

December 2, 2005

VIA EMAIL & REGULAR MAIL

Ellen J. Schneiter, Deputy Director
Governor's Office of Health Policy & Finance
State House Station 15
Augusta, Maine 04333-0015

**RE: COMMENTS ON DRAFT OF MAINE'S STATE HEALTH PLAN -
A ROAD MAP TO BETTER HEALTH, NOVEMBER 2005**

Dear Ellen:

I am writing to follow up my oral presentation at the public hearing in Portland on November 22, 2005 about the draft State Health Plan. The Maine Medical Association (MMA) is a professional organization representing more than 2700 physicians, residents, and medical students in Maine.

The purpose of the MMA is to unite and support the physicians of Maine in promoting the health of Maine's citizens, protecting and promoting the quality of medicine, and supporting the physicians' function as advocates for their patients. Much of this purpose overlaps with the priorities of the draft Plan, most notably in the areas of public health and promoting quality care. We commend the authors of the draft Plan and support many of the priorities stated in the draft. We are particularly pleased with the emphasis placed on prevention, public health, improving quality, emphasizing personal responsibility, and encouraging adoption of the chronic illness model. The recommendations to better integrate mental health and physical illness are superb and will be particularly appreciated by the Maine Association of Psychiatric Physicians (MAPP).

The MMA's concern is not so much what is in the draft Plan, as what is omitted. Foremost among the omissions is the lack of attention to MaineCare and the failure to note the issue of professional liability and the need for reform of the state's medical malpractice environment.

With respect to MaineCare, the program's problems are barely mentioned in the draft, despite it being the safety net for more than 250,000 Mainers, more than one in every five citizens. While the section on Access to Health Care (p. 44) discusses issues related to the federal waiver for childless adults earning less than 125% of the federal poverty level, nowhere in the draft is there a plan to improve the implementation of MaineCare and to re-establish trust with the provider community. The entire future of MaineCare has been rocked by the failure of the claims management system (MECMS) to function at the expected level and by chronic low reimbursement. In attempting to fix the MECMS problem, DHHS officials have acknowledged that the Office of MaineCare Services (OMS) needs a complete transformation into an office that serves both enrollees and providers in an efficient, service-oriented manner. A cultural change is needed throughout the Office and given the magnitude of the program (well in excess of \$2 billion annually), a section of the draft should focus on MaineCare, its shortcomings and solutions to the problems. The failure to do so is a major oversight.

Medical liability issues continue to be a major problem for physicians, hospitals, and other providers such as podiatrists and nursing care facilities. A significant increase in premiums for many Maine physicians took effect on October 1, 2005, with emergency physicians receiving an increase of 79%. The average increase was about 25%. Maine physicians cannot afford to pay increasing premiums when reimbursements of all types are flat or decreasing. In addition, the psychological and emotional toll of defending one's medical judgment in proceedings that drag on for 5 to 7 years places an enormous burden on our health care providers. And, as unfair as the system is to providers, it does not work well for patients either. Patients who are injured by negligence wait far too long to receive compensation and then receive less than 40% of premium dollars with more than 50% of funds going to attorneys on both sides. No reasonable person can justify such an inefficient system. Imagine the reaction if Anthem's loss ratio for health insurance was under 40%!

In addition to the inefficiency of the medical liability system, the cost of defensive medicine also contributes significantly to high health care costs in Maine. While it is difficult to quantify, there is not a physician in Maine who does not acknowledge that, to some degree, the liability system results in more exams and medical treatments and interventions than medically necessary.

The following are specific comments on sections of the draft Plan:

- Reference is made on page 21 to The Public Health Work Group comprised of 26 members. The MMA is not mentioned among the participants although we are a part of the Work Group and have been represented in its important work by Lisa Letourneau, M.D., chair of our Public Health Committee. We respectfully request that the MMA be included among the participants noted in the draft.

- On page 60 of the draft, reference is made to giving priority to CON projects that devote 1% of the total value or cost of the project to new investment in a related public health effort that is aimed at reducing the demand for the service proposed under the application, at the population level. While this recommendation sounds good on the surface, the MMA believes that CON decisions should be based strictly upon the need for the project and the traditional criteria such as ability to finance it. To add other criteria puts physicians at a distinct disadvantage vis-a-vis facilities and perverts the original purpose of the state certificate of need law.
- The state's existing CON law has been labeled the strictest law in the country by national observers. That being the case, there is real danger that Mainers will be put at a clinical disadvantage relative to the dissemination of cutting edge technology if further criteria and process are added to the already complex law.
- If CON is to be a useful tool for health planning in the state, it is imperative that the CON division of DHHS be adequately staffed. That has not been the case historically and even now, the Director is serving only in an "acting" capacity while a new Director is hired. While we are aware of the intended move of the office into the Commissioner's office, this move alone will do nothing to solve the chronic problem of under-resourcing the office.

As the Association does not support the CON law, the comments offered above should not be seen as inconsistent with our historic position. If there is to be a CON law, our recommendations stand as offered above. Many states have survived quite nicely without any CON law and there is no evidence to suggest that Maine's law is needed in a state that is chronically short of both physicians and facilities. And, as noted in our oral testimony offered in Portland, artificial constraints on capital will simply serve to exacerbate a two-tier health care system, with persons of means going to facilities out of state. Not only does such a result end up with people having to travel for their care, but it also denies the Maine economy the funds expended.

There are areas of Maine that would benefit from competition between hospitals and physicians, such as Portland and Bangor. The rural areas have historically not seen such competition and, in our view, you would not see it because of the mutual dependency between the two. But, in the more urban areas, patients and insurers would benefit from having more facilities to go to or to contract with. Maine's strict CON law increases costs and denies choice in these areas. The law is anti-competitive, a position accepted by the Federal Trade Commission. Those states that have repealed their laws have not seen health care costs rise faster than Maine's, so what is the law achieving?

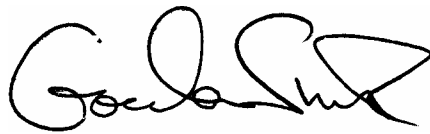
Finally, the questioning following the MMA testimony in Portland developed a recommendation that we had not intended to include in our original testimony. Because of the trend toward physician employment, by hospitals, rural

health centers, and other entities, MMA recommends that the State review the phenomenon of physician employment, determining whether there are implications to the state, physicians, and patients, financially or otherwise. Most of the phenomenon involves primary care, such that some observers have declared primary care in the private practice model to be near death in the state. If this is indeed the case, it is time for someone to take a look at it to see if there are any negative implications to its demise. While there is a similar trend nationally, it appears limited to small, rural states.

Let us reiterate what we noted in our oral testimony, that MMA's mission includes representing the interests of our members whether those physicians are in private practice or employment. We do not prefer one mode of practice over another. But, we do prefer for physicians to have a choice, and likewise for patients to have choices. Because of the trend, those choices appear to be eroding. It would seem appropriate for any State Health Plan to acknowledge the trend and recommend someone or some entity taking a look at it.

In conclusion, Maine is a small state and we are all in this together, whether providers, policy makers, patients, or insurers. We all must look for the common ground and for opportunities to collaborate toward the goal of improving the health care system in our state. It is in this spirit that these comments are offered on the draft Plan. Again, we commend the Governor's Office of Health Policy & Finance on a good first draft and we look forward to working with the GOHPF staff and the Advisory Council on Health System Development as we go down this road together. "A Road Map to Better Health" is an appropriate name for the Plan and we look forward to the MMA and the physicians of Maine being partners in the journey down this most interesting road.

Sincerely,

A handwritten signature in black ink, appearing to read "Gordon H. Smith". The signature is fluid and cursive, with a large initial "G" and a stylized "S".

Gordon H. Smith

cc: Members, Joint Standing Committee on Health & Human Services