TESTIMONY OF KEVIN S. FLANIGAN, M.D.

REGARDING

CHALLENGES FOR PRIMARY CARE PHYSICIANS IN MAINE

Commission to Study Primary Care Medical Practice
Room 209, Cross State Office Building
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Good morning Senator Marrache, Representative Connor, & Members of the Commission to Study Primary Care Medical Practice. As you know, I am Kevin Flanigan and I am a Board Certified Pediatrician specializing in the care of infants, toddlers, children, and adolescents. I also am a Board Certified Internist specializing in the care of adult patients. I would like to thank you for the opportunity to speak before you today.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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