A N N U A L R E P O R T

OF

THE ADVISORY COMMITTEE ON MEDICAL EDUCATION

TO THE 111th LEGISLATURE

STATE OF MAINE

JANUARY 1984

GRADUATE HEALTH PROFESSIONS PROGRAM

Annual Report to the Legislature

The Post Graduate Health Professions Program (Contract Program) attracts Maine's outstanding and talented young people from every county throughout the State to pursue health professions in one of four disciplines: veterinary medicine, optometry, allopathic medicine, or dentistry. Five of twenty-three entering seats are distributed as follows: veterinary medicine - two; dentistry - two; and optometry - one. The remaining eighteen entering seats are allocated to allopathic medicine.

Within this program, the State of Maine contracts with schools of professional health education to reserve a certain number of places in an entering class for qualified Maine students in exchange for State dollars which underwrite the cost of that education. This system guarantees that a certain number of qualified Maine students will have the opportunity to receive post graduate education in these professions even though the State itself does not offer these programs through the University system.

The Post Graduate Health Professions Program is administered by the Department of Educational and Cultural Services. Input from outside the Department is provided to the Commissioner of Education by an Advisory Committee comprised of fifteen members representing not only the various disciplines involved in the program but other activities within the State that are affected by the Program.*

The Report submitted by this Committee for the previous year, January - December 1982, focused on Program modifications that resulted from changes in the authorizing legislation which occurred in 1981.** Three important legislative changes in the Program occurred: 1) a reduction in actual numbers of contract spaces available from 64 entering students per year in all disciplines to only 23 (only thirty six percent of the opportunities previously available); 2) an increased cost to the student; and 3) a more

*See Appendix 1
**See Appendix 2

restrictive forgiveness policy for the classes entering in 1981 or later. The latter change impacted primarily on physician participants in the contract, affecting not only the type of practice the contract physician can establish, but also where that practice might be established. The Committee, despite these changes, reiterated its position to support the existence of the Contract Program to provide Maine students with access to opportunities in graduate health professions education above and beyond any rationale premised on the ability to fill manpower needs alone.

In addition to the allocation of contract monies to secure seats in health professions programs, the legislation provides for the program and the Advisory Committee to address several related areas including rural preceptorships for Maine students, residency training opportunities, and continuing medical education activities. These issues, while of considerable concern to the Committee, have not been addressed because no funding has been made available for either study or developmental activities in these other areas. Recently the Committee has learned that family practice residencies are in jeopardy because of new interpretations of Medicare regulations affecting reimbursement for education programs. The Committee recognizes the importance of these other topics and feels that further study and action is warranted.

In 1981, with the legislative cutback, osteopathic medicine was removed from the Contract Program. The osteopathic community continues to be represented on the Advisory Committee for Medical Education and supported this move, viewing the loan as a more appropriate vehicle in meeting student needs than was assured access to schools of osteopathic medicine. The Osteopathic Loan bill accordingly was introduced in the 1981 session of the Legislature, in which a phase-in proposal was passed which assures recipients in each class of continued support throughout their medical school training. The loan may be offered to other students if the recipient chooses not to accept the loan for all four years of training. Appropriations raised for the Osteopathic Loan are as follows:

1981/'82 - $30,000; 1982/'83 - $60,000; 1983/'84 - $90,000; and 1984/'85 - $120,000.

Six loans have been distributed in each of three successive academic years, with a fourth year appropriation anticipated in FY '85, completing the phase-in of the funding level for all four classes. All but two of the loans to date have been distributed to Maine students attending the New England College of Osteopathic Medicine in Biddeford, Maine. Of the twenty loan recipients since 1981, 70% are from communities under 10,000 population and represent one-half the counties in the State. Fifty percent are women.

Terms of the loan are dollar payback; they do not provide service forgiveness. The loan directly defrays tuition. Osteopathic loans must be repaid following the completion of professional training, within ten years, at 09% interest.

During the past year the Committee identified four problem areas primarily related to the previously listed modifications that it feels need to be addressed if the Contract Program is to be of value to the State and the citizens it is designed to serve.

These four problem areas are: the low number of Maine students per capita entering educational programs covered by the Contract Program; the cost to the student of those educational programs; the career limitations imposed by payback provisions of the Program; and the recruitment and retention issues related to the structure of the program.

- Low number of entering students - Even with these seats guaranteed, access to post graduate health professions education remains a problem for Maine students. For example, in allopathic medical education Maine has dropped from a position of 44th to 50th out of 52 (including the 50 states plus Puerto Rico and the District of Columbia) in the number of students entering medical school per hundred thousand population.

- Cost to the student - Maine students participating in the Contract Program under the new provisions passed in 1981 assume a financial burden for education in these professions far in excess of their counterparts at state supported programs in other areas of the United States. Most of the

students under the Contract must pay not only full tuition to the school they attend but must also pay back to the State the amount it has committed to reserve their seats.* This combined cost for allopathic medical students approaches $20,000 per year plus room and board and miscellaneous fees which usually add another $6000 - $8000 per year. Students of allopathic and veterinary medicine who establish certain types of practices in underserved areas of the State may be forgiven all or a portion of their debt to the State.

° Limited career opportunities bacause of payback restrictions - In order to be forgiven repayment of the State's capitation, the Maine professional in allopathic medicine or veterinary medicine may work for five years in certain types of practices in areas designated by the Department of Human Services or the Department of Agriculture. Rules and regulations governing these practices and geographic areas have been developed.** These areas are characterized as chronically underserved. Practice types are limited to general and primary care practices. Maine students desiring to pursue an academic or research career or specialty career in allopathic or veterinary medicine are discouraged from doing so because of the additional debt they must repay if the State capitation payment is not forgiven. Students currently in medical or veterinary school have no indication what areas might be underserved when they finish training. The current administration at the Department of Human Services has indicated that it will make sure that areas are designated as long as there are students to fill the areas. There is no guarantee in the regulations that this will occur if there is a change in that administration.

° Recruitment and retention issues - Although one desired outcome of the Contract Program as it is currently structured is to meet some of the manpower needs of the state, the provisions of the Program may work against this goal. While the legislation specifically calls for a portion of the Maine student's education to take place in Maine, there is no formal mechanism or funds to assure that students have this opportunity and that opportunities exist in rural as well as urban areas.

The limited payback options and the size of their debt may in fact encourage students to establish practices in professional specialties and geographic locations where compensation for services is significantly higher, in order to facilitate repayment of their debt by generating a higher income. Although the Program itself is aimed at solving manpower as well as access problems, the current funding level only permits the Program to partially address access problems.

*See Appendix 3
**See Appendices 4 and 5

In order to strengthen the Contract Program in its present configuration, the Committee in 1983 has undertaken several activities designed to enhance and maintain communications with curernt contract students and graduates regarding:

- practice opportunities in Maine, particularly in underserved areas;
- manpower needs and projections with assistance from the Departments of Human Services and Agriculture;
- determination of other benefits of the Program to the State of Maine;
- methods of solving problems the Contract Program was established to address.

Five classes will have graduated under the "return to Maine" provisions of 1976 and 1978 before those affected by the changes in the law in 1981 and 1982 complete their training. As of July 1982, in addition to 19 contract physicians in training in Maine residency programs, 75% of the contract professionals who have completed training have returned to practice in the State of Maine. These professionals include 24 dentists, nine physicians, seven veterinarians, and one optometrist.*

As more contract practitioners graduate under more restrictive contracts and consider returning to Maine in the coming years, the Advisory Committee on Medical Education will direct its efforts both toward facilitating the identification of potential practice settings in the designated underserved areas of the State and monitoring the functions mandated to the Advisory Committee by statute. Incentives for recruitment and retention of contract physicians will continue to be a Committee priority in the coming year in determining the benefits of the Program to the State of Maine.

*See Appendix 6

APPENDIX

APPENDIX 1

ADVISORY COMMITTEE ON MEDICAL EDUCATION

1983

Edward C. Andrews, Jr., MD
President, Maine Medical Center
22 Bramhall Street
Portland, ME 04102
871-2491

Nona Boyink
Kennebec Valley RHA
Box 728
Waterville, ME 04901
873-1127

Stephen J. Campbell
Associate Director
Waldo County Gen. Hosp.
Belfast, ME 04915
338-2500

Karl B. Colbath, OD
28 Meadow Road
Augusta, ME 04330
623-3554

Marjorie Harris
Executive Director
Maine Dental Assn.
Foreside Mall, Rt. #1
Falmouth, ME 04105
781-2839

John LaCasse
Executive Director
Medical Care Development
11 Parkwood Drive
Augusta, ME 04330
622-7566

Costas Lambrew, MD
Acting Vice President for
Health Affairs
Maine Medical Center
22 Bramhall Street
Portland, ME 04102
871-2137

Charles Lyons, Ed.D.
Director, Office of Health
Prof. Education
University of Maine System
221 Bailey Hall
Gorham, ME 04038
780-5224

Charles D. McEvoy, Jr., MD
Medical Director - EMMC
489 State Street
Bangor, ME 04401
947-3711, Ext. 2302

Lawrence M. Newth, DO
RFD #3
High Point Drive
Saco, ME 04072
283-0171

Russell Pinfold, DVM
Mere Point Road
Box 3119
Brunswick, ME 04011
729-9194

Shirley Powell, Director
Bethel Area Health Center
Lower Main Street
PO Box 180
Bethel, ME 04217
824-2193

J. Chase Rand, DO, Chairman
Family Practice Residency Program
Osteopathic Hospital of Portland
c/o 846 Main Street
Westbrook, ME 04092
856-6771

Franklin L. Roberts, Ph.D.
Winslow Hall
University of Maine
Orono, ME 04473
581-3210

Frank O. Stred
Executive Director
Maine Medical Assn.
524 Western Avenue
Augusta, ME 04330
622-3374

APPENDIX 1 CON'T

EX OFFICIO MEMBERSHIP

ADVISORY COMMITTEE ON MEDICAL EDUCATION

1983

Joseph Bean
Vice President for
Human Resources
Maine Hospital Association
151 Capital Street
Augusta, ME 04330
622-4794

Senator Larry M. Brown
44 Washington Street
Lubec, ME 04652
733-2051

Gordon Browne, Director
Bureau of Health
Planning, DHS
State House Station #11
Augusta, ME 04333
289-2716

Richard T. Chamberlin, MD
Bingham Associates Fund
171 Harrison Avenue
Boston, MA 02111
(617) 956-5656

Paul Forman, MD
Lovejoy Health Center
Albion, ME 04910
437-9388

Philip N. Johnson
Maine Osteopathic Association
303 State Street
Augusta, ME 04330
623-1101

James Michaud, OD
225 Water Street
Gardiner, ME 04345
582- 2125

James L. Schmidt, DMD
Dental Service
US Veterans Administration
Togus, ME 04330
623-8411, Ext. 514

John Smiley
Department of Agriculture
State House Station #28
Augusta, ME 04333
289-3701

Rep. Mavourneen Thompson
48 Vincent Street
South Portland, ME 04106
799-5131

TERMS OF MEMBERSHIP FOR 1983

ADVISORY COMMITTEE ON MEDICAL EDUCATION

Members Whose Terms Expire as of July 31, 1985

Stephen Campbell
Karl B. Colbath, OD
Costas Lambrew, MD
Lawrence M. Newth, DO
Russell Pinfold, DVM
Shirley Powell
Franklin Roberts, Ph.D.

Members Whose Terms Expire as of July 31, 1984

Edward Andrews, Jr., MD
Nona Boyink
Marjorie Harris
John LaCasse
Charles Lyons, Ed.D.
Charles McEvoy, MD
J. Chase Rand, DO
Frank Stred

Ex Officio Membership (One Year Terms)

Joseph Bean
Sen. Larry Brown
Gordon Browne
Richard Chamberlin, MD
Paul Forman, MD
Philip Johnson
James Michaud, OD
James L. Schmidt, DMD
John Smiley
Rep. Mavourneen Thompson

CHAPTER 421

POSTGRADUATE EDUCATION IN THE FIELD OF MEDICINE

§ 11801. Legislative intent

1. Admission of Maine residents to educational institutions. It is the intent of the Legislature to assure, to the greatest extent possible, the admission of qualified Maine residents to educational institutions providing programs of instruction leading to doctoral degrees in allopathic medicine, dentistry, optometry and veterinary medicine.

2. Responsibility for program. It is the intent of the Legislature, consistent with the purposes of this chapter, that the commissioner shall administer the program and develop a plan which assures, to the extent practicable, that Maine contract students, or a similar number of out-of-state medical school graduates, return to practice their profession within the State, particularly in primary care in underserved areas.

3. Advisory committee. It is the intent of the Legislature, consistent with the purposes of this chapter, to establish an Advisory Committee on Medical Education to assist the commissioner in planning and administration of the professional health program and particularly in the development of clinical education sites and continuing education, which are funded primarily by sources other than patient charges.

§ 11802. Definitions

For the purposes of this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Clinical education site. "Clinical education site" includes both clinical clerkship sites and preceptorship sites.

A. "Clinical clerkship site" means an on-location teaching environment in conjunction with residency training.

B. "Preceptorship site" means a training site ranging from a one-to-one training site between a physician and medical student to a training site in a health clinic or hospital without a residency program.

2. Final determination of residency. "Final determination of residency" means the decision on residency made subject to rules of the department. Criteria for these rules shall include

length of residence, secondary school attended, legal residence of parent, voting registration and place where taxes are paid.

3. Primary care. "Primary care" means the practice of general or family medicine, internal medicine, pediatrics, obstetrics and gynecology.

4. State capitation payment. "State capitation payment" means the amount agreed on between the State and the institution for the purchase of the student space.

5. State contract student. A "state contract student" means a Maine resident who is enrolled in an educational program at an educational institution for which program the State:

A. Has entered into a contractual arrangement with the institution; and

B. Expends funds under this arrangement in return for a guarantee on the part of the institution that student positions will be made available to Maine residents.

6. Underserved areas. "Underserved areas" means those geographic locations which meet the Health Maintenance Organization Act definition of medically underserved areas as described in the Federal Register, Vol. 42, number 201, October 15, 1976, or its successor.

§ 11803. Agreement of state contract student with the State; September 1, 1977, to June 30, 1981

1. Agreement. State contract students commencing their professional education between September 1, 1977, and June 30, 1981, shall, as a condition precedent to the commencement of that education, enter into an agreement with the State under which the student shall agree:

A. To pay tuition to the institution;

B. That, on the conclusion of his professional education, including internship, residency and obligated public health service and Armed Forces' service, he shall pay the State an amount of money equal to the state capitation payment for the student position which he occupied. The commissioner may adopt or amend rules to define the conclusion of professional education; and

C. The payments shall be payable at 6% simple annual interest in not more than 10 equal annual installments.

2. Forgiveness of indebtedness. The agreement shall provide that ¼ of the indebtedness shall be forgiven for each year in which the state contract student practices his profession within

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the State in primary care or other specialized areas as determined by the commissioner, with the advice of the Advisory Committee on Medical Education. For other state contract students returning to practice their profession in Maine, ¼ of their indebtedness shall be forgiven for each of the first 2 years of practice.

§ 11804. Agreement for contract students after July 1, 1981

Any state contract student commencing professional education on or after July 1, 1981, shall, as a condition precedent to the commencement of the education, enter into an agreement with the State under which the student shall agree:

1. Tuition to institution. To pay tuition to the institution; and

2. Repayment to State. Upon the conclusion of professional education, including internship, residency and obligated public health service, to pay the State an amount of money equal to the state capitation payment expended by the State in purchasing the state contracted position which the student occupied.

A. This amount shall be payable at 9% simple annual interest in not more than 10 annual equal installments.

B. These installment payments shall commence upon conclusion of the state contract student's professional education under rules promulgated by the commissioner.

§ 11805. Positions

1. Negotiations. The commissioner shall, directly or through the New England Board of Higher Education, negotiate with educational institutions to secure positions for state contract students in the fields of allopathic medicine, dentistry, optometry and veterinary medicine.

2. Purchase of positions at medical schools; September 1, 1977, and June 30, 1981. Money to purchase positions at medical schools may be expended between September 1, 1977 and June 30, 1981 as follows.

A. The commissioner may expend appropriated money between September 1, 1977, and June 30, 1981, for the purchase of positions at accredited medical schools, for not more than:

(1) A total of 40 positions each year, divided among the University of Vermont College of Medicine, Tufts University School of Medicine, Dartmouth Medical

School or other accredited medical schools, to a total of 160;

(2) A total of 10 positions each year divided among Tufts School of Dental Medicine or other accredited dental schools, to a total of 25;

(3) A total of 4 positions each year, divided among the University of Pennsylvania School of Veterinary Medicine, the New York State College of Veterinary Medicine at Cornell University, Tufts University School of Veterinary Medicine or other accredited schools of veterinary medicine, to a total of 16;

(4) A total of 2 positions each year at the New England College of Optometry, to a total of 8; and

(5) A total of 10 positions each year at the New England College of Osteopathic Medicine, to a total of 40.

B. The department shall not exceed the total number of spaces, but may allocate the number of spaces at the various institutions based on the spaces available for the academic school years, the cost of securing the student space, the number of applications and the primary care residency program needs.

3. Purchase of positions at medical schools after July 1, 1981. Money to purchase positions at medical schools may be expended after July 1, 1981 as follows:

A. The Department of Educational and Cultural Services may expend the money appropriated by the Legislature, for the purchase of positions at accredited medical schools to purchase:

(1) Up to 18 positions each year, to a total of 72 positions, at accredited schools of allopathic medicine;

(2) Up to 2 positions each year, to a total of 8 positions, at accredited schools of dentistry;

(3) Up to 2 positions each year, to a total of 8 positions, at accredited schools of veterinary medicine; and

(4) Up to one position each year, to a total of 4 positions, at accredited schools of optometry.

B. The department shall not exceed the total number of spaces identified in this subsection for students commencing their professional education on or after July 1, 1981, but may allocate the number of spaces at the various institutions based on:

(1) The spaces available for the academic school years;

(2) The cost of securing the student's space;

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§ 11806. Instate clinical education programs; development of a plan

1. Return to practice in Maine. The commissioner shall develop a plan which assures, to the extent practicable, that contract students, or a similar number of out-of-state medical school graduates, return to practice their profession within the State, particularly in primary care in underserved areas of the State. This plan shall be completed and presented to the Legislature and the Governor before February 1st each year.

2. Plan. This plan shall include:

A. The development of a coordinated mechanism for the administration of the compact;

B. The projected number of student spaces needed and projected costs in all professional health fields;

C. Recommendations for the future need of this program;

D. The development of sites for student clinical training;

E. The percentage of the total amount expended for the purchase of the space at the contract institutes that will return with the student undertaking clinical education in the State;

F. The development of incentives to practice in primary care and underserved areas; and

G. Recommendations for utilizing contract funds to provide assistance to Maine residency programs.

3. Coordination. To avoid duplication in the undertaking of this plan, the commissioner shall coordinate all activities with other professional health agencies and organizations.

§ 11807. Advisory Committee on Medical Education

1. Committee. The Advisory Committee on Medical Education shall assist the commissioner in developing the plan.

2. Members. The advisory committee shall consist of 15 members, who shall be appointed by the commissioner and subject to approval by the committee having jurisdiction over education. Membership of the advisory committee shall include representatives from those health care agencies and associations, public and private, whose activities are relevant to the objec-

tives of the plan, as determined by the commissioner. Members shall be appointed for a 2-year term.

3. Vacancies. In the case of vacancies or resignations, appointments shall be made as for a new member to fill the vacancies until the expiration of the terms.

§ 11808. Nonlapsing fund

Any unexpended money appropriated by the Legislature under section 11805 shall not lapse, but shall be carried forward to the following year to be expended by the department for the purpose of purchasing positions at medical schools. Moneys returned to the State shall be deposited in a revolving account, to be expended for the purpose of purchasing contract spaces at medical schools.

§ 11809. Annual review

The legislative committee having jurisdiction over appropriations and financial affairs shall annually review the program established under this chapter.

Sec. 22. 20-A MRSA §11804, sub-§§3 and 4 are enacted to read:

3. Forgiveness. Any student who, upon the conclusion of his professional education, including, if applicable, internship, residency and obligated public health service, elects to serve as a general, family, pediatric or veterinary practitioner in an underserved rural geographic area in the State shall be forgiven 20% of the indebtedness, as determined in subsection 2, for each of the first 5 years of that service.

4. Determination. The Commissioner of Human Services shall determine underserved rural areas for general, family or pediatric services. The Commissioner of Agriculture, Food and Rural Resources shall determine underserved rural areas for veterinary services.

APPENDIX 3

UNIVERSITY OF VERMONT COLLEGE OF MEDICINE
ESTIMATED 1982-1983 MEDICAL STUDENT BUDGETS[1]

	FIRST YEAR/TEN MONTHS		SECOND YEAR/TWELVE MONTHS	
Tuition	Single	Married	Single	Married
Vermont	$ 5,700	$ 5,700	$ 5,700	$ 5,700
Maine	8,180	8,180	8,400	8,400
Rhode Island	8,400	8,400	8,400	8,400
New York	10,200	10,200	10,200	10,200
All Other States	14,900	14,900	14,900	14,900
Fees	260	260	210	210
Books, Equipment	670	670	200	200
Shelter	2,200	4,275	2,640	5,125
Food	1,340	2,140	1,610	2,565
Transportation	710	1,135	855	1,370
Personal and Miscellaneous	915	1,455	1,100	1,750
Total Expenses	$ 6,095	$ 9,935	$ 6,615	$11,220
* Total Tuition and Expenses				
Vermont	$11,795	$15,635	$12,315	$16,920
Maine	$14,275	$18,115	$15,015	$19,620
Rhode Island	$14,495	$18,335	$15,015	$19,620
New York	$16,295	$20,135	$16,815	$21,420
All Other States	$20,995	$24,835	$21,515	$26,120

	THIRD YEAR/TWELVE MONTHS		FOURTH YEAR/TEN MONTHS	
Tuition	Single	Married	Single	Married
Vermont	$ 5,700	$ 5,700	$ 5,700	$ 5,700
Maine	8,400	8,400	8,400	8,400
Rhode Island	8,400	8,400	8,400	8,400
New York	10,200	10,200	10,200	10,200
All Other States	13,240	13,240	13,240	13,240
Fees	160	160	160	160
Books and Equipment	200	200	200	200
Shelter	2,640	5,125	2,200	4,275
Food	1,610	2,565	1,340	2,140
Transportation	855	1,370	710	1,135
Personal and Miscellaneous	1,100	1,750	915	1,455
Total Expenses	$ 6,565	$11,170	$ 5,525	$ 9,365
* Total Tuition and Expenses				
Vermont	$12,265	$16,870	$11,225	$15,065
Maine	$14,965	$19,570	$13,925	$17,765
Rhode Island	$14,965	$19,570	$13,925	$17,765
New York	$16,765	$21,370	$15,725	$19,565
All Other States	$19,805	$24,410	$18,765	$22,605

[1] Fees include: Health Fee @ $100; Athletic Fee @ $48; Activity Fee @ $10; First Year Microscope Fee @ $100; Second Year Microscope Fee @ $50.00.

Child Allowance and spouse-in-school allowances will be added to budgets when applicable.

May 1982

* In addition to the above figures, the Maine Contract Student is responsible for $11,500 per year (expended by the state) plus 09% interest

APPENDIX 4

TO: Secretary of State
ATTN: Administrative Procedures Officer
State House, Augusta, Maine 04333

ACCEPTED FOR FILING
SEP 19 1983
SECRETARY OF STATE

83-257

1. Agency: Department of Human Services, Bureau of Health Planning and Development

2. Agency umbrella and unit #: 10-144A

3. Title of rules(s): Rule for Implementing the 1982 Amendment to the Maine Medical Compact Act, 20-A M.R.S.A. §11804

4. Number assigned to the rule(s): Chapter 504, Code of Maine Regulations

5. Date(s)/method(s) of notification of rule-making proposal: Notice published May 11, 1983 in the Bangor Daily News, the Kennebec Journal, the Portland Press Herald, the Lewiston Daily Sun, and the Waterville Morning Sentinel

6. Date(s)/place(s) of hearing(s) on proposed rule(s): No public hearing was requested; none was held.

7. Type of rule: [X] new rule [ ] amendment of existing rule [ ] suspension of existing rule [ ] repeal of existing rule [ ] emergency rule

8. Name/phone of agency contact person: Gordon A. Browne, Director, Bureau of Health Planning and Development, 289-2716

9. Certification Statement: "I, Michael R. Petit, Commissioner hereby certify that the attached is a true copy of the rule described above and lawfully adopted by the Department of Human Services on X SEPTEMBER 19 1983

Signature: x Michael R. Petit

Michael R. Petit, Commissioner,
Department of Human Services

10. Approved as to form and legality by the Attorney General on September 19, 1983

Signature: Edward E White

Printed Name: Edward E. White, Jr. Assistant Attorney General

Department of Human Services
Rules for Implementing the 1982 Amendments to the
Maine Medical Compact Act

This rule establishes definitions, procedures, and criteria necessary for the implementation of amendments to the Maine Medical Compact Act passed by the 110th Maine Legislature to become effective retroactively to July 1, 1981, and re-enacted by the 111th Legislature to continue beyond June 30, 1983.

1. Definitions

The following words and phrases shall have the following meanings:

a. Family/General Practitioner (for the purposes of determining eligibility for forgiveness) - a licensed physician whose practice assumes continuing responsibility for supervising the health and coordinating the care of all family members, regardless of age. This practitioner generally provides the basic medical services given when a patient first seeks assistance from the medical care system and provides for care of the simpler and more common illnesses. The provider of these services usually also assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. These services are comprehensive in the sense that the provider takes responsibility for the coordination of the care of the patient's health problems, be they biological, behavioral or social. The appropriate use of consultants and community resources is an important part of an effective family/general medical practice. Such work demands specific skills including functioning as medical managers, advocates, educators and counselors for their patients.

b. Pediatric Practitioner (for the purposes of determining eligibility for forgiveness) - a licensed physician whose practice assumes responsibility for providing continuing medical care dealing with the development of infants, children, and adolescents, and with the treatment of their diseases, along with counselling and prevention.

c. Primary Care Physicians (for the purpose of determining underserved areas) - are active doctors of medicine (M.D.) and doctors of osteopathy (D.O.) who spend at least 60 percent of their active practice time engaged in direct patient care in the medical fields of general or family practice, pediatrics, internal medicine, or obstetrics and gynecology. These fields of medicine are defined through use of the American Medical Association Specialty and Osteopathic Physician Practice Area classifications as reported in the Bureau of Health Planning and Development's Cooperative Health Manpower Resources Inventories. For this purpose, no distinction shall be made between civilian physicians and National Health Service Corps physicians and other federal physicians (except those who exclusively serve Indians or on military bases).

d. Rural Areas - all those Primary Care Analysis Areas (PCAAs), as defined in the most recent State Health Plan, that do not include a trade and employment center, as defined by the State Planning Office, within their boundaries.

e. Underserved Rural Geographic Area - is a rural PCAA that has comparatively fewer primary care physician resources to meet the medical needs of the population than other rural PCAA's have and which meets the criteria stated below in this rule.

f. Full-Time-Equivalent Primary Care Physician - is a primary care physician who provides patient care an average of forty hours per week. For primary care physicians who provide patient care for fewer than forty hours per week, every four hours spent in providing patient care will be counted as 0.1 full-time-equivalent.

g. Population to Primary Care Physician Ratio - is determined by dividing the population of a Primary Care Analysis Area by the number of full-time-equivalent primary care physicians who practice within the Area. The ratio for each Primary Care Analysis Area will be expressed as a number of people per one primary care physician (e.g., 2,100:1).

2. Procedure

No later than May 1 of each year, beginning in 1984, the Commissioner of Human Services shall designate underserved rural areas. Such areas shall be those Primary Care Analysis Areas which meet the definition of rural and the criteria for underservice defined below. The designations for underservice shall be in effect for one year from the date of designation.

The Commissioner of Human Services, in making such designations, shall utilize the Department's Cooperative Health Manpower Resource Inventories, the Primary Care Analysis Areas as defined in the most recent State Health Plan for Maine, the most current population estimates prepared by the State Planning Office or the Bureau of Health Planning and Development, and such other information as may be available and appropriate.

Before designating underserved rural areas, the Commissioner of Human Services will provide an opportunity for the Advisory Committee on Medical Education to review and comment on the list of areas he proposes to designate.

No more than two physicians may establish practices in the same rural Primary Care Analysis Area in any one year and be eligible for foregiveness of their loans. In making his designations of rural underserved areas, the Commissioner will count, as part of the total number of primary care providers in an area, those general, family, or pediatric practioners who were compact students and who established practices in those areas to have their loans forgiven under this Act. Those practitioners will continue to be eligible for forgiveness if they continue to practice in an area that was designated as underserved when they established their practice, regardless of whether or not the area is designated as a rural underserved area in subsequent years.

3. Criteria

a. The Commissioner of Human Services will designate a rural Primary Care Analysis Area as underserved if it has a population to primary care physician ratio of 3,000 or more:1.

b. The Commissioner of Human Services may designate a rural Primary Care Analysis Area as underserved if it has a population to primary care physician ratio of between 2,000 and 2,999:1, if, in his judgement, other factors indicate the likelihood of the Area's population being underserved. Such factors will include but are not limited to:

1) Insufficient capacity of the Area's existing primary care providers to serve the Area's population. Insufficient capacity as determined by the Department may be indicated by any of the following:

(a) Unusually long waits for appointments for routine medical services (i.e., more than 7 days for established patients and 14 days for new patients);

(b) Excessive average waiting time at primary care providers (longer than one hour where patients have appointments or two hours where patients are treated on a first-come, first-served basis);

(c) Evidence of excessive use of emergency room facilities for routine primary care;

(d) A substantial proportion (2/3 or more) of the Area's physicians do not accept new patients;

(e) A substantial proportion (2/3 or more) of the Area's physicians do not accept Medicaid patients;

2) Unusually high health needs of the Area's population. Such health needs may be indicated by the following:

(a) The area has more than 100 births per year per 1,000 women aged 15-44;

(b) The area has more than 20 infant deaths per 1,000 live births;

(c) More than 20% of the population (or of all households) have incomes below the poverty level;

(d) The Area has an incidence rate for preventable and communicable diseases which is higher than the State-wide rate;

(e) The population has a hospital admission rate for diseases or conditions which could have been prevented or treated on an ambulatory basis which is higher than the State-wide rate.

TO: Secretary of State
ATTN: Administrative Procedure Officer
State House, Augusta, Maine 04333

EMERGENCY FILING
SEP 29 1983
SECRETARY OF STATE

OCT 3 '83
83-271

APPENDIX 5

1. Agency: * Maine Department of Agriculture, Food and Rural Resources

2. Agency umbrella and unit #: 01-001

3. Title of rule(s): Rule to implement the 1982 Amendment to the Maine Medical Compact Program

4. Number assigned to the rule(s): 50

5. Date(s)/method(s) of notice: Notice of Agency Rule-Making Proposal (July 27, 1983)

6. Date(s)/place(s) of hearing(s): None Scheduled

7. Type of rule: ☒ new rule ☐ amendment of existing rule ☐ suspension of existing rule ☐ repeal of existing rule ☐ emergency rule

8. Name/phone of agency contact person: John A. Smiley Phone: 289-3701

9. Certification Statement: I, Daniel Harlan, hereby certify that the attached is a true copy of the rule(s) described above and lawfully adopted by Department of Agriculture, Food and Rural Resources on September 27, 1983

Signature Daniel Harlan

Printed Name & Title DANIEL HARLAN, DEPUTY COMMISSIONER

10. Approved as to form and legality by the Attorney General on Sept 28 1983

Signature

Printed Name Jeff Pidot

*For instructions on completing this cover sheet see "A Guide to Rule-making for State Agencies", pp.8-10.

Form No. MAPA-1

01-001
DEPARTMENT OF AGRICULTURE, FOOD AND RURAL RESOURCES

Chapter 50 UNDERSERVED RURAL AREAS FOR VETERINARY SERVICES

Summary: This chapter establishes underserved rural areas for veterinary services for purposes of the loan forgiveness program for certain state contract veterinary students.

1. Underserved rural areas. Underserved rural areas for veterinary services shall consist of those economic summary areas of the State of Maine which meet the following criteria:

A. Are not urban in character;

B. Are not served by more than one veterinarian per 10,000 residents; and

C. Would not have a ratio of practicing veterinarians to general population of less than 1:10,000 upon the arrival of an additional practitioner.

Any economic summary area containing total population in excess of 50,000, or having within its territory a city of 15,000 or more population, shall be considered urban in character for purposes of this chapter.

2. Initial determination. The Commissioner of Agriculture, Food and Rural Resources has determined according to the foregoing criteria that the following economic summary areas are currently underserved rural areas for veterinary services:

ESA	Towns included
Bangor suburban	(Argyle, Bradley, Carmel, Clifton, Corinna, Corinth, Dixmont, Eddington, Etna, Exeter, Glenburn, Greenbush, Greenfield, Hampden, Hermon, Holden, Hudson, Kenduskeag, Levant, Milford, Newburgh, Newport, Orrington, Plymouth, Stetson
Calais	Alexander, Baileyville, Baring Plt., Brookton Twp, Calais, Charlotte, Codyville, Cooper, Crawford, Forest Twp., Grand Lake Stream, Lambert Lake, Meddybemps, No 21 Plt., Princeton, Robbinston, Talmage, Topsfield, Vanceboro, Waite
Fort Kent	Allagash Plt., Eagle Lake, Fort Kent, Frenchville, New Canada Plt., St. Agatha, St. Francis, St. John Plt., Wallagrass Plt., Winterville Plt.

Fryeburg	Baldwin, Brownfield, Cornish, Denmark, Fryeburg, Hiram, Lovell, Parsonsfield, Porter, Stoneham, Sweden
Lincoln	Burlington, Carroll Plt., Chester, Drew Plt., Enfield, Grand Falls Plt., Howland, Kingman, Lakeville Plt., Lee, Lincoln, Lowell, Mattawamkeag, Maxfield, Passadumkeag, Prentiss Plt., Seboeis, Springfield, Webster Plt., Winn
Livermore	Canton, Fayette, Jay, Livermore, Livermore Falls
Madawaska	Cyr Plt., Grand Isle, Hamlin Plt., Madawaska, Van Buren

3. Subsequent determinations.

A. The Commissioner of Agriculture, Food and Rural Resources shall on an annual basis re-determine underserved rural areas for veterinary services according to the criteria contained in section 1.

B. Notwithstanding paragraph A, the Commissioner may at any time strike an economic summary area from the list of underserved rural areas if reasonable investigation reveals that the ratio of practicing veterinarians to general population is less than 1:10,000. Contract students who have notified the Commissioner in writing of their intent to establish a practice within the specified ESA listed in section 2 shall be deemed practicing veterinarians for purposes of this paragraph in the order that such notices are received. To be valid, written notice of intent must be received by the Commissioner between January 1 and June 30 of the contract student's final year of professional training. Contract students who are deemed practicing veterinarians through having filed written notice of intent must establish their practice no later than September 30 of the year of filing. No contract student may have outstanding more than one notice of intent during any one calendar year.

STATUTORY AUTHORITY: 20 M.R.S.A. § 2273(1-C)

EFFECTIVE DATE: OCT 4 1983

BASIS STATEMENT:

P.L. 1981, c. 705, § D, 1, amending 20 M.R.S.A. § 2273, institutes a forgiveness of indebtedness for certain state contract veterinary students who, at the conclusion of their professional training, practice in underserved rural areas in Maine. The statute directs the Commissioner to identify those rural areas which are underserved by veterinarians for purposes of this program. This determination has two components: establishment of

a guideline ratio of veterinarians to general population, and definition of the term "rural areas."

Upon consultation with the Board of Veterinary Medicine, the Commissioner has determined that a minimally acceptable availability of veterinarians is one practitioner per 10,000 population. An area having a lower practitioner to population ratio is considered underserved. However, in order to encourage settlement of veterinarians in the more sparsely served areas, section 1(C) omits from the category of underserved those ESA's which presently meet this standard, but which would no longer have a veterinarian/population ratio below 1:10,000 if another practitioner were to settle in the area.

For purposes of this chapter, we have conceptually divided the populated areas of the State into two groups: rural and urban. For demographic purposes the State Planning Office has divided the organized access of the State into a grid of 43 economic summary areas. A list of these 43 ESA's is attached hereto as Exhibit A. Exhibit A also lists for each ESA the 1980 population, the number of practicing veterinarians, and the ratio of veterinarians to population.

Population density is the best indicator of whether an area is rural or urban in character. We have determined that any ESA having within its borders a city of over 15,000 population or having a total population of over 50,000 is urban in character. ESA's which do not have a city of over 15,000 within their borders and which have a total population of not more than 50,000 are deemed rural in character.

Under these criteria, 34 of Maine's 43 ESA's are rural in character. Seven of these 34, are underserved as defined previously. (See Exhibit B) The Bangor Suburban ESA currently has one veterinarian serving forty thousand twenty-five (40,025) people. The remaining six underserved rural areas have populations ranging from ten thousand forty-five (10,045) to twelve thousand seven hundred sixteen (12,716) and are not served by any veterinarians.

Any town within these seven ESA's was hence deemed underserved for purposes of the loan forgiveness program. The determination of underserved rural areas is to be made annually by the Department of Agriculture, Food and Rural Resources.

During the comment period there was one inquiry stating that Milford be included separately in these regulations. This question was addressed in the initial determination where Milford was listed in the ESA Bangor Suburban.

Section 3B serves two functions. First, it permits the Commissioner to revoke an ESA's status as an underserved area between the determination made annually should a veterinarian move into the area. Secondly, this provision establishes a priority system for awarding practice locations to contract students who

have chosen to settle in the same underserved rural area, but who have not yet established a practice. A priority system is necessary because six of the seven underserved rural ESA's will not be underserved if one additional practitioner settled in the area. The exception to this is Bangor Suburban. The priority system adopted is the date of notice of intent to establish a practice within a specified ESA between January 1 and June 30 of any calendar year by the contract student.

Adoption of this chapter will not have any adverse impact on small businesses.

APPENDIX 5 CON'T

VETERINARIAN TO POPULATION RATIOS
ECONOMIC SUMMARY AREAS

SOURCE: DHS 1/80 and SPO 1/79

		# VETS	1980 POP.	RATIO
I.	SOUTHERN MAINE	14	148,569	1:10,612
	#1 Kittery	4	34,984	1:8746
	#2 Kennebunk	1	11,723	1:11,723
	#3 Biddeford	4	50,602	1:12,650
	#4 Sanford	5	40,221	1:8044
	#5 Fryeburg	0	11,039	0:11,039
II.	CUMBERLAND	24	190,307	1:7929
	#6 Portland	10	99,260	1:9926
	#7 Portland Suburban	12	65,153	1:5429
	#8 Sebago Lake	2	25,894	1:12,947
III.	ANDROSCOGGIN	20	171,359	1:8568
	#9 Lewiston	6	72,378	1:12,063
	#10 Lewiston Suburban	3	25,061	1:8354
	#11 Paris	5	19,422	1:3884
	#12 Rumford	3	20,753	1:6918
	#13 Farmington	3	18,146	1:6048
	#14 Livermore	0	12,121	0:12,121
	#15 Rangeley	0	3,478	0:3478
IV.	KENNEBEC	24	162,978	1:6790
	#16 Augusta	10	65,167	1:6517
	#17 Waterville	7	59,297	1:8471
	#18 Skowhegan	5	23,729	1:4746
	#19 Pittsfield	2	11,258	1:5629
	#20 Jackman	0	3,518	0:3518
V.	MID-COAST	24	117,920	1:4913
	#21 Brunswick	9	48,326	1:5369
	#22 Damariscotta	7	22,708	1:3244
	#23 Rockland	3	24,003	1:8001
	#24 Camden	1	10,816	1:10,816
	#25 Belfast	4	14,067	1:3516
VI.	EASTERN MAINE	8	71,652	1:8950
	#26 Ellsworth	4	22,742	1:5685
	#27 Blue Hill	0	9,041	0:9041
	#28 Bar Harbor	2	9,842	1:4921
	#29 Jonesport	0	8,569	0:8569

APPENDIX 5 CON'T

REVISED VETERINARY TO POPULATION RATIOS

BY ECONOMIC SUMMARY AREA

1983

ESA's WITH PRACTITIONER RATIO: 0: 3400 - 0: 9000

Rangeley	0:	3478
Jackman	0:	3518
Blue Hill	0:	9041
Jonesport	0:	8569

ESA's WITH PRACTITIONER RATIO 1: 10,000:

Kittery	1:	8746	**Augusta	1:	6517
**Sanford	1:	8044	**Waterville	1:	8471
**Portland	1:	9926	Skowhegan	1:	4746
**Portland Suburban	1:	5429	Pittsfield	1:	5629
Lewiston Suburban	1:	8354	**Brunswick	1:	5369
Paris	1:	3884	Damariscotta	1:	3244
Rumford	1:	6918	Rockland	1:	8001
Farmington	1:	6048	Belfast	1:	3516
Machias	1:	7012	Ellsworth	1:	5685
Eastport	1:	6032	Bar Harbor	1:	4921
Winterport	1:	7508	Patten	1:	6304
**Bangor	1:	6859	Dover-Foxcroft	1:	6791

ESA's WITH PRACTITIONER RATIO 0: 10,000-> 0:12,000

Fryeburg	0:	11,039
Lincoln	0:	12,716
Madawaska	0:	10,045
Livermore	0:	12,121
Fort Kent	0:	11,096
Calais	0:	10,264

ESA's WITH PRACTITIONER RATIO 1: 10,000-> 1:12,000

**Biddeford	1:	12,650
*Sebago Lake	1:	12,947
Bangor Suburban	1:	40,025
*Houlton	1:	12,910
Presque Isle	1:	17,121
**Lewiston	1:	12,063
*Millinocket	1:	12,036
*Kennebunk	1:	11,723
*Camden	1:	10,816

** ESA's exempted as urban
* These ESA's in which additional vet practitioner would lower the ratio below 1: 10,000, thereby disqualifying ESA as underserved

SOURCES: DHS ('80), SPO ('79), BD/REG VET MED ('82)

EXHIBIT B

APPENDIX 5 CON'T

	#30 Machias	1	7,012	1:7012
	#31 Eastport	1	6,032	1:6032
	#32 Calais	0	10,264	0:10,264
VII.	PENOBSCOT	15	154,475	1:11,034
	#33 Winterport	1	7,508	1:7508
	#34 Bangor	9	61,728	1:6859
	#35 Bangor Suburban	1	40,025	1:40,025
	#36 Dover-Foxcroft	3	20,372	1:6791
	#37 Lincoln	0	12,716	0:12,716
	#38 Millinocket	1	12,036	1:12,036
VIII.	NORTHERN MAINE	5	93,614	1:18,723
	#39 Houlton	1	12,910	1:12,910
	#40 Patten	1	6,304	1:6304
	#41 Presque Isle	3	51,364	1:17,121
	#42 Madawaska	0	10,045	0:10,045
	#43 Fort Kent	0	11,096	0:11,096
	TOTAL	134	1,110,874*	1:8290

*Does not include unorganized territories

EXHIBIT A

APPENDIX 6

DISTRIBUTION OF MAINE CONTRACT PRACTITIONERS IN MAINE

1983

Dentists (24)

Portland (4)
Camden
Auburn (2)
Bangor (2)
N. Windham
Fort Kent
Millinocket
Harrison
Old Orchard
Bath
Saco
Madison
Calais
Skowhegan
Falmouth
York
Topsham
Scarborough
Lincoln

Veterinarians (7)

E. Lebanon
Skowhegan
Island Falls
Turner
Augusta
So. Berwisk
Dover-Foxcroft

Optometrist (1)

Skowhegan

Allopathic Physicians (9)

Lewiston
Bar Harbor
Guilford
Farmington
Fort Kent
N. Windham
Kennebunk
Bingham
Richmond