Testimony of Dr. David McDermott to the Advisory Council on Health Systems Development regarding payment reform, 30 October 2009.

Good afternoon. Thank you for the opportunity to speak with you this afternoon regarding payment reform models in health care. I am David McDermott, the director of Emergency Services at Mayo Regional Hospital in Dover-Foxcroft. I trained in Maine in Family Practice at Maine Medical Center and Mercy Hospital in the late 1980's, then spent four years on active duty with the US Air Force and returned to Maine in 1993 to practice family medicine in Dover-Foxcroft. I transitioned to full-time work in Emergency Medicine a year ago, having done both primary care and emergency medicine for 15 years in the Maine Highlands. I am here today as the President of the Maine Medical Association, and speak to you on behalf of our 3300 members.

I have always been an employed physician, a model that has worked well for me personally and professionally. In Piscataquis County virtually all of our physicians have chosen a model of employment, including some who had been in private practices for over 25 years. Of the 28 members of the active staff at Mayo Regional Hospital fully 24 are employees of the hospital, and two of the others practice part-time as contractors to the hospital. I have watched this trend of hospital employment develop in Maine. When I moved to Dover-Foxcroft in 1993 the hospital had to create a special corporate entity to be able to employ me, their first physician employee. I now know that hospitals employ 45 percent of all physicians in Maine, and fully 78% of the primary care physician workforce. In rural Piscataquis County the employed model allows us to see all patients who need care regardless of their payor status. We don't have to worry about limiting the number of patients in our

practices who have MaineCare, Medicare, or who have no insurance whatsoever. We can do what we went into medicine to do: see and care for our patients.

The Maine Medical Association has been very active in the dialogue about health system reform and different payment models. We brought Dr. Eliot Fisher to Maine in September of 2008 to be the keynote speaker at a conference convened by us and cosponsored by the Maine Hospital Association and the Maine Osteopathic Association. Dr. Fisher introduced the discussions of Accountable Care Organizations to this Maine audience, and talked about the way he envisions them working to change the landscape of health payments. We have been busy with looking at variation analysis for over thirty years, beginning with the formation of the Maine Medical Assessment Foundation (whose work was recently highlighted in a series of broadcasts on National Public Radio) in the late 1970s. We continue to educate our members on these issues through the work of our Committee on Physician Quality and our Payor Liaison Committee. Our Executive Vice President, Gordon Smith, and I attended the recent forum you hosted at USM three weeks ago in Portland. We have been using our communications tools to bring information about payment reform models to our member physicians and are now working to understand the concerns that they have about them and the questions we can answer for them about this, bringing their voice to the table in these critical discussions. We are starting to use social networking tools like Twitter and Linked In to share information about these models and promote discussion amongst our members about them. The Maine Medical Association is engaged in these discussions and working to keep the physician community in Maine current in their awareness of the changes that are happening.

In many respects Maine is well positioned to pilot a trial of alternative systems for payment. There is a high level of physician employment, with three to four large health care systems dominating care in our largest markets and supporting care in many of the rural communities around them. However, there are challenges with our commercial carriers all headquartered out of state, and getting them to attend to unique programs in Maine can be hard.

There will always be a need for some fee for service care in Maine. Not all of the smaller hospitals are currently financially aligned with one of the large systems (my own hospital, Mayo Regional Hospital, being an example of that). Several of our members remain strongly committed to a private practice model, and we as an association remain committed to helping to support them in this endeavor. We have to be very careful in crafting plans that might not keep viable options for them open. Although I believe that employment is a model that works for many physicians and I can attest that it has been the right model for me, I recognize that we have to maintain the options for private physicians who find that private practice is right for them. We need appropriate models for specialists as well as primary care physicians in this debate. As we meet here today it is important to note that there are over 120 physicians and practice managers meeting today at Maple Hill Farm in their second learning collaborative preparing to build their practices into medical homes through the Maine Medical Home Pilot. As Dr. Fisher said when he was here in Maine a year ago: the medical home is a great model, but we really have to look at how it fits into the medical neighborhood. At the Maine Medical

Association we represent both primary care and specialty physicians, and want to advocate for change that helps both help their patients.

Critical to some of these discussions will be changes in the anti-trust statutes. As the experience of the Maine Health Alliance attests: when physicians and hospitals from across a region try to come together for shared savings and contracting this can raise concerns from regulators, and that can threaten the viability of an innovative model for care integration. In addition, we need to stay aware of the role of medical liability statutes in our consideration of changes, as this remains in the minds of many of our practicing physicians and does make a difference in care decisions.

No single payment system is likely to solve the problems associated with high and inappropriate utilization of care, or with variations in care delivery. As long as we have variations in care capacity we will still struggle with variations in care delivery. We need to continue to work on these issues of variation analysis independent of payment reform solutions.

Thank you for the opportunity to speak today on behalf of the physician members of the Maine Medical Association. I'd be happy to answer any questions that you might have.