



Task Force on Health Care Access and Reimbursement

Established under Senate Bill 107

ADDENDUM:
Comments on the Recommendations
and Final Report from Stakeholders
December 2008

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August 21, 2008

Secretary John M. Colmers
Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, MD 21201-2399

Dear Secretary Colmers:

With the next meeting of the Governor's Task Force on Health Care Access and Reimbursement right around the corner, and the deadline to develop final recommendations fast approaching, we wanted to update you on developments arising from our recent meeting with representatives of MedChi. Our President and CEO, Chet Burrell, and I met with MedChi leadership to discuss areas of common interest on which to focus efforts to improve access and reimbursement.

As might be expected, there are issues and approaches about which CareFirst and MedChi differ. But more importantly, there are substantive approaches that both parties agree hold the potential to address matters before the Task Force – particularly those that relate to access to health care. While we cannot speak for MedChi, we believe there is a shared interest in a number of substantive approaches, including:

- ***ALTERNATIVE APPROACHES TO IMPROVING ACCESS TO CARE, ESPECIALLY PRIMARY CARE SERVICES***

The rotation of specialists and use of part-time physicians in rural areas could help alleviate some isolated access issues that exist in the state. Smaller hospitals and physicians in rural areas should be encouraged to affiliate with larger metropolitan counterparts to enable rotations and part time practices of specialists and subspecialists in rural areas. The expanded use of telemedicine can also play a role in addressing this issue. CareFirst also believes that improving access to primary care services through the use of allied health care providers (nurse practitioners, physician assistants, retail clinics, etc.) could help address some of the primary care issues that exist.

SECRETARY JOHN M. COLMERS
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- ***PHYSICIAN/RESIDENT LOAN FORGIVENESS PROGRAMS***
We strongly support physician/resident loan forgiveness programs targeting underserved areas. Any such program should include requirements that participating physicians commit to 5 years of service in an underserved area of the state. We believe loan forgiveness programs should be permanently established to provide incentives for current and future medical residents to choose Maryland to establish their primary care practice.
- ***TORT REFORM***
While we recognize that tort reform is not easily achieved, it could play a key role in removing adverse incentives for physicians practicing in the Emergency Department. Increased “charitable immunity” for emergency consults for uninsured patients and a broadened view of “emergency services” to include access to urgent care outside of hospital settings is necessary. The Health Services Cost Review Commission has received a Medicare grant to study the provision of urgent care and CareFirst supports using this grant to consider issues related to emergency care reimbursement. Although Tort Reform may not be within the scope of this Task Force, the information presented to the Task Force regarding the favorable results in Texas was very impressive.
- ***EXPLORE ALL-PAYER HOSPITAL-BASED PHYSICIAN PAYMENT SYSTEM***
We understand that MedChi would like to partner on a pilot-project through which rates for hospital-based emergency room physicians would be set by the Maryland Health Care Commission (MHCC). CareFirst could potentially support such a project if it were expanded to include all hospital-based physicians.

We are heartened that there are many areas of agreement between CareFirst and MedChi, and, we stand ready to work with you, MedChi and other members of the Task Force to develop recommendations and – where necessary – draft legislation to move forward on these important steps to improve health care access for Marylanders.

However, it is important to point out that on other matters – primarily those related to reimbursement – there remain philosophical differences between CareFirst and MedChi. As we presented to the Task Force, CareFirst is moving forward on a number of fronts that seek to more closely align reimbursement with improved care quality – such as our CareFirst Quality Reward incentive program and our Medical Home pilot projects. MedChi did express an interest in these pay-for-performance pilots and offered to explore them with us.

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Efforts such as these are essential to confront the affordability issue resulting from rising costs and utilization. Proposals and recommendations that focus solely on increasing reimbursement as a remedy for access issues were not supported by a number of the presentations to the Task Force and actually threaten access in Maryland. Adding costs to the existing system will do nothing to make care and coverage more affordable and available.

We look forward to the continued work of the Task Force in preparing the Final Report. As always, we are available to discuss our recommendations as well as any other recommendation from the Task Force members and staff.

Sincerely,

A handwritten signature in black ink, appearing to read "Dave", written in a cursive style.

David D. Wolf

cc: Chet Burrell
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TASK FORCE ON HEALTH CARE ACCESS & REIMBURSEMENT

MARYLAND HOSPITAL ASSOCIATION (MHA) COMMENTS/RECOMMENDATIONS SEPTEMBER 2008

I. BACKGROUND:

As the MHA/MedChi Physician Work Force Study showed, Maryland has 16 percent fewer physicians available for clinical practice than the national average. (See attached charts). The physician shortages are most acute in three regions of the state—Eastern Shore, Southern Maryland, and Western Maryland. And, these shortages are projected to worsen over the next seven years.

If the shortages are not addressed, consumers will face additional problems gaining access to care; experience increased waiting times to see a physician; and, face greater reliance on already crowded emergency rooms. A combination of short, intermediate, and long term strategies is needed to comprehensively address both primary and specialty care shortages across Maryland.

Enhancing reimbursement is absolutely fundamental/critical/essential to the effort. Today, Maryland physicians' reimbursement from commercial carriers is at the bottom 25 percent of the states, while medical liability insurance and other expenses have continued to rise in one of the highest cost of living states. And, the domination by two insurers in the Maryland market leads to a "take it or leave it" attitude in contract negotiations.

II. RETENTION:

HMO Balanced Billing (Options 3.1, 3.2)

- Require carriers to reimburse billed charges for services provided to an HMO enrollee by an out-of-network physician and hold the enrollee harmless for balance billing.

Rationale: The current prohibition on balance billing in the HMO market effectively eliminates any negotiating leverage for non participating providers. It creates a ceiling for reimbursement and allows HMOs to establish arbitrarily low reimbursement rates.

Shifting responsibility to the carrier to ensure providers are adequately reimbursed, while ensuring their subscribers are held harmless from balance billing, would correct this imbalance. Physicians would have a greater willingness to contract with the health plans due to a greater ability to negotiate a fair rate.

Prohibit Linking Hospital to Hospital-Based Physician Participation (Option 3.3)

- Prohibit carriers (creates an unfair trade practice) from linking hospital participation in a carrier's network to an independent physician's decision of whether to contract with the carrier.

Rationale: Carriers contract with enrollees, in exchange for a premium, to provide an adequate network of providers. The carrier is contractually responsible for having an adequate in-network panel of physicians—including hospital-based physicians. Off-loading that responsibility creates an undue and unfair burden on the hospital and puts the hospital in the middle of what is the carrier's responsibility to their enrollees.

Facilitate Creation and Reimbursement for Medical Homes (Options 5.2, 8.1 8.3, 10.5)

- Encourage/require insurers to provide incentive payments to practices for technology upgrades/medical home development/expanded hours, etc.
- Use the Governor's newly established Quality and Cost Council to create a uniform statewide approach, with equitable funding, to assist physicians to establish patient centered medical homes.
- Apply for CMS Medical Home Demonstration Project.

Rationale: The current delivery system is poorly prepared to meet the current and future needs of an aging population. Health care cost continue to grow faster than the economy, employers are cutting back on worker and retiree health insurance coverage and benefits, funding for the Medicare programs is being accomplished through cutbacks in services, decreasing reimbursement to physicians, and passing premium increases along to beneficiaries.

Our system for reimbursement emphasizes episodic treatment for acute care. Care management, proactive or planned, active cross-discipline management, and even some preventive care are often uncovered services or are poorly reimbursed. Yet, 45 percent of the US population has a chronic medical condition and about half of these have multiple chronic conditions. For the Medicare program, 83 percent of beneficiaries have one or more chronic conditions and 23 percent have five or more chronic conditions. And, by the year 2015, and estimated 150 Americans will have at least one chronic condition.

Development of a medical home model in Maryland presents an opportunity to change the reimbursement structure to demonstrate and acknowledge the value of coordinated, patient-centered, physician directed care that is enabled by health information technology and accountability for achieving measurable improvements in the quality of care provided. Fundamental to this effort is the provision of upfront funding to assist physician practices in instituting the infrastructure necessary to redesign their practices – similar to the CMS EHR demonstration project.

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 Maryland Hospital Association (MHA) Comments/Recommendations
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Engaging multiple payers in a uniform approach provides physician practices with greater incentives to participate. It would eliminate the practices having to put different systems in place for different carriers, could be used to provide funding for the upfront costs across a multiple payers, and may provide leverage for additional funding under the CMS Medical Home Demonstration Project.

Mental Health (Option 9)

- Require commercial carriers to pay primary care providers under the medical benefit for a reasonable number of visits per year, per condition to diagnose and treat mental health disorders.

Rationale: The vast majority of adults with mental health disorders rely on their PCPs to make diagnoses and manage psychotropic medication. Over 25 percent of adults receiving primary care have a diagnosable mental disorder, most commonly depression and anxiety. While from a health care delivery perspective, treatment of less complex mental health disorders in primary care is appropriate and logical, from a work flow and a short-term financial perspective, there is less support for integration. The time required to diagnose and counsel a patient with a mental disorder is lengthier than required for most medical conditions.

Because physicians treat patients from a variety of health plans and a given health plan may only account for a fraction of the PCP's practice, physicians tend to manage their operations according to the overall composition of their payor arrangements. As a result, PCPs may avoid use of psychiatric CPT codes and submit claims with a primary diagnosis of "symptom codes" (e.g., fatigue, insomnia, etc.) or place the mental health diagnosis in a secondary diagnostic position. PCPs may also avoid use of extended service codes that compensate them for the longer visits required to manage mental health problems in order to reduce risk of claim denials.

- Require commercial carriers to coordinate the mental health and medical benefits.

Rationale: The vast majority of Marylanders receive mental health coverage under the management of mental health carve-outs through managed behavioral health organizations (MBHOs). Insurance risk for mental health services is isolated from the overall insurance and covered in a separate contract between the payor (insurer or employer) and a mental health vendor with a distinct provider network and financial incentive arrangement.

PCPs are typically not included in the MBHO provider networks and, therefore, are not paid for the providing mental health care under the mental health benefit or the medical benefit.

Physician Data Collection (Option 10.4)

- Enhance Board of Physician's licensure renewal data collection to include full time/part-time status; direct patient care as a percentage of practice time; specialty area, including areas of

concentration; whether currently practicing in Maryland, out-of-state, or inactive; use of electronic medical records, etc.

Rationale: Solid workforce projections are essential to assure Marylanders will continue to have access to the care they need.

Credentialing Simplification

- Direct DHMH to convene regulators, payors, and providers to develop procedures to streamline and standardize the physician credentialing process.

Rationale: The physician credentialing process is an extremely time-consuming, detailed, and labor-intensive process for all parties involved. Physicians in Maryland often apply for privileges at multiple facilities and/or carrier panels. The data collection process is fragmented, duplicative and uncoordinated, creating unnecessary and overlapping burdens on both the physician applicants, as well as those performing the credentialing activities.

Aggressive Enforcement of Network Adequacy Regulations

- Direct the Maryland Insurance Administration to monitor carrier network adequacy standards aggressively in shortage areas.

Rationale: Effective this fall, Maryland Insurance Administration regulations will require carriers to demonstrate an adequate “network” of providers to meet the needs of their members.

Pilot Voluntary Reimbursement System for Emergency Physicians (Option 5.1)

Need consensus among hospital-based physicians as to the desirability of such a system at this time.

Medical Liability

- Recommend enactment of Good Samaritan protection legislation for physicians practicing/providing consultation in the emergency departments.

Rationale: Would facilitate appropriate on-call coverage in the emergency department.

- Recommend enactment of apology protection legislation.

Rationale: Would facilitate quality and patient safety improvements.

- Require medical liability insurers to provide additional mechanisms for Maryland physicians to institute risk management strategies in exchange for premium reductions; i.e., telemedicine, EMRs, chronic disease management, medical home designations, etc.

Rationale: Investments for technology upgrades that enhance patient safety and improve patient outcomes reduce liability risk.

- Require medical liability insurers to offer retired/part-time physician policies that do not require “tail” coverage.

Rationale: Provides flexibility/incentives for retired physicians to practice part-time.

Oversight of P4P Programs (Option 4)

- Require carriers in their filings to the MIA to define high performance plans based on factors that include more than just costs.

Rationale: This would provide additional transparency as to what carriers are expecting of providers and would enable the MIA to track trends in carrier P4P programs. These programs should be focused on rewarding and enhancing quality and better health outcomes. They should not be focused on penalizing providers who are already under compensated and subject to ever increasing administrative burdens.

Further, oversight of these programs should be coordinated at the state level. The MHCC HMO Report Card initiative, the HSCRC P4P initiative, the Governor’s Quality Council, and other programs already play an important role in quality improvement and oversight

III. RECRUITMENT:

Greater Flexibility for LARP (Option 10.2)

- Expand loan forgiveness programs targeted at “shortage areas” and/or “shortage specialties” beyond the limited MUA/HPSA designated areas.
- Allow other “nonprofit” organizations, such as hospitals, nursing homes, clinics, hospices, etc., to sponsor a physician for loan assistance reimbursement program (LARP) purposes.

Rationale: LARP is a collaborative effort among state and federal entities that offers physicians an opportunity to practice in a community that lacks adequate primary and/or mental health care services, while also paying off their educational loans. The amount of the loan assistance provided varies in accordance with the number of years of service a physician agrees to provide. Eligible primary care practitioners include those who are board certified or have completed a residency in family practice, OB/GYN, internal medicine, pediatrics, or general psychiatry and who are employed in a non-profit setting.

Limiting opportunities for loan assistance repayment to those physicians who agree to work in a non-profit setting severely limits recruitment efforts in shortage areas. The focus should be on the broader issue of addressing the shortages in these areas for the long term. Allowing a physician to establish a private practice in a shortage area while qualifying for loan repayment assistance would facilitate the retention of that physician in that community on a long term basis.

Funding Options for LARP Expansion (Options 10.2, 10.3)

- Adjust the current assessment on physician licenses to expand and/or increase flexibility of LARP.

Rationale: Currently, 14 percent of the physician license fees (12 percent beginning in FY 2009) are dedicated and split between two programs: 1) grants under the Health Manpower Shortage Incentive Grant Program; and, 2) the Loan Assistance Repayment Program for primary care physicians. For FY 2008, the grants awarded under the Health Manpower Shortage Incentive Grant Program totaled \$499,098, and were split between 39 different postsecondary institutions. The LARP for primary care physicians in FY 2008 totaled \$432,500, with an average of \$25,441 provided to 17 physicians.

- Allow hospitals in shortage areas to establish loan forgiveness approaches under the all-payor system in exchange for a commitment to practice in the shortage area—similar to the Nurse Support Programs I and II.

Rationale: Generating additional revenue from all payors for the state portion of LARP funding could be used to draw down additional federal funding and/or establish a state program with greater flexibility.

- Allocate a portion of fines assessed by the MIA for health care carrier violations of certain consumer protection laws to LARP.

Rationale: Linking a portion of fines assessed by the MIA to LARP would better align incentives towards creating a better physician climate in Maryland.

Teaching Programs

- Encourage teaching programs to offer greater exposure to family practice settings, greater exposure to specialties in short supply, and rotations in shortage areas.

Rationale: Focusing on the types of specialties in short supply, including family medicine, and exposure to shortage area practice settings could generate interest at the medical school level (before residencies/specialties are selected). Early identification of students with an interest in practicing in shortage areas would also be useful in earlier identification of students with an interest in those types of settings.

IV. FEDERAL INITIATIVES:***Increase Number of Residency Slots***

- Increase the number of residency slots/programs in Maryland.

Rationale: The 1997 Balanced Budget Act froze the number of residency positions the Medicare program would support to more closely align it with the number of graduates of U.S. medical schools. The failure of tightly organized managed care and the aging of the US population have now led to calls for reconsideration of that policy. In 2006, the AAMC recommended a 30 percent increase in medical student enrollment and a 15 percent increase in the number of Medicare-supported GME positions. In addition, both MedPac and COGME, have suggested that policymakers focus on the number of residency slots/resources devoted to family medicine.

The number of all applicants, including graduates of foreign medical schools and colleges of osteopathy, has declined for a decade and has decreased precipitously among graduates of US medical schools. In 1997, of the 3,262 training positions in family medicine, 2,905 (89.1 percent) were filled—71.7 percent by graduates of US medical schools. In 2008, of the 2,654 residency positions offered in family medicine, 2,404 (90.6 percent) were filled, but only 1,172 (44.2 percent) were filled by graduates of US schools.

Expand Residency Training Venues

- Broaden definition of eligible “training venues”.

Rationale: Medical practice and education are shifting more to the ambulatory setting for both primary and specialty care services but GME funding continues to be primarily tied to inpatient hospital care. Adding additional training venues would better reflect the shift to ambulatory settings and likely increase the number of eligible venues in rural areas.

Loan Assistance Repayment Programs (LARP)

- Provide flexibility in the federal LARP requirements to allow physicians in private practice settings in shortage areas to qualify for the program.

Rationale: LARP is a collaborative effort among state and federal entities that offers physicians an opportunity to practice in a community that lacks adequate primary and/or mental health care services, while also paying off their educational loans. The amount of the loan assistance provided varies in accordance with the number of years of service a physician agrees to provide. Eligible primary care practitioners include those who are board certified or have completed a residency in family practice, OB/GYN, internal medicine, pediatrics, or general psychiatry and who are employed in a non-profit setting.

Limiting opportunities for loan assistance repayment to those physicians who agree to work in a non-profit setting severely limits recruitment efforts in shortage areas. The focus should

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be on the broader issue of addressing the shortages in these areas for the long term. Allowing a physician to establish a private practice in a shortage area while qualifying for loan repayment assistance would facilitate the retention of that physician in that community on a long term basis.

National Health Service Corps

- Restore/expand funding for the National Health Service Corps (NHSC) Scholarships and Loan Repayment.

Rationale: Since its inception in 1972, the NHSC has supported over 28,000 primary and dental professionals through scholarships and loans repayment in return for service in HPSA-designated areas. Service commitment is a minimum of two years, and salaries are covered by the place of employment. In FY 2006, 4,109 health care professionals were participating in the NHSC scholarship and loan repayment program. At the same time, the NHSC Jobs Opportunity List for FY 2008 indicated that 4,888 positions went unfilled because of a lack of funding to support them.

Despite the number of unfilled positions, federal appropriations for the NHSC have steadily declined—from a peak of \$169.9 million in FY 2004 to \$123.5 in FY 2008. At \$121 million, the Administration’s FY 2009 request continues this trend.

J-1 Visa Program

- Revitalize the J-1 visa program.

Rationale: The J-1 Visa allows foreign nationals to enter the U.S. for educational purposes and requires that they then return to their home country for two years before applying for a U.S. immigrant visa, permanent residence, or another type of visa. The State Department issues waivers to the return-home requirement for primary care physicians who practice in designated HPSAs. A GAO survey of the states found that in 2005 there were 3,128 waiver physicians practicing in underserved areas – significantly higher than the number of U.S. physicians participating in the NHSC.

Over the last several years, however, the number of J-1 Visas has declined, triggered in large part by the expansion of H1-B work-related visas and a real preference among residency programs to take H1-B foreign trained US citizens over J-1 Visa physicians. Policy changes are needed to revitalize or replace this vital pipeline to underserved communities.

Telemedicine

- Seek Medicare reimbursement for a broader range of telemedicine services.

Rationale: Medicare currently limits reimbursement for telemedicine to “interactive clinical services that otherwise would be provided face-to-face.” Monitoring chronic disease at home, providing continuing medical education to local providers in rural areas, clinical

integration, improving communication among providers, payors, and patients, etc., all have the potential to significantly improve the efficiency and effectiveness of health care delivery in shortage areas.

Expand MUA/HPSA Designations

- Revise criteria for MUA/HPSA designations to qualify additional shortage areas for designation in Maryland.

Rationale: Obtaining a federal designation as a Medically Underserved Area/Population (MUA/P) or Health Professional Shortage Area (HPSA) makes them eligible for multiple federal program resources and benefits; e.g., FQHCs, J-1 Visa, Loan Assistance Repayment, National Health Service Corps, enhanced Medicaid and Medicare reimbursement.

The current regulations, however, are complex and limited in scope as to what geographic areas would qualify as well as what professionals are included. Expanding the scope of these programs would enable shortage areas to attract other types of medical professionals needed in their communities and facilitate the location of professionals in emerging shortage areas.

Providing additional resources to state offices of rural health may be appropriate to ensure timely designations of these shortage areas.

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September 12, 2008

The Honorable John M. Colmers
 Secretary, Department of Health and Mental Hygiene
 201 West Preston Street
 Baltimore, Maryland 21201

Re: Healthcare Access and Reimbursement Task Force Meeting
 of September 8, 2008

Dear Secretary Colmers:

We are writing to you in your capacity as Chair of the Healthcare Access and Reimbursement Task Force. We understand that during the meeting on September 8, 2008, the Task Force was presented with the information regarding the following issue: "whether Primary Care Physicians (PCP) should be allowed to receive reimbursement for providing mental health services."

The Maryland Psychological Association asks that you review this letter, and distribute it to other members of the Healthcare Access and Reimbursement Task Force. In addition, we ask that you allow the Maryland Psychological Association to present additional information on this issue to the Task Force as soon as is practicable.

As you know, the Maryland Psychological Association has consistently strongly advocated for mental health consumers in Maryland. We were directly involved in promoting parity in Maryland, vigorously worked to ensure that adequate health benefits were included in the small business benefit package, and have consistently worked with provider and consumer groups to ensure adequate mental health benefits for Maryland's citizens.

The Maryland Psychological Association has also long recognized and supported the involvement of PCPs in the mental health delivery system. Many psychologists collaborate with many PCPs in the treatment of their mutual patients. The Maryland Psychological Association is aware that PCPs prescribe the vast majority of psychotropic medications for patients with mental health disorders. They certainly should be reimbursed for the extra time spent with these patients.

The Maryland Psychological Association was actively involved in the discussions surrounding House Bill 499 and this specific issue this past legislative year. We met with Delegate Shirley Nathan-Pulliam, testified at a sub-committee hearing, and participated in a small group discussion convened by Delegate Nathan-Pulliam. We would like the opportunity to present information which we believe would be of benefit to the Task Force members.

The Maryland Psychological Association is well aware of the data which shows that the majority of visits to PCPs are directly related to their patients' mental health problems and many of our members enjoy warm and collaborative relationships with many PCPs.

The Honorable John M. Colmers
September 12, 2008
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Our specific concern with House Bill 499 as it was originally introduced, and with its subsequent amendments, is directly related to the confusing language that would have allowed PCPs to be reimbursed for treatment of mental health disorders. Primary Care Physicians are already able to bill for, and be reimbursed for, treating patients with mental illness using CPT codes for office visits of varying durations and complexity and for medication management.

In contrast, PCPs are typically not reimbursed for “Psychiatric or Diagnostic or Evaluative Interview Procedures”, “Psychiatric Therapeutic Procedures”, and for “Other Psychotherapy” which are included in CPT Codes 90801 – 90857. We believe this is appropriate.

CPT codes 90801–90857 all require the provision of psychotherapy. Our specific concern with regard to this issue is that PCPs are not trained to provide psychotherapy and, therefore, should not be reimbursed for CPT codes 90801 – 90857.

Primary Care Physicians do not have the necessary education or training to provide psychotherapeutic services, including psychotherapy, to their patients. Licensed mental health professionals (clinical professional counselors; social workers – clinical; psychologists; and psychiatrists) have between two years and eight years of education beyond the bachelor’s degree and a minimum of two thousand (2000) hours of supervised clinical experience. In contrast, PCPs, at best, have several months of limited experience in medical school working with individuals with mental health disorders.

We know there is an access problem for mental health services and we know that some patients are reluctant to see specialists for needed treatment. But there are more appropriate solutions to these issues than to allow an untrained individual to be reimbursed for providing services for which they are not trained. Primary Care Physicians have the responsibility to ensure that their patients receive appropriate treatment and appropriate referrals. ***There is no excuse for allowing an untrained medical practitioner to provide services for which they do not have the necessary training and education.***

Primary Care Physicians are not experts in all areas of medicine and routinely refer to appropriate specialists, including cardiologists, orthopedists, allergists, optometrists and ophthalmologists. Historically, PCPs have referred patients with mental health problems to licensed mental health professionals. **Patients should not be allowed to be inadequately treated because they have a mental health problem.**

Again, we would appreciate the opportunity to present these issues to the Task Force at a future meeting.

Thank you, as always.

Sincerely,



M. Kathryn Seifert, Ph.D.
President



Paul C. Berman, Ph.D.
Professional Affairs Officer

**MEDCHI COMMENTS ON TASK FORCE “OPTIONS” DOCUMENT
 (“REQUIRED AREAS FOR RECOMMENDATION”)**

Option No. 2: Messenger Model - This is a series of proposals to encourage the “messenger model” for fee negotiations between physician practices and insurers in order that physician practices can achieve higher fees. This “Option” has been available for years under the Federal Anti-Trust laws and MedChi believes it holds very little promise for realistic assistance. The “messenger model” has not proven effective in other states and, indeed, in Delaware resulted in indictments on the basis that participating doctors had not followed the legal requirements of the “messenger model.” As noted in the “Options” document itself, physician organizations including the American Medical Association have no confidence in the efficacy of the messenger model.

MedChi supports option 1.3 to establish a Physician Practice Development Program (See MedChi Recommendation No.7).

Option No. 3: Balance Billing Statutory Formula - MedChi would support making the present statutory formula for the reimbursement of non-contracting physicians more transparent. MedChi views with great skepticism the proposal (Option 3.2) to extend the current law to PPO and EHO products which it believes will already compound the difficulties particularly if health insurers are “protected” by state law from paying non-participating doctors their billed charges. Similarly, Option 3.3 will further compound the present problem by having hospitals place pressure on doctors to accept unfair contracts from HMOs.

As indicated in its Recommendation No. 2, MedChi believes that the current statutory formula contained in Health General Article §19-710.1, can be improved by substituting the law of Colorado.

Option No. 4: MIA and Attorney General Authority - MedChi does not fully understand this Option but to the extent it would give the MIA or the Attorney General an ability to “penalize” doctors who “perform poorly,” MedChi would object. The MIA should be penalizing insurers that “perform poorly” and not exercising judgment with respect to doctors for which that agency has no expertise.

Option No. 5: Physician Payment System - MedChi believes that Option 5.1 is worth pursuing as specified in MedChi Recommendation No. 6 but Option 5.2 is a more complicated proposal which should not be even considered until existing initiatives have played out.

Option No. 6: Pay For Performance (P4P) – P4P programs have generated enormous controversy in the medical community. The problem with P4P programs is that patients do not necessarily receive “quality” medical care because doctors perform according to a standard set of indices. This same notion was advanced in American business circles 30

years ago (Six Sigma) and proved not only time consuming but, ultimately non-productive, as it served to stifle creativity.

Nevertheless, as the present push for P4P continues, there should be standards on insurers to benefit both consumers and physicians in analyzing the P4P rating systems. National insurance carriers (for example, United) clearly want to export their agreement with New York to all other states.

Option No. 8: Increased Reimbursement For Certain Services – MedChi fully supports increased reimbursement for after hours and electronic services as mentioned in this Option but with one change: strike the word “encourage” and substitute the word “require.” To the extent that state law “requires” fully insured plans to compensate doctors in certain ways, ERISA plans may follow suit as insurers do not form separate panels of doctors depending upon whether a patient is in an insured plan or an ERISA plan.

See MedChi Recommendation No. 3 which presents a fuller discussion of this particular Option.

Option No. 9: Mental Health Services - MedChi supports this Option which would assist primary care physicians in being reimbursed for the provisions of mental health services.

Option No. 10: Physician Shortages - MedChi would support Option 10.2 (See MedChi Recommendation No. 1), 10.3 and 10.5 (MedChi Recommendation No. 4 and Recommendation 5) with the proviso that Option 10.5 be edited to strike “and CareFirst.”

**MEDCHI'S PROPOSED RECOMMENDATIONS TO GOVERNOR'S
TASK FORCE ON HEALTH CARE ACCESS AND REIMBURSEMENT**

Recommendation No 1: Establish a five-year loan forgiveness program for medical school debts to any graduate of an American medical school who agrees to practice primary care in a Maryland shortage area. Debt will be remitted at the rate of 20% per year until extinguished. This program would be complimentary and coordinated with the existing LARP program but, in the end, the goal would be to locate primary care physicians in Maryland (not federal) defined shortage areas with a complete five-year payback program. Eligible primary care physicians would include those who are board certified and who have completed residency in family practice, OB-Gyn, internal medicine, pediatrics or general psychiatry.

The Following Information Is Excerpted From One Report of a Separate Task Force to Review Physician Shortages In Rural Areas:

- Establish/expand loan forgiveness programs targeted at “shortage areas.”

Rationale: Need to have multiple recruitment mechanisms when average debt of a medical school graduate is \$147,000 and Maryland is a low reimbursement, high-cost of living state.

The current program is only available for primary/mental health care and only if the physician is practicing in a nonprofit setting in a federally designated shortage area.

- Allow other “nonprofit” organizations, *such as hospitals, nursing homes, clinics, hospices, etc.*, to sponsor a physician for loan assistance reimbursement program (LARP) purposes but also includes “for profit” organizations such as a physician’s private practice to qualify.

Rationale: Requiring the physician to work in a “nonprofit setting” limits recruitment efforts by private physicians in shortage areas. *Allowing a nonprofit to “sponsor” the physician and permit the physician to work in a private practice setting would greatly expand the opportunities for retaining the physician in that community on a long term basis.*

- Adjust the current assessment on physician licenses to expand LARP.

Rationale: *Currently, 14% of the physician license fees are dedicated and split between two programs: 1) grants under the Health Manpower Shortage Incentive Grant Program; and 2) the Loan Assistance Repayment Program for primary care physicians. For FY 2008 the grants awarded under the Health Manpower Shortage Incentive Grant Program totaled \$499,098 and were split between 39 different postsecondary institutions. The LARP for primary care physicians in FY*

2008 totaled \$432,500, with an average of \$25,441 provided to 17 physicians.

Generating additional revenue for the state portion of LARP funding could be used to draw down additional federal funding and/or establish a state program with greater flexibility. *Further discussion may also be warranted to determine whether the grants awarded under the Health Manpower Incentive Grant Program are too small/diluted to have the impact originally intended.*

- Allow hospitals in shortage areas to establish loan forgiveness approaches under the all-payer system in exchange for a commitment to practice in the shortage area – similar to the Nurse Support Programs I and II.

Rationale: Generating additional revenue *from all payers* for the state portion of LARP funding could be used to draw down additional federal funding and/or establish a state program with greater flexibility.

- Aggressively pursue additional HPSA/MUA designations for Maryland through the Office of Primary Care.

Rationale: Locations or population groups that meet the criteria for federal designation are eligible for more than 30 federal program resources and benefits.

- Create a Maryland Health Service Corps program for all Maryland shortage areas.

Rationale: Shortages exist in areas and specialties in Maryland beyond the limited focus of the national program.

Recommendation No 2: Change Maryland’s current statutory formula applicable to non-participating physicians treating HMO patients to Colorado law where the “balance” of a non-participating doctor’s bill is paid by the HMO not by the patient.

Rationale: Maryland’s current statutory formula requires an HMO to pay a non-par doctor the “greater of” 125% of the rate that the HMO pays in the same geographic area to a similarly licensed provider under written contract with the HMO or the rate that the HMO paid as of January 1, 2000. Health General Article §19-710.1(b). The Maryland Insurance Administration (MIA) has ratified the practices of most HMOs which are to pay the 125% of the lowest rate paid to a similarly licensed provider. The only court to ever consider the issue was the Circuit Court of Anne Arundel County which ruled that HMOs must pay 125% of the “average” paid by the HMO to similarly licensed providers. The Anne Arundel County case is known as Delmar Emergency Specialists, et al. v. MD-IPA et al. (Civil Case No.: 02-C-05-110040IT) and the ruling was by Judge Paul Hackner (Order attached to hard copy of this letter). After being advised of Judge Hackner’s decision, the MIA refused to reconsider its position (Birrane letter of April 9, 2007 attached to hard copy of this letter).

MedChi believes that the proper reading of the statute is that the “average” rate should be the basis for the 125% multiplication. However, neither the “lowest” or the “average” rate remedies the problem with the current statutory formula because the rates are not transparent. Each company has different contractual rates. The use of a transparent standard such as the Medicare fee schedule would be the easiest to administer but, unfortunately, certain specialties (particularly anesthesiology) are adversely impacted by the use of Medicare fees. Perhaps a compromise would be to use the Medicare fee schedule for most specialties and maintain a variant of the present system (125% of average) for those specialties for which Medicare is inappropriate.

One method to enforce the “average” calculation would be to amend Insurance Article 15-113 which requires “carriers” (including HMOs) to provide a health care practitioner with a written copy of a schedule of applicable fees for up to the 50 services billed by a health care practitioner in that specialty.

MedChi believes, however, that the cleanest method would be to adopt the law of Colorado which requires the HMO to be responsible for the “balance” of any doctor’s bill. In most cases, hospital based doctors are being pressured by hospital administrators to sign contracts and will do so if the reimbursement offered is appropriate. Moreover, HMOs are required to have “adequate” networks so that a patient is not sent to a “participating” doctor where there are no participating doctors. Many advantages accrue to doctors who “participate” but there will be no incentive to enter into contracts as long as HMOs are able to manipulate the payment to non-par doctors with respect to their HMO patients.

Recommendation No. 3: Require carriers to reimburse PCPs a premium for visits after the 5:00 p.m. workday and, on weekends and to provide a compensation schedule to PCPs for phone and e-visit communications delivered to a patient.

Rationale: At the present time, most primary care doctors are not additionally compensated for night time office visits or for telephone and email communications with patients. As email has expanded throughout American life, there is no reason that a doctor should not be able to interact with a patient by use of this medium or by use of the telephone. Such communication can “save” an office visit for a patient who is unable to accommodate an inpatient visit into their schedule.

The potential dollar savings are dramatic. For instance, a primary care doctor in Maryland is paid approximately \$37 per office visit whether that office visit occurs during the normal business hours or after hours. Since the doctor is paid no more for nighttime visits, a referral is often made to the Emergency Department for a patient who feels that they need to be examined. The Emergency Department visit will typically cost between \$135 and \$150 with an expected long wait. Paying a primary care doctor double his or her office visit rate for a nighttime visit (\$74) would result in significant savings as well as greater convenience to the patient.

Recommendation No. 4: The enactment of medical malpractice reforms consistent with the laws of California and Texas.

Rationale: California and Texas are two states which provide a favorable environment for physicians. The California MICRA law has been in effect since the early 1980s and results in significantly reduced premiums for medical malpractice insurance. Texas, on the other hand, saw a crushing rise in malpractice premiums until it enacted reforms a few years ago. The result of those reforms: significant reductions in malpractice premiums and a flood of doctors seeking to practice in Texas.

The “canary in the mine” for the malpractice environment is the rate charged to an OB-Gyn. The Maryland OB-Gyn rate is so high that it not only indicates that Maryland is a toxic malpractice environment but has resulted in the early retirements or abandonment of OB practices by numerous doctors. Real reform can reduce the Maryland OB-Gyn rate to that of California or Texas. According to the Medical Liability Monitor (October 2007, Vol. 32, No. 10) the average 2007 manual rate for OB-Gyns (exclusive of all credits and dividends) in Maryland was \$133,117 as opposed to the California figure of \$62,892 and the Texas figure of \$83,678.

The reduction of the OB-Gyn rate will mean that all rates have come into line.

Recommendation No. 5: Establishment of a primary care demonstration project under the auspices of the Maryland Health Care Commission with health insurer support of primary care practices with increased E and M fees for doctors who take part in a “medical home” practice. Med Pac, the congressional think tank, has proposed increased payment for Medicare E and M codes to those practices which are “primary care” with the notion being that primary care doctors can address medical problems that may otherwise be referred to specialists because of inadequate reimbursements.

Rationale: The Governor’s newly established Quality and Cost Council should create a uniform statewide approach with equitable funding, to assist physicians to establish patient centered medical homes. Providing information technology improvement funding, similar to the current CMS demonstration now under way, would eliminate a huge barrier in making these investments, will enhance quality improvement and patient safety initiatives and may create leverage for additional federal funding under the CMS Medical Home Demonstration Project. **It is critical that this demonstration project identify the true cost for a medical home practice and develop a proper level of reimbursement so that a primary care doctor can be financially successful.**

A state sponsored demonstration project may well provide a pathway to recognize both an increased role and increased reimbursement for primary care physicians. Increased reimbursement is critical to retaining and recruiting such physicians.

Recommendation No. 6: A pilot project under the auspices of the Maryland Healthcare Commission for volunteer Emergency Departments to come under the current “all payer” system and to have this system apply to reimbursement of the covered Emergency Department practice.

Rationale: The Maryland Hospital All-Payer System is a model for fair reimbursement. The reimbursement levels are set by independent state agencies and are required to be reimbursed by “all payers.”

Maryland presents a case study in inequitable bargaining power between health insurance carriers and physicians. Maryland physician practices tend to be small and two insurance carriers control perhaps 80% of the market. It seems reasonable to conduct a pilot project to see whether a hospital based physician specialty could be integrated into the current system at a particular hospital.

Some have suggested that Medicare would not be supportive of the inclusion of hospital based physician practices. However, when the hospital rate commission was first established it asserted jurisdiction over all hospital based physician practices only to lose its assertion of jurisdiction in a number of court decisions. Even at the present time, two emergency departments are subject to HSCRC jurisdiction (the Chester River Hospital in Kent County and the McCready Hospital in Crisfield). Hence, to the degree two of our state’s emergency departments are already covered by current Medicare waiver; it may be that Medicare would look favorably on a pilot project.

Recommendation No. 7: MedChi supports many of the recommendations and proposals contained in the SAGE presentation which is being presented to this Task Force on Monday, October 6th, particularly those designed to encourage the creation of private physician practices in Maryland.



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September 17, 2008

John Colmers
Secretary
Department of Health & Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201

Dear Secretary Colmers:

MedChi is appreciative of the time that you and the Governor's Task Force have spent studying the present problems facing physicians in Maryland. As the MedChi/MHA Workforce Study has demonstrated, there is a present shortage of physicians in certain areas of the state and there will be a shortage in all areas of the state in just a few years. This shortage is particularly evident in primary care but extends to other specialties. Furthermore, another overall trend is clear: physicians are abandoning the private practice of medicine and becoming employees of hospital systems and hospitals have no way of recouping their increasing costs for physician practices.

Against this background, we were disheartened by the tone of the last Task Force meeting in its discussion of "Options" to correct the present state of affairs. For instance, emphasis was placed on the limitations placed on the Task Force by virtue of the federal ERISA law but there was little if any emphasis placed on the possibilities available to counter those limitations. Perhaps the largest ERISA plan is the State of Maryland itself and, in the past, the State Plan has accepted as policy legislative enactments of the General Assembly. Is there any reason to believe that this would not be the case with respect to Task Force recommendations?

The suggested options section pertaining to the Maryland law prohibiting balance billing is a second example of how the "options" presented to the Task Force by staff are in discord with the situation facing Maryland. The Task Force was presented with a great deal of information regarding Maryland's HMO balance billing law and the statutory formula that currently exists to reimburse non-participating physicians. It is clear that the current formula is contributing to the negative situation for physicians. We believe that it would be relatively easy to surgically correct the HMO balance



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billing law. However, the “Options” document suggests an extension of the balance billing law to non-HMO products. We find it difficult to understand how extension of a policy that negatively affects physicians will achieve any objective other than to compound existing difficulties and are concerned that by seriously considering this option, the Task Force is setting the wrong tone for a meaningful discussion of how the environment for physician practice can be improved.

MedChi had great hopes when the Task Force was formed. We believed that elected officials had come finally to the realization that serious study was needed so that the dislocations in the physician workforce would not be magnified. We remain hopeful but, frankly, are disappointed with what we see as the direction of the Task Force. Never, for example, has there been any discussion of excessive insurance company profits and surplus.

Prior to the next Task Force meeting, Med Chi pledges to provide the Task Force with feedback on the various options that have been identified. Further we will advance additional proposals that we do not believe are adequately reflected in the “Options” document. Despite our present “tonal” concerns, it remains the hope of MedChi that the Task Force’s final recommendations will be insightful, aggressive and effective.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Bruce M. Smoller MD".

Bruce M. Smoller, M.D.
President

cc: All Task Force Members



MARYLAND SOCIETY OF ANESTHESIOLOGISTS

September 29, 2008

John M. Colmers, Secretary of Health & Mental Hygiene
Office of Secretary
Department of Health & Mental Hygiene
201 West Preston St.
Baltimore, MD 21201 - 2399

Dear Secretary Colmers and Members of the Task Force:

We are writing to provide you and the members of the Governor's Task Force on Health Care Access and Reimbursement with our recommendations and suggestions on the options that have been presented for discussion. The Maryland Society of Anesthesiologists (MSA) is comprised of the anesthesiologists who practice within the city of Baltimore and the 24 counties of the State of Maryland. We advocate policies that preserve the appropriateness and safety of the delivery of anesthesia care in Maryland.

The Maryland Hospital Association (MHA) and MedChi Physician Workforce Survey conducted in 2007 (findings released in 2008) reinforced our findings from an informal survey the MSA conducted in 2006. What both the surveys showed is that there is a critical shortage of anesthesiologists in the State. In fact our 2006 survey indicated that 65% of hospitals that responded to our survey were closing at least one operating room per week because of the shortage. Three hospitals were staffed solely with temporary staff (locum tenens). Temporary staff does not usually take call or contribute to the overall operation and continuity of the anesthesia department, placing an additional burden on the permanent staff. If a hospital is staffed with only locums, who takes call?

What we are looking for from the Task Force are meaningful solutions to bring Maryland in line with other states in our ability to compete for physicians. Physician reimbursement reform is essential to increase the physician supply in Maryland, and ensure that the infrastructure exists to ensure access to care.

Priority Recommendation:

We reviewed all of the options detailed in Section 3 (3.1, 3.2, 3.2.1, & 3.2.2). Our priority is to change Maryland law so that the responsibility is shifted to the HMO to hold the subscriber harmless from balance billing. We point to the Colorado statute as a model. The consumer protection to the subscriber is maintained, but valuable negotiating leverage is returned to the

physician. Other states with statutes and regulations in a similar posture include Florida, New Jersey, and Virginia.

The medical specialty of Anesthesiology has traditionally been a hospital based practice. The net effect of the current HMO nonparticipating physician reimbursement methodology and ban on balance billing in the Maryland HMO market is driving anesthesiologists out of the Maryland hospitals that provide round the clock care and where the need for services is greater; into ambulatory and office based surgery centers where the hours are shorter and predictable, and the patients are far less acute. Not only are we seeing many long time hospital based physicians leaving for non-hospital practice settings, but many of the new anesthesiologists trained in Maryland are leaving the State once their residency is complete.

The time to reverse this trend is now and the most direct way is through substantial reform in the HMO market. Any attempt to make changes to the PPO market is premature.

Comments on other Options under Task Force consideration:

Option 3.3 – “Link Designation of preferred hospitals to-Network Participation of Hospital-based Physicians”

This recommendation is a step backwards in that the hospitals will ultimately continue to carry a heavy financial burden in the form of physician subsidies; and represents an unfair trade practice.

Option 5.1 – “Develop a hospital-based payment system demonstration starting with one specialty, but expanding to all hospital-based physicians and all private sector carriers”

There is no consensus within the anesthesia community or the physician community to move forward with such a system. We strongly suggest that a comprehensive study be conducted on not only the feasibility of such a system, but the anticipated economic impacts.

Option 6 – “The advisability of the use of payment method linked to quality of care or outcomes”

We believe that this recommendation needs further study with consideration given to:

- * Practice location and the population served by that practice, and
- * The patient’s condition at the time they started receiving care

Other initiatives that need to be addressed *in conjunction with or after reimbursement reform* include: medical liability reform and cost relief for physicians, and design and implementation of electronic medical records system and IT infrastructure for physicians, insurers and hospitals.

Conclusion:

We ask that you and the members of the Task Force give strong consideration to meaningful reform in the HMO market for nonparticipating physicians. Physicians want to contract with the insurers, but they want to be able to negotiate a fair rate; a rate that is comparable to what the experience is nationally. The concentration of 2 insurers holding the predominant majority of the market in Maryland makes negotiation difficult as well.

We cannot continue to lose hospital-based physicians to other states and practice settings. If we continue to stretch our resources too thin we will be facing a patient access crisis starting with the Eastern Shore, Western and Southern Maryland eventually extending to the Central Maryland region.

As evidenced by the Prince Georges Hospital crisis, it is usually the populations most at risk for lack of access to care who suffer from physician shortages and medical cost shifting. A hospital-based physician reimbursement system that relies on subsidies to keep doctors in the hospital is not viable in the long term and must be replaced with a system that protects the consumer but provides the physician with the ability to negotiate fair and equitable contracts with insurers.

We look forward to working with you and others to bring forward the substantial and critical reforms needed to Maryland's health care system.

Sincerely,

A handwritten signature in black ink that reads "Jeremy Roth M.D." The signature is written in a cursive style.

Jeremy Roth M.D.
President, Maryland Society of Anesthesiologists

Attachment 1:

Colorado Statute

Participating Facilities and Non-Participating Physicians - FAQs on SB06-213

SB06-213 was signed into law on June 2, 2006. The bill codifies the Division of Insurance's interpretation that the Network Adequacy statute, CRS 10-16-704 (3), requires consumers who receive services at an in-network facility from a non-network provider to be held harmless from charges beyond those of an in-network provider.

What health plans does this requirement apply to?

The law applies to individual, small and large group managed care plans under Colorado law. Colorado health insurance laws do not apply to the federal employee plans, self-funded health policies, and they typically do not apply to a policy that was issued to an employer located in another state that includes Colorado residents.

When is this statute triggered?

There are several conditions that must be met:

1. The services were provided to the consumer at an in-network facility.
2. The services are covered benefits under the plan.
3. The consumer did not specifically choose a non-network provider instead of an in network provider at the in-network facility.

For what amount is the consumer liable?

Under this statute, the consumer is liable for the in-network deductibles, co-pays and coinsurance for the covered services they receive.

Can a physician balance-bill the consumer?

If the insurance company does not reimburse 100% of billed charges, a physician may balance bill the consumer. The consumer should forward the non-network provider's bill to their managed care plan.

What is the managed care plan supposed to do with a non-network provider's balance bill to a consumer?

The managed care plan is required by law to hold the consumer harmless from the non-network provider's "balance bill." The managed care plan may attempt to negotiate with the provider to accept the in-network reimbursement amount or another amount. If no agreement is reached, the managed care plan must reimburse the full amount of the provider's charges.

Attachment 2:

**Provisions in New Jersey Regulations regarding
Non-Par Providers and Reimbursement**

New Jersey Administrative Code – Title 11 Department of Banking and Insurance – Division of Insurance, Chapter 24 HMOs, Subchapter 5. Health Care Services

11:24-5.1 Provision of health care services

(a) The HMO shall, at a minimum, provide or arrange for the provision to its members all basic comprehensive health care services and all other services enumerated in this subchapter and in N.J.S.A. 26:2J-1 et seq., as it may be amended from time to time.

1. If the HMO refers a member out of network, the service or supply shall be covered as an in-network service or supply, such that the HMO is fully responsible for payment to the provider and the member is only responsible for any applicable in-network level copay, coinsurance or deductible for the service or supply.

New Jersey Administrative Code – Title 11 Department of Banking and Insurance – Division of Insurance, Chapter 24 HMOs, Subchapter 9. Member Rights and Responsibilities and Disclosure to Consumers

11:24-9.1(d)(9) Policies and Procedures

(d) The statement of the member's rights shall include at least the right:

9. To be free from balance billing by providers for medically necessary services that were authorized or covered by the HMO except as permitted for copayments, coinsurance and deductibles by contract;

From the State of New Jersey Department of Banking and Insurance
July 23, 2007 Order No. A07-59 against Aetna

19. The above regulations establish that for services rendered by non-participating providers for emergency care, during admissions to a network hospital by a network provider and where a member is referred by the HMO to a non-participating provider, the member has no liability for the difference between the non-participating provider's billed charges and the benefit paid by the HMO because the member is responsible only for the network copayment, coinsurance or deductible.

20. Accordingly, in such situations, Aetna must pay the non-participating provider a benefit large enough to insure that the non-participating provider does not balance bill the member for the difference between his billed charges and the Aetna payment, even if it means that Aetna must pay the provider's billed charges less the member's network copayment, coinsurance or deductible.

Attachment 3:

ALFRED W. GROSS
 COMMISSIONER OF INSURANCE
 STATE CORPORATION COMMISSION
 BUREAU OF INSURANCE



P.O. BOX 1157
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HDJN PC

June 16, 2008

JUN 18 2008

Administrative Letter 2008 - 09

To: All Health Maintenance Organizations Licensed in Virginia and Interested Parties

Re: Emergency Services
 § 38.2-4312.3 of the Code of Virginia

The purpose of this administrative letter is to provide all HMOs with guidance for compliance with the requirements of subsection B of Code of Virginia § 38.2-4312.3, patient access to emergency services, addressing federal Emergency Medical Treatment and Active Labor Act ("EMTALA") claims and reimbursements. It should be noted that this letter addresses requirements specifically addressed in subsection B of the statute only.

§ 38.2-4312.3 B states:

A health maintenance organization shall reimburse a hospital emergency facility and provider, less any applicable copayments, deductibles, or coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which the member presented in the hospital emergency facility if (i) the health maintenance organization or its designee or the member's primary care physician or its designee authorized, directed, or referred a member to use the hospital emergency facility; or (ii) the health maintenance organization fails to have a system for provision of twenty-four-hour access in accordance with subsection A above. For purposes of (i) above, a primary care physician may include a physician with whom the primary care physician has made arrangements for on-call backup coverage.

Subsection B of § 38.2-4312.3 requires an HMO to reimburse hospital emergency facilities and providers for EMTALA services rendered to its members "less any applicable copayments, deductibles, and coinsurance." This is the only guidance the statute provides regarding the level of reimbursement for EMTALA services. The provision does not state that non-participating providers are entitled to be fully reimbursed for their billed charges, nor does it say what the rate of reimbursement should otherwise be. The statute also does not distinguish between EMTALA services rendered by participating providers and EMTALA services rendered by non-participating providers. The plain language of the statute requires that the HMO pay the non-participating provider an amount sufficient to prevent the member from being balance billed. This does not mean that the HMO must always pay non-participating providers the exact amount it has been billed. The HMO is free to negotiate a lower amount with the provider.

Administrative Letter 2008-09
June 16, 2008
Page 2 of 2

If the HMO pays a provider an amount insufficient to prevent the member from being balance billed, then it is not reimbursing the provider "less any copayments, deductibles and coinsurance". This procedure does not meet the requirements of the statute.

Further, HMOs are required under § 38.2-4312.3 B to directly reimburse non-participating providers for EMTALA services. This is also supported by the plain meaning of the statute. An HMO may not reimburse the member, rather than the provider, for screening and stabilization services rendered to meet the requirements of EMTALA.

The Bureau requires all HMOs to review their procedures associated with emergency services to ensure that they are compliant with § 38.2-4312.3 B and to notify the Bureau within 60 days of the date of this letter of any prospective and retrospective corrective measures that will be implemented if noncompliant procedures have been identified.

Questions concerning this letter may be directed IN WRITING to:

Jacqueline K. Cunningham
Deputy Commissioner
Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218

Cordially,



Alfred W. Gross
Commissioner of Insurance

AWG

NOTE: Please note that the Bureau of Insurance will be converting to Sircon for States, a new web-based computer system, effective Tuesday, September 16. As a result, the Bureau will be unable to process any transactions or provide information for producer licensing, consumer services, or company admissions from 5:00 p.m., Thursday, September 4 through Monday, September 15. Please keep these dates in mind as you plan for your business needs in September. See the Bureau website for further details.

NOTE: This bill has been prepared for the signature of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.



SENATE BILL 06-213

BY SENATOR(S) Hagedorn, Boyd, Fitz-Gerald, Tochtrop, Tupa, Veiga, and Williams;
also REPRESENTATIVE(S) Penry, Berens, Borodkin, Carroll M., Coleman, Frangas, Garcia, Hall, Jahn, Kerr A., McCluskey, Paccione, Rose, Solano, Stafford, Sullivan, White, and Witwer.

CONCERNING THE REQUIREMENT THAT HEALTH CARE SERVICES PROVIDED AT AN IN-NETWORK FACILITY BE PROVIDED TO THE COVERED PERSON AT NO GREATER COST THAN SERVICES PROVIDED BY AN IN-NETWORK PROVIDER.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 10-16-704 (3), Colorado Revised Statutes, is amended to read:

10-16-704. Network adequacy - legislative declaration.
(3) (a) (I) IN 1997, THE GENERAL ASSEMBLY ENACTED THIS PART 7 WITH THE EXPRESS INTENT TO INCORPORATE CONSUMER PROTECTIONS INTO THE CREATION AND MAINTENANCE OF PROVIDER NETWORKS AND TO ESTABLISH STANDARDS TO ASSURE THE ADEQUACY, ACCESSIBILITY, AND QUALITY OF HEALTH CARE SERVICES OFFERED UNDER A MANAGED CARE PLAN.

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(II) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT THERE ARE SITUATIONS IN WHICH INSURED CONSUMERS RECEIVE HEALTH CARE SERVICES, INCLUDING PROCEDURES APPROVED BY THEIR INSURANCE CARRIER, IN A NETWORK FACILITY, WITH A PRIMARY PROVIDER THAT IS A NETWORK PROVIDER, BUT IN WHICH OTHER HEALTH CARE PROFESSIONALS ASSISTING WITH SUCH PROCEDURES MAY NOT BE IN-NETWORK PROVIDERS. IN SUCH SITUATIONS, THE CONSUMER IS NOT AWARE THAT THE ASSISTING PROVIDERS ARE OUT-OF-NETWORK PROVIDERS. FURTHER, THE CONSUMER MAY HAVE LITTLE OR NO DIRECT CONTACT WITH THE ASSISTING HEALTH CARE PROFESSIONALS. THE DIVISION OF INSURANCE HAS INTERPRETED THE NETWORK ADEQUACY PROVISIONS IN THIS SECTION, ALONG WITH THE PROVISIONS RELATED TO RELATIONSHIPS BETWEEN AN INSURER AND A HEALTH CARE PROVIDER IN SECTION 10-16-705, TO HOLD THE CONSUMER HARMLESS FOR ADDITIONAL CHARGES FROM OUT-OF-NETWORK PROVIDERS FOR CARE RENDERED IN A NETWORK FACILITY. THE DIVISION OF INSURANCE'S INTERPRETATION OF THESE STATUTES WAS CHALLENGED BY AN INSURER AND INVALIDATED BY A DIVISION OF THE COLORADO COURT OF APPEALS IN *PACIFIC LIFE & ANNUITY CO. V. COLORADO DIV. OF INS.*, NO 04CA216 (SLIP OP.) (FEB. 23, 2006).

(III) THE GENERAL ASSEMBLY FINDS, DETERMINES, AND DECLARES THAT THE DIVISION OF INSURANCE HAS CORRECTLY INTERPRETED THE PROVISIONS OF THIS SECTION TO PROTECT THE INSURED FROM THE ADDITIONAL EXPENSE CHARGED BY AN ASSISTING PROVIDER WHO IS AN OUT-OF-NETWORK PROVIDER, AND HAS PROPERLY REQUIRED INSURERS TO HOLD THE CONSUMER HARMLESS. THE DIVISION OF INSURANCE DOES NOT HAVE REGULATORY AUTHORITY OVER ALL HEALTH PLANS. SOME CONSUMERS ARE ENROLLED IN SELF-FUNDED HEALTH INSURANCE PROGRAMS THAT ARE GOVERNED UNDER THE FEDERAL "EMPLOYEE RETIREMENT INCOME SECURITY ACT". THEREFORE, THE GENERAL ASSEMBLY ENCOURAGES HEALTH CARE FACILITIES, CARRIERS, AND PROVIDERS TO PROVIDE CONSUMERS DISCLOSURE ABOUT THE POTENTIAL IMPACT OF RECEIVING SERVICES FROM AN OUT-OF-NETWORK PROVIDER.

(IV) THE GENERAL ASSEMBLY FINDS, DETERMINES, AND DECLARES THAT SOME CONSUMERS INTENTIONALLY USE OUT-OF-NETWORK PROVIDERS, WHICH IS THE CONSUMERS' PREROGATIVE UNDER CERTAIN HEALTH BENEFIT PLANS. WHEN CONSUMERS INTENTIONALLY USE AN OUT-OF-NETWORK PROVIDER, THE CONSUMER IS ONLY ENTITLED TO BENEFITS AT THE OUT-OF-NETWORK RATE AND MAY BE SUBJECT TO BALANCE BILLING BY THE

OUT-OF-NETWORK PROVIDER.

(V) THEREFORE, THE GENERAL ASSEMBLY FINDS, DETERMINES, AND DECLARES THAT THE PURPOSE OF SENATE BILL 06-213 IS TO CODIFY THE INTERPRETATION OF THE DIVISION OF INSURANCE THAT HOLDS CONSUMERS HARMLESS FOR CHARGES OVER AND ABOVE THE IN-NETWORK RATES FOR SERVICES RENDERED IN A NETWORK FACILITY.

(b) When a covered person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit. COVERED SERVICES OR TREATMENT RENDERED AT A NETWORK FACILITY, INCLUDING COVERED ANCILLARY SERVICES OR TREATMENT RENDERED BY AN OUT-OF-NETWORK PROVIDER PERFORMING THE SERVICES OR TREATMENT AT A NETWORK FACILITY, SHALL BE COVERED AT NO GREATER COST TO THE COVERED PERSON THAN IF THE SERVICES OR TREATMENT WERE OBTAINED FROM AN IN-NETWORK PROVIDER.

(c) (I) THIS SUBSECTION (3) IS REPEALED, EFFECTIVE JULY 1, 2010. PRIOR TO SUCH REPEAL, THE DIVISION SHALL CONDUCT AN EVALUATION TO INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING:

(A) THE EFFECTS OF THIS SUBSECTION (3) ON NETWORK ADEQUACY;

(B) THE FREQUENCY THAT NONPARTICIPATING PROVIDERS SUBMIT MORE THAN NETWORK REIMBURSEMENT RATES FOR SERVICES RENDERED IN AN IN-NETWORK FACILITY COMPARED TO THE CARRIER'S BOOK OF BUSINESS FOR THAT LINE OF INSURANCE;

(C) THE AMOUNTS PAID BY CARRIERS TO NONPARTICIPATING PROVIDERS; AND

(D) THE IMPACT OF THIS SUBSECTION (3) ON CONSUMERS.

(II) THE DIVISION SHALL COMPLETE THE EVALUATION ON OR BEFORE JANUARY 15, 2010, AND SHALL REPORT ITS FINDINGS TO THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE AND THE HOUSE OF REPRESENTATIVES BUSINESS AFFAIRS AND LABOR COMMITTEE, OR ANY SUCCESSOR COMMITTEES. THE LEGISLATIVE STAFF FOR SUCH COMMITTEES SHALL NOTIFY THE COMMITTEE CHAIRS OF THE EXPECTATION OF THE EVALUATION

AND THE REPEAL OF THIS SUBSECTION (3) ON OR BEFORE JULY 1, 2009.

SECTION 2. Applicability. This act shall apply to services and treatment rendered on or after the effective date of this act.

SECTION 3. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Joan Fitz-Gerald
PRESIDENT OF
THE SENATE

Andrew Romanoff
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Karen Goldman
SECRETARY OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED _____

Bill Owens
GOVERNOR OF THE STATE OF COLORADO



Maryland Chapter American College of Emergency Physicians

September 29, 2008

John M. Colmers, Secretary of Health & Mental Hygiene
Office of Secretary
Department of Health & Mental Hygiene
201 West Preston St.
Baltimore, MD 21201 - 2399

VIA EMAIL – HARD COPY TO FOLLOW

RE: Recommendations and Suggestions in response to the Task Force on Health Care Access and Reimbursement Document titled “Required Areas For Recommendation”

Dear Secretary Colmers and Members of the Task Force:

We are writing to provide you with our recommendations and suggestions regarding the work of the Task Force and the options that have been presented for discussion.

Who We Are:

Maryland ACEP represents the interests of emergency physicians and their patients throughout the State of Maryland. Our mission is the preservation of quality emergency care, patient advocacy, emergency medical training, and continuing education for emergency physicians, nurses, and technicians. The college promotes policy that preserves the integrity of emergency medicine.

As emergency physicians we are in the unique position of being on the front lines of Maryland’s health care system. We proudly serve as the **safety net** providing care for everyone, including the poor, uninsured, and the disenfranchised. We cannot and do not deny care to anyone; all stabilizing medical care including x-rays, lab work and consulting of specialists cannot be delayed to inquire about methods of payment or of insurance coverage. Often times we may be a person’s only source of medical care.

The Challenge:

Being at the front lines affords us a first hand view of how Maryland’s health care system is operating. What we are seeing today and have been for the last 5 years is a fraying of the safety net. Increasing numbers of patients with more complex problems are coming to the emergency department every year, leading to long wait times and overcrowded emergency departments. This surge has been coupled with a steady decline in physician reimbursement, complicated by already high levels of uncompensated and undercompensated care.

We want to be clear that low physician reimbursement is most felt not in our own pockets but in the ability to safely staff our emergency departments. Inadequate reimbursement impedes our ability to recruit and retain trained emergency physicians; the results are unsafe staffing levels, substitution of midlevel providers for qualified emergency physicians, and the hiring of lower paid physicians who have not completed emergency medicine residencies. Maryland emergency departments are ripe for an incident like the one in the news article regarding the patient who died waiting in an ED in Texas. There is a national market in which we have to compete to bring in the best and the brightest physicians. In order to attract and retain these physicians we have to reshuffle our funding and staffing priorities and rely on subsidies and financial support from our hospitals to make up the difference in the low reimbursement.

Our Response:

We have looked at other states and how physicians are reimbursed: Maryland is an outlier. In Maryland we are faced with one of if not the lowest HMO rates in the country. The current system can no longer sustain itself. Without a meaningful solution patient access to care is going to suffer.

The prohibition on balance billing eliminates any leverage in negotiations with HMO's. We don't want to be non-par. But we have to be non-par when the rates do not come close to covering the costs of providing coverage and the HMO's refuse to negotiate because they don't need to: they get a great deal when we are non-par.

We have thoroughly examined all of the options outlined in the HCAR document handed out at the September 8th meeting. We have focused our comments to the following areas as detailed below. We urge the Task Force to give strong consideration to our suggestions and recommendations.

Non-Participating Provider Reimbursement in the HMO market - Options 3.1; 3.2; 3.2.1; 3.2.2

We need to move to a system where the HMO, not the physician, is responsible for unpaid charges, protecting and holding the subscriber harmless. This will give physicians the leverage they need to negotiate reasonable agreements with HMO's.

In a letter to the Task Force dated July 9th we provided examples of statutes and regulations from other states where there is the consumer protection against balance billing. Those states included New Jersey and Florida. We have since identified two other states Colorado and Virginia. In these states the responsibility is on the HMO, insurer or health plan to hold their subscribers harmless from balance billing.

They are not suffering to the extent that Maryland is in recruiting and retaining physicians. In these 4 states evidence suggests that there has not been an exodus of providers dropping contracts or refusing to contract, but the opposite: willingness to contract with the health plans due to a greater ability to negotiate a fair rate. There is no

indication that states with HMO laws mandating payment based upon charges have average charges that greatly exceed the national average. Rather charges continue to be developed based upon practice expenses.

During the 2006 and 2007 Legislative Sessions efforts were made to revise the methodology that is currently in statute (Health General 19-710.1). What became clear during those discussions is that there is **no** "one size fits" all revision that will provide the immediate and necessary relief.

The best and only way to provide relief in the HMO market across all specialties is to shift the responsibility of holding subscribers harmless from balancing billing to the HMO.

The inequity in the HMO market must be corrected before there is any action taken in the PPO market.

Link Designation of preferred hospitals to-Network Participation of Hospital-based Physicians - Option 3.3

We believe this option would allow payers to establish below market rates and continue to place hospitals in the position of having to provide subsidies in order to ensure the communities in which they serve continue to have access to quality healthcare.

It would further limit the ability for hospital based physicians to negotiate fair contractual rates.

This represents an unfair trade practice.

Develop hospital based payment system demonstration - Option 5.1

Currently there is no consensus among hospital based physicians as to the desirability of such a system. In discussions within our own college, it becomes clear that we simply do not know enough about what this might look like. Before any action is taken, we must better understand the implementation and consider both the clinical and economic impacts.

Encourage commercial payers to pay PCPs a premium for visits after the end of the 5:00pm work day and on weekends - Option 8.1

In addition to this option we would ask that commercial payers be encouraged to pay for these common after-hours service codes:

99050 which is "services provided in the office at times other than regularly scheduled office hours", and

99051 which is "services provided during regularly scheduled evening, weekend, or holiday office hours."

Additional Recommendations:

We feel that in addition to the issues discussed above the following essential initiatives need to be addressed:

Tort Reform – Malpractice costs remain high and add a continual economic burden to our system. Enactment of Good Samaritan protection for emergency physicians and providers of EMTALA mandated care would ease this burden.

Medical Home – As discussions continue regarding Medical Homes, it must include the safety net of emergency care.

Credentialing reform and IT improvements - Developing procedures that streamline and standardize the credentialing process; and adoption of a uniform IT format for electronic medical records and billing transactions

In Summary:

The purpose of the Task Force and its recommendations must be to bring Maryland more in line with other states and their levels of reimbursement in order to attract new physicians to the state and to retain those who have completed their medical schooling and training. There is a shortage of physicians in Maryland and there can only be access to care if physicians are here to treat the patients.

We strongly urge the Task Force to support our recommendation to reform the HMO non-participating reimbursement system to one that is based on the HMO taking responsibility for their subscriber being held harmless from balance billing.

We are ready to work with you, members of the task force, insurers and the other physician stakeholders on a solution moving in that direction.

Sincerely,

Richard Alcorta M.D.
President, Maryland ACEP

Laura Pimentel M.D.
Public Policy Chair, Maryland ACEP

MedChi

The Maryland State Medical Society

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October 1, 2008

The Honorable John Colmers, Secretary
Department of Health & Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201

By Hand Delivery

RE: Proposed Recommendations/Comments on “Options” Document
To Governor’s Task Force on Health Care Access and Reimbursement

Dear Secretary Colmers:

First, MedChi wishes to thank you and your fellow Task Force members for your tireless and good efforts on behalf of both the citizens and physicians of Maryland and looks forward to your Final Report directed toward a resolution of the present access and physician reimbursement problems facing our state.

MedChi believes that there is a serious problem in Maryland with respect to the fair reimbursement of physicians which is compounding health care access for Maryland citizens. As the MedChi/Maryland Hospital Association study has indicated, Maryland has 16% fewer physicians available for clinical practice than the national average and there are physician shortages in three regions of the state (Eastern Shore, Southern Maryland and Western Maryland) and coming shortages in all areas of the state. At a time when the state is “expanding” its coverage of uninsured individuals by approximately 100,000 there are not enough doctors to take care of the existing patient population. Moreover, new doctors are not coming to Maryland because of its equation of low reimbursement/high liability cost/ high cost of living.

Enhancing reimbursement is fundamental and essential to retaining the current physician workforce and recruiting new physicians into the state.

We believe that the hearings of your Task Force have demonstrated that the shortages are particularly evident in primary care (family practice, OB/Gyn, internal medicine, pediatrics, general psychiatry). Moreover, these shortages have overwhelmed emergency departments where patients take their medical problems. The emergency departments themselves are challenged by the lack of on-site and on-call specialists available to care for the ever increasing numbers of patients who have nowhere else to go for their care. Emergency department care is considerably more expensive than care delivered in a primary care office, yet primary care

doctors are not adequately reimbursed for after hour visits which contributes again to the overload of emergency departments.

With this background, please find enclosed MedChi's Recommendations for the Task Force to consider and, hopefully, endorse in its Final Report. You will note that these recommendations are particularly directed to the problems of primary care and emergency medicine which, MedChi believes, are the physician specialties now in current distress.

MedChi believes that the problems of these specialties must be addressed now while consideration is given to the overriding issue which hangs over Maryland's future: extremely low reimbursement rates for physicians made more pervasive by the market power of CareFirst and United which control perhaps 80% of the health marketplace.

Also find enclosed comments on the Task Force document ("Options" document) entitled "Required Areas for Recommendation" which was distributed to the Task Force at its September meeting.

Very truly yours,

Ronald C. Sroka, M.D.

cc: Members of Governor's Task Force on Health Care Access and Reimbursement

MedChi

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October 10, 2008

The Honorable John Colmers, Secretary
Department of Health & Mental Hygiene
201 W. Preston Street, 5th Floor
Baltimore, MD 21201

**Electronically and
by Messenger**

RE: Further Information Concerning MedChi Recommendation No. 1
(Loan Forgiveness Program) to Governor's Task Force on Health
Care Access and Reimbursement

Dear Secretary Colmers:

In response to your questions at the meeting of the Governor's Task Force on Monday, October 6th, MedChi believes that an effective loan forgiveness program would have an annual budget of \$2 million in its first year with annual increments of \$2 million (years 2-5) with a total budget of \$10 million per year once the program is fully operational.

MedChi envisions that primary care physicians who locate in Maryland shortage areas would be reimbursed up to \$20,000 per year on their medical school debt with total reimbursement over 5 years not to exceed \$100,000 per person.

MedChi believes that 100 physicians per year would be enrolled in the program. Excluding hospitalists, Maryland has 2,980 primary care physicians in outpatient practice so that an addition of 500 physicians over the 5 years would result in a net increase of over 16%. See MHA/MedChi "Maryland Physician Workforce Study" at page 25. This increase would effectively remedy the existing shortages.

Initial emphasis would be in those areas of the state with the most need (Southern region, Western region and the Eastern region in that order) until such time as those regions come into balance with the rest of the state.

MedChi must emphasize, however, that expenditure of state monies is prudent only if the Task Force requires Maryland's insurers to pay adequate reimbursement so that Maryland becomes a healthy place for doctors to start and nurture their practices.

There are several funding sources for such a program. One funding source is a diversion of a portion of the Maryland HMO tax to support this program. Recently, those tax revenues supported physician malpractice premiums but that is no longer the case. MedChi was a longtime proponent and supporter of this tax which was enacted and took effect in 2005.

A second source of funding would be to redirect the current diversion of physician license fees, 7% of which are presently directed to grants under the Health Manpower Shortage Incentive Grant Program. This currently funds programs at different post-secondary institutions such as community colleges. In FY 2008, this diversion amounted to approximately \$500,000. This money is currently contributed **only by physicians** but supports non-physician programs.

There is one other diversion of physician license fees (again 7%) but these monies fund a physician support program known as the Loan Assistance Repayment Program (LARP) which supports primary care physicians in shortage areas.

Finally, MedChi believes that there may be an ability to generate additional revenue **from all payers** by allowing hospitals in shortage areas to establish loan forgiveness approaches similar to the Nurse Support Programs I and II. MedChi believes that \$5 million of the program's budget could be raised in this manner and it may be that the entire program could be funded in this way.

In sum, MedChi believes the state should commit to an active recruitment of an additional 100 primary care physicians per year in Maryland shortage areas for each of the next 5 years; if this 5-year program is successful in remedying the current shortages, the program can then be directed to other specialties as needs appear. MedChi has no doubt that an incentive which remits up to \$100,000 of medical school debt will be an attractive and effective recruitment tool for new physicians.

Very truly yours,

Ronald C. Sroka, M.D.

cc: Members of Governor's Task Force

David D. Wolf
Executive Vice President
Medical Management and
Strategic Planning

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October 1, 2008

Joseph S. Fastow, M.D.
7900 Wisconsin Avenue
Suite 406
Bethesda, Maryland 20814:

Dear Joe:

In advance of our meeting, I wanted to state that CareFirst is supportive of the Maryland Health Care Commission (MHCC) conducting a study to determine the feasibility of centralizing physician credentialing in Maryland. The objectives should be to reduce the administrative burden on physicians and achieve savings that can be used to fund a loan forgiveness program targeted to primary care in rural areas.

I would also like to clarify some confusion around CareFirst's costs associated with the credentialing and re-credentialing process for Maryland physicians. Currently, CareFirst employs approximately nine full-time equivalents (9 FTE's) at an annual salary cost of \$388,000 to credential and re-credential Maryland physicians. In addition, CareFirst spends approximately \$23,000 annually for CAQH fees, NPDB fees, etc. We delegate credentialing under NCQA guidelines to twenty provider groups covering 10,100 physicians.

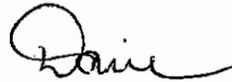
A successful program must meet the applicable standards from outside accreditation agencies and government regulations. The following are samples of the issues that will need to be addressed by MHCC as they build their business case for centralizing credentialing:

1. Reaction from NCQA and COMAR? Centralizing credentialing may require legislative changes.
2. Does Medicare have unique requirements for provider networks supporting their programs, such as Medicare Advantage?
3. If the Physician Board conducts the credentialing, what system/infrastructure will they use?

4. Will the Physician Board have to qualify as a CVO under NCQA?
5. Will the Physician Board use the CAQH database and process? Will they be able to send payers information electronically? Will this present an opportunity to mandate the use of CAQH?
6. What issues will the hospitals have with this approach? For example, credentialing by hospitals tend to be more extensive, such as verifying a physician's scope of services.
7. How will this impact providers, such as Hopkins and MedStar, who have delegated credentialing?
8. Will credentialing and re-credentialing in Maryland be done for all networks? Are the criteria different by network? This may need to be uniform if it is centralized.
9. Will all professional providers be credentialing, not just physicians? What about institutional providers? What about vendors such as Magellan and Davis Vision?

I look forward to discussing this and other opportunities with you at our meeting.

Sincerely,



David D. Wolf

Secretary John M. Colmers
Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201-2399
October 25, 2008
Dear Secretary Colmers,

I want to thank you for allowing me to participate in the Governor's Task Force on Health Care Access and Reimbursement. It has been an honor working with such knowledgeable professionals on this task force and all the tremendous input provided by so many organizations and individuals.

I am enclosing my recommendations to be included in the final report to the Governor as required by SB 107. I have made my recommendations in the ten question format provided to the task force. The task force has met monthly for over a year, and there is little doubt that after the hours of testimony and hundreds of pages of documents provided to this task force there are drastic changes needed to provide quality health access to the citizens of Maryland. Significant priorities need to happen specifically in Southern Maryland, Western Maryland and the lower Eastern Shore of Maryland. Testimony to this Task Force has proven physician shortages can be attributed to very specific areas in determining the cause and affect to access to health care for Maryland Citizens.

In accordance with SB 107 from 2007 and SB 744 from 2008, my recommendations are as follows:

THE TASK FORCE SHALL EXAMINE:

(1) SPECIFIC OPTIONS THAT ARE AVAILABLE, GIVEN LIMITATIONS OF THE FEDERAL ERISA LAW, TO CHANGE PHYSICIAN AND OTHER HEALTH CARE PROVIDER REIMBURSEMENTS, IF NEEDED.

RECOMMENDATION (1):

The State of Maryland must enact designated incentive programs to attract physicians to practice in shortage areas within the state of Maryland, such as;

Loan forgiveness programs for Physicians who will commit to providing health care for a minimum of five years in the designated shortage areas. This should be in combination with existing federal programs.

Physician credentialing should be by public policy established as a statewide standard in law and be maintained by the Board of Physicians. These standards should be accepted by all licensed providers, insurance carriers and hospitals in Maryland. This credentialing can be based on national standards and adopted state wide.

All licensed physicians should be able to have admitting and treatment privileges at the closest hospital to their private offices if they are working within a shortage region within the state of Maryland.

(2) THE SUFFICIENCY OF PRESENT STATUTORY FORMULAS FOR THE REIMBURSEMENT OF NONCONTRACTING PHYSICIANS AND OTHER HEALTH CARE PROVIDERS BY HEALTH MAINTENANCE ORGANIZATIONS.

RECOMMENDATION (2):

Insurance Carriers should be required to maintain an adequate level of providers in each region in Maryland. Areas that have shortages of Primary Care Providers, Emergency Physicians, Pediatricians, and OB/GYN providers should be reimbursed for their cost of providing their services in full and the insurance carrier should be required to reimburse the health care provider for not maintaining adequate levels of care for their customers in specific shortage regions.

(3) WHETHER THE MARYLAND INSURANCE ADMINISTRATION AND THE ATTORNEY GENERAL CURRENTLY HAVE SUFFICIENT AUTHORITY TO REGULATE RATE SETTING AND MARKET-RELATED PRACTICES BY INSURANCE COMPANIES OF HEALTH INSURANCE CARRIERS THAT MAY HAVE THE EFFECT OF UNREASONABLY REDUCING REIMBURSEMENTS.

RECOMMENDATION (3):

Maryland already has established requirements that regulate reimbursement rates to physicians and HMO's. (Health General Article §19-710.1(b)) The law needs to be changed to provide an equal and fair rate for health care providers. The current law allows for the lowest rate paid to a similarly licensed provider. According to testimony provided, the only court to ever consider the issue was the Circuit Court of Anne Arundel County which ruled that HMOs must pay 125% of the "average" paid by the HMO to similarly licensed providers. The Anne Arundel County case is known as Delmar Emergency Specialists, et al. v. MD-IPA et al. (Civil Case No.: 02-C-05-110040IT) and the ruling was by Judge Paul Hackner.

I recommend that the Health General Article be changed to the average rate paid and insurance carriers provide health care providers a copy of the current reimbursement average rates for services provided for their individual specialties billing codes when billed for services provided.

(4) WHETHER THERE IS A NEED TO ENHANCE THE ABILITY OF PHYSICIANS AND OTHER HEALTH CARE PROVIDERS TO NEGOTIATE REIMBURSEMENT RATES WITH PRIVATE HEALTH PLANS HEALTH INSURANCE CARRIERS, WITHOUT UNDULY IMPAIRING THE ABILITY OF THE PLANS CARRIERS TO APPROPRIATELY MANAGE THEIR PHYSICIAN PROVIDER NETWORKS.

RECOMMENDATION(4):

Prohibit health insurance carriers from linking hospital participation in a carrier's network to an independent physician's decision of whether to contract with the health insurance carrier. Require health insurance carriers to maintain adequate access to health care providers in shortage areas through incentives such as; increased reimbursements, after hours and weekend coverage increased reimbursements with specific codes to indentify the additional costs, and full reimbursements to non-participating health care providers in shortage areas.

(5) WHETHER THERE IS A NEED TO ESTABLISH A RATE-SETTING SYSTEM FOR PHYSICIANS AND OTHER HEALTH CARE PROVIDERS SIMILAR TO THE SYSTEM ESTABLISHED TO SET HOSPITAL RATES IN MARYLAND.

RECOMMENDATION (5):

The Maryland Insurance Administration, Secretary of the Department of Health and Mental Hygiene in conjunction with HSCRC, MEDCHI and the Maryland Hospital Association should determine if hospital based Physicians and specifically hospital based Emergency Department Physicians and Anesthesiologists should establish a rate setting system.

This should assist in the recruitment of physicians in community based hospital emergency rooms and lower the constant wait times and overcrowding as a result of uninsured citizens. This program can be established as a pilot program at targeted community based hospitals in the state's shortage regions.

(6) THE ADVISABILITY OF THE USE OF PAYMENT METHODS LINKED TO QUALITY OF CARE OR OUTCOMES.

RECOMMENDATION (6):

The state of Maryland under the coordination of the Maryland Health Care Commission and the Maryland Insurance Administration and the HSCRC should establish a pilot program for the Advanced Medical Home for Primary Care Providers.

Reimbursement rates should be established as incentives based on outcome, quality of care and efficiency as established in advanced in writing by the health insurance carriers and approved by the MHCC and MIA. Physicians should volunteer to participate in the program separate from existing agreements with insurance carriers.

Incentives should include reimbursements for electronic medical records, disease management education, and patient access in shortage regions after normal work day hours and weekends. This pilot program should initially focus on specific disease management areas such as diabetes, breast cancer, and obesity as established by the oversight committees.

(7) THE NEED TO PROHIBIT A HEALTH INSURANCE CARRIER FROM REQUIRING HEALTH CARE PROVIDERS WHO JOIN A PROVIDER NETWORK OF THE CARRIER TO ALSO SERVE ON A PROVIDER NETWORK OF A DIFFERENT CARRIER.

RECOMMENDATION (7):

N/A Passage of HB 1219 and signed into law May 22, 2008 by the Governor of Maryland.

(8) WHETHER THERE IS A NEED TO PROVIDE INCENTIVES FOR PHYSICIANS AND OTHER HEALTH CARE PROVIDERS TO BE AVAILABLE TO PROVIDE CARE ON EVENINGS AND ON WEEKENDS.

RECOMMENDATION (8):

Physicians who are primary care providers should be reimbursed at an additional rate for after hours and weekend care. This rate should be approved by the Insurance Administration. There also should be incentives for efficiency in patient care by providing incentives for electronic and telemedicine care, such as email and webcam consultations with patients recuperating at home. This should provide significant savings in costs of care in the use of the emergency department for after hours and weekend care.

(9) THE ABILITY OF PRIMARY CARE PHYSICIANS TO BE REIMBURSED FOR MENTAL HEALTH SERVICES PERFORMED WITHIN THEIR SCOPE OF PRACTICE.

RECOMMENDATION (9):

Primary Care Providers should ensure they have adequate training to diagnose mental health disorders when presented to them. Health insurers must coordinate medical and mental health care to provide access to treatment for patients who present with mental health disorders such as depression and anxiety. MEDCHI, Secretary of the Department of Health and Mental Hygiene, and the Institutes of Higher Education in cooperation with the Health Insurance Carriers should develop training and certification process for Primary Care Providers to diagnose and treatment mental health disorders at the primary care provider’s level of expertise and training.

In conclusion -

Loan forgiveness programs for Physicians who will commit to providing health care for a minimum of five years in the designated shortage areas. This should be in combination with existing federal programs and allow hospitals, and private physician group practices to sponsor loan repayment programs as a recruitment tool in designated shortage regions.

Insurance Carriers should be required to maintain an adequate level of providers in each region in Maryland. Areas that have shortages of Primary Care Providers, Emergency Physicians, Pediatricians, and OB/GYN providers should be reimbursed for their cost of providing their services in full and the insurance carrier should be required to reimburse the health care provider for not maintaining adequate levels of care for their customers in specific shortage regions.

Physician credentialing should be by public policy established as a statewide standard in law and be maintained by the Board of Physicians. These standards should be accepted by all licensed providers, insurance carriers and hospitals in Maryland.

All licensed physicians should be able to have admitting and treatment privileges at the closest hospital to their private offices if they are working within a shortage region within the state of Maryland.

Tort reform continues to be a major area of concern for certain specialty practices. Changes to the current statute must be addressed specifically in certain areas of medical practice such as; OB/GYN, neurosurgery, cardiac surgery and emergency care.

Levels of reform must allow for a division of claims to allow for “apology clause” in certain claims of malpractice.

Medical liability carriers should also allow for reduction in premiums for risk management practice, electronic medical records in patient management.

Emergency Department Physicians must have the addition protection of the Good Samaritan law.

The state of Maryland in cooperation with MEDCHI, the Maryland Hospital Association must develop a statewide standard for electronic medical records in compliance with HIPPA standards that can be used statewide by all health care providers, health insurance carriers and hospitals to allow better patient care and access to patient records when a patient is treated in different parts of the state or receives treatment at different hospitals within Maryland.

Respectfully submitted,

Delegate Robert A. Costa



October 28, 2008

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The Honorable John M. Colmers
Secretary, Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Re: Task Force on Health Care Access and Reimbursement
Options, October 6, 2008
Option 9

Dear Secretary Colmers:

We have reviewed the Option presented by the Task Force on October 6, 2008. On September 12, 2008 (copy enclosed) we sent a letter to the Task Force which has a direct bearing on Option 9. The Maryland Psychological Association would like to take this opportunity to reiterate our opposition to Option 9 as it is currently being considered by the Task Force.

Option 9, in part, states the following: *“Require commercial payers to pay primary care physicians...to diagnose and treat mental health disorders.”*

We believe two distinct questions are at issue in Option 9:

- 1. Should primary care physicians be reimbursed for services they provide to their patients?

Without any doubt, primary care physicians should be reimbursed for the time they spend with their patients. We know that primary care physicians provide counseling for their patients with mental health disorders. We also know that the vast majority of prescriptions for individuals with mental health disorders are being written by primary care physicians. Therefore, primary care physicians should be reimbursed for their time and reimbursement should not be linked to the Diagnosis code (e.g., Depression, Anxiety, etc.)

- 2. Should primary care physicians be reimbursed for all services used to treat mental health disorders, including CPT codes 90801 – 90857, which are considered Psychiatry CPT codes and utilized by licensed mental health professionals when they provide psychotherapy?

Primary Care Physicians are highly trained to provide needed services that are reimbursed appropriately under the Evaluation and Management Codes. However, we believe that reimbursement should not include the CPT codes for Psychiatry, which are for specific treatments, and must include the provision of **psychotherapy** for reimbursement. Psychotherapy is a specific service that requires highly specialized education and training. This training

The Honorable John M. Colmers
Secretary, Department of Health and Mental Hygiene
October 28, 2008
Page 2

has been obtained by licensed mental health professionals but not by Primary Care Physicians. Therefore, Primary Care Physicians should not be reimbursed for these specific CPT codes.

MPA recommendation:

Option 9, viii. shall be amended to read: "Require commercial payers to pay primary care physicians under the medical benefit for a reasonable number of visits per year per condition to diagnose and treat mental health disorders. Reimbursement shall be under Evaluation and Management Codes 99201 – 99499 and shall not include Psychiatry codes (CPT codes 90801 – 90857)."

Thank you, as always.

Sincerely,



Katherine Seifert, Ph.D.
President



Paul C. Berman, Ph.D.
Professional Affairs Officer



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October 31, 2008

The Honorable John Colmers, Secretary
 Department of Health & Mental Hygiene
 201 W. Preston Street
 Baltimore, Maryland 21201

Re: Proposed Areas for Recommendation to Governor’s Task Force on Health Care Access and Reimbursement.

Dear Secretary Colmers:

I am writing today on behalf of the League of Life and Health Insurers of Maryland, Inc., the state trade association representing the interests of life and health insurers doing business in Maryland (the “League”), and America’s Health Insurance Plans, the national trade association representing nearly 1300 member companies providing health benefits to more than 200 million Americans (“AHIP”). The members of the League and AHIP appreciate the significant amount of time and work that the Task Force has committed examining the issues before them.

One issue addressed in the Areas of Recommendation raises great concern for the League and AHIP. Specifically, Option 11.1.1 (New Options Not Previously Considered) requests that the Task Force assess the feasibility of establishing a centralized credentialing clearinghouse operation in the Board of Physicians. The members of the League and AHIP respectfully submit that Maryland should not establish a centralized credentialing clearinghouse, as this will increase costs and slow down the credentialing process.

Activity in other states is very instructive. Both Florida and Arkansas have tried to centralize the credentialing primary source verification process. Florida created CoreSTAT in 2001 to maintain a credentials collections program. Because the State determined that CoreSTAT did not eliminate duplication in the verification of core credentials and resulted in healthcare providers paying fees for benefits not received, the State disbanded the project several years later.

Arkansas is currently the only state in the country that is centralizing the primary source verification process, and Arkansas' experience has been similar to Florida. The time frame for credentialing in Arkansas is at least twice as long as anywhere else in the country. Moreover, the cost for primary source verification of Arkansas physicians is more expensive than for physicians anywhere else in the country.

Finally, it is important to note that carriers have already centralized the credentialing process in order to achieve the best economies of scale and to reduce redundancy and costs. Each carrier performs the credentialing process at one centralized location for all its contracting providers throughout the country. Carving out Maryland providers will duplicate effort, increase costs and slow down the process.

We look forward to working with you and the members of the Task Force in the months ahead.

Sincerely,



Deborah R. Rivkin, Esq.





October 31, 2008

Secretary John M. Colmers
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Secretary Colmers:

The Maryland Ambulatory Surgical Association (MASA) would like to comment on the work being performed by the Maryland Department of Mental Health and Hygiene's Task Force on Health Care Access and Reimbursement dealing with Options and Recommendations to the Governor and General Assembly.

MASA is the state-wide trade association representing the interests of ASCs, our physicians and nurses, and the patients that they treat. Procedures performed in ASCs are the types where patients are typically discharged the same day into the care of a responsible adult and do not require open invasion of major body cavities. There are also various types of ASCs across the state. Some may be able to perform multiple types of procedures, while others may specialize only in certain specialties such as orthopedics, GI, ophthalmology, etc.

MASA feels that the work performed by the Task Force is a good first step at looking at provider reimbursement issues across the State of Maryland. We hope that in the future, that issues faced by other provider types would be up for meaningful discussion. We would like to comment on one aspect of the plan related to using pay for performance to improve the delivery of health care services.

Option 5.2: Work to create a new pay for performance system that rewards efficiency, effectiveness, and quality. Identify opportunities to participate in CMS payment demonstrations.

MASA strongly supports the use of quality reporting across all health care settings to promote high quality care and feels that ASCs should also be allowed to participate in a voluntary pay for performance plan. Using quality

data to improve outcomes is a hallmark of the ASC industry. Since the mid-1990s members of the ASC Association have participated in a

Secretary John M. Colmers
October 31, 2008
Page Two

voluntary data reporting project. These measures include the following:

- Post-Surgical Wound Infection
- Unscheduled Direct Transfers
- Patient Death
- Return to Surgery
- Wrong Site, Side, Procedure, Implant or Patient
- Prophylactic IV Antibiotic Administration On-Time

MASA strongly supports transparency across different care settings, and we believe use of comparable quality measures would further this goal. The ASC facility-level measures currently endorsed by the NQF focus on (1) patient falls, (2) patient burns, (3) hospital transfer/admission, (4) wrong site/wrong side/wrong patient/wrong procedure/wrong implant, and (5) the timing of the administration of intravenous antibiotics for prophylaxis of surgical site infection. The first four measures have applicability to all outpatient surgical facilities, and the fifth measure has been specifically designed to correspond to similar measures developed to evaluate physician performance in this area.

As the State works on a quality reporting system, it should focus on minimizing the administrative and financial burden of reporting quality measures. Consumers should be able to access quality and cost information on websites that are organized to allow easy comparisons, while also protecting the rights of providers to assure the information is correct, up-to-date, and clearly presented.

Thank you for your consideration of our comments.

Sincerely,



Ahsan Khan
Executive Director, MASA

AK/deo

MEDICAL MUTUAL

Liability Insurance Society of Maryland

November 13, 2008

The Honorable John Colmers
Secretary, Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201-2399

Re: *Task Force on Health Care Access and Reimbursement - Medical Liability
Recommendations*

Dear Secretary Colmers and Members of the Task Force:

I write on behalf of Medical Mutual Liability Insurance Society of Maryland (“Medical Mutual”) in response to various recommendations concerning medical liability offered by the Maryland Hospital Association (“MHA”) to the Task Force on Health Care Access and Reimbursement (“Task Force”).

Medical Mutual is supportive of mechanisms that reduce medical liability exposure and reduce the frequency and severity of claims. As you know, the Maryland General Assembly previously has considered legislation to provide Good Samaritan civil immunity protection for physicians providing health care in emergency departments and to repeal the provision of law that makes an expression of liability or fault admissible as evidence in a medical malpractice action. Medical Mutual has supported these proposals in the past and supports their inclusion in the Final Report of the Task Force.

There are, however, two additional recommendations related to medical liability insurance that may present adverse, unintended consequences for physicians who purchase medical liability insurance in the State.¹ The first recommendation requires medical liability insurers to provide premium reductions in exchange for physician implementation of risk management strategies, such as telemedicine, electronic medical records (“EMRs”), etc.

The current risk management credits offered by Medical Mutual have been carefully selected and are specifically targeted toward reducing medical liability exposure. It is often difficult to quantify what effect certain risk management initiatives will have on liability exposure. For example, while some reports have shown that EMRs have improved the systemic errors associated with manual medical records (e.g., illegibility of handwriting, misplaced lab results, etc.) other reports have found that EMRs present new, challenging liability exposure issues (e.g., physician reliance on incorrect information in shared EMRs). It would be imprudent to implement a premium reduction for a risk management initiative until there is some objective evidence that a new mechanism has a positive influence on

¹ These two recommendations were also made to the Task Force to Review Physician Shortages in Rural Areas and the same objections were noted by Medical Mutual in a letter to that task force dated September 5, 2008.

MEDICAL MUTUAL

Liability Insurance Society of Maryland

liability risk. Moreover, to provide a premium reduction for a physician that employs the mechanism may unfairly disadvantage physicians who do not.

The second recommendation would require medical liability insurers to offer retired/part-time physician policies that do not require tail coverage. Extended Reporting Period Coverage (also known as “tail” coverage) is available upon cancellation or non-renewal of an insured’s claims-made policy. If purchased, it allows doctors to keep reporting claims resulting from medical liability incidents that occurred on or after the date that the policyholder obtained insurance with the company and before the policy termination date. Essentially, tail coverage extends the amount of time that claims may be reported into the future so that a physician is still protected for services rendered in the past. This is important because there may be a lag of many years between the time that services are rendered and the time that a malpractice claim is filed.

Some companies offer an occurrence policy that does not require the insured to purchase tail coverage for claims made after policy termination. However, regardless of the way a policy is structured, physicians who want coverage for claims made after policy termination must pay for such coverage. For that reason, a correctly priced occurrence policy is much more expensive than a claims-made policy and the savings from the claims made policy, over the life of the policy, approximates the cost of tail coverage. Most professional liability insurance carriers, including Medical Mutual, do not offer occurrence policies in the State.

Medical Mutual does not require a physician to purchase tail coverage on a claims-made policy. But, without tail coverage, a physician would have no coverage for claims that are reported after the termination of the physician’s policy. Medical Mutual does offer part-time policies at significant discounts. And, if a doctor keeps the policy open for at least one year, the tail coverage is provided at no charge if the doctor retires from the practice of medicine. This, of course, is in addition to providing tail coverage at no charge if the doctor dies or becomes disabled at any point during the policy term.

Medical Mutual would like to thank the members of the Task Force for its diligent effort to strengthen access to health care in the State. Should you have any questions about this letter, please do not hesitate to contact me at (410) 785-0050.

Sincerely,



Cheryl F. Matricciani
Vice President, General Counsel
and Secretary

cc: Members, Task Force on Health Care Access and Reimbursement



Maryland Chiropractic Association

720 Light Street, Baltimore, MD 21230 • (410) 625-1155 • Fax (410) 752-8295 • E-Mail: MCA@assnhqtrs.com

November 24, 2008

Secretary John M. Colmers
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Secretary Colmers:

The Maryland Chiropractic Association (MCA) is a professional organization founded in 1928 acting as the leading voice for chiropractors in Maryland. Comprised of individual members, our mission is to elevate the chiropractic profession by educating the public and advancing chiropractic care for the citizens of Maryland. Members of MCA are dedicated to excellence in chiropractic techniques and procedures. Because of the emphasis on continued education and training, MCA's members are leaders in chiropractic procedures.

As the voice of chiropractic practitioners in the state of Maryland, we have long been at the forefront of the industry in advocating for patient access to full medical services including those given by alternate providers. We applaud your efforts to address the current problems with access and reimbursement, but we feel that the task force has not been as thorough as was originally intended.

When the idea for this task force came about during the 2007 General Assembly Session, we were excited at the prospect of contributing to the discussion and debate. We were sorely disappointed to learn that no alternative, non-physician, providers were asked to participate. Additionally, the task force seems to be dominated by large group practices and hospitals, leaving out many primary care and small group practitioners. These are voices that need to be heard to give a full view of the breadth of care offered to the citizens of Maryland. In fact, a study published in the Journal of the American Medical Association regarding trends in alternative medicine use found that the total visits to alternative medicine practitioners is on the rise, even exceeding total visits to all US primary care physicians.

The MCA also feels that the task force has spent too much time addressing access issues and not enough on reimbursement, even though that was clearly part of the original intent. We would like to argue that reimbursement is doubly important because it directly contributes to problems of access. Due to the current, low rates of reimbursement in Maryland, experienced practitioners are closing their doors and new doctors are hesitant to open practices in Maryland, choosing instead to start businesses in other, more favorable states. In order to make sure their practices are profitable, other medical practitioners are refusing to accept Medicare and Medicaid patients and are cutting down on the number of accepted insurance plans. This creates an increasingly smaller and smaller pool of doctors that patients can turn to. Clearly, this speaks directly to access.

A study released by MedChi and the Maryland Hospital Association in January showed that Maryland ranked 16 percent below the national average for number of doctors per residents. The study recommended increasing reimbursements to keep doctors in Maryland and lure more into medical practice. This similar trend could be applicable to chiropractic.

Over the last 10 years reimbursement for the primary services provided by chiropractors has declined in excess of 25 percent. During the same time period, the cost of doing business, as determined by the key indices of rent, labor, utilities, and insurance, has escalated by greater than 25 percent. This disparity has

created a crisis in the chiropractic economy whereby practices are closing and access is narrowing for our patients. The MCA fears that if these trends continue that quality of care issues may come to the forefront. We request that the task force take strong action before quality of care and access issues reach crisis levels.

In closing, we ask you to take our comments into consideration regarding the Task Force on Health Care Access and Reimbursement as you create your final report to the Governor and as you look to the 2009 General Assembly session and beyond. Thank you for your time and consideration. Feel free to contact MCA headquarters (410-625-1155) if you have any questions regarding this matter.

Cordially,



Donald Hirsh, DC
Immediate Past-President
Chair, Legislative Committee



Richard Schmitt, DC
President

David D. Wolf
Executive Vice President
Medical Management and
Strategic Planning

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December 1, 2008

Secretary John Colmers
Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201-2399

Dear Secretary ^{John} Colmers:

I have several comments regarding the Draft recommendation that was reviewed at the last task force meeting. They are as follow:

- **EXECUTIVE SUMMARY AND INTRODUCTION:** One of the fundamental guidelines that this task force discussed and followed over the past 18 months was the concern over **affordability** and its impact on Maryland’s citizens’ ability to obtain health insurance. This point is not brought forward within the document and we recommend that there be reference within the Executive Summary as well as the Introduction.
- **EXECUTIVE SUMMARY AND INTRODUCTION (PAGE 4):** One omission from this report is a recommendation pertaining to the link between reimbursement and quality. In the opening paragraph you state that the task force was directed to make a recommendation to the General Assembly on seven broad questions, one of those pertaining to the “desirability of linking reimbursement to quality.” CareFirst has made several references to link reimbursement with quality through programs such as Medical Home, Pay-4-Performance, etc. The final report should address this issue.
- **EXECUTIVE SUMMARY (PAGE 5):** CareFirst is in agreement with the recommendation regarding the higher of reimbursement for non-participating hospital-based physicians, but feel that the estimated impact is understated. Since MHCC data reflects that Maryland’s non-par payments on average approximate 100% of Medicare, and the new methodology will reimburse the higher of 125% - 140% of Medicare (depending on type of service) or 125% of average in-network fees, it would be expected that the impact would be somewhere between 125% and 140% of current non-par payments. When you consider the contracting leverage this will allow HBPs and potential for moving to non-par, this impact will increase even higher. Therefore, the reference in the recommendation that states “The task Force estimates that non-par payments will increase **about** 25% if this proposal is adopted” is understated and should be changed to note that **the minimum impact** will be between 125% - 140%, assuming no change in physician behavior (in respect to de-participation).

SECRETARY JOHN COLMERS
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- **OVERVIEW OF THE HEALTH CARE MARKET; PHYSICIAN SUPPLY (PAGE 14):** The overview states concern raised by several notable healthcare scholars regarding the need to increase enrollment in medical schools by 30%, but the recommendation section does not reflect appropriate action steps. We would recommend that the final recommendation include an action step to require a plan be drafted to immediately address the need for increased medical enrollment with specific action steps for implementation within the next 2 years.
- **POLICY INITIATIVES; NEW MODELS OF CARE (PAGE 22):** An area of clarification. The draft recommendation states correctly that the vast majority of Maryland residents receives mental health services under a carve-out agreement with a mental health vendor, but incorrectly states that the vendor assumes risk for the management and treatment of members under this arrangement. CareFirst does have a carve-out arrangement with Magellan Behavioral Health, but CareFirst maintains the risk associated with the care and treatment of its members. The vendor assumes no risk. Please correct this statement.
- **RECOMMENDATION (1) TO PROMOTE PRACTICE FORMATION (PAGE 24):** Under section 1.a. the recommendation states the HSCRC should establish a program to allow **physicians** to access the LARP program. While this point was mention at the meeting, I believe the recommendation should be specific to say "... allow **Primary Care Physicians** to access..." This is in line with the task force's focus to address the major concern around primary care services.
- **Recommendation (2) regarding Credentialing (Page 27):** The last paragraph states that the CAQH board will consider **implementing** a primary source of verification by spring 2009. My understanding is that CAQH will complete their feasibility assessment by spring 2009.
- **RECOMMENDATION (3) PERTAINING TO REIMBURSING NON-PARTICIPATING PROVIDERS (PAGE 28-31):** I brought up the distinction and reference to "similarly licensed provider" vs. "similarly licensed **provider practice**" several times over the past few meetings and would like the recommendation to be specific when we reference non-par reimbursement. CareFirst contracts and reimburses at the "practice" level and therefore, requests that the reimbursement references be changed. In addition, CareFirst does not retain rendering provider/physician information for all claims. Therefore, we recommend the term "similarly licensed provider practice" rather than simply "similarly licensed provider". Otherwise, compliance, while not impacting reimbursement greatly, would cause a major impact to our existing contracts and reimbursement process.

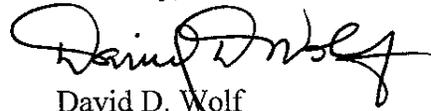
SECRETARY JOHN COLMERS
PAGE THREE
DECEMBER 2, 2008

- **RECOMMENDATION (3) PERTAINING TO REIMBURSING NON-PARTICIPATING PROVIDERS (PAGE 32):** As I stated earlier, I believe the forecasted impact to payers and system is understated and should be changed to note that **the minimum impact** will be between 125% - 140%, assuming no change in physician behavior (in respect to de-participation). Any financial dollar impact should be calculated from the higher estimated percentages.
- **RECOMMENDATION (5) REGARDING MEDICAL HOME (PAGE 37-39):** I have concern over our attempt to define Medical Home and its translation through the General Assembly. Currently, Medical Home is a concept open for interpretation and modifications. Some references include Medical Home, Advanced Medical Home, Primary Care vs. Specialty Home, etc. I suggest that we articulate that Medical Home is not ready for a specific definition and as such recommend that you remove pages 49-50 and replace with the 7 guiding principles document that I have attached and are recognized by several national associations as noted on the document.
- **RECOMMENDATION (6) REGARDING AFTER-HOURS CARE (PAGE 40):** Under section 2. the recommendation states that payers should reimburse providers for phone and e-visit communications as long as the electronic communication is not part of an in-person visit. We support this recommendation but believe that the wording needs to state that in addition, the e-visit must be a replacement for an actual in-office visit. Kathy Paez, PhD. mentioned this fact at the September meeting to avoid the ability of physicians to bill for unnecessary and frivolous items.
- **RECOMMENDATION (7) REGARDING MENTAL HEALTH SERVICES (PAGE 43):** In the last sentence, you use the word diffusing, I think you meant "disseminating."

In addition, there are some charts and tables between pages 31-34 that should include a source reference same as the other tables and references throughout the recommendation.

I would like to thank you and your staff for an extended commitment to follow up on these issues and keep the task force well informed and grounded throughout the past year. We look forward to reviewing the final document and, as always, are available to discuss our recommendations with you at any time.

Sincerely,



David D. Wolf

cc: Chet Burrell
Bruce Edwards
John Hamper
Bill Casey
Ben Steffen

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Dec 3rd, 2008

Secretary John Colmers
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore Md 21201-2399

Dear John:

I would like to thank you and the staff of the Task Force on Health Care Access and Reimbursement for your hard work and dedication to producing a quality product. I believe the report of the Task Force will advance the discussion of ways in which the crisis in physician supply can be remedied.

With regard to the substance of the report, I would endorse the comments made in the MedChi letter, dated October 1, 2008. I would also like to note my disappointment that the Task Force chose not to address the impact that malpractice rates have on the physician shortage, even though the report records the finding of the Task Force that "the future supply of obstetricians is compromised by the high cost of malpractice insurance." (Meeting Draft at 15)

As our representative and others stated at the meeting on November 25, the use of the material labeled as "Table 1" (Meeting Draft at 29) will likely, confuse rather than enlighten future readers of the report. The intended purpose of the table, according to Task Force staff, was to illustrate the discrepancies between the higher paid, often procedurally-focused specialties, and the lower paid specialties, focusing on evaluation and management services. This is a worthy point; however, Table 1's use of national income numbers (with no source or explanation provided in the draft) will likely create the misimpression in the reader that these figures are representative of the income of Maryland physicians. Our review of past national data has indicated that Maryland incomes run significantly lower than national incomes. In addition, even comparisons of regional income levels within the United States indicate that physician incomes in this part of the United States are lower than the national figure. We would strongly suggest that the same information be conveyed in a less prejudicial manner by use of the narrative description already contained in the text ("[As calculated from national statistics (source)] family practice physicians have an average income of about 37 percent of the highest paid specialty."

The Task Force elected not to examine the behavior of Maryland's health insurers with respect to medical loss ratios, reserves, surplus accumulation and related matters. Given the unhealthy concentration of two insurers in the Maryland market, I believe that this was a mistake. Indeed, many of the difficulties encountered by primary care physicians are directly attributable to the reimbursement practices of health insurance companies, which have continued the downward reimbursement spiral, leading to the shortages of primary care physicians.

I also note the comment in David Wolf's letter on behalf of CareFirst suggesting that the increase in the HMO non-par reimbursement formula is "understated." Mr. Wolf relies upon MHCC data to suggest that non-par physicians are currently receiving Medicare rates from HMOs. This data must be hopelessly flawed as non-par physicians are supposed to receive 125% of the contracted rate paid by an HMO in a particular area. This would mean, therefore, that HMOs are paying contracted physicians approximately 80% of Medicare across the board. I do not believe that this is the case. The increase in the non-par reimbursement rate will be a modest increase, not a 25% to 40% increase.

I thank you for the opportunity to make these comments and appreciated the opportunity to work with you and the other members of the Task Force in addressing this important matter.

Sincerely,

George H. A. Bone, M.D.

**Joseph S. Fastow, M.D., M.P.H.
7900 Wisconsin Avenue - #406
Bethesda, Maryland 20814**

4 December 08

**Secretary John Colmers
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore Md 21201-2399**

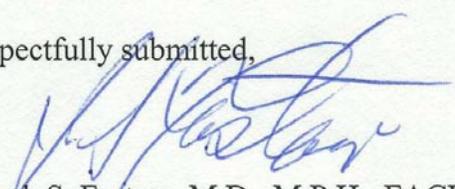
Dear John:

I am responding to your request for comments on the final draft of our Task Force report and the letters you have received from David Wolf and George Bone. I want to thank you for all of your efforts and the excellent work of your staff during this process.

I share the concern expressed by Dr. Bone that medical malpractice has received only cursory mention in the final report. While I am aware of the political environment in which the report is rendered, the impact that medical liability has on access and reimbursement should not be ignored. As a consequence of high malpractice premiums, access to emergency care and obstetrical care will continue to deteriorate and the Task Force report should at least acknowledge that fact, if not suggest solutions.

The letter from Mr. Wolf repeats a familiar, and appropriate, refrain regarding affordability. However, information presented to the Task Force documented the escalating cost incurred by hospitals to subsidize essential physician services. The market for hospital based specialists is nationwide and inadequate reimbursement from commercial carriers in Maryland forces hospitals to subsidize these specialists in order to maintain essential services. Can Maryland, one of the wealthiest states in the country, afford to jeopardize the quality and availability of these services, and risk losing its Medicare waiver? That question needs to be asked, and answered.

Respectfully submitted,



Joseph S. Fastow, M.D., M.P.H., FACEP

JSF:vb



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