Date: October 25, 2019

Dear Health Policy Commission,

Please allow me to provide written testimony as I was unable to attend the Cost Trends Hearing on October 22 and 23.

I am speaking as a private independent family physician who was born and raised in Massachusetts, and who has served north central Massachusetts patients, hospitals, and community for over 20 years.

While I am acutely aware of the trends in healthcare affecting patients in the Commonwealth, and the difficult job our legislature has in controlling costs and ensuring quality care, I want to be sure that the Commission understands with equal awareness the challenges facing physicians “in the trenches” in providing for our patients. I am perplexed as to why there was so little representation of this perspective in such an important hearing and would respectfully request that in the future the commission consider including presentations by the Massachusetts Academy of Family Physicians, Massachusetts Medical Society, and other organizations representing clinical care.

There are 3 topics I would like to highlight:

1. All of the challenges presented (pharmacy costs, administrative burden, patient and physician satisfaction, access to care, etc) would be resolved by investment in Direct Primary Care.

2. Scope of practice changes allowing Nurse Practitioners to practice independently would appear to save money but actually incur increased costs in other ways to the healthcare system.

3. The administrative burden placed on practitioners is not just driving the “primary care shortage” due to dissatisfaction, it is harming patient care.

First let me explain that Direct Primary Care (DPC) is the only innovative medical model of care which saves the system money and delivers extremely high-quality care at a low cost. It is NOT concierge care and has important differences, in that physicians do not bill insurance, and try to save patients money in several ways (no copays, fewer ER and urgent care visits, and in some states wholesale labs and meds). Patients pay a monthly membership fee for easy access to their physician via text, video chat, and same day visits. DPC offers extended visits, home visits, and hospital care oversight. Continuity and accountability are paramount and provide the highest degree of safety and quality. “The buck stops here. We will get it done.” Anyone who has accessed the healthcare system recently can tell you harrowing stories of how care is fragmented, unaccountable, noncaring, and downright dangerous. A “team” of care is limited by its weakest link, and if you cannot hire, train, retain, and integrate the communication of such a team, it produces ineffective and inadequate care. The cost of trying to achieve all that is built into our healthcare costs, while all the while care is getting worse and more expensive.

I have included a reference page at the end, where the American Academy of Family Physicians (AAFP) endorses the DPC model of care and points out its virtues. It pairs best with high-deductible health insurance plans by filling in the primary care piece at an affordable cost, where the goal is to NOT use the health insurance whenever possible, and to SAVE money on cheaper labs and wholesale prescription medication. In other states where DPC physicians dispense, literally millions of dollars have been saved by cutting out the middlemen.

Second, the scope of practice changes allowing Nurse Practitioners (NPs) to practice independently would appear to save money in salaries only by saving the hospitals and other healthcare systems on their own payroll. However, NPs incur steep costs in other ways to the healthcare system because they order more tests and refer to specialists more often (again, raising profits to the hospitals/systems) at the expense of higher costs to insurance plans and taxpayers. The training and knowledge base of NPs is not equivalent to that of a physician (MD) and this is blatantly obvious to those of us who supervise them. There has been no study of the quality of independent NPs, as all the research is done with NPs who have physician oversight. They can handle most “cookbook” problems, but when things are complex, they cannot problem-solve effectively. The online training available for the NP degree is inadequate and there is a movement to educate new nursing grads who have not had any clinical experience. Patients are often confused about the level of practitioner treating them and are not given any choice in that matter.

Third, when we discuss the administrative burdens of healthcare, please know that most of the organizations presenting in your hearing are profiting from this broken system and would like to maintain the status quo as much as possible. The administrative burdens to physicians in the process of billing, collecting quality data, and being forced to fragment care in order to increase profits, is overwhelming. Physicians are quitting, retiring early, changing to administrative jobs, or in the worst cases, committing suicide. Practicing medicine is stressful enough managing psychosocial problems with patients, without having added burdens in the form of electronic records and prior authorization barriers to care.

It has been argued that we do not have a primary care shortage, because for every one hour spent face to face with patients, physicians spend 2 hours on electronic health records and paperwork (reference: https://www.jwatch.org/fw111995/2016/09/06/half-physician-time-spent-ehrs-and-paperwork). If that burden was taken away we would be able to double our workforce!

The data being collected rarely benefits patients and seems to serve the health insurance plans in planning their premiums. It does actively take away from time spent listening to, caring for, and educating patients. It has increased mistakes and lapses in care. Physicians are forced to accept this way of practicing without any evidence of improved quality of care, and hence they suffer a “moral injury” whereby they are unable to provide the time and type of care that inspired them to become healers in the first place.

I would be happy to provide more information and participate with the commission in any way that would be useful to improve the delivery of care in our state, in the most thorough, high-quality, cost-effective strategy I know.

Thank you for allowing me to contribute.

Sincerely,

Michele C Parker, MD

DIRECT PRIMARY CARE from https://www.aafp.org/about/policies/all/direct-primary.html

The Direct Primary Care (DPC) model is a practice and payment model where patients/consumers pay their physician or practice directly in the form of periodic payments for a defined set of primary care services. DPC practices typically charge patients a flat monthly or annual fee, under terms of a contract, in exchange for access to a broad range of primary care and medical administrative services. The DPC practice framework includes any practice model structured around direct contracting with patients/consumers for monthly or annual fees which serve to replace the traditional system of third party insurance coverage for primary care services. Typically, these periodic payments provide patients enhanced services over traditional fee-for-service medicine. Such services may include real time access via advanced communication technology to their personal physician, extended visits, in some cases home-based medical visits, and highly personalized, coordinated, and comprehensive care administration. The AAFP supports the physician and patient choice to, respectively, provide and receive healthcare in any ethical healthcare delivery system model, including the DPC practice-setting.

The DPC contract between a patient and his/her physician provides for regular, recurring monthly revenue to practices which typically replaces traditional fee-for-service billing to third party insurance plan providers. For family physicians, this revenue model can stabilize practice finances, allowing the physician and office staff to focus on the needs of the patient and improving their health outcomes rather than coding and billing. Patients, in turn, benefit from having a DPC practice because the contract fee covers the cost of many primary care services furnished in the DPC practice. This effectively removes any additional financial barriers the patient may encounter in accessing routine care primary care, including preventative, wellness, and chronic care services. Most patients, depending on affordability, still carry insurance for coverage of healthcare services that cannot be provided in the primary care practice setting, such as specialty care and hospitalizations. The model is especially well suited for those patients with high deductible plans where they might normally be paying out of pocket for any primary care services that are not considered preventive.

Ideally, the DPC model is structured to emphasize and prioritize the intrinsic power of the relationship between a patient and his/her family physician to improve health outcomes and lower overall health care costs. The DPC contract fee structure can enable physicians to spend more time with their patients, both in face-to-face visits, and through telephonic or electronic communications mediums should they choose, since they are not bound by insurance reimbursement restrictions. For these reasons, the DPC model is consistent with the American Academy of Family Physicians' (AAFP) advocacy of the advanced primary care functions and a blended payment method of paying family medicine practices. The AAFP provides resources for members tranforming to this model, including CME credit, and will continue to promote and support Direct Primary Care as an innovative advanced practice model. (2013 COD) (2018 COD)