paid at significantly lower rates than hospital based practices, FQHCs or RHCs.

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

PANEL DISCUSSION - CHALLENGES FOR PRIMARY CARE MEDICAL PRACTICES

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

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

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

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

Maine Primary Care Association (MPCA) - Kevin Lewis (Executive Director of MPCA), Dawn Cook (Chief Executive Officer of Health Access Network), Noah Nesin, MD (Medical Director for Health Access Network) and Reverend Robert Carlson (President, Penobscot Community Health Care) presented information on the Federally Qualified Health Centers (FQHCs), and other primary care networks organized to provide access and a safety net for primary care.

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

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

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

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

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

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

Gordon Smith indicated that MMA represents employed and self-employed physicians. He indicated that while MMA would like for patients to be able to choose from both models, those choices are not always available in all counties in Maine. He pointed out that recent state budgets have included funding for increasing physician reimbursement through MaineCare. Regarding recruitment, he noted that Maine can't pay what other states pay doctors and that issues such as medical malpractice, overhead costs and quality of life issues influence doctor's decisions to be employed or self-employed. He provided an outline entitled "Legal Implications for Physicians of Hospital Employment," which starts on page 2 of the information that can be found at: http://www.maine.gov/legis/opla/MMApresent.pdf.

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

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

Before the Baldacci administration included funds for increases in MaineCare reimbursement in recent budgets, physicians in Maine went 21 years without an increased rate of reimbursement from MaineCare.

Dr. Hanson discussed the difficulty of dealing with increased scrutiny from the federal Drug Enforcement Administration (DEA) related to prescribing medication as well as the administrative burdens imposed by out of state managers of care for approval of insurance claims, patient confidentiality requirements, prior authorization procedures and requirements of continuing education as a solo practitioner. He also mentioned the increased "call" burden, which he currently shares with 5 other doctors in the area.

Panel Discussion Q & A

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

There was a discussion of FQHCs and FQHC look-a-likes. The MPCA indicated that there is only one "look-a-like" left and that look-a-likes get the same FQHC reimbursement rates but do not receive the 330 grant provided to FQHCs. The 330 grant provides approximately 16% of the total revenue provided to FQHCs. A Commission member requested information on the total number of providers that are retained by moving to a FQHC and the number of new doctors recruited to FQHCs. Members of the MPCA indicated that 10 new doctors (including dentists) were recruited through the Health Access Network and the Penobscot Community Health Care recruited 10 new dentist, 1 new pediatrician and 2 new primary care doctors that were not currently in practice in Maine. Members of the MAFP indicated that there 2 new FQHCs in northern Aroostook County with 1 new private practice and 3 internists. In parts of Maine, all the independent practices are gone as the system has moved to hospital employed physicians.

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

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

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

Commission Discussion/Planning

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

SECOND MEETING (OCTOBER 26)

COMMISSION FOCUS: Continue Gathering Information on Primary Care Practice in Maine

10:00 a.m. **Opening Remarks**

10:15 a.m. **Presentation - Department of Health and Human Services**

- Follow-up from 9/14/07 meeting
- Muskie School Study
- Information on Physician Incentive Program

10:30 a.m. **Panel Discussion – Business Climate, Malpractice, Insurance and Rate Negotiations**

- Martha Ridge, Anthem Blue Cross and Blue Shield
- Douglas J. Jorgensen, D.O., C.P.C., Jorgensen Consulting, L.L.C.
- Terrence J. Sheehan, M.D., President and Chief Executive Officer, Medical Mutual Insurance Company of Maine
- Mark Souders, Director of Payer & Employer Contracting, Kennebec Regional Health Alliance and MaineGeneral Health

11:30 a.m. **Panel Discussion – Challenges for Primary Care Physicians in Maine**

- Kevin S. Flanigan, M.D.
- John H. Irwin, D.O.
- Jeffrey M. Lovitz, M.D.
- Maine Dartmouth Family Practice Residency
    - Timothy Pieh, M.D.- Third Year, MDFP
    - Amy Madden, M.D.- Second Year- FMI
    - Kelley J. Harmon, D.O.- First Year - MDFP

12:30 p.m. **Working Lunch**

1:00 p.m. **Patient Centered Medical Home Pilot Project**

- Presentation by Jeffrey Jan Aalberg, M.D.

1:30 p.m. **Panel Discussion – Future of Primary Care and Regional Issues**

- Jacquelyn Cawley, D.O., Interim Dean/VP Health Services, University of New England College of Osteopathic Medicine
- Hugh F. Harwood, M.D.
- Jud Knox, President and Chief Executive Officer, York Hospital
- Jeffrey Landfair, M.D.
- Virginia Ann La Noce, F.N.P., NP Family Medicine
- Partners of Primary Care Practice - Full Circle Health Care
    - Cathy Bradley, F.N.P.
    - E. Victoria Grover, PA-C

3:00 p.m. **Public Comment Period**

3:30 p.m. **Commission Discussion/Planning**

4:00 p.m. **Adjourn**

Commission to Study Primary Care Medical Practice
Meeting Summary – October 26, 2007

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

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

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

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

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

negotiating contracts, restrictive covenants that hospitals put into employed physicians contracts, administrative burden and low reimbursement rates.

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

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

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

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

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

burden and quality of life issues, these young physicians said they would prefer a private practice where they could be directly involved in the practice decisions.

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

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

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

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

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

Jud Knox, President and Chief Executive Officer of York Hospital, talked about the need for the hospital to hire primary care physicians as the area lost solo practices. York Hospital competes with the New Hampshire market in which 90% of primary care practices are owned by hospitals. While he believes low reimbursement rates are related to the shift to employed primary care positions, he does not believe it is the driving factor. He indicated that life-style issues are a big factor in a physician's decision to become employed. It's a trade off between autonomy and stability. He suggested that in addressing issues of the

eroding primary care base, the Commission should look at medical homes, increased use of mid-level practitioners and physician income guarantees. While he contends that hospitals do not control employed-physician referral patterns, he acknowledged that as an administrator he wants to know if there are reasons why referrals are not being made to specialists at his hospital.

Jeffrey Landfair, M.D. came to Maine due to quality of life issues. He believes that factors influencing a primary care physician's decisions on location and type of practice include lifestyle, ability to pay-off or have educational debt relief, administrative burden issues and whether or not a doctor wants to deal with the business aspects of a practice. He talked about his recent experience in seeking employment and noted that many hospitals as well as group practices offer repayment of debt. He believes that it is important for physicians to have a variety of practice choices.

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

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

THIRD MEETING (NOVEMBER 9)

COMMISSION FOCUS: Continue Gathering Information & Start Developing Findings/Recommendations

10:00 a.m. **Opening Remarks**

10:15 a.m. **Information Overview**

10:30 a.m. **Understanding Changes to Physician Practice Arrangements In Maine and New Hampshire – Institute for Health Policy, Muskie School of Public Service**

- Catherine McGuire, Director, Health Data Resources/Senior Policy Analyst
- Jennifer Lenardson, Research Analyst

11:00 a.m. **Retail Clinics** – Michael Bergeron, M.D., ASAP Medical Clinics

11:30 a.m. **Medical Education and Career Choice**

- **Medical Education Programs – Finance Authority of Maine (FAME)**
  - Bill Norbert, Governmental Affairs and Communications Manager
  - Katryn Gabrielson, Assistant Counsel

- **Area Health Education Center Programs**
  - Mark Ruggiero, MHS

12:00 p.m. **Follow-up Information from Previous Meetings**

- **Medical Home Programs** (North Carolina, University of Kansas)
- **Maine Primary Care Association**
- **Maine Hospital Association**

12:30 **Lunch**

1:30 p.m. **Work Session**

3:30 p.m. **Commission Discussion/Planning**

4:00 p.m. **Adjourn**

Commission to Study Primary Care Medical Practice

Meeting Summary – November 9, 2007

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

Understanding Changes to Physician Practice Arrangements In Maine and New Hampshire - Jennifer Lenardson (Research Analyst) and Catherine McGuire (Director, Health Data Resources/Senior Policy Analyst) from the Institute for Health Policy at the Muskie School of Public Service provided a presentation on a recent study conducted by the school. The study examined trends in the organization and ownership of physician practices. Among the trends they identified the conversion of private or hospital-based practices to other arrangements including Federally Qualified Health Centers (FQHC) and Community Health Centers (CHC). In Maine, Medicaid enrollment doubled between the years 2000 and 2006. Yet Primary Care Physician (PCP) payments per claim declined from $73 to $47 during the same period. Economic factors including higher Medicaid, Medicare and private insurance reimbursement for FQHCs, influence practice conversion. There is not a lot of quantitative data on how long physicians stay FQHCs. Ms. Lenardson and Ms. McGuire noted that they did not find evidence of practices closing due to MaineCare reimbursement issues. However, they did hear about doctors could not accept additional MaineCare patients due to low reimbursement and the complexity of the patients needs. In particular, doctors in Maine's "rim" counties indicated that they cannot practice independently due to high Medicaid population and low reimbursement. In addition to reimbursement rates, other factors influencing practice arrangements include lifestyle, financial risk, costs for infrastructure/administration/overhead, call time and repayment of student loans. There was also discussion of physician incentives and payment for performance. A draft of the executive summary from the Muskie School study can be found on the Commission's website at: http://www.maine.gov/legis/opla/primarycare.htm.

Retail Clinics – Michael Bergeron, M.D. of ASAP Medical Clinic provided a presentation on the walk-in clinic that he founded with his partner Dr. Peter Beeckel. They recognized the need to provide basic medical care that was affordable and accessible to the uninsured and under insured. Their model is different from other retail clinics in that it is free-standing with a private waiting area and is not affiliated with a pharmacy. While some medication is dispensed on site, they do not dispense or even prescribe narcotics. Dr. Bergeron believes ASAP enhances the national model and builds on the medical home concept. He emphasized that the clinic does not replace primary care physicians and they work to connect people without primary care physicians to doctors who are accepting new patients. Similar to other retail clinics, ASAP is staffed by Physician Assistants and Nurse Practitioners with support from MDs. The clinic operates on a "cash-only" basis. The clinic's Electronic Medical Office System (EMOS) includes electronic medical records as well as other systems for managing patient visits. Patients use a self-register kiosk that is accessed by a thumb print scan for protection of records and ease of follow-up. The EMOS includes safeguard checks for medication interaction. Records are faxed to a patient's primary care physician following each visit. Currently they are seeing approximately 10-20 patients per day and have the capacity to see 40 patients in 12 hours with full staff. The facility has the capacity for 80 patients. A copy of Dr. Bergeron's presentation, information on ASAP Medical Clinic and general information on retail medical clinics can be found on the Commission's website.

Medical Education and Career Choice - Bill Norbert (Governmental Affairs and Communications Manager) and Katryn Gabrielson (Assistant Counsel)from the Finance Authority of Maine (FAME) talked about medical education programs including loan and access programs. They indicated that some students doing Maine primary care residency in underserved areas can get approximately $100,000 paid

off for them in 2 years. They noted that 20 access seats have been available since 1993 and they just now are getting data on how many of those students end up practicing in Maine. More information on the Medical Education Program and Health Professional Loan Program is available on the Commission's website.

Mark Ruggiero, MHS of the Area Health Education Center (AHEC) provided information on the Maine AHEC Network. The program was created in 1985 by the University of New England's (UNE) College of Osteopathic Medicine. The goal of the program is to increase the supply of primary care physicians, particularly in underserved areas, through training, distant learning and outreach to youth. With more funding the AHEC could provide more out reach and residencies for UNE health professionals. More information can be found on the Commission's website.

Follow-up Information from Previous Meetings - The Commission received additional information on Medical Home Programs (North Carolina, University of Kansas) as well as follow-up from the Maine Hospital Association and Maine Primary Care Association. Materials can be found on the Commission's website.

Work Session/Commission Discussion/Planning - During their work session the Commission discussed the need to establish some high level goals and set the stage for long term system changes, including a shift to a preventative care model. The Commission developed tentative recommendations in the areas of education and training, health care system changes, business climate and payment for care. The Commission plans to discuss the areas of MaineCare, research and technology at the final meeting on December 7th as well as finalize recommendations including any legislation.

FOURTH MEETING (DECEMBER 7)

COMMISSION FOCUS: Finalize Findings/Recommendations

10:00 a.m. **Opening Remarks**

10:05 a.m. **Information Overview/Follow-up Information**

10:10 a.m. **Work Session**

12:00 a.m. **Lunch**

1:00 p.m. **Work Session**

4:00 p.m. **Adjourn**

Commission to Study Primary Care Medical Practice
Meeting Summary – December 7, 2007

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

Work Session - The Commission spent the entire meeting in a work session at which they finalized findings and recommendations for the report.