Changing Physician Practice Arrangements in Maine: Trends and Implications

Background

Maine’s Medicaid program -- MaineCare -- has observed a trend in the conversion of physicians from private practice to other practice arrangements including Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), hospital-owned practices, and hospital outpatient departments. Physician payment is significantly higher for care provided in these settings than under the fee schedule for care provided within an independent private practice. Faced with increased costs, MaineCare sought to understand more about these changes, including their magnitude, the forces driving them, and their implications. This study examines these trends nationally and in Maine.

Key Findings

Physician and Practice Characteristics

A declining number of Maine physicians practice in independent solo and group arrangements. Increasing numbers of Maine physicians practice in hospital affiliated practices, FQHCs, and RHCs. Likewise, national analyses reveal growing numbers of physicians practicing in medium and large medical groups and health care facilities. Nationally and in Maine, Medicaid, uninsured, and charity care patients are concentrated among facility-based providers. Our analysis of the Maine physician resource inventory reveals that fewer physicians continue to accept MaineCare patients in recent years.

In 2002, the Bush Administration launched the Federal Health Center Growth Initiative to add new FQHCs or expand medical capacity at existing FQHCs. The Initiative appears to be impacting the number of FQHCs in Maine, with 18 health centers as of 2007 compared to 12 in 2002.

MaineCare Cost Increases

MaineCare data confirm that physician-based primary and specialty care is moving from physician offices to hospital outpatient departments, RHCs, and FQHCs. Costs for services delivered in FQHCs increased nearly 10 fold between 2000 and 2006 (Figure 1), while costs for all hospital outpatient and RHC care increased five fold (costs include physician and all outpatient services). Overall costs were driven by substantial increases in the number of patients served and costs per patient. By contrast, physician offices experienced the smallest cost increases of any setting, doubling during this time. Physician costs are held down by the Medicaid fee schedule which has changed once since 2000; hospitals, RHCs, and FQHCs receive annual increases through cost-based reimbursement.
Economic Factors Driving These Trends

Several economic factors are influencing these trends in Maine. Especially in rural Maine, private practice physicians serving a large MaineCare caseload report that they cannot afford to absorb the program's low reimbursement. In addition, physicians are concerned with low reimbursement from Medicare and commercial payers. Higher reimbursement has triggered conversions from solo and independent practice to other types of arrangements. A few interviewees observed that enhanced reimbursement under a facility allowed struggling practices to survive. Substantial medical school debt was also identified as a factor. The average new physician has nearly $140,000 in debt and may be concerned about the financial risks inherent in running a small practice.

Physician Preferences

Hospital and other facility-based practices report that physician recruitment influences decisions to buy or sell practices. Facility-based practices can offer an attractive recruitment package of salary, benefits, and established office infrastructure. The complexities of practice administration and the need to implement costly health information technology (HIT) systems have also affected growth in facility-based practice. Sustaining a practice upon physician retirement was cited frequently as a reason to join an FQHC. Group practices can offer a less isolating approach to rural health care, while interdisciplinary teams available at clinics can serve a broad array of patient needs, giving physicians less on-call time and greater collegial support.

Benefits to these Changes

Respondents to key informant interviews identified several benefits have resulted from the trend toward large, facility-based settings, including financial stability, enhanced services, and preserved access to care. Large health facilities have enough physicians generating income that they achieve economies of scale to support their billing and administration staff and capital expenses. Large settings also provide financial security that can lead to other important goals, such as active participation in quality assurance initiatives and implementing HIT systems.

For providers such as FQHCs, the trend toward larger settings has contributed to expanded service availability, such as dental, mental health, pharmacy programs, chronic disease management, and case management.

As Maine independent practitioners limit the number of MaineCare patients they see, Medicaid beneficiaries are becoming more concentrated among fewer, large provider groups. The trend toward larger settings may preserve access for beneficiaries.

Policy Implications

- There are few policy options available to influence physician preferences in the practice of medicine. Increased reimbursement is unlikely to change these trends, though it would support the physicians that remain in office settings and introduce payment equity for services that differ only by location or arrangement.

- Maine should examine key measures of access, quality, and cost to determine whether these new arrangements offer enhanced value.

- States currently pay higher reimbursement rates for FQHCs and RHCs though they have limited authority over those designations. Maine should continue discussions with federal and state agencies charged with administering these programs to have input into their location, administration, and reimbursement. State policymakers should be more involved in identifying priorities in the creation of new or expanded community health center sites.

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