LATE-FILED
RESOLUTION &
REPORTS FOR ACTION
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DElegates

Item #: 16
Code: Late Resolution A-18 B-207
Title: Physician Dining Rooms
Sponsors: Cecilia Mikalac, MD
Marian Craighill, MD, MPH
Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

Whereas, MMS strategic priorities include: 1. ensuring that the Society is a productive and credible voice for physicians; 2. advocating for practice viability and physician professionalism, … a sustainable physician workforce, and an optimal practice environment, which, among other things, combat physician burnout; and 3. advocating for health care settings that foster a culture of professionalism to ensure patient-centered, physician-led care teams promote a sense of community, professional satisfaction, and meaning and

Whereas, Physicians across the commonwealth feel the increasing pressures of physician burnout (see Vital Signs¹); and rarely see one another to discuss problems

Whereas allowing physicians to dine together without concerns that others will be privy to casual conversation is a positive action that can be taken to address physician burnout; therefore, be it

1. RESOLVED, That the MMS support the return of physician dining rooms in hospitals across the Commonwealth; and, be it further (HP)

2. RESOLVED, That the MMS work with the Massachusetts Hospital Association and other interested parties to bring back, promote, and maintain physician-only dining spaces in hospitals. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)
FTE: Existing Staff
(Staff Effort to Complete Project)

Item #: 17
Code: Late COSPP Report A-18 B-10
Title: Protecting the Patient-Physician Relationship: MassHealth ACO
Sponsor: Committee on Sustainability of Private Practice
Hugh Taylor, MD, Chair
Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

Background
As of March 1, 2018, MassHealth introduced an accountable care organization (ACO) model of delivering care. Most patients who had MassHealth prior to March 1 were transitioned to an ACO plan and assigned a primary care physician (PCP). Patients are now expected to obtain the majority of their care from providers within the network to which the PCP belongs, including specialists.

Prior to the introduction of this ACO care model, concerns were expressed by MMS leadership, including President Dr. Henry Dorkin, to MassHealth administration about the risks of disrupting well-established patient-physician relationships if patients require specialty care by a physician outside of the network of the PCP. MMS leadership requested assurances that patient-physician relationships would not be frayed but these assurances were not provided.

Current MMS Policy
MMS has existing policy regarding ACOs including principles that are based upon the American Medical Association ACO principles from 2010. The policy’s guiding principle includes the idea that ACOs should increase access to care and calls on the physicians to maintain their primary ethical and professional obligation to the well-being and safety of the patient. It also calls for flexibility in patient referrals. Further policy also states, “The Massachusetts Medical Society will advocate that the Commonwealth of Massachusetts respect the primacy of the relationship between patients and their physicians and incorporate this as it develops health care delivery plans.”

Relevance to MMS Strategic Priorities
The CSSP has identified several MSS strategic priorities related to this issue. The report demonstrates that the MMS is monitoring the rapidly changing health care landscape and ensuring that the voices of physicians and their patients are heard regarding barriers to accessing quality care. The recommendations allow the MMS to provide a productive and credible voice for physicians and patients at the state level.

Discussion
MassHealth has provided patients with several options to help maintain continuity of care with their current physicians. The MassHealth Program has expanded the 30 day continuity of care limitation to 90 days: May 31, 2018, during which existing prior authorizations for services will be honored. This may be extended for certain conditions, such as pregnancy. MassHealth has also created exceptions to the service area limits
for ACOs—thus enabling patients who meet those exceptions to maintain their physician-patient relationship. Patients also have a 90-day plan-selection period to opt to change their plan so as to maintain current patient-physician relationships.

Regardless of the plans in place to smooth this transition, multiple anecdotal reports from physicians throughout Massachusetts have begun to surface, noting patients who are forced to choose either a new PCP or a new specialist. These reports have been noted at the MMS Board of Trustees meeting in April and in the practices of several members of this committee.

While it is expected that all the MassHealth ACOs will have sufficient breadth of specialist services for more routine medical conditions, making the transfer to a new specialist within the PCP’s network possible, there are many medical issues that may require specific subspecialty care, which is available only outside of the PCP’s network.

In this case the patient must make the difficult choice of choosing a less-qualified specialist to manage his or her condition, so as to maintain all the other patient-physician relationships he or she currently has, or choosing to continue to receive care from the subspecialist outside of his or her network, which now necessitates having to choose a new primary care physician and multiple other specialists to match the network to which the subspecialist belongs.

Although the initial 90-day continuity-of-care period will be over when the House of Delegates discusses this issue, there will continue to be instances in the future when established relationships will be disrupted, such as when a new diagnosis requires care by a specific specialist or subspecialist during the middle of a plan year.

There is a multitude of data out there about the benefits of a strong patient-physician relationship. In fact, in 2013, Paul Mendis, MD, Chief Medical Officer for Neighborhood Health Plan touted the benefits of having a PCP with one advantage being that “By developing a relationship with a PCP, you are ensuring that other physicians and medical staff within the practice also know your medical history. This “health care team” can more easily detect patterns in your health and recommend lifestyle changes to prevent future complications requiring expensive specialty care. For example, simple testing during a visit with your PCP can reveal health problems, such as high blood pressure, that may go unnoticed leading to more serious issues later in life.”.¹ Breaking up a long-running, well-established relationship with a PCP can undermines the ability to detect patterns in patients’ health. It often takes several visits to be able to learn a patient’s medical history well enough to gain significant insight into previously unseen connections. Asking patients to establish new PCP relationships could be expected to increase cost of overall care as new PCPs may order duplicate testing and imaging, because records from prior physicians may not be available for review, given the lack of electronic health records interoperability.

¹ www.mass.gov. The Importance of Having a Primary Care Physician. Paul Mendis, MD, chief medical officer, Neighborhood Health Plan. Fall 2013 edition of the newsletter. (Hard copy on file with sponsor and reference committee.)
Higher longitudinal continuity of care has been associated with reduced likelihood of death, shown to improve patient satisfaction with visits, and lower risk of hospitalization of seniors with multiple medical issues. Conversely, lower continuity of care has been associated with higher rates of adverse outcomes for persons with multiple chronic medical conditions. Several of these studies specifically identified that continuity is particularly important for more vulnerable patients, such as in a Medicaid population. Some groups of patients benefited from continuity with both primary care and specialty physicians. Further, mounting evidence suggests that continuity of care for patients with chronic conditions prevents hospitalizations, reduces health care costs, and may prolong life in some populations. A study on the Medicaid population in California demonstrated reduced emergency department visits and hospitalizations with primary care continuity.

When a patient-physician relationship is disrupted, it can take time to build the new relationship. In 2013, the MMS released its ninth annual Patient Access to Care Study, which showed long wait times to see a new PCP and that half or more of primary care practices remain closed to new patients. Wait times averaged 39 and 50 days to see a family or internal medicine physician, respectively, and 25 days for pediatric practices. New patients waited between 22 and 37 days for an appointment with a specialist. Specialty practices saw an average of 22- to 37-day wait for a new patient appointment. A Merritt Hawkins survey in 2017 found that in Boston, it took an average of 52.4 days to see a new PCP and 24.1 days to see a physician for a new patient appointment, which is an increase of 30% compared with 2014. While a patient is waiting to see his or her new physician, routine chronic and preventive care is delayed. Specialist care is further delayed as necessary referrals cannot be generated until the appointment with the PCP has taken place. These delays can result in medications not being taken, psychiatric care not being provided, and increased use of urgent and emergency care, resulting in further disruption of continuity of care with all of its attendant negative downstream consequences.

Conclusion

MassHealth has changed its delivery system to an ACO model as of March 1, 2018. This requires patients to obtain referrals from their PCP to obtain specialist care and most specialists must be within the same network as the PCP. Although patients are given an

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8 www.merrithawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf.
opportunity to change their chosen plan to maintain prior patient-physician relationships, there is significant concern and anecdotal evidence that this model will disrupt long-standing, patient-PCP and patient-specialist relationships, forcing patients to choose between maintaining a PCP relationship at the cost of the specialist or a specialist relationship at the cost of a new PCP.

The voluminous body of research both from the United States and multiple other countries demonstrate the benefits of continuous relationships between patients with both their PCP and their specialists. These benefits have been demonstrated in a variety of populations and are likely to be particularly important for a Medicaid population. Based on this evidence, it would be expected that the newly established MassHealth ACO model will result in disrupted relationships, with a variety of negative health consequences, including poorer control of chronic diseases, higher overall mortality, and increased costs to the Commonwealth.

The MMS can and should take a leading role in advocating for patients and physicians by continuing to engage multiple parties at multiple levels in the Commonwealth to re-evaluate current MassHealth policies that may lead to disruption of patient-physician relationships in favor of more flexible policies that protect these valued, proven relationships.

Recommendations:

1. That the MMS reaffirm the primacy of the patient-physician relationship. (HP)

2. That the MMS expeditiously request that MassHealth or other relevant state agencies recognize the importance of patient-physician continuity of care and honor all pre-existing patient-physician relationships. (D)

3. That the MMS continue to engage MassHealth or other relevant state agencies to craft directives and policies that support and foster established patient-physician relationships. (D)

4. That the MMS request that MassHealth develop measurement tools to assess the impact of the current accountable care organization implementation, particularly in regard to the effect that disruption of patient-physician relationships has on health status and overall health care costs. (D)

Fiscal Note: No Significant Impact (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)
Background

High-deductible health plans disincentivize patients from seeking appropriate health care. According to a recent Kaiser Family Foundation report, the average deductible for an employee in 2017 was $1,500 per year; in some cases, deductibles can reach $5,000 or more per year. The 2009 Affordable Care Act (ACA) requires that preventive services recommended by the US Preventive Services Task Force be covered by insurers without a deductible. But, outpatient visits for care of common conditions such as hypertension, diabetes, hypothyroidism, etc., are not considered preventive, and therefore require that the patient pay in full for these visits, until the deductible is met. As a result, many patients decide not to get appropriate care for their health conditions. Our committee has heard from many physicians who have observed this phenomenon in their practices, particularly in the first few months of the year, when deductibles are unlikely to have been met.

Several studies have found that improved access to a doctor’s office to control chronic disease and provide early treatment of medical problems will reduce total health care costs through decreased use of emergency room and in-patient care. (See the February 2016 report of the Patient Centered Primary Care Collaborative, “Annual Review of the Evidence,” for 21 separate studies that reach this conclusion.)

In addition to their adverse effect on patients’ access to care, high-deductible health plans threaten the economic viability of physician practices. Our committee has found this to be a significant concern among physicians in private practice. While physicians are able to collect copayments at the time of the visit, we are not able to charge for a deductible until a claim for the visit has been submitted to the insurer, and the insurer has responded to the claim. This delay in submitting the claim to the patient inexorably leads to a decrease in the collection rate for this portion of the fee. It is well known among private practice physicians that there is a steady decrease in collection rate as time goes on after the visit. In addition, physicians are usually not able to ascertain, at the time of service, how much of the patient’s deductible has been met; so that even if a patient will eventually be found to be responsible for payment for the visit, the physician

is unable to ask for payment at the time of the visit. For these reasons, high-deductible plans are a financial burden on physician practices.

Our committee found it interesting to note that the Massachusetts Health Safety Net reimburses eligible hospitals for the deductibles for physician outpatient services provided to low-income patients. This policy holds for patients insured by private insurers. In this setting, Massachusetts has recognized that the deductibles built into most insurance plans pose an unacceptable burden on the provider.

In summary, high-deductible plans can have a negative effect on patient health, may increase total health care costs, and pose a threat to the economic viability of physician practices. The MMS needs to take steps to address these problems.

Current MMS Policy
The MMS Board of Trustees (as indicated in BOT Informational Report A-18-1) recently adopted the following policy related to high-deductible health plans and cost-sharing:

1. That, in the face of any possible changes in federal laws regarding health insurance coverage, the MMS support and advocate for continuation of the state individual mandate to purchase health insurance, the state’s Minimum Creditable Coverage standards, and the state Connector Care Program. (D)
2. That the MMS support and advocate for value-based cost sharing measures for high-deductible health plans and patients’ out-of-pocket costs. (D)
3. That the MMS support and advocate that the Commonwealth assess the impact of cost-sharing on access to care, health outcomes, and medical debt for patients.
4. That the MMS support and advocate that the Commonwealth assess the impact of cost sharing on provider’s due to patients’ inability to pay when there is cost-sharing. (D)
5. That the MMS continue to be a strong voice of concern about the adverse effects of cost-sharing on patient health. (HP)

Relevance to MMS Strategic Priorities
Relevant strategic priorities include:
- Ensure that the Society is a productive and credible voice for physicians and patients at the state and federal level, as well as local and national health care organizations.
- Provide a leadership voice through its advocacy, collaboration, and public health efforts, and will continue to carefully monitor the impact of the rapidly transforming health care landscape on Massachusetts physicians and patients.
- Advocate to improve the physician practice environment and work toward improved patient care and outcomes.
- Ensure that the voices of physicians and their patients are heard during the ongoing debate on health care reform, while promoting transparency and addressing barriers that impede access to quality care, such as administrative burdens and excessive regulations.

Discussion
Our committee considered several potential solutions to address the negative effects of high-deductible health plans on patients and physicians. We decided that one change that would provide significant relief to both patients and physicians would be to exempt
outpatient physician evaluation and management codes (99201–05, and 99211–15) from the deductible.

As noted in the previous background section, there is precedent for this policy. The ACA requires that insurance plans exempt preventive services recommended by the USPSTF from deductible payments. In addition, the Massachusetts Health Safety Net reimburses eligible hospitals for the deductible payments associated with outpatient medical visits for insured, low-income patients.

The committee wanted to know how much of the insurers’ medical payments would be affected by this exemption. The best data we could find came from the November 2016 report of the Health Care Cost Institute Inc. This report studied health care costs for the population under age 65. In 2015, the average per capita cost of health care for this population was $5,141. Of this, the amount spent on doctors’ outpatient visits, excluding preventive care, was $300, or 5.8%. This total includes codes other than 99201–05 and 99211–15; so, the 5.8% figure is an overestimate of the impact on the insurers.

Deductibles are considered to be a method to control utilization of services by patients; and high-deductible plans usually have a lower premium cost compared to low-deductible plans. We think it is likely that exempting 5.8% of health care costs from the deductible would have a low impact on the health insurance premium.

There would be significant benefits that would accrue due to exempting these codes from payment of the deductible. This policy would improve patient access to needed care, would likely reduce utilization of emergency room and in-patient services, and would help to stabilize the economic viability of physician practices.

Conclusion

The Committee on the Sustainability of Private Practice recommends that the Massachusetts Medical Society advocate for legislative or regulatory policy to specify that codes 99201–05 and 99211–15 for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments; so that insurers will pay the usual fee for these codes, without triggering any deductible payment by the patient.

Recommendation:

That the Massachusetts Medical Society advocate for legislative or regulatory policy to specify that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments; so that insurers will pay the entire usual fee for these codes, without triggering any deductible payment by the patient. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)