



Task Force on Health Care Access and Reimbursement

Established under Senate Bill 107

Final Report and Recommendations
December 2008

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Executive Summary

Chapter 505 of the 2007 Acts of the Maryland General Assembly established the 14-member Task Force on Health Care Access and Reimbursement to examine issues on access to and reimbursement of physicians and other health care professionals. The Task Force was directed to make recommendations to the General Assembly on seven broad questions pertaining to patients' access to providers, payers' policies on participation, adequacy of current reimbursement levels, alternatives to the present system of payment, and the desirability of linking reimbursement to quality. Chapter 447 of the 2008 Acts of the General Assembly added new duties and extended the submission of the Final Report to December 2008. This report describes the work of the Task Force and presents recommendations in eight broad areas that cover the legislative charge.

The Task Force held 14 meetings from the fall of 2007 through the fall of 2008. Task Force members were briefed on the Maryland health care environment, insurance market concentration, and reimbursement rates for health professionals. The group was provided information indicating that fees for services in Maryland were below the national average, but per capita spending for physician services was closer to national levels than fee levels would suggest. The Task Force was told that Maryland's uninsured rate was below the national average, but above the rate in 16 other states. Health care premiums for family policies in Maryland have been near the national averages for both health maintenance organization (HMO) and non-HMO products.

The Task Force spent considerable time analyzing physician supply issues. Recent work by the Council on Graduate Medical Education (COGME) forecasts a national physician shortage of about 100,000 physicians by 2020. The Maryland Hospital Association (MHA)/MedChi work force study for Maryland reported similar long-term deficits, but highlighted immediate shortages in rural areas. Task Force members heard from several national health care experts that the primary care work force was already in crisis. The consequence of this challenge cannot be overstated, as the health of any given region is impacted by the density of primary care physicians (PCPs), as noted by Barbara Starfield and her colleagues at Johns Hopkins Bloomberg School of Public Health.¹ Recommendation 1 begins to address supply problems by expanding loan programs in the state and promoting practice development, particularly in primary care.

Regarding Recommendation 2, the Task Force found that duplicative source verification by health plans and hospitals during the credentialing process is expensive and time-consuming. The Task Force recommends that state agencies permit a single organization to conduct primary and secondary source verification on behalf of health plans and hospitals, if that arrangement is agreeable to the provider being credentialed. Medical societies and the MHA agreed to encourage private entities to conduct primary source verification. State agencies will advocate that the National Committee for Quality Assurance (NCQA) and The Joint Commission accept information from a single private entity when that is the provider's preference and the entity has taken the appropriate steps to document accuracy in source documents.

Alternatives to the current fee-for-service payment system were debated in detail. The Task Force heard that incremental reforms by the Centers for Medicare & Medicaid Services (CMS) to adjust fees of underpaid services have had limited success. A workgroup was formed to consider whether a payment system could be

1 Starfield B, Shi L, Grover A, and Macinko J. The Effects of Specialist Supply on Populations' Health: Assessing the Evidence. *Health Affairs* Web Exclusive. March 15, 2005.

developed for hospital-based physicians, starting with a demonstration at a limited number of hospitals. Some hospital-based physicians were supportive of the concept, but there was little consensus among specialties. The Health Services Cost Review Commission (HSCRC) reminded the workgroup that including hospital-based physicians in the current hospital rate-setting system could violate the state's Medicare waiver under Section 1814(b) of the Social Security Act. No change in law is recommended at this time, although state agencies should proactively pursue opportunities to launch a demonstration through CMS.

The Task Force developed Recommendation 3 to resolve the long-standing problem of reimbursement for noncontracting providers that treat HMO enrollees. The recommendation establishes a more equitable and transparent floor on payments pegged to the greater of 140 percent of the Medicare fee and 125 percent of the average of the in-network rate for evaluation and management services. Procedures, tests, and imaging will be reimbursed at 125 percent of the average in-network rate under the recommendation. The proposal also provides a formula to adjust the noncontracting payment floor for medical inflation. The Task Force estimates that total payments to noncontracting providers will increase about 25 percent, if this proposal is adopted. Increases in costs to HMO health plans will vary, but HMO-wide reimbursement for all physician reimbursement will grow by less than 2 percent, assuming physicians continue to participate in networks as they have in the past. On the other hand, if physicians respond to changes in the law by dropping out of HMO networks, health plans would need to increase in-network provider fees to maintain adequate networks and overall physician payments would climb.

The Task Force recognized the importance of linking reimbursement to performance. Major payers in the state have pay-for-performance initiatives under way, but the Task Force found that designs and incentives varied, and evidence is too limited to recommend one approach over another. Further experimentation is desirable to identify the “best in breed” of the first-generation systems. Increased transparency and outside review could legitimize the new systems and speed adoption. In Recommendation 4, the Task Force recommends that Maryland establish requirements on carriers and plans for physician performance measurement systems. Plans operating in New York have already committed to such an arrangement via an agreement signed with the Office of the Attorney General in New York.² Similar agreements should be adopted with plans operating in Maryland to protect consumers and providers.

Consensus was achieved on the importance of promoting new models of care, such as the Advanced Medical Home model (Recommendation 5). In a medical home model, primary care clinicians and allied professionals provide conventional diagnostic and therapeutic services, as well as coordination of care for patients who require services not available in primary care settings. The primary care clinicians serve as advocates for patients and are paid to coordinate their care, thus averting unnecessary tests and procedures, hospital admissions, and avoidable complications. The Task Force believes such a new approach has considerable potential benefit, but further testing is necessary. Our recommendation focuses on steps Maryland needs to take to build multi-stakeholder coalitions that will be needed to develop, promote, test, and fund the medical home.

Widespread adoption of the medical home model will require testing, but the Task Force recommends that insurance carriers and health plans promote one component of the medical home model—24-hour access—by immediately paying a premium for after-hours and weekend care. In addition, the Task Force recommends that eVisits and telephone calls be reimbursed in certain situations when the electronic event replaces a face-to-face visit. All of these services, when used appropriately, have the potential for preventing more expensive office or even emergency room visits. It seems appropriate that primary care providers benefit for

2 Office of the Attorney General, State of New York. *Agreement Concerning Physician Performance Measurement, Reporting and Tiering Programs*. November 15, 2007. (See Appendix 3.)

providing care during off-hours. The Task Force did not make a specific recommendation on the amount of the premium for after-hours care, because the premium will likely need to be incorporated into established reward programs offered by plans.

The Task Force examined whether PCPs should be reimbursed for mental health services. A study conducted on behalf of the Task Force identified confusion among payers and PCPs as to when services could be billed. The Office of the Attorney General suggests that passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act should clarify that primary care providers can provide and bill mental health services when rendered in their scope of practice. The Task Force recommends that health plans and MedChi develop guidance and training sessions for primary care providers requesting information on billing for mental health services.

The Task Force has identified a number of data gaps in attempting to analyze issues within its charge. Information on physician supply is quite limited, and data on nonphysician providers are virtually nonexistent. Recommendation 8 outlines expansions for data collection on the provider work force in Maryland. More and higher quality information will be needed if state policymakers are to address work force issues in a coherent way.

Table 1-EX lists each of the eight recommendations and describes the type of state action that will be required. Five of the recommendations will require statutory or regulatory changes. If policymakers decide to mandate payment for after-hours and weekend care, a statutory change also would be required. When possible, the specific language that needs revision is provided in the report.

TABLE 1-EX. Task Force Recommendations and Type of State Action Required

RECOMMENDATIONS	TYPE OF ACTION REQUIRED
1. Recommendation on Approaches to Promote Practice Formation in Maryland	Changes to Education Article § 18-1501–18-1502
2. Recommendation for Simplifying the Credentialing of Physicians by Hospitals and Health Plans	Change to Health General Article § 15-103.4 and Health General Article § 19-319
3. Recommendation for Changing the Formula for Reimbursing Nonparticipating Providers That Treat HMO Patients	Modification to Health General Article § 19.710.1
4. Recommendation That Health Insurance Plans Must Agree to Use Common Nationally Recognized Measures in Performance Plans	Yes, changes to Insurance and Health General Article
5. Recommendation for Enhancing Delivery of Primary Care and Development of the Medical Home Model	No legislation required
6. Recommendation on Elevated Payment for After-Hours and Weekend Care	Yes, if stakeholders wish to mandate
7. Recommendation for Reimbursing Primary Care Providers That Provide Mental Health Services	No legislation required
8. Recommendation on Improving Data on Physician Supply	Changes to Code of Maryland Regulations 10.25.14

Conclusion

The legislative charge did not ask the Task Force to consider the cost implications of the recommendations. The impact on the affordability of health care insurance was raised at many points during the Task Force's work. The absence of users of health care from the Task Force should not be taken as an admission that the interests of employers and consumers were simply ignored. As a whole, the recommendations reflect the need for greater administrative simplicity, increased practice efficiency, new models of care such as the medical home, and realigned reimbursement that rewards primary care in general and high-quality care in particular. The recommendations also begin to address provider shortages that are readily apparent in some areas of the state. Lastly, a recommendation provides a compromise to the long-standing issue of payments to noncontracting providers.

The work of the Task Force could not have been accomplished without the active participation of all members, but especially the health plans and physicians that approached the difficult questions in a spirit of cooperation and mutual respect.

Introduction

Established in 2007, through the passage of Maryland Senate Bill 107, the Task Force on Health Care Access and Reimbursement was mandated to examine a number of issues related to health care access and provider reimbursement in the state of Maryland. The following issues were identified:

1. Reimbursement rates and total payments paid to Maryland physicians and other health care providers by specialty and geographic area, and trends in such reimbursements and total payments, including a comparison of reimbursement rates, total payments, and trends in other states.
2. The impact of changes in reimbursements on access to health care and on health care disparities, volume of services, and quality of care.
3. The effect of competition (among payers) on payments to physicians and other health care providers.
4. Physician and other health care provider shortages, by specialty and geographic area, and any impact on health care access and quality caused by such shortages, including emergency department overcrowding.
5. The amount of uncompensated care being provided by physicians and other health care providers and the trends in uncompensated care in Maryland and in other states.
6. The extent to which current reimbursement methods recognize and reward higher quality of care.
7. Methods used by large purchasers of health care to evaluate network adequacy and cost of provider networks.

In addition, Senate Bill 744 (Task Force on Health Care Access and Reimbursement—Additional Duties)—passed during the 2008 Legislation Session—requires the Task Force to provide recommendations on two new questions that were added as amendments during the legislative debate:

- Should carriers provide incentives to practices for offering after-hours care?
- Should primary care physicians (PCPs) be allowed to receive reimbursement for mental health services?

Chronology of Task Force Meetings

The Task Force held 14 meetings from the fall of 2007 through the end of 2008. The meetings were organized around issues identified in the charge. Presentations were made by the Maryland Health Care Commission (MHCC), the Maryland Insurance Administration (MIA), the Office of the Attorney General, the University of Maryland School of Medicine, the Johns Hopkins Bloomberg School of Public Health, MedChi, the American College of Physicians (ACP), the American College of Emergency Medicine, the Maryland Hospital Association (MHA), the Rural Roundtable, Aetna, CareFirst, United HealthCare, and several independent consultants under contract to MHCC. Table 1 identifies issues discussed at each meeting.

As important issues arose, the Chairman formed workgroups to examine issues in greater detail and then report back to the full Task Force. Workgroups were formed to examine the potential for establishing a payment system for hospital-based physicians, development of primary source credentialing, payments for noncontracting providers that treat health maintenance organization (HMO) patients, and the initiatives to promote practice development in Maryland.

The Task Force authorized Social & Scientific Systems, Inc., of Silver Spring, Maryland, to conduct studies on whether carriers should provide incentives to practices for offering after-hours care and whether PCPs should be allowed to receive reimbursement for mental health services. These questions were assigned to the Task Force as a result of legislation passed in 2008.

The September, October, and November 2008 Task Force meetings were dedicated to identifying and discussing recommendations. An initial list of options was generated by the staff and circulated at the September meeting. Task Force members and interested parties offered additional options during September. Appendix 1 summarizes the recommendations offered by Task Force members and interested parties during September and October. An expanded list of options, including many of those offered by the interested parties, was discussed in October and early November. When possible, options that addressed the same issue were consolidated into a single recommendation. At the final meeting on November 25, recommendations in eight issue areas were developed and approved. The Chairman asked that the drafts of the final report be shared with the Task Force during late November and early December. All members also had an opportunity to review the report before it was released to the Governor and the General Assembly.

A detailed catalog of meeting minutes, presentations, and reports is available at <http://dhmh.maryland.gov/hcar>.

TABLE 1. Issue Areas Discussed by the Task Force—September 2007 through November 2008

ISSUE AS IDENTIFIED IN SENATE BILL 107 AND SENATE BILL 744	MEETING DATE													
	Sept. 20	Oct. 15	Nov. 14	Dec. 14	Jan. 28	Feb. 25	Apr. 25	May 12	June 10	July 11	Sept. 8	Oct. 6	Nov. 3	
1. Reimbursement rates and total payments paid to Maryland physicians and other health care providers.	■	■				■	■							
2. The impact of changes in reimbursements on access to health care and on health care disparities, volume of services, and quality of care.		■				■								
3. The effect of payer competition on payments to health professionals.		■	■						■					
4. Trends in physician and other health care provider shortages by specialty and geographic area and any impact on health care access and quality caused by such shortages.	■	■		■	■	■							■	
5. The amount of uncompensated care being provided by physicians and other health care providers and the trends in uncompensated care in Maryland and in other states.									■	■	■			
6. The extent to which current reimbursement methods recognize and reward higher quality of care.						■	■	■	■	■				
7. Methods used by large purchasers of health care to evaluate adequacy and cost of provider networks.			■	■	■									
8. The practice of requiring health care providers who join a carrier’s provider network to also serve on a provider network of a different carrier.			■	■	■	■								
9. Should carriers provide incentives to practices for offering after-hours care?											■	■	■	
10. Should PCPs be eligible for reimbursement for mental health services?											■	■	■	

An Overview of the Health Care Market

In order to provide a context for the issues examined by the Task Force and the recommendations that follow, this section provides general background on the health care market nationally and in Maryland.

INSURANCE MARKET CONCENTRATION Nationally, two-thirds of adults under the age of 65 have private health insurance coverage, and the figure is higher in the state of Maryland.³ Insurers act as an intermediary between patients and health care providers, collecting premiums from employers or directly from consumers and distributing these funds—in the form of payment for services—to providers. In this capacity, insurers not only set premium levels and reimbursement rates at the service level but are increasingly involved in guiding patients to specific providers, prescription drugs, and approaches to care through the development of physician networks, drug formularies, and approval of treatment regimens. Through their role as purchasers of physician services, insurers have substantial influence on physician compensation and access to health care services.

Health insurance markets in the United States are highly concentrated, with a small number of insurers providing services. Two insurers control 36 percent of the commercial health insurance market nationally. In most states, one to three insurers hold at least half of the market and, in 299 of 313 markets recently studied, one health plan accounts for at least 30 percent of the combined HMO/preferred provider organization (PPO) market.^{4,5}

In Maryland, the concentration of the insurance market may be represented in at least two ways. In terms of premium dollars, two insurers account for almost three-quarters of earned premiums. Alternately, the proportion of HMO/PPO enrollment held by those same two insurers was close to 50 percent in the Maryland region in which they were least dominant (Bethesda-Gaithersburg-Frederick) and over three-quarters in the two markets in which they had the greatest presence (Salisbury and Baltimore-Towson).

In recent years, insurance markets have become increasingly concentrated at both the national and state level through acquisitions and mergers. Among the motivations for these mergers are the achievement of economies of scale, the decline of HMOs and growth of PPOs that more easily operate on a large scale, and the potential for earnings growth. There are both benefits and costs to insurance market concentration. Most concerns center on the potential for inefficiencies in the setting of prices due to the market power of a small number of purchasers—this could have the potential to raise premiums, consumer cost-sharing, or insurer profits, or to reduce rates paid to providers. On the other hand, fewer insurers could lead to lower administrative costs and increased investment in infrastructure, such as information systems or disease management programs that would lead to overall reduced costs of delivery. Payer consolidation can benefit providers, because office administrative overhead declines when a practice reduces the number of payers with whom it participates. Whether increased negotiating power on behalf of insurers leads to low provider margins and service shortages on the one hand, or efficient reduction of provider reimbursement on the other, is open to question.

3 Maryland Health Care Commission. *Health Insurance Coverage in Maryland Through 2007*. Forthcoming January 2009.

4 American Medical Association. *Competition in Health Insurance, A Comprehensive Study of U.S. Markets, 2007 Update*. Accessed at http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf.

5 Chollet, Deborah. *The Health Care Environment in Maryland: The Private Insurance Market*. Presentation to the Maryland Task Force on Health Care Access and Reimbursement, October 15, 2007.

Based on the central role that insurers play in the health care marketplace, almost all the issues facing the Task Force relate in some way to the provision of insurance and, specifically, to the relationship between insurers and health care providers. Several are quite specific to the role of insurers vis-à-vis providers. One of the broad issues identified as part of the Task Force's mandate is the impact of competition and market concentration on payments to health care providers, as described above. Specifically, do highly concentrated insurance markets lead to lower physician compensation? In addition, the concentration of insurance markets may be relevant to the methods used by large purchasers of health care to evaluate adequacy and cost of provider networks. How does reduced competition among insurers affect the ability of providers to join networks, and what is the associated impact on their reimbursement and on consumer choice?

Specific questions addressed by the Task Force related to insurance concentration include:

- Is there a need to enhance the ability of physicians and other health care providers to negotiate reimbursement rates with health insurance carriers?
- Should health insurance carriers be allowed to require health care providers as a condition of participation to also be in the provider network of another carrier?
- Should the requirements related to balance billing for nonparticipating providers be changed?

PHYSICIAN PRACTICE ATTRIBUTES In stark contrast to high insurer concentration, physician practices tend to be small in Maryland. The predominance of smaller practices exists despite a move in recent years toward larger practices—the proportion of solo and two-physician practices has experienced an 8 percent drop since 1997. Even with this drop, in 2005, close to two-thirds of physicians who were self-employed or employed by a physician-owned group were in practices of five or fewer physicians.⁶ There is limited evidence as to whether physician practice size differs in Maryland compared to the United States overall: an analysis by MHCC staff of 2006–2007 unaudited physician license renewal files suggests that an even higher proportion of Maryland physicians are in small practices. However, it is unclear whether there are specific factors either encouraging small practice size or presenting obstacles to the growth of larger practices in the state. Independent practice associations are precluded from forming for the sole purpose of rate negotiations with insurers, but they are free to form for broader reasons such as increasing efficiency or improving quality.

From a policy perspective, the small scale of physician practices may be important for several reasons. First, physicians in smaller practices have less bargaining power in their interactions with insurers; this is especially true in the current market, where a large number of physician practices are negotiating with a small number of insurers. Second, there is some evidence that large multi-specialty groups deliver higher quality care—for example, patients in larger groups are more likely to receive recommended preventive care and have better intermediate outcomes, and physicians in these groups tend to be better performers on standardized quality metrics. Third, physicians in smaller practices tend to be less productive as measured by relative value unit output than physicians in a large practice.⁷ Even moderately sized practices with six to ten doctors have limited access to capital and the technical resources required for expansion or other large-scale investments in infrastructure.

6 Pham, Hoangmai. *Practice Formation: Learning from National Studies*. Presentation to the Maryland Task Force on Health Care Access and Reimbursement, July 11, 2008.

7 Pope, Gregory, and Burge, Russell. 1996. Economies of Scale in Physician Practice. *Medical Care Research and Review* 53(4): 417–440.

TABLE 2. Distribution of Maryland Practices by Number of Physicians, 2005–2006

PRACTICE SIZE (Number of Full-Time Physicians)	PRACTICES
Fewer than 6	4,707
6 to 10	143
11 or more	52
TOTAL	4,902

SOURCE: MHCC analysis of 2006–2007 unaudited physician license renewal files from the Maryland Board of Pharmacy

Limited access to capital also inhibits practices from competing for new physicians, because compensation packages often include adjustments for relocation costs and for past medical education expense.

In terms of the mandate of the Task Force, the issue of physician practice size is relevant when addressing the competitiveness of the health care market. To the extent that physician practice size may have an impact on physician reimbursement, or the methods used by large purchasers to establish and evaluate networks, then the factors affecting the structure of physician practices as well as any barriers to practice formation are relevant to the mission of the Task Force. Payer expectations for efficiency—including pay for performance or resource-use profiling—have been identified as potentially facilitating formation of large multi-specialty groups.

Specific questions raised include:

- Are physician practices smaller in Maryland than nationally and, if so, are there state-level barriers to practice formation?
- What are the mechanisms that could be used to encourage formation of larger practices?
- Would larger practice sizes increase the ability of physicians to negotiate effectively with insurers? Would they facilitate additional investment in infrastructure and quality improvement?

PHYSICIAN SUPPLY Until recently, most estimates of the national physician supply suggested that supply was more than adequate to meet need. The Council on Graduate Medical Education (COGME), the organization charged with setting policy on the physician work force at the national level, reported that the United States possessed an oversupply of physicians, particularly specialists. However, in its 2005 report, COGME reversed course; it estimated that the United States could have a deficit of 85,000 to 96,000 physicians in 2020, if current demand and service utilization patterns continue. Much of the shortage was estimated to be among medical and surgical specialties, the very groups that had been forecast to be in oversupply during the 1990s.

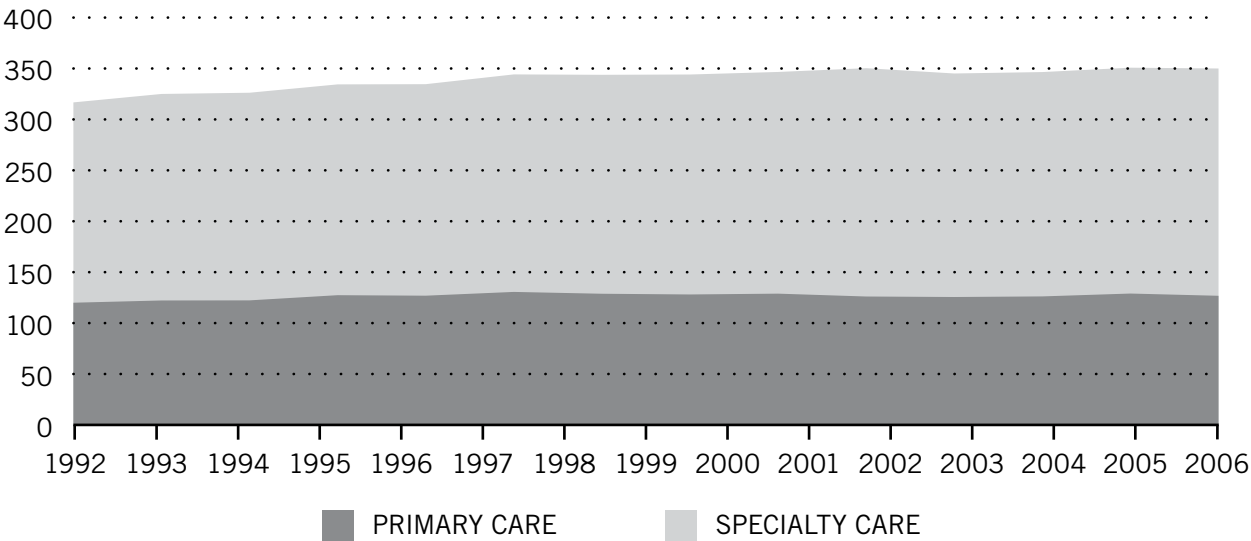
For primary care, the situation could be even direr. Assuming that generalist medicine will continue to lose favor among young physicians, COGME projects that the generalist physician-to-population ratio will fall 9 percent from 2005 to 2020. Some experts point to nonphysician providers as the solution to shortages in primary care. Nurse practitioners (NPs) and physician assistants (PAs) alone are not likely to close the generalist gap. Almost 42 percent of patient visits to NPs/PAs are in offices of specialists, not PCPs.^{8,9} Figure 1 presents Maryland

8 Council on Graduate Medical Education. January 2005. *Sixteenth Report: Physician Workforce Policy Guidelines for the United States, 2000–2020*. Washington D.C.

9 Bodenheimer, Thomas. Coordinating Care—A Perilous Journey Through the Health Care System. *The New England Journal of Medicine* 358 (March 6, 2008).

physicians per 100,000 from 1992 through 2006. During that period, the head count number of physicians that reported being in patient care climbed from 316 to 350. As the chart shows, virtually all the growth was in specialty care. These trends mirror similar growth patterns for the United States overall.

FIGURE 1. Maryland Physicians in Patient Care, 1992–2006



SOURCE: MHCC analysis of the American Medical Association Masterfile data for 1992–2006, Physicians in Patient Care.

It is unlikely that new nonphysician graduates will reduce the looming national shortages in primary care. Nurse practitioners’ annual graduate numbers are projected at 4,000 by 2015; about 65 percent of NPs work in primary care settings. PA graduate numbers have been stable at around 4,200 per year, but only one-third of PAs practice in primary care. Clearly, physicians are not the only providers who are attracted to specialty care. The number of PAs practicing in primary care is likely to be about 28,000 in 2020, and the number of NPs practicing in primary care may reach 100,000. Adding estimated PCP, NP, and PA numbers for 2020, the primary care clinician-to-population ratio will fall by 9 percent from 2005 to 2020. In contrast, the specialist physician-to-population ratio will rise by 14 percent during those years. There is no evidence that distributions in Maryland will be any different than the national forecasts.

In 2006, the American Association of Medical Colleges called for a 30 percent increase in total medical school enrollment over the next decade, a goal physician work force experts say can be achieved only by increasing class sizes in existing schools and establishing new medical schools. Richard Cooper, former Dean of the University of Wisconsin Medical School, and colleagues at Temple University estimated a net shortfall of 200,000 physicians by 2015.^{10, 11} Other researchers have looked at COGME’s and Cooper’s estimates with skepticism. David Goodman, Professor of Pediatrics and Community and Family Medicine at the Center for the Evaluative Clinical Sciences, Dartmouth Medical School, has pointed out that higher physician supply per se does not amount to better access, quality, or outcomes.^{12, 13, 14, 15} Other researchers have sought to distinguish

10 Cooper RA. Weighing the Evidence for Expanding Physician Supply. *Annals of Internal Medicine* 141:705–714.
11 Cooper RA, Getzen TE, McKee HJ, and Laud P. Economic and Demographic Trends Signal an Impending Physician Shortage. *Health Affairs* 21(1):140–154.
12 Goodman DC and Grumbach K. Does Having More Physicians Lead to Better Health System Performance? *Journal of the American Medical Association* 299:335–337.
13 Goodman DC. The Physician Workforce Crisis: Where Is the Evidence? *Health Affairs* Web Exclusive. March 15, 2005.
14 Goodman DC. Trends: Twenty-Year Trends in Regional Variations in the U.S. Physician Workforce. *Health Affairs* Web Exclusive. October 7, 2004.
15 Goodman DC. Perspective: Do We Need More Physicians? *Health Affairs* Web Exclusive. February 4, 2004.

between supplies of PCPs and specialty care physicians. Barbara Starfield and her colleagues at the Johns Hopkins Bloomberg School of Public Health found that a greater supply of PCPs was generally associated with lower county mortality rates, while a greater specialist supply was associated with higher mortality.¹⁶

The MHA and MedChi, the Maryland State Medical Society, commissioned a study to examine physician work force needs to 2015.¹⁷ The study found that, overall, Maryland is 16 percent below the national average for number of physicians available for clinical practice. The report projected looming shortages in rapidly growing outer suburban and rural areas of the state by 2010, and shortages in many specialties for most of the state by 2015, if existing demand assumptions continued. The report was presented to the Task Force in December 2007. The report finding sparked considerable comment in the Task Force, given that the Health Resources and Services Administration (HRSA), using American Medical Association Masterfile information, had pegged Maryland physician supply among the highest in the country. The large differences in estimates were, in part, attributable to differing assumptions regarding the time physicians spent in direct clinical care. The MHA/MedChi study attributed the lower clinical productivity in Maryland, as measured by percentage of time in clinical care, to more part-time practice and greater involvement of Maryland physicians in other activities, such as leisure, research, and teaching. The Task Force convened a workgroup to reconcile the different estimates and to identify areas of general agreement.

Consensus was reached on the following issues:

- Current and future access to primary care (pediatrics, family practice, and general internal medicine), emergency medicine, and obstetrics are critical needs for all communities. This concern extends beyond the number of physicians in practice to concerns about viability and affordability of access to PCPs under the delivery and (fee-for-service) payment models that are currently in use in Maryland.
- The future supply of obstetricians is compromised by the high cost of malpractice insurance, the extended years of liability, and quality-of-life issues relative to on-call time. The Task Force supports expanded efforts to ensure the continued availability of high-quality obstetrical services in the future, as current practitioners retire or reduce their scope of service.
- The appropriate level of primary care and specialty care in rural areas of the state and the outer suburban areas that are transitioning to more dense population warrants special attention through enhanced loan repayment. Current state and federal efforts to improve access to PCPs in rural areas have had limited impact largely due to inadequate funding. Impending retirements and changes in the demographics of physicians and patients in all areas (both urban and rural) will increase the risk of diminishing supply in rural areas, if not addressed with proactive training, recruitment, and retention tactics, as well as considering alternative approaches to delivering care. Rapid change in outer suburban areas will require careful planning for all health care services, including physician care.
- Urban areas in central Maryland and the National Capital Area have competitive advantages relative to other areas of the state that may enable these areas to maintain current physician levels even in the face of increased competition for physicians. Although overall physician supply may be more adequate in these areas, special attention should continue to be paid to populations with limited access to care.

PAYMENT DIFFERENCES ACROSS SPECIALTIES Overall compensation of physicians varies considerably by specialty: national survey data indicate that annual compensation in 2006 was about \$190,000 for primary care specialties (including family practice, general internal medicine, and general pediatrics), while compensation for other medical specialties and for surgical specialties was more than twice as much. While these are national data, the patterns are likely to be similar to those we would see in data for Maryland. These differences across specialties could arise from a number of sources, including the hours worked, the mix of services

¹⁶ Starfield et al., op. cit.

¹⁷ Maryland Hospital Association/MedChi. April 2008. *Maryland Physician Workforce Study*. Baltimore, Maryland.

TABLE 3. Average Income for Selected Specialties in the United States

	ANNUAL INCOME	INCOME RELATIVE TO RADIATION ONCOLOGIST'S INCOME
Radiation Oncology	\$489,765	100%
Orthopedic Surgery	\$476,781	97%
Diagnostic Radiology	\$449,664	92%
Plastic Surgery	\$408,065	83%
Dermatology	\$390,274	80%
Anesthesiology	\$371,066	76%
Otolaryngology	\$369,154	75%
General Surgery	\$330,215	67%
OB/GYN	\$296,399	61%
Emergency Medicine	\$258,088	53%
Neurology	\$254,558	52%
Internal Medicine	\$191,526	39%
Pediatrics	\$188,496	38%
Family Practice	\$178,829	37%

SOURCE: Medical Group Management Association (MGMA). *Physician Compensation and Production Survey: 2007 Report*, based on 2006 data as published in the *New York Times*; accessed at http://www.nytimes.com/2008/03/19/fashion/19beauty.html?_r=2&scp=1&sq=the+price+of+beauty&st=nyt; Maryland-specific results are not available due to small cell sizes.

provided, and the payments per service. In fact, survey data show that there is little variation in number of hours worked annually, with a range of about 1,800 to 1,900 hours. Thus, differences in hours worked are not responsible for the variation in compensation.¹⁸

The low reimbursement for evaluation and management generates lower net incomes for these categories of providers and likely distorts future specialization decisions on the part of medical graduates. As Table 3 shows, family practice physicians have an average income of about 37 percent of the income of the highest paid specialty. Emergency medicine physicians, the lowest of the hospital-based specialties, earn about 53 percent of the highest paid specialty.¹⁹ Although the data shown in the table are based on national averages, the pattern of earnings among specialties likely looks the same in Maryland.

The Task Force concluded that raising the non-par ceiling on evaluation and management services delivered in out-of-network situations would alleviate some of the current imbalance in the payment for these types of services. Other specialties also would benefit to the extent they provided evaluation and management services.²⁰ However, the mix of services and the payments per service do vary by specialty. Comparing different specialties using a simple breakdown by broad service categories, 61 percent of services provided

18 Medical Group Management Association. *Physician Compensation and Production Survey: 2007 Report*. Based on 2006 data; tabulations are provided by MGMA from the survey database.

19 The comparisons are based on national income levels. Although absolute incomes may differ in Maryland, it is likely that the proportional differences among specialties are similar.

20 Recommendation 3 in this report changes the formula for reimbursing noncontracting physicians who treat HMO patients.

by PCPs are categorized as evaluation and management compared to 50 percent for physicians as a whole. Approximately one-fifth of services by medical and surgical specialists are procedures, but procedures represent only 10 percent of services for all physicians and only 3 percent for PCPs.

The variation in payment per service is related to the amount of work and expected time per service, as measured under the Medicare fee schedule, and is a major factor in determining physician compensation. Analyzing mean payment received per expected minute of physician time, the differences across specialty in terms of payment were demonstrated in a recent analysis for the Maryland Health Care Commission.²¹ This analysis showed primary care to be consistently below average across all measures and the only specialty below average for the payment per time measure.

Because payment per time has a substantial impact on physician compensation overall, it is important that the expected time requirement used in calculating payments match the actual time physicians currently spend providing that service. In fact, there is some evidence that these time estimates have not kept pace with technology-induced productivity changes, so that, over time, certain specialties are able to produce more “work” in less time; because the services provided by PCPs tend not to benefit from these productivity increases, this results in rising compensation for these specialties, relative to primary care, over time.²²

A major focus of the Task Force was how reimbursement rates and total payments to health care providers affect physician recruitment and retention and, ultimately, access to health care services. Specific attention was paid to primary care because of the relatively low compensation of PCPs and the concern that compensation may be a factor in the persistent challenges in recruiting and retaining primary care providers.

Specific questions addressed by the Task Force related to this topic include:

- Do lower payments to PCPs affect access to primary care services?
- What are the options for changing the payment system so as to increase reimbursement to PCPs?

21 Maryland Health Care Commission. *Spotlight on Maryland: Paying for Physician Care in Maryland: What Are the Factors Contributing to Differences Across Specialties?* July 2008. Accessed at http://mhcc.maryland.gov/spotlight/physiciancare_200808.pdf.

22 Hogan, Christopher. *Current Structure of Medicare Physician Reimbursement: A Long-Term Perspective*. Presentation to the Maryland Task Force on Health Care Access and Reimbursement, February 25, 2008.

Policy Initiatives Aimed at Addressing the Issues

In this section, we discuss several recent and ongoing policy initiatives focused on correcting some of the weaknesses in the current health care delivery system raised in the previous section. These policy efforts largely focus on the relationship between payers and providers, attempting to more carefully target the signals sent to providers by the payment system. The underlying purpose has been to use the manner in which providers are reimbursed to promote the efficient delivery of health care services. While attention has always been given to maintaining and enhancing access to care through these initiatives, more recently, promoting quality of care through payment systems has taken center stage. One of the issues set out by the legislature for the Task Force was to examine these initiatives and, specifically, “the impact of changes in reimbursements on access to health care, health care disparities, volume of services, and quality of care.”

REIMBURSEMENT REFORMS There have been a number of changes to how physicians are reimbursed for their services. Traditionally, payment systems were fee-for-service (FFS), meaning that providers were paid based on the volume of services provided. In other words, the more services a physician provided, the more he or she was paid, creating a potential incentive to provide more services. During the 1980s, the volume of health care services—particularly diagnostic services—increased and health care costs rose. One of the responses to the rapid increase in health care costs was a move by insurers to managed care and capitated reimbursement systems.

Under a capitated reimbursement system, a provider is paid a fixed amount for each person and the onus is on the physician to provide an “appropriate” bundle of services. Capitation was intended to promote efficiency by removing the link between payment and volume of services, but because the payment is capped regardless of the number of services provided, there is a potential incentive to provide fewer services. In fact, there were concerns that, in some cases, too few services were being provided under capitation. Dissatisfaction with both these payment systems—one that could lead to too many services and one that could lead to too few services—helped contribute to the growing emphasis on providing incentives to promote quality.

PRIVATE PAYER INITIATIVES TO REFOCUS SYSTEMS OF PAYMENT In addition to growing dissatisfaction with the perverse incentives engendered by both FFS and capitated reimbursement, increasing evidence of poor-quality health care led to efforts to incorporate quality of care into the payment system. A major impetus was provided by the Institute of Medicine report *Crossing the Quality Chasm*, which had among its recommendations to (i) examine current payment methods to remove barriers that impede quality improvement, and (ii) incorporate stronger incentives for quality enhancement, i.e., reward physicians for care practices that improve patients’ health.²³

First-generation systems used credentialing or tiered networks wherein plans credential providers or define provider tiers based on prices and efficiency as measured by cost per episode of care and, occasionally, quality. Credentialing was often linked to reporting initiatives to promote informed decisionmaking among patients; patients were sometimes rewarded with lower premiums or copays for seeking out top-tier providers, but payment to providers was not directly affected.

23 Committee on Quality of Health Care in America, Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington D.C.: National Academies Press.

In the next phase, payment systems—often referred to as pay-for-performance (P4P)—emerged that were based on reporting of data related to meeting standards of care. These generally fell into three types—process (receipt of preventive screening such as mammogram, electronic recordkeeping), service (patient satisfaction ratings, weekend or evening hours), and outcomes (clinical measurements such as lower cholesterol, HbA1c control, or readmission rates). These systems often incorporate a direct link to payment with a percentage increase in the fee schedule or per-member/per-month payment for meeting the standards. While P4P-type systems are becoming more widespread nationally with private payers, they are still frequently in the planning or pilot phase. It is important to note that P4P continues to layer payment on an FFS system; in other words, payments are linked to the provision of specific services.

In Maryland, the major insurers are at varying stages vis-à-vis the adoption of quality-based programs. While United HealthCare has a P4P program that is being piloted in selected jurisdictions across the country, as of early 2008, United HealthCare had not implemented a P4P program in Maryland in which physicians were financially rewarded for meeting specific quality standards. Instead, United HealthCare relies on a physician tiering program in which physicians are rated on quality and efficiency, but there is no direct link to payment. CareFirst has begun to implement its Quality Rewards program in Maryland; this initiative allows for reimbursement levels up to 7 percent of the base fee schedule beginning in 2009, based on adherence to a set of quality and service-oriented business practice measures. In addition to their physician tiering program in which consumers face a lower copayment for choosing top-tier physicians, Aetna has implemented a Bridges to Excellence P4P program in Maryland that focuses on two chronic conditions. Both the Aetna and CareFirst programs are currently limited to a small number of physician specialties.²⁴

These programs are directly relevant to another of the issues facing the Task Force—the extent to which current reimbursement methods recognize and reward higher quality of care.

EXPANSION OF RATE-SETTING IN THE STATE Recently establishing a rate-setting system for physicians has attracted renewed interest. Many advocates point to the benefits the hospital-setting rate-setting system has brought to Maryland hospitals. In particular, the system has provided a framework for equitably distributing hospital uncompensated care. In the last several years, state policymakers and hospitals have shown that the rate-setting system can be evolved using a new classification system, “All Patient Refined Diagnoses Related Groups,” to equitably reimburse increasing wide variations in the complexity of care. Future development suggests that the system can also be the foundation on which a P4P system will be built. Careful management of rate increases has also left sufficient slack in the system to help finance public programs for nurse education and, most recently, health IT expansion.

Hospital-based physicians have expressed the most interest in a physician rate-setting system. Hospital-based physicians contend that private sector in-network payments, although often higher than Medicare fees for the same service, are insufficient to subsidize uncompensated care losses. Table 4 presents physician-reported uncompensated care hours per month for the principal hospital-based specialties.

24 Schur, Claudia. *Private Payer Initiatives to Refocus Systems of Payment*. Presentation to the Maryland Task Force on Health Care Access and Reimbursement, February 25, 2008.

TABLE 4. Reported Hours of Uncompensated Care per Month (Charity and Noncollectible)

Specialty Primary Concentration	Physician Reported Hours Per Month	Number of Physicians Responding
Anesthesiology	12.4	294
Emergency Medicine	20.2	109
Pathology	8.5	33
Radiology, Diagnostic	7.3	125
Critical Care	13.9	33

SOURCE: MHCC analysis of 2005–2006 physician license renewal survey from the Maryland Board of Physicians

WHICH SPECIALTIES HAVE THE MOST UNCOMPENSATED CARE? Results from the Health Services Cost Review Commission (HSCRC) annual filings suggest that hospitals experience losses on their physician operations. For 2007, Maryland hospitals reported physician expenses of \$385 million and revenue of \$237 million.²⁵ Care must be taken in interpreting these losses, however, because physician expenses include direct patient care and a variety of activities, including on-call payments, recruitment, professional liability expense, and other permitted physician expenses paid by the hospitals.

A workgroup was formed to consider whether a payment system could be developed for hospital-based physicians, starting with a demonstration at a limited number of hospitals. The workgroup identified several benefits to the system. A payment system would:

- Distribute physician uncompensated-care losses in the hospital setting (reduce hospitals' Part B physician losses);
- Reduce differences in payment per specialty;
- Take payment issues out of participation decisions: the par/non-par debate would disappear;
- Encourage increased "systemness" between payers, hospitals, and providers; and
- Encourage competition on dimensions other than prices.

Some hospital-based physicians were supportive of the concept, but there was little consensus among specialties. Both groups identified a number of challenges, the most significant being lack of a clear champion for a system and the hurdle posed in obtaining Centers for Medicare & Medicaid Services (CMS) approval, given the likelihood that Medicare fees for the specialties most interested in participating would increase. The workgroup concluded that a stand-alone physician payment system would be difficult to launch without participation of all specialties.

Incorporating hospital-based physicians in the current rate system has significant challenges. The HSCRC reminded the workgroup that including hospital-based physicians in the current hospital rate-setting system could violate the state's Medicare waiver under Section 1814(b) of the Social Security Act. No change in law is recommended at the current time, although state agencies should proactively pursue opportunities to launch a demonstration through CMS.

25 Health Services Cost Review Commission. 2008. *Hospital Disclosure Report FY 2007*. Baltimore, Maryland.

NEW MODELS OF CARE While the value-based purchasing initiatives described above attempt to realign the incentives facing physicians, a range of strategies are being considered for maintaining or improving access to primary care services. Several of the options currently being explored make substantial changes in the way that care in primary care practices is delivered, coordinated, and paid for. Two other aspects of care provided or potentially provided by PCPs—after-hours care and mental health care—were called out by the legislature for specific attention by the Task Force.

One initiative currently receiving attention is the “medical home,” developed by the American Academy of Family Practitioners (AAFP) and the ACP, which focuses on coordination of care and management of chronic diseases with a single physician serving as the focal point for a broader range of a patient’s needs. Payment for the medical home may include multiple components, such as a prospective bundled component, an FFS per-visit component, and a performance-based incentive component, each risk-adjusted to reflect the patient’s health status. The medical home not only responds to the need for a greater emphasis on chronic disease management but also rewards PCPs for those aspects of care not fully recognized by the current reimbursement system with its service-by-service focus.²⁶

The interest in expanding after-hours care stems from increased overcrowding of emergency departments, the high costs of treating nonemergent patients in the emergency department, and the Institute of Medicine’s focus on timely care as an essential pillar of quality care. While urgent care centers and retail clinics have begun to offer extended hours and meet some of the demand for after-hours care, concerns about continuity and timeliness of care when PCPs are not available to respond to patients, coupled with the desire to reach a broader range of patients, led to interest in having physicians in private practices offer appointments outside of the usual 9-to-5 daily schedule. Offering an expanded schedule, however, imposes time and potentially financial burdens on physicians, particularly those in smaller practices.²⁷

While practices are slowly changing, most commercial payers in Maryland and across the country do not compensate PCPs for telephone or e-mail communications (eVisits) or pay a premium for after-hours, face-to-face visits. Aetna, Blue Cross Blue Shield, and CIGNA pay for eVisits in some markets, and United HealthCare reimburses for specific after-hours visit codes when care is provided outside of normal posted office hours or results in the disruption of the physician’s regular practice during office hours. Within Maryland, CareFirst recently began a pay-for-quality program that includes extended hours as one of the criteria for receiving points that can lead to enhanced payments.

The issue of the provision of mental health care by PCPs has surfaced because of the increasing prevalence of mental health issues and the current reliance of the vast majority of adults with mental health disorders on their PCPs to make a diagnosis and manage psychotropic medications. Despite the role that PCPs play in screening and managing medications for mental health issues, concerns have been expressed that Maryland PCPs are not compensated or are compensated at lower rates for providing mental health care services.

Although integrated systems such as Kaiser Permanente do provide coverage for patients being treated by PCPs for mental health problems, the vast majority of Maryland’s privately insured residents 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 included in the overall insurance product

26 The medical home concept is discussed briefly in *Paying for Physician Care in Maryland: What Are the Factors Contributing to Differences Across Specialties?* Op. cit. See also Berenson, RA. et al. A House Is Not a Home: Keeping Patients at the Center of Practice Redesign. *Health Affairs* 27(5):1219–1230.

27 Paez, Kathryn. *Study to Support the Health Care Access and Reimbursement Task Force*. Presentation to the Maryland Task Force on Health Care Access and Reimbursement, September 8, 2008.

for fully insured contracts, but mental health insurance risk may be separated in self-insured contracts and covered in a separate contract between the payer (insurer or employer) and a mental health vendor. In either arrangement, the mental health vendor will have a distinct provider network and separate financial incentive programs. PCPs are not included in MBHO provider networks, so they usually are not paid for providing mental health care under the mental health benefit or the medical benefit. In order to reduce risk of claims denial, PCPs may avoid use of psychiatric Current Procedural Terminology (CPT®) codes and submit claims with a primary diagnosis of “symptom codes” (e.g., fatigue, insomnia) or place the mental health diagnosis in the secondary diagnostic position.²⁸ PCPs also may avoid use of extended service codes that compensate them for the longer visits required to manage mental health problems in order to reduce the risk of claim denials.

Recent passage by the U.S. Congress of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 should change how mental health services are covered. The law affects large group plans, barring them from setting higher copayments or deductibles for mental health or substance abuse treatment than for medical care when a mental health benefit is included in the contract. Lower mental health benefit limits would be illegal, along with caps on the number of outpatient therapy sessions or inpatient treatment days. Plan enrollees would have to be covered for out-of-network mental health care if their plan includes out-of-network medical coverage. However, the new law does not mandate insurance coverage for mental health services. Employers that offer health benefits under the Employee Retirement Income Security Act of 1974 (ERISA) will not be required to offer mental health benefits. If they do offer mental health coverage, the benefits must be equivalent. In Maryland, fully insured products must, by law, include a mental health benefit; Maryland law already requires that carriers must reimburse any licensed provider for mental health services if these services are within the licensed provider’s scope of practice.

However, given the history of PCP experience with denial (or fear of denial) of claims for mental health services, there is still some concern about how the implementation of the new law will affect actual practice. There is also some risk that employers may now have additional incentives to self-insure; by so doing, they could drop a mental health benefit and avoid the new law. These employers would be beyond the reach of state law due to the ERISA preemption.

Related questions discussed by the Task Force include:

- What changes can be made in the structure of physician payment that will increase access to the full range of health services?
- How can reimbursement to PCPs be improved?
- Will enhanced payment for after-hours care reduce overall costs through reductions in use of more costly emergency department care?

28 Kautz C, Mauch D, and Smith SA. 2008. *Reimbursement of Mental Health Services in Primary Care Settings*. HHS Pub. No. SMA-08-4324. Rockville, Maryland: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

RECOMMENDATION 1: Approaches to Promote Practice Formation in Maryland

1. Establish an expanded loan program.
 - a. The HSCRC should establish a program (Loan Assistance Repayment Program State Only [LARP-SO]) to allow physicians in shortage areas as defined by the Office of Primary Care (OPC) at the Department of Health and Mental Hygiene (DHMH) to access the repayment program administered by DHMH and the Maryland Higher Education Commission (MHEC). The Task Force anticipates that OPC would address deficiencies in the federal definitions of provider shortage areas. Under the LARP-SO program, PCPs practicing in a state-defined shortage area could be eligible for loan repayment in exchange for a commitment to practice in the shortage area. The HSCRC should establish a program, provided that such a program:
 - Is in the public interest;
 - Is not in violation of the state's Medicare waiver under Section 1814(b) of the Social Security Act; and
 - Does not result in significantly increasing costs to Medicare or placing the Medicare waiver in potential jeopardy.
 - b. The HSCRC should consider various funding models when determining the most effective way to implement the loan repayment program, including:
 - A Nurse Support Program I approach, which provides additional funding to hospitals based on detailed proposals for use of the funds;
 - A Nurse Support II approach, which establishes a fund within MHEC and utilizes the expertise of MHEC to administer the loan repayment program;
 - The administrative creation of a fund within the HSCRC for this purpose as utilized for other HSCRC programs; and
 - Other appropriate funding models.
 - c. In conjunction, the General Assembly should enact legislation:
 - To change the definition of eligible field of employment in Education Article § 18-1501 to include for-profit physician settings. (Note that under the current LARP program, this is not possible due to federal funding restrictions; however, this would not be an issue if funds came from the HSCRC.)²⁹; and
 - That allows other physician specialties to participate in loan forgiveness as long as the specialty has been identified by DHMH as being in shortage in the area.

RATIONALE Generation of additional revenue from all payers for the LARP-SO could be used to draw additional federal funding and/or establish a state program with greater flexibility.

SOURCES OF FUNDING The amount to be included in hospital rates shall be based on an objective review of the need for the loan repayment program, but not to exceed 0.1 percent of hospital net patient revenue. This would be the primary source for the loan/development fund. If the funding plan meets the requirements of the Medicare waiver and CMS, the HSCRC currently has the authority to implement such a plan.

29 Under the J-1 visa waiver program designed to allow international medical graduates to practice in underserved areas, states and federal agencies requesting waivers for non-primary-care physicians are required to demonstrate a shortage of health care professionals able to provide services in that medical specialty for the patients who would be served by that physician, based on their own criteria, 8 U.S.C. § 1184(l)(1)(D)(iii). A similar provision does not exist under LARP.

A second source of funding comes from reallocating the portion of physician license fees currently assigned to the Health Personnel Shortage Incentive Grant Program (HPSIG), which is designed to increase the number of graduates eligible for licensure, certification, or registration in designated health shortage occupations. In parallel, license fees for other allied health professionals may need to be increased modestly to sustain the HPSIG program once the physician license fees are reallocated.

TOTAL FUNDS AVAILABLE A surcharge of up to 0.1 percent on inpatient hospital revenues could generate up to \$9.7 million (FY 2008) in inpatient revenue and up to \$3.6 million from outpatient revenue.

Currently, 14 percent of the physician license fees are dedicated to loan repayment and split between two programs: (1) grants under the HPSIG, and (2) the LARP for PCPs. In FY 2009, this percentage decreased to 12 percent. For FY 2008, the grants awarded under the HPSIG totaled \$499,098 and were split among 39 different postsecondary institutions in a number of health professional occupations. The LARP for PCPs in FY 2008 totaled \$432,500, with an average of \$25,441 provided to 17 physicians.

2. DHMH in collaboration with MHEC should establish a program that allows medical schools operating in Maryland to offer tuition assistance and admission preference to otherwise qualified in-state applicants who agree to stay and practice in shortage areas as defined by OPC for five years.

SOURCE OF FUNDING A portion of funds generated under Option 1 should serve as the funding source for this initiative.

3. Medical practices should be eligible to participate in state technical assistance programs established by the Maryland Department of Business and Economic Development (DBED). Maryland provides business assistance funding to high-tech and bio-tech companies to enhance their service offerings. The state provides outside business consultants, entrepreneurial training, pro bono legal services, and additional networking opportunities with investors and assists in depth strategy planning. The MHCC and DBED should report to the General Assembly on the feasibility of expanding eligibility to state development programs to practices in medically underserved and health provider shortage areas.
4. Encourage insurers to provide incentive payments to practices in shortage areas for technology upgrades and practice development.

RATIONALE Providing upfront IT improvement funding (similar to the CMS Electronic Health Record [EHR] demonstration currently under development in the state) eliminates a huge barrier to 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.

RECOMMENDATION 2: Simplifying the Credentialing of Physicians by Hospitals and Health Plans

Health General Article § 15-103.4 should be modified and Health General Article § 19-319 should be modified to recognize an electronic uniform credentialing form developed by CAQH®, a national nonprofit alliance of health plans and trade associations. The Office of Health Care Quality (OHCQ) and the MIA should clarify regulations to enable hospitals and health plans to accept information from standard credentialing forms or information gathered directly from physicians by a nonprofit alliance of health plans and trade associations when the information is identical.

1. The OHCQ should align information on its standard credentialing form to be consistent with information collected by a nonprofit alliance of health plans and trade associations.
2. The OHCQ and the MHA should work collaboratively with The Joint Commission to permit hospitals to use primary source information held by a nonprofit alliance of health plans and trade associations.
3. The OHCQ and the MIA should endorse efforts by a nonprofit alliance of health plans to collect primary source information and advocate that this information be a recognized source for credentialing by The Joint Commission and the National Committee on Quality Assurance (NCQA).
4. The MHCC and the MIA, in consultation with the OHCQ and the Maryland Board of Physicians (MBP), should conduct a study of the average credentialing time for providers submitting information by paper and electronically, and report these findings and any recommendations to the General Assembly by December 1, 2009.

Nothing in these recommendations should prevent hospitals or health plans from requesting additional explanatory information that is not provided in the standard credentialing form.

THE PROBLEM Data gathering for credentialing is time-consuming and expensive for hospitals and health plans. Providers must respond to redundant data requests, delay providing care, and suffer a loss in revenue because of delays in review of documentation. Centralizing credentialing enables health plans and hospitals to obtain information from several common trusted sources and enables providers to submit most information just once. Centralized access to linked information from trusted sources cuts administrative expense and allows organizations to focus their resources on review and evaluation of provider credentials and documentation.

RATIONALE The Task Force gathered information from the MBP, the OHCQ, the MHA, the Maryland Association of Life and Health Insurers, and CAQH®. OHCQ and MIA have adopted common standard credentialing forms that physicians file to hospitals and health plans licensed in the state. The MIA credentialing form is aligned with the CAQH® credentialing form. Physicians may submit either the paper MIA or the CAQH® equivalent to health plans. OHCQ has not yet aligned its form with CAQH® forms.

The NCQA and The Joint Commission have different rules regarding use of data held by the MBP in the credentialing process. In general, the NCQA allows health plans more flexibility in determining information sources used for credentialing physicians than The Joint Commission allows hospitals. Both organizations recognize the MBP as the primary source for licensure information. The MBP maintains the following information as

part of its licensure responsibilities: practitioner's name, license number, graduation date, license status, date license issued, license expiration, and Maryland disciplinary actions. The NCQA allows health plans to rely on the primary source verification of educational credentials performed by the MBP in the course of its licensure process, but The Joint Commission does not. Drug Enforcement Administration numbers are not held by the MBP, and medical liability carriers change frequently and could not be easily tracked by the MBP.

The Task Force concluded that establishing a central repository for credentialing at the MBP is not viable. A similar initiative in Florida under the Board of Physicians (CoreStat) was abandoned in 2003. Arkansas is the only state that houses a centralized credentialing function. The Arkansas board is accredited by NCQA as a credentials verification organization, but health plans contend that turnaround time is below industry averages. Large national carriers, including Aetna and CIGNA, oppose any Maryland credentialing initiative because it adds expense.³⁰

A demonstration using CAQH® to support hospital credentialing is beginning in Vermont. That demonstration would rely on information from the CAQH® centralized information repository for hospital credentialing. The CAQH® board will complete a feasibility assessment of implementing a primary source verification function in the spring of 2009. The Task Force concluded that CAQH® likely offered the best promise for future efficiencies. State organizations (MIA, OHCQ) should align their standards to capture future efficiencies. The current recommendation, if adopted, would improve efficiency by eliminating duplicate hospital and health plan data collection, thereby reducing time delays. It is unclear if greater reliance on CAQH® will initially generate significant costs savings that could be dedicated to physician loan repayment or other public initiatives. Longer term, hospitals and health plans may see savings due to reduced staffing for credentialing and privileging functions.

30 Testimony from the Maryland League of Life and Health Insurers, October 30, 2008.

RECOMMENDATION 3: Changing the Formula for Reimbursing Nonparticipating Providers That Treat HMO Patients

Note that these recommendations apply only to services provided by nonparticipating providers with HMO plans.

1. The current law (Health General Article § 19.710.1) should be changed as follows:

- **DEFINITIONS**
 - a. Define the term “similarly licensed provider” by adding a definition of this term to mean a health care provider holding the same type of license or, for physicians, a physician board-certified or eligible in the same practice specialty.
 - b. Medicare Economic Index (MEI) is a fixed-weight input price index that measures the weighted average annual price change for various inputs needed to produce physicians’ services. It is used by CMS in the calculation of reimbursement of physicians’ services under Part B of Medicare (Title XVIII of the Social Security Act).
 - c. Berenson-Eggers Type of Service (BETOS) is a classification developed by CMS that groups Current Procedural Terminology (CPT-4®) codes together based on clinical consistency.³¹
- **MODIFY PAYMENT FORMULA FOR EVALUATION AND MANAGEMENT SERVICES** A health care practitioner providing an evaluation and management service, as defined in the BETOS definition developed by CMS, is reimbursed at least at the greater of:
 - a. 140 percent of the rate paid by the Medicare program, as published by CMS, for the same covered service to a similarly licensed provider or similar specialty practice in the same geographic area as of August 1, 2008, inflated by the change in the MEI from 2008 to the current year; or
 - b. 125 percent of the average rate the HMO paid to similarly licensed providers or a similar specialty practice under written contract in the same geographic area, as defined by CMS, for the same covered service as of January 1 of the previous calendar year.³²
- **MODIFY PAYMENT FORMULA FOR NON-EVALUATION AND MANAGEMENT SERVICES** For any other service, a health care practitioner is reimbursed at 125 percent of the average rate the HMO paid to similarly licensed providers under written contract in the same geographic area, as defined by CMS, for the same covered service as of January 1 of the previous calendar year.
- **MAINTAIN CURRENT PAYMENT FORMULA FOR TRAUMA SERVICES** The funding formula for reimbursing noncontracting trauma physicians should be aligned to include an annual cost inflation adjustment using the MEI as described above. The funding percentages (greater of 140 percent of Medicare and 125 percent of in-network fees) should not be changed from current law.

2. The MHCC should annually review the payment to providers not under written contract with the HMO to determine compliance with this section and report its findings to the MIA. The MIA should take appropriate action, including conducting an examination under Title 2 Subtitle 2 of the Insurance Article, to ensure compliance with this section.

³¹ Evaluation and management services, as defined under the BETOS Classification System, are posted on the Health Care Access and Reimbursement Task Force Web site at <http://dhmh.state.md.us/hcar/>.

³² Some health plans set fees by individual physician, others by practice; in either instance, the weighted average fee will be developed by summing all reimbursement across all fee levels for that service divided by the total number of services.

3. The law should become effective on January 1, 2010, and sunset at the end of five years (December 31, 2014).
4. No recommendation is made on balance billing of patients in preferred provider plans.

BACKGROUND “Balance billing,” i.e., billing the patient for the “balance” remaining for health service charges not reimbursed by the health plan of an HMO enrollee for a covered service, has been prohibited under Maryland law since the late 1980s.^{33, 34}

The prohibition on balance billing and the reimbursement floor established for noncontracting providers cover only HMO health plans. Patients enrolled in PPOs, other forms of managed care, and indemnity plans are liable for paying the difference between the insurance carrier’s allowed payment and the provider’s billed charge, if the provider does not participate in the insurance carrier’s network. Individuals insured by these plans typically pay more for out-of-network services. In nonemergency situations, patients choose whether they wish to absorb additional expense by going out-of-network. When individuals select these types of plans, they expect to pay a balance bill for out-of-network services. When patient choice is not an option, as is the case with most emergency services, patients expect that a payer’s network will include a sufficient range of providers to cover needed services.

Providers that participate in HMO networks must accept as payment in full the rate they negotiated with the HMO as payment. Out-of-network providers must accept an amount defined in statute.³⁵ Providers have voiced the following complaints about the current law:

- Fees paid by HMOs to noncontracting providers are too low;
- Some plans do not pay what is required under the law;
- Statutorily established fees serve as the ceiling on reimbursement, not the floor, as was intended by the General Assembly; and
- Enforcement has been difficult due to the lack of clarity in the statute.

RATIONALE The Task Force has received significant testimony over the past year regarding the inadequacy of the current fee-for-service reimbursement. Representatives of provider groups presented information about Colorado, New Jersey, Florida, and Virginia, where HMOs are responsible for holding subscribers harmless from balance billing. It was suggested that Maryland align its policies with policies in those four states by compelling HMOs to pay noncontracting providers billed charges. Health Care Access and Reimbursement Task Force staff presented information that showed that payments to noncontracting physicians averaged 56 percent of billed charges. Staff suggested that requiring HMOs to pay billed charges would significantly weaken smaller health plans, because the significantly higher reimbursement would trigger an exodus of providers from their provider networks. Unlike the two largest plans, these HMOs have less leverage in offering market share in exchange for network participation. The end result would be further pressure on small plans and greater concentration of market share among the two largest health plans.

The Task Force recognized that the current formula was susceptible to gaming by plans, was not transparent to providers, and was difficult to enforce due to the ambiguous language. Current fee schedules are particularly inadequate for evaluation and management services, which are often rendered by PCPs, emergency medicine physicians, hospitalists, and critical care specialists. These specialties provide principally cognitive services that are defined in the evaluation and management category of service.

³³ Health General Article § 19-710(f)(3).

³⁴ Office of the Attorney General. 83 Op. Att’y Gen. 128. September 28, 1998, pp. 128–141.

³⁵ Office of the Attorney General. 88 Op. Att’y Gen. 44. March 13, 2003, pp. 44–54.

The Task Force examined current payment levels relative to Medicare and as a portion of billed charges for hospital-based services provided to HMO patients. Average reimbursement to noncontracting providers for all services (including the plan and assumed patient reimbursement) was about 200 percent of Medicare and about 55 percent of billed charges (Table 5). Evaluation and management services were paid approximately 167 percent of the comparable Medicare fee. Although this percentage may suggest private non-par reimbursement is adequate, the Medicare Payment Advisory Commission has recommended significant increases in evaluation and management reimbursement. Fees paid to noncontracting physicians appear to be above that required under current law for 75 percent (data not shown) of non-par services. In the other 25 percent of services (data not shown), fees on average are 125 percent or less of the Medicare fee. These reimbursement levels raise questions about whether all carriers are complying with the law. About 39 percent of evaluation and management fees are below the 125 percent threshold. This finding suggests that more aggressive enforcement is warranted in all categories of service, but especially in evaluation and management.

TABLE 5. Par/Non-Par Payments for HMO Plans to Maryland Providers Services Paid by HMOs in Hospital Inpatient, Outpatient, and Emergency Department Settings

			Average Ratio of Private Payment to Medicare Payment	Average Ratio of Private Payment to Billed Charges	Average Medicare Payment	Average Private Payment
	Service/ Procedures	Less than 125 Percent of Medicare				
PARTICIPATING	Total	1,297,502	1.32	0.43	\$131.49	\$170.76
	Evaluation and Management	427,185	67%	1.24	96.30	116.96
	Procedures	261,168	55%	1.67	410.74	556.74
	Imaging	429,367	84%	1.09	34.48	37.89
	Tests	160,228	55%	1.55	34.30	47.71
NONPARTICIPATING	Total	165,746	1.97	0.62	98.32	187.77
	Evaluation and Management	84,081	39%	1.67	102.79	161.50
	Procedures	29,814	14%	2.45	205.79	490.13
	Imaging	18,348	28%	2.22	32.74	68.88
	Tests	31,967	25%	2.2	23.76	44.94

SOURCE: MHCC analysis of the 2006 Medical Care Data Base

A change in the law setting payment for physicians not under contract to the HMO will have varying impact on the health plans operating in Maryland. Impact of a change in law will be a function of the health plan's interpretation of current law—specifically, the provision regarding the requirement that non-par payment be set at 125 percent of the fee paid to a similarly contracting physician.

A health plan's ability or willingness to contract with hospital-based physicians is quite variable in Maryland. As shown in Table 6, non-par services constitute from less than 1 percent to over 30 percent of total hospital physicians services (column 2). Factors that may contribute to the ability to contract could be in-network fee levels and the plan's market share. Physician policies also contribute to the non-par service volume. Plans whose membership is primarily located in rural areas may have more of a challenge contracting because of a single practice's ability to negotiate price more aggressively.

From 3 percent to 70 percent of non-par claims were reimbursed at fees 125 percent or less of the Medicare rate (column 4). Setting a non-par fee below 125 percent of Medicare would not constitute a violation of current law, because non-par rates are pegged to a health plan's contracting rates. The percentage of services paid out-of-network is only weakly linked to the percentage of non-par services paid below 125 percent of Medicare. Payers 5, 6, and 7 have relatively small shares of claims paid out-of-network; however, over 50 percent of non-par services for each plan are paid below a hypothetical floor under the proposed changes. Reimbursement for non-par services would increase by over 27 percent if the formula were set at 125 percent of the comparable Medicare fee.

TABLE 6. Implications on Payers of a Change in Non-Par Law: Percentage of Non-Par Services Paid Under 125 Percent of Medicare

	Percentage of Payer's Hospital-based Services Paid Out of Network	Share of All Maryland Total Non-Par Services Paid Below 125 Percent of Medicare	Percentage of Payer's Non-Par Services Paid Below 125 Percent of Medicare	Percentage Increase in Cost of Non-Par Services Due to the Proposed Changes, Assuming no Physician Behavioral Response*
Payer 1	0.9%	0.1%	9.4%	
Payer 2	0.3%	0.4%	10.1%	
Payer 3	27.8%	48.6%	33.7%	
Payer 4	30.6%	4.8%	5.1%	
Payer 5	14.6%	16.8%	70.1%	
Payer 6	8.8%	10.6%	58.4%	
Payer 7	8.6%	18.8%	52.7%	
Payer 8	27.2%	0.1%	2.7%	
TOTAL	11.3%	100.0%	30.9%	27.5%

*Payers have been blinded; it is impossible to show changes in costs without violating the anonymity of specific payers.

SOURCE: MHCC analysis of the 2006 Medical Care Data Base

Table 7 presents the impact of the proposed change in law. Evaluation and management services are reimbursed at the greater of 140 percent of the comparable Medicare fee and 125 percent of the average in-network rate. Other services, including anesthesiology, procedures, tests, and imaging, are assumed to be reimbursed at 125 percent of the average in-network rate. As previously noted, evaluation and management services provided by emergency medicine and other medical specialists constitute a significant share of non-par services. Evaluation and management accounts for 21 percent of non-par payments under current law (column 2). If the law is changed, non-par payment would increase by about 25 percent (column 3). The change would increase non-par reimbursement as a share of total plan reimbursement for all services categories. For example, non-par evaluation and management reimbursement as a share of total evaluation and management reimbursement grows from just over 21 percent to nearly 26 percent. If the Task Force wishes to increase reimbursement for evaluation and management, and perhaps provide incentives to plans to also raise in-network evaluation and management fees, then this proposal would produce some of the desired outcome. Over 60 percent of the total fee increase will go to evaluation and management because the volume of non-par services falls in that category and the more generous payment formula for those services under the proposal.

Total reimbursement for all HMO hospital-based care would increase by about 3 percent and increase payments by about \$17 million. The total cost of including hospital- and non-hospital-based services would be between \$25 million and \$30 million per year in 2006 dollars, or less than 2 percent a year.³⁶ The cost impact to any plan would differ, depending on the volume of services paid non-par and the gap between a health plan's non-par payment formula under current law and the proposed change. The estimates shown in Table 4 also must be qualified because they do not take into account any behavioral response on the part of physicians. It is possible that some contracting physicians will drop their contracts as the non-par rates increase and become more transparent. It is reasonable to assume that increases in contracting rates would be necessary to maintain adequate networks, particularly in more rural areas where a single practice may dominate.

TABLE 7. Implication of a Change in the Non-Par Law (§ 19.710.1)*

BETOS AGGREGATE SERVICE CATEGORY	Non-Par Payments as a Share of Current Law HMO Payments	Percentage Increase in Total Non-Par Payments as a Result of Proposal	Non-Par Payments as a Share of Proposed Total HMO Payments	Total Increase In Physician Payments	Share of Total Increase
TOTAL	10.9%	27.5%	13.5%	3.0%	100.0%
Evaluation and Management	21.4%	27.9%	25.8%	6.0%	60.5%
Procedures	5.4%	26.3%	6.7%	1.4%	26.5%
Imaging	7.2%	25.6%	8.9%	1.8%	5.1%
Tests	15.8%	28.4%	19.4%	4.5%	6.5%
Nonclassified	8.5%	36.2%	11.2%	3.1%	1.2%

*Reimburse evaluation and management at the greater of 140 percent of Medicare or 125 percent of in-network fees; all other non-par services at 125 percent of the in-network average (in-hospital services only)

SOURCE: MHCC analysis of the 2006 Medical Care Data Base. Note that this analysis includes only services provided in a hospital setting by noncontracting providers. Services provided in a nonhospital setting could also be affected; however, only about 1 percent of nonhospital services are provided by noncontracting providers.

36 This estimate does not include payments made to noncontracting physicians providing care outside the hospital setting. Historically, the volume of these services is small relative to noncontracting services in hospital settings.

RECOMMENDATION 4: Health Insurance Plans Must Agree to Use Common Nationally Recognized Measures in Performance Plans

1. The General Assembly should pass legislation requiring that health plans licensed by the MIA must fully disclose to consumers and physicians important aspects of their ranking system. Insurers will:
 - a. Ensure that rankings for doctors are not based solely on cost and that they clearly identify the degree to which any ranking is based on cost;
 - b. Use established national standards to measure quality and cost-efficiency, including measures endorsed by the National Quality Forum and other generally accepted national standards;
 - c. Employ several measures to foster more accurate physician comparisons, including risk adjustment and valid sampling;
 - d. Disclose to consumers how the program is designed and how doctors are ranked, and provide a process for consumers to register complaints about the system;
 - e. Disclose to physicians how rankings are designed, and provide a process to appeal disputed ratings;
 - f. Nominate and pay for the Ratings Examiner, subject to the approval of the Attorney General, who will oversee compliance with all aspects of the new ranking model, and report to the Office of the Maryland Attorney General annually; the Ratings Examiner must be a “national standard-setting organization” and will be national in scope, independent, and an Internal Revenue Code § 501(c)(3) organization.
2. The General Assembly should look at the consent agreement developed by the Office of the Attorney General of the State of New York for health plans in that state.³⁷ The Office of the Maryland Attorney General and the MIA should jointly develop the regulations needed to enforce the statute.
3. The General Assembly should provide for funding to support the incremental increase in workload at the Office of the Maryland Attorney General and MIA as a result of the passage of the statute.

RATIONALE Meaningful efforts to measure and publicly report the comparative quality of physician practices are needed to help consumers make informed choices of where and from whom to seek care. Experience has shown that measuring and publicly reporting physicians’ performance based on quality and cost-efficiency support provider efforts to improve their performance. Complete information provided to the consumer better educates all parties.

Physician performance measurement is relatively new, complex, and rapidly evolving. The need for transparency, accuracy, and oversight in the process is significant. Potential conflicts exist when the sponsor of performance measurement is an insurer; the profit motive may affect its program of physician measurement and/or reporting. This potential conflict of interest requires scrutiny, disclosure, and oversight by appropriate authorities if physicians, consumers, and purchasers are to have confidence in these systems.

Consumers are entitled to receive reliable and accurate information, unclouded by potential conflicts of interest, when making important health care decisions, such as choosing a PCP or specialist. The independence, integrity, and verifiable nature of the rating process are paramount to building trust in the new systems.

³⁷ Office of the Attorney General, State of New York. *Agreement Concerning Physician Performance Measurement, Reporting and Tiering Programs*. November 15, 2007. (See Appendix 3.)

RECOMMENDATION 5: Enhancing Delivery of Primary Care and Development of the Medical Home Model

To further promote early adoption of the medical home model, the Task Force recommends the following steps.

1. The newly established Quality and Cost Council should be charged with creating a uniform statewide approach to assist physician practices in establishing medical homes by:
 - a. Promoting the formation of medical homes based on the ACP's principles for medical homes³⁸;
 - b. Creating multi-stakeholder coalitions composed of payers, providers, and purchasers that will develop common reimbursement and performance incentives for medical homes;
 - c. Identifying equitable sources of start-up funding so that initial costs can be shared among providers, payers, and purchasers commensurate with the longer-term benefits; and
 - d. Mobilizing the multi-stakeholder coalitions to compete for medical home demonstrations offered by CMS and various nonprofit organizations.
2. Urge insurers to provide incentive payments to practices for infrastructure upgrades associated with medical home adoption.
3. MedChi, with the assistance of the primary care specialty societies such as the AAFP, ACP, and the American Academy of Pediatrics, should develop a medical home education and outreach program. MedChi should raise awareness of medical homes by making available assessment tools for gauging readiness to become a medical home and education programs with Continuing Medical Education credit.
 - a. MedChi should set ambitious goals for primary care practices in the state to encourage NCQA medical home recognition at Level II or above by 2011.
 - b. MedChi should work with practices in the state to leverage existing demonstrations, such as the CMS electronic health record program now under way, to migrate practices to a medical home model.
4. The Maryland DBED and MHCC should report to the General Assembly by December 2009 on the feasibility of making state economic development funds available to practices for evolving to medical homes.

RATIONALE In the medical home model, primary care clinicians and allied professionals provide conventional diagnostic and therapeutic services, as well as coordination of care for patients who require services not available in primary care settings. The primary care clinicians serve as advocates for patients and are paid to coordinate their care, thus averting unnecessary tests and procedures, hospital admissions, and avoidable complications. A set of principles has been developed and a recognition program is under way (see Appendix 2). Proponents have great aspirations to reduce cost, increase access, and improve quality.

Evidence that the medical home can meet these great aspirations is very limited. Demonstrations are under way in 22 states to test the medical home concept, of which 12 are multi-stakeholder. The demonstrations are listed in Table 8.

38 American College of Physicians. 2006. *The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care*. Washington, D.C.

TABLE 8. Medical Home Demonstrations Now Under Way*

UnitedHealth Group Patient-Centered Medical Home (PCMH) Demonstration Program (AZ)	MediQhome Quality Project: Patient-Centered Advanced Medical Home Quality Improvement Initiative (ND)
<i>Colorado Multi-Stakeholder Multi-State PCMH Pilot (CO)</i>	CDPHP PCMH Pilot (NY)
Wellstar Health System (GA)	EmblemHealth Medical Home High Value Network Project (NY)
<i>Quality Quest Medical Home (IL)</i>	<i>New York Hudson Valley P4P/Medical Home Project (NY)</i>
<i>Louisiana Health Care Quality Forum Medical Home Initiative (LA)</i>	Cincinnati Medical Home Pilot Initiative (OH)
<i>Maine Multi-Payer PCMH Pilot (ME)</i>	<i>Greater Cincinnati Aligning Forces for Quality Medical Home Pilot (OH)</i>
Aligning PCMH Stakeholders in Michigan (MI)	<i>Southeastern Pennsylvania Rollout of the Chronic Care Initiative (PA)</i>
Blue Cross Blue Shield of Michigan Physician Group Incentive Program (MI)	<i>Rhode Island Chronic Care Sustainability Initiative (RI)</i>
CIGNA and Dartmouth-Hitchcock PCMH Pilot (NH)	<i>Memphis Multi-Payer PCMH (TN)</i>
<i>New Hampshire Multi-Stakeholder Medical Home Pilot (NH)</i>	<i>Texas PCMH Demonstration Project (TX)</i>
PCMH—Diabetes Management (ND)	PCMH—Vermont (VT)

*Multi-stakeholder demonstrations in italics

SOURCE: Patient-Centered Primary Care Coalition. Accessed at http://www.pcpcc.net/content/pcpcc_pilot_report.pdf.

Maryland does not currently have any medical home demonstrations under way. CareFirst has made NCQA recognition as a medical home a component of its primary care reward program. It expects to launch a medical home demonstration with ten practices participating in 2009.

The limited capabilities of small practices to meet the infrastructure requirements may be a constraint on rapid development of PCMHs in Maryland. As noted previously, over 90 percent of Maryland practices contain five or fewer physicians. There is much to be done. About 60 Maryland physicians have received recognition through the NCQA Practice Connection programs for electronic health records, and two Maryland practices have achieved recognition as NCQA Advanced Medical Homes.

The evolution of a primary care practice to a medical home involves the development of new practice processes and a significant injection of capital. Deloitte Consulting recently pegged the initial conversion costs at \$100,000 per full-time equivalent (FTE), and the AAFP puts one-time expenses at up to \$75,000 per physician.^{39 40} It is extremely difficult to envision one- and two-person practices evolving to a medical home without outside access to technical advice and capital. The medical home concept has caught the attention of health

39 Deloitte Consulting, Center for Health Care Solutions. 2008. *The Medical Home, Disruptive Innovations*. Washington, D.C. Accessed at http://www.deloitte.com/dtt/cda/doc/content/us_chs_MedicalHome_w.pdf.

40 American Academy of Family Practice. 2004. *The Future of Family Medicine*, Accessed at http://www.annfamed.org/cgi/reprint/2/suppl_3/s1.

care providers and payers in Maryland. Purchasers and consumers have not yet been brought to the table. In other states, purchasers have taken a proactive role in promoting demonstration projects and have played significant roles in encouraging players to proceed with demonstration. The lack of evidence of improvements from the model, the high start-up costs, and the absence of key program champions, particularly payers, makes Maryland a less than perfect location for future demonstrations or early adoption. The importance that the major insurer in the state has placed on the initiative is an advantage; however, providers are generally distrustful of payer-only initiatives that do not have broader endorsement.

Broad multi-stakeholder demonstrations are needed to build the necessary momentum to fully test the medical home model. The conversion of a primary care practice to a medical home transforms technical, business, and clinical operations in a practice. For example, the implementation of an electronic health record system, a key requirement of a medical home, may take a year or more to fully implement. Due to the work flow changes that also must occur during that time, office productivity may decrease.⁴¹ New functions, such as a care coordinator who will support patients needing ongoing care, must be defined and new staff hired or existing staff trained to serve the function.⁴² The costs of these changes are difficult for a practice to justify if only one sponsor supports the adoption of the medical home model.

A single sponsor will find it difficult to launch a demonstration that includes more than a handful of practices or to capture significant savings that result. Most of the cost savings that a sponsor can achieve will accrue through the enhanced care coordination and management functions of the medical home.⁴³ As those functions come online after the new technical and clinical infrastructure is in place, savings will be generated only after a medical home is fully operational or even later. If multiple sponsors are available, the initial cost can be more widely distributed. Broader stakeholder support will reassure practices that their investments will yield a return, a part of which will return to the practice.

41 Congressional Budget Office. May 2008. *Evidence on the Costs and Benefits of Health Information Technology*. Washington, D.C. Accessed at <http://www.cbo.gov/doc.cfm?index=9168&type=1>.

42 Deloitte Consulting, Center for Health Care Solutions, op. cit.

43 Rollow, William. *EmblemHealth Medical Home High Value Network Project*. Patient-Centered Primary Care Collaborative, December 2, 2008.

RECOMMENDATION 6: Elevated Payment for After-Hours and Weekend Care

1. The Task Force urges insurance carriers and health plans to pay primary care providers a premium for visits after the 5:00 p.m. end of the workday and on weekends for scheduled and unscheduled appointments (after-hours). Plans should:
 - a. Pay primary care providers a bonus when care is delivered after-hours (CPT codes 99050-99060 are billed in addition to the usual evaluation and management codes); or
 - b. Award PCPs bonus points in a payer's performance payment system, if a PCP offers after-hours appointments.
2. The Task Force urges insurance carriers and health plans to compensate primary care providers for telephone and eVisit communications with patients that include evaluation and management services delivered at any time of the day or night, as long as the electronic communication is not part of an in-person evaluation and management visit delivered in the previous 48 hours.

RATIONALE Lack of access to primary care providers after-hours is an important barrier to high-quality care in the United States, where 60 percent of PCPs report not offering arrangements in which patients can be seen by a physician or nurse, if needed, when the practice is closed.⁴⁴ An equal number of adults (60 percent) report having difficulty getting care on nights, weekends, or holidays without going to the emergency department.⁴⁵ Limited availability of after-hours primary care is most likely a contributing problem to the overburdened emergency medical system in Maryland. Almost 35 percent of Maryland emergency department visits in 2005 were classified as either nonemergent or emergent (i.e., requiring care within 12 hours), but could have been treated in primary care settings.⁴⁶

Inappropriate use of emergency departments leads to misuse not only of scarce services but also of scarce health care dollars. In 2006, the median emergency department expense, including facility and physician expense, was over six times greater than an office-based visit (\$72 vs. \$460).

Most commercial payers in Maryland and across the country do not compensate PCPs for telephone or eVisit communications or pay a premium for after-hours face-to-face visits. This practice is slowly changing in response to the crisis in emergency department overcrowding and the Institute of Medicine's focus on timely care as an essential pillar of quality care.⁴⁷

Enhanced access, with open scheduling, expanded hours, and non-face-to-face modes of communication, is identified as an integral component of the medical home construct.⁴⁸ In a medical home model, a PCP coordinates and facilitates a patient's care using evidence-based medicine and clinical support tools to create an integrated, coherent plan for care. Physician practice size and limited resources are major barriers to

44 Schoen C, Osborn R, Huynh P, Doty M, Peugh J, and Zapert K. 2006. On the Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries. *Health Affairs* 25(6):555–571.

45 How KH, Shih A, Lau J, and Schoen C. 2008. *Public Views on U.S. Health System Organization: A Call for New Directions*. 1158(11). The Commonwealth Fund Commission on a High Performance Health System.

46 Maryland Health Care Commission. 2007. *Use of Maryland Hospital Emergency Departments: An Update and Recommended Strategies To Address Crowding*.

47 Committee on Quality of Health Care in America, Institute of Medicine, op. cit.

48 American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. 2007. *Joint Principles of the Patient-Centered Medical Home*.

widespread implementation of the medical home concept in the near term. Most physicians in Maryland are in practices with five or fewer physicians and lack the basic infrastructure of people, technology, space, and capital to meet the medical home requirements. A scaled approach to medical home payment could be adopted that rewards physicians for incremental changes toward transforming their practice into a medical home, with after-hours care as one component of coordinated care that is worthy of incentives.

RECOMMENDATION 7: Reimbursing Primary Care Providers That Provide Mental Health Services

The Task Force recommends no changes to Maryland law. Recent changes in federal law establishing parity for mental health services require reimbursement to PCPs who provide mental health services to enrollees covered under insurance products governed by current state law. Plans offered under state law currently must include a mental health benefit. The new federal law requires that mental health benefits be equivalent with physical health benefits.

The Task Force recognizes that significant confusion exists among primary care providers about reimbursement for mental health services. Further confusion is likely to develop due to the recent changes in federal law. The Task Force recommends:

1. MedChi, primary care specialty societies, and payers collaborate in resolving the confusion by:
 - a. Studying and correcting claims coding issues associated with services provided by primary care providers; and
 - b. Correcting misconceptions through primary care provider education.

BACKGROUND Legislation passed during the 2008 session of the Maryland General Assembly expanded the charge of the Task Force, requiring it to provide recommendations on whether PCPs should be allowed to receive reimbursement for providing mental health services. Despite the role that PCPs play in screening and managing medications for mental health issues, concerns have been expressed that Maryland PCPs are not compensated or are compensated at lower rates for providing mental health care services. A study conducted on behalf of the Task Force by MHCC and consultants developed three recommendations:

- Require commercial payers 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.
- Require commercial payers to coordinate the mental health benefit and the medical benefit.
- Convene a “Mid-America Style” Task Force of payers and providers to:
 1. Study and correct claims problems:
 - PCP payment if first diagnostic code is a mental health diagnosis.
 - PCP payment for evaluation and management service codes according to time spent, when appropriate, if visit is coded as a mental health diagnosis.
 2. Correct misconceptions through primary care provider education.

RATIONALE The U.S. Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 as part of the financial markets rescue legislation that was passed in final days of the 110th Congress. Employers that offer health benefits under ERISA are not required to offer mental health benefits; however, those that do must comply with this new law. The law affects large group plans, barring them from setting higher copayments or deductibles for mental health or substance abuse treatment than for medical care when a mental health benefit is included in the contract. Lower mental health benefit limits would be illegal, along with caps on the number of outpatient therapy sessions or inpatient treatment days. Plan enrollees would have to be covered for out-of-network mental health care if their plan includes out-of-network medical coverage.

Staff recommends not adopting the first recommendation in the mental health study. Setting a limit on the number of mental health visits to a primary care provider will not be permitted under the new federal law. In addition, for fully insured contracts, Maryland law already requires that carriers must reimburse any licensed provider for mental health services if these services are within the licensed provider's scope of practice.

The second mental health study recommendation is already required for insurance products written under Maryland law. Self-insured plans exempt from Maryland law will not be affected by recommendation two. Staff recommends no action on this recommendation.

The mental health study found considerable confusion among physician practices on billing for mental health services. Efforts to clarify plan rules could eliminate confusion by practices regarding claim-coding issues. A provider and payer task force could resolve a number of myths pertaining to coding and billing of mental health services.

MedChi, the Maryland College of Physicians, the Maryland Academy of Family Physicians, the Maryland Academy of Pediatrics, and the Maryland Medical Group Management Association could assist in disseminating accurate information on billing for mental health services by primary care providers.

RECOMMENDATION 8: Improving Data on Physician Supply

1. The Task Force recommends that the Secretary of DHMH direct the MBP and MHCC to adopt regulations codifying agency roles in the collection of physician information through the online license renewal. The regulations should define the collection and the exchange of current information and expand the survey to include information identified by the Task Force, including:
 - Hours per week spent in “patient care and related activities,” overall and by practice site;
 - Hours per week spent in “primary/preventive care” (as a percentage of the hours reported);
 - Number of physicians practicing at each site;
 - Admitting privileges at non-Maryland hospitals;
 - Physical practice location; and
 - Information on the diffusion of information technology.
2. The Secretary of DHMH should direct the MBP and MHCC to establish a workgroup consisting of MBP, MHCC, Office of Health Policy and Planning, MedChi, MHA, CareFirst, and other payers, to plan analyses and improvements in data collections and to plan the transition to obtaining all survey information electronically.
3. The Secretary of DHMH should direct the health licensing boards to promulgate regulations authorizing the sharing of information on nonphysician clinical supply with the OPC and MHCC for workforce planning needs in the state.

RATIONALE The MBP licensure data are the primary source for analyzing physician supply in Maryland, because it is the most comprehensive source of information on physicians who actively practice in the state. The MBP renewal questionnaire (including MHCC’s practice questions) should be further refined and the data quality enhanced to include more detailed information on percentage of time in patient care, practice characteristics, and amount of time spent in primary care activities. To build stakeholders’ confidence in the supply projections generated from these data, more accurate information is needed on physician work activities, specialty designations, and geographic location.

AN ISSUE OF PARTICULAR IMPORTANCE TO EXAMINE A finding of the MHA/MedChi study was that Maryland physicians spent 15 percent less of their time in patient care than did physicians generally in the United States (69 percent versus 79 percent of an FTE).⁴⁹ Factors that contribute to lower clinical practice hours in Maryland compared to the United States need to be better understood. The significant number of Maryland physicians who are principally engaged in patient care, but also are on the faculties of the two medical schools or on the staff at the National Institutes of Health, may explain the smaller proportion of time Maryland physicians devote to patient care. The small size of many practices in Maryland may require a greater number of physicians to devote significant portions of their time to nonclinical issues. Differences in the demographic mix of the physician workforce also may play a role: older physicians and women physicians in general tend to work fewer hours. Whatever the cause, fewer hours spent delivering patient care mean that Maryland needs a higher head count number of physicians than the United States overall to achieve equivalent numbers of FTE physicians in clinical practice. Conversely, increasing the amount of time Maryland physicians are engaged in patient care could contribute to resolving supply problems in some areas. This important issue is an area of study that requires further analysis before a recommendation can be developed.

49 Maryland Hospital Association and MedChi. April 2008. *Maryland Physician Workforce Study*. Baltimore, Maryland. p. 24.

Conclusion and a Note on Affordability

The impact on the affordability of health care insurance was raised at many points during the Task Force's work. One simple measure of the affordability of health care is the percentage of the population that is uninsured. For 2006–2007, the nonelderly uninsured rate was 15.4 percent, with an average of about 760,000 nonelderly uninsured Maryland residents per year. Maryland's nonelderly uninsured rate is below the national average of 17.5 percent.⁵⁰ However, Maryland ranks only in the middle of 50 states in terms of percentage of the population that is uninsured. Despite being among the four states with the highest median household income, a significant portion of the population does not have access to insurance coverage or cannot afford coverage, if offered. The Task Force was mindful of those concerns as it weighed different proposals. Overall, the recommendations that resulted from the Task Force reflect the recognition that greater administrative simplicity is needed, practice efficiency must improve, and reimbursement must be aligned to reward primary care in general and high-quality care in particular. The Task Force also took important steps toward resolving long-standing payment issues that have stalled cooperation in the past.

50 Maryland Health Care Commission. *Health Insurance Coverage in Maryland Through 2007*. Forthcoming January 2009.

APPENDIX 1. Status of Recommendations Offered by Interested Parties

RECOMMENDATION	REASON NOT RECOMMENDED	OFFERED BY
CREDENTIALING ENHANCEMENT		
Direct DHMH to convene regulators, payers, and providers to develop procedures to streamline and standardize the physician credentialing process.	Included in Recommendation 2.	MHA
Develop procedures that streamline and standardize the credentialing process, and adoption of a uniform IT format for electronic medical records and billing transactions.	Included in Recommendation 2.	MDCREP*, MedChi
Physician credentialing should be, by public policy, established as a statewide standard in law and be maintained by the MBP. 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 statewide.	Subsumed in Recommendation 2.	Delegate Costa
COMPETITION AND REIMBURSEMENT		
The state should encourage physician practices to make use of messenger model fee negotiations. Designate a state agency as the messenger, if carriers and practices cannot reach agreement.	No Action (NA). Messenger models have been found to be ineffective or courts find attempted negotiations in violation of anti-trust.	HCAR** staff
Define a payer's unwillingness to negotiate with the messenger as a predatory practice, subject to MIA penalties.	NA. Same as above.	HCAR staff
Give MIA authority to permit plans to have more flexibility with payment, penalize providers that perform poorly, and limit payment for repeated care or for performing services that are known to be of limited effectiveness.	NA. Opposition from provider groups.	HCAR staff
Include services provided by nonparticipating providers to PPO patients in balance billing prohibitions. Apply HMO out-of-network payment rules to PPO services.	NA. Task Force was sensitive to issues some consumers face, but felt that solution for non-par HMO services had not yet been found.	HCAR staff

* Maryland American College of Emergency Physicians

** Health Care Access and Reimbursement Task Force

RECOMMENDATION	REASON NOT RECOMMENDED	OFFERED BY
Health General Article § 19.710.1 should be changed to 125 percent of 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.	Included in Recommendation 3.	Delegate Costa
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 the 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.	NA.	Delegate Costa
ENHANCING PRIMARY CARE		
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 telephone and eVisit communications delivered to a patient.	Incorporated in Recommendation 6.	MedChi, Delegate Costa
Require insurance plans that participate in the State Employee Health Plan to pay physicians bonus payments of 10 percent, if they provide a service in a population defined as a Health Professional Shortage Area (HPSA) in the state.	NA. Concern from DBM*; RFP** responses due shortly and possible additional cost.	HCAR Staff
Require insurance plans that participate in the State Employee Health Plan to pay PCPs a premium for visits after the 5:00 p.m. end of the workday and on weekends. Compensate PCPs for telephone and eVisit communications delivered at any time of the day or night, if the provider agrees to accept those communications and if the communications are independent of a face-to-face visit provided in the previous 48 hours.	NA. Concern from DBM; RFP responses due shortly and possible additional cost.	HCAR staff

* Maryland Department of Budget and Management

** Requests for Proposals

RECOMMENDATION	REASON NOT RECOMMENDED	OFFERED BY
NETWORK PARTICIPATION		
Link designation of preferred hospitals to network participation of hospital-based physicians.	NA. Physician and hospital opposition.	HCAR
Prohibit carriers (create 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.	NA. Payer opposition.	MHA
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, and full reimbursements to nonparticipating health care providers in shortage areas.	Covered under existing network adequacy regulations.	Delegate Costa
PAYMENT REFORM		
Establish a pilot project under the auspices of the MHCC for emergency departments to come "voluntarily" under the current "all payer" system and to have this system apply to reimbursement of the covered emergency department practice.	HSCRC opposed because allowing a voluntary demonstration would not produce any savings.	MedChi
MEDICAL HOME DEVELOPMENT		
Encourage/require insurers to provide incentive payments to practices for technology upgrades/medical home development/expanded hours.	Expanded hours concept Included in Recommendation 6. Health IT initiatives already under way by CMS and several private payers. Medical home development is at the demonstration stage—not yet clear what savings will be to system.	MHA
Apply for CMS Medical Home Demonstration.	Assume in Recommendation 5.	MHA
Establishment of a primary care demonstration project under the auspices of the MHCC with health insurer support of primary care practices with increased evaluation and management fees for doctors who take part in a "medical home" practice.	Concepts included in Recommendation 5.	MedChi

RECOMMENDATION	REASON NOT RECOMMENDED	OFFERED BY
Use 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.	Concept included in Recommendation 5 for medical home.	MHA
The state of Maryland under the coordination of the MHCC, the MIA, and the HSCRC should establish a pilot program for the Advanced Medical Home for Primary Care Providers. Reimbursement rates established as incentives based on outcome, quality of care, and efficiency as established in advance in writing by the health insurance carriers.	NA.	Delegate Costa
ENHANCING PHYSICIAN SUPPLY IN SHORTAGE AREAS		
Encourage teaching programs to offer greater exposure to family practice settings, greater exposure to specialists in short supply, and rotations in shortage areas.	NA.	MHA
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.	Included in Recommendation 1.	Delegate Costa
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.	Included in concept in the LARP-SO Recommendation 1.	MHA
Allocate a portion of the fines assessed by the MIA for health care carrier violations of certain consumer protections laws to LARP.	NA.	MHA
Increase the number of residency slots, revise and expand Maryland Underserved Areas/HPSA designations, increase J-1 visa programs, and expand National Health Services Corps and CMS support for telemedicine.	Secretary will work with Congressional delegation to raise awareness and assess approaches for developing HRSA programs that better meet Maryland's needs.	MHA
Establish a five-year loan forgiveness program for medical school debts to any graduate of a U.S. medical school who agrees to practice primary care in a Maryland shortage area. Debt will be remitted at the rate of 20 percent per year until extinguished.	Included in Recommendation 1. MHCC exploring feasibility of including all medical schools.	MedChi

RECOMMENDATION	REASON NOT RECOMMENDED	OFFERED BY
Establish a rural residency training program at eligible Maryland hospitals. An “eligible hospital” means, with respect to a loan, a nonprofit hospital that, as of the date of the loan submission application, meets four specific criteria.	NA. Uncertainty about whether COGME would approve. Questions about CMS providing long-term funding.	HCAR Staff
TREATMENT OF MENTAL CONDITIONS BY PCPS		
MedChi, Secretary of the DHMH, and the Institutes of Higher Education, in cooperation with the health insurance carriers, should develop a training and certification process for primary care providers to diagnose and treat mental health disorders at the primary care provider’s level of expertise and training.	NA. Mental health screening and medication management are covered under scope of practice. Mental health providers oppose expansion of PCP scope of practice.	Delegate Costa
PROFESSIONAL LIABILITY		
Enactment of “Good Samaritan” protection for physicians practicing/providing consultation in emergency departments.	NA. Professional liability issues were not included in Task Force charge.	MHA
Enactment of apology protection legislation.	NA. Professional liability issues were not included in Task Force charge.	MHA
Enact legislation that would establish a floor on the loss ratio on premiums.	NA.	MHA

For facsimiles of written correspondence from interested parties, see *Task Force on Health Care Access and Reimbursement Established under Senate Bill 107 Addendum: Comments on the Recommendations and Final Report December 2008*.

APPENDIX 2. Principles of the Medical Home

American Academy of Family Physicians (AAFP)

American Academy of Pediatrics (AAP)

American College of Physicians (ACP)

American Osteopathic Association (AOA)

FEBRUARY 2007

Introduction

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth, and adults. The PCMH is a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family. The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH.

Principles

PERSONAL PHYSICIAN Each patient has an ongoing relationship with a personal physician trained to provide first contact continuous and comprehensive care.

PHYSICIAN-DIRECTED MEDICAL PRACTICE The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

WHOLE PERSON ORIENTATION The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end-of-life care.

CARE IS COORDINATED AND/OR INTEGRATED across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to ensure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

QUALITY AND SAFETY are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decisionmaking.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decisionmaking, and feedback is sought to ensure patients' expectations are being met.

- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate nongovernmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

ENHANCED ACCESS to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.

PAYMENT appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and nonphysician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

BACKGROUND OF THE MEDICAL HOME CONCEPT The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

FOR MORE INFORMATION

American Academy of Family Physicians: <http://www.futurefamilymed.org>

American Academy of Pediatrics: http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians: <http://www.acponline.org/advocacy/?hp>

American Osteopathic Association: <http://www.osteopathic.org>

Critical Features of the Medical Home

PERSONAL PHYSICIAN Each patient has an ongoing relationship with a primary care physician (PCP) as well as clinician health coaches who are trained to provide first-contact continuous and comprehensive care. These clinicians are competent in the use of active listening, health coaching, evidence-based holistic medicine, clinical information technology, population-based outcome improvement and measurement, care team recruitment, and leadership.

PHYSICIAN-DIRECTED PRIMARY CARE PROFESSIONAL ORGANIZATION A physician leads a team of health coaches who collectively take responsibility for the ongoing care of patients. The day-to-day operation of the practice is focused on managing population-based outcomes and maximizing individual patient adherence to a distinct, customized, self-care management program that leverages information technology. Note: A health coach is an allied professional (nurse/patient educator) with specialized training in patient behavior modification and motivational interviewing to match patient values, preferences, and triggers to specific, measurable, short-term, self-care lifestyle modifications.

“WHOLE PERSON” ORIENTATION TOWARD ADHERENCE, NOT COMPLIANCE, INCORPORATING HOLISTIC METHODS WITH CONVENTIONAL ALLOPATHIC INTERVENTIONS The primary care team is responsible for providing all of the patient's health care needs and appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services, and end-of-life care, with strong consideration for the individual's value system, personal preferences, and level of engagement in decisionmaking. A key focus is the dispensation of directives (prompts, alerts, reminders) in teachable moments to patients and family members/significant influencers to expedite adherence to self-care suggestions (not just compliance to directives). In these clinical models, holistic therapeutic interventions, such as mindful daily practices, are integrated with traditional therapeutic interventions.

MONITORED, COORDINATED, AND INTEGRATED CARE USING ELECTRONIC MEDICAL RECORDS AND PERSONAL HEALTH RECORDS Care is facilitated across all elements of the complex health system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services) by registries, health information exchanges, and other electronic means to ensure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner. The information exchanges among members of the patient's care team are synchronized and real-time. These technologies are also used to reduce unnecessary visits, tests, and referrals. Sharing information among medical homes and other providers in the local and regional care system is indicative of an advanced medical home model.

MEASURED AND MANAGED ADHERENCE TO EVIDENCE-BASED PRACTICES BY THE CARE TEAM AND THE PATIENT Results measures are hallmarks of the medical home. They range from measures of processes and outcomes to patient satisfaction and success rates in changing behavior:

- Evidence-based medicine and clinical decision-support tools guide decisionmaking. Nonadherence by the care team and/or the patient is monitored and measured, and root-cause analysis is conducted to assess errors and near-misses.
- Physicians in the practice accept accountability for continuous quality improvement by voluntarily engaging in performance measurement and improvement.
- Patients actively participate in decisionmaking, and feedback is sought to ensure patients' expectations are being met.
- Information technology is used to appropriately support optimal patient care, performance measurement, patient education, and enhanced communication.
- Patients and families participate in quality improvement activities at the practice level.

ENHANCED ACCESSIBILITY: CARE ANYWHERE, ANYTIME Care is available via open scheduling, expanded hours, and new communications options among patients, their personal physician, and practice staff. Innovations such as group visits, cyber-visits, robust customized educational tools, and self-monitoring devices are available through the practice.

EMPHASIS ON PHYSICIAN INCENTIVES FOR IMPROVEMENTS IN SELF-CARE MANAGEMENT Physician reimbursements appropriately recognize the added value provided to patients who have a patient-centered medical home. The payment structure should:

- Reflect the value of patient-centered care management work that falls outside of the face-to-face visit.
- Pay for services associated with care coordination within a given practice and among consultants, ancillary providers, and community resources.
- Support adoption and use of health information technology for quality improvement.
- Support enhanced communication access such as secure e-mail and telephone consultation.
- Recognize the value of technology-based physician work associated with remote monitoring of clinical data.
- Allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in reduced payments for face-to-face visits.)
- Recognize case mix differences in the patient population being treated within the practice.
- Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- Allow additional payments for achieving measurable and continuous quality improvements.

SOURCE: Deloitte Consulting, Center for Health Care Solutions. 2008. *The Medical Home, Disruptive Innovations*. Washington, D.C. Accessed at http://www.deloitte.com/dtt/cda/doc/content/us_chs_MedicalHome_w.pdf.

APPENDIX 3. Consent Agreement Between the Office of the Attorney General of the State of New York and United HealthCare

ATTORNEY GENERAL OF THE STATE OF NEW YORK

In the Matter of

**UNITEDHEALTHCARE OF NEW YORK, INC.,
UNITED HEALTHCARE INSURANCE COMPANY
OF NEW YORK, OXFORD HEALTH PLANS,
INC., OXFORD HEALTH INSURANCE, INC.**

AGREEMENT CONCERNING PHYSICIAN PERFORMANCE MEASUREMENT, REPORTING AND TIERING PROGRAMS

1. Pursuant to the provisions of Article 22-A of the General Business Law, Andrew M. Cuomo, Attorney General of the State of New York (the “Attorney General”) caused an industry-wide inquiry to be made into certain business practices regarding physician performance measurement, reporting and tiering programs. The inquiry included UnitedHealthcare of New York, Inc., United HealthCare Insurance Company of New York, Oxford Health Plans, Inc., Oxford Health Insurance, Inc., and affiliated entities providing insurance or related services (collectively “UNITEDHEALTHCARE”).

2. The wide variation in the quality and cost-efficiency of care delivered by health care providers and professionals is well-documented. As a result, meaningful efforts to measure and publicly report the comparative quality of physician practice are needed to help consumers make informed choices of where and from whom to seek care. In addition, experience has shown that measuring and publicly reporting physicians’ performance based on quality and cost-efficiency supports provider efforts to improve their performance. The Attorney General believes that more and complete information provided to the consumer better educates all parties. However, because measuring physician performance is relatively new, complex and rapidly evolving, the need for transparency, accuracy and oversight in the process is great. In addition, when the sponsor is an insurer, the profit motive may affect its program of physician measurement and/or reporting. This is a potential conflict of interest and therefore requires scrutiny, disclosure and oversight by appropriate authorities. When making important healthcare decisions, such as choosing a primary care physician or specialist, consumers are entitled to receive reliable and

accurate information unclouded by potential conflicts of interest. The independence, integrity, and verifiable nature of the rating process are paramount. UNITEDHEALTHCARE considers itself and seeks to be an industry leader in the area of health care transparency and consumer information.

THE ATTORNEY GENERAL'S INQUIRY

3. The Office of the Attorney General (the "OAG") received information that UNITEDHEALTHCARE was in the process of rolling out a physician performance measurement, reporting or tiering program. Specifically, UNITEDHEALTHCARE has created a program to measure, report and/or tier physicians known as the "Premium Designation Program." This program rates or measures physicians based on performance and cost-efficiency, as determined by UNITEDHEALTHCARE. Employers who design benefit plans around physician designations from the Premium Designation Program may create financial incentives, such as reduced co-payments or deductibles, to encourage their employees to use those designated physicians. Because of this, consumers who select physicians who do not obtain Premium Designation status may pay more than consumers who select physicians who have obtained designation. As part of an industry-wide inquiry, the Attorney General examined whether programs such as the Premium Designation Program could potentially confuse or deceive consumers in violation of consumer protection laws.

4. UNITEDHEALTHCARE has fully cooperated with this inquiry by providing documents and information to the OAG and by conferring with the OAG.

5. The Attorney General's investigation included a review of documents, meetings with representatives from UNITEDHEALTHCARE, other insurers, consumer, labor and employer groups, medical societies and organizations, and experts in the field of measuring physician performance.

FINDINGS OF THE ATTORNEY GENERAL'S INQUIRY

6. The Attorney General finds that any initiatives to measure quality and cost-efficiency of physicians, such as the Premium Designation Program, have the potential to cause confusion if not conducted and communicated appropriately, and could result in a violation of law.

THEREFORE,

IT NOW APPEARS that UNITEDHEALTHCARE and the OAG are willing to enter into this Agreement concerning UNITEDHEALTHCARE's Premium Designation Program and any other physician performance measurement, reporting or tiering program operated by UNITEDHEALTHCARE.

**CORE PRINCIPLES: ACCURACY AND TRANSPARENCY
OF INFORMATION, OVERSIGHT OF THE PROCESS,
AND FAIRNESS IN COMPARISON OF PHYSICIANS**

7. The core principles of this settlement are *accuracy* and *transparency* of information, and *oversight* of the process. Terms and conditions of accuracy and transparency are contained herein as well as an oversight mechanism of an independent monitor which will examine, and report on, compliance with the terms herein.

Accuracy/Transparency

Performance Measurement

8. Two categories of measurement may be included in the rating: “quality of performance” and “cost-efficiency.” In information for consumers and public reporting, measures of cost-efficiency and measures of quality of performance shall be calculated separately and disclosed as such. To the extent the individual scores for quality of performance and cost efficiency are combined for a total ranking, the proportion of each measure shall be clearly disclosed. For example, a company could maintain separate cost efficiency scores and quality of performance ratings to disclose to the consumer. In the event the company decides to combine the cost efficiency and quality of performance scores for a total combined score, the individual component scores, and their proportion of the total combined score, shall be clearly disclosed.

9. In evaluating physician quality and cost-efficiency, UNITEDHEALTHCARE should seek to achieve the goals of safe, timely, effective, efficient, equitable and patient-centered care, to the extent possible. UNITEDHEALTHCARE should seek to include patient experience as a measure of patient-centeredness. UNITEDHEALTHCARE shall use measures to determine quality of performance that are based on nationally-recognized evidence-based and/or consensus-based clinical recommendations or guidelines. Where available, UNITEDHEALTHCARE shall use measures endorsed by the National Quality Forum (“NQF”) or other entities whose work in the area of physician quality performance is generally accepted in the healthcare industry. Where NQF-endorsed measures are unavailable, UNITEDHEALTHCARE shall use measures endorsed by the AQA and accreditors. Where NQF, AQA, or accreditors’ measures are unavailable, or data to calculate the measures are unavailable to UNITEDHEALTHCARE, UNITEDHEALTHCARE shall use measures based on other *bona fide*

nationally-recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship. The basis and data used, and its relative weight or relevance to the overall rating, shall be fully disclosed.

10. In light of the need for greater consistency in physician quality performance and cost-efficiency evaluations, UNITEDHEALTHCARE agrees to support the development and use of standardized quality and cost-efficiency measures.

11. At least 45 days prior to implementation of a material change to UNITEDHEALTHCARE's program, UNITEDHEALTHCARE shall inform physicians of its intent to use and process for using measures or other criteria to determine quality performance, cost-efficiency, or placement in a performance network.

12. In evaluating physician cost-efficiency performance, UNITEDHEALTHCARE shall use appropriate and comprehensive episode of care software and shall ensure that any appropriate risk adjustment occurs as described below. In measuring physician cost-efficiency, UNITEDHEALTHCARE shall compare physicians within the same specialty within the appropriate geographical market. The basis and data used, and its relative weight or relevance to the overall rating, shall be fully disclosed.

13. The oversight mechanism provided for in this Agreement shall examine compliance with the provisions and measurements described herein.

Accuracy in Sample Size

14. UNITEDHEALTHCARE shall describe the statistical basis for the number of patients for each disease state or specialty and use accurate, reliable and valid measurements of a physician's quality performance.

15. UNITEDHEALTHCARE shall describe the statistical basis for the number of patient episodes of care and use accurate, reliable and valid measurements of a physician's cost-efficiency performance.

16. The oversight mechanism provided for in this Agreement shall examine compliance with this section.

Measurements Adjustments

17. In determining a physician's performance for quality and cost-efficiency, UNITEDHEALTHCARE shall use appropriate risk adjustment to account for the characteristics of the physician's patient population, such as case mix, severity of the patient's condition, co-morbidities, outlier episodes and other factors.

18. The oversight mechanism provided for in this Agreement shall examine compliance with this section.

Attribution

19. In deciding physician attribution for quality measurement, UNITEDHEALTHCARE shall determine which physician or physicians should be held reasonably accountable for a patient's care and shall fully disclose the methodology used for such attribution.

20. The oversight mechanism provided for in this Agreement shall examine compliance with this section.

Transparency in Rankings

21. In describing its physician performance program and how physicians are selected for the Premium Designation Program or any other physician measurement, rating, ranking or tiering program, UNITEDHEALTHCARE shall clearly indicate the measurements for each criteria and its relative weight in overall evaluation. In ratings for consumers' use, measures of cost-efficiency should be used in conjunction with measures of quality of performance. UNITEDHEALTHCARE shall not conduct rankings based solely on cost-efficiency, but shall consider quality dimensions. Specifically, UNITEDHEALTHCARE shall disclose to what extent the rankings and selection process are based on cost-efficiency and on quality. To the extent that UNITEDHEALTHCARE presents a combined score or rating using cost-efficiency and quality, UNITEDHEALTHCARE shall disclose the specific measures for each category and their relative weight in determining a combined score.

22. UNITEDHEALTHCARE shall disclose how the perspectives of consumers, consumer advocates, employers, labor, and/or physicians were incorporated in the development of the physician reporting program.

Transparency - Disclosure to Consumers

23. For existing programs, not later than 30 days from the effective date of this Agreement, UNITEDHEALTHCARE shall disclose to consumers: (1) where its physician performance ratings are found; (2) that physician performance ratings are only a guide to choosing a physician, that consumers should confer with their existing physicians before making a decision, and that such ratings have a risk of error and should not be the sole basis for selecting a doctor; (3) information explaining the physician rating system, including the basis upon which physician performance is measured, and the basis for determining that a physician is not currently rated due to insufficient data or a pending appeal; (4) any limitations of the data UNITEDHEALTHCARE uses to measure physician performance; (5) how physicians are selected for inclusion or exclusion in the Premium Designation Program or any other physician measurement, rating, ranking or tiering program; (6) details on the factors and criteria used in UNITEDHEALTHCARE's rating systems, specifically its quality performance measures, cost-efficiency measures and other methodologies as prescribed herein; and (7) how the consumer may register a complaint about the Premium Designation Program or any other physician measurement, rating, ranking or tiering program with UNITEDHEALTHCARE and the oversight monitor. UNITEDHEALTHCARE agrees to directly and prominently display this information on its website(s) and other appropriate locations in accordance with the standards and template when provided by the oversight monitor described below. To assure compliance with items one through seven of this paragraph, UNITEDHEALTHCARE shall apply for and obtain review by the oversight monitor described below.

24. For programs UNITEDHEALTHCARE will be implementing in the future, at the time the program is made public, UNITEDHEALTHCARE shall document that it has already completed or has applied to complete a review by the oversight monitor described below. UNITEDHEALTHCARE will conspicuously disclose to consumers on its website(s) and other appropriate locations and formats information that describes its processes with regard to the above seven items and such other processes and procedures as are set forth in this Agreement, in accordance with the standards and requirements set forth by the oversight monitor described below.

Transparency - Disclosure to Physicians

25. For existing programs, no later than 30 days from the effective date of this Agreement UNITEDHEALTHCARE shall apply for and obtain review by the oversight monitor described below, to enable reporting of the detailed data and methodologies to physicians in an independent and easily-accessible manner, including measures and other criteria, that UNITEDHEALTHCARE used to determine physician quality and cost-efficiency ratings and inclusion or exclusion in the Premium Designation Program or any other physician measurement, rating, ranking or tiering program. In addition, UNITEDHEALTHCARE shall explain to physicians that they have the right to correct errors and seek review of data, quality and cost-efficiency performance ratings and inclusion or exclusion from the Premium Designation Program or any other physician measurement, rating, ranking or tiering program. UNITEDHEALTHCARE shall also inform physicians they may submit any additional information, including that contained in medical charts, for consideration. UNITEDHEALTHCARE shall also provide a reasonable, prompt, and transparent appeals process.

26. For programs UNITEDHEALTHCARE will be implementing in the future, at the time the program is made public, UNITEDHEALTHCARE shall document that it has already completed or has applied to complete review by the oversight monitor described below.

27. At least 45 days before making available to consumers any new or revised quality or cost-efficiency evaluations or any new or revised inclusions or exclusions from the Premium Designation Program or any other physician measurement, rating, ranking or tiering program, UNITEDHEALTHCARE shall provide physicians with notice of the proposed change; an explanation of and access to the data used for a particular physician; methodology and measures used to assess physicians, including attribution; and an explanation of the physician's right to make corrections and appeal. If a physician makes a timely appeal, UNITEDHEALTHCARE shall make no change in the physician's quality and cost-efficiency rankings or designation until the appeal is completed. The oversight monitor shall have oversight and review of the physician appeals process.

Use of Data

28. Data collection is a critical part of physician performance measurement. In order to produce the most reliable and meaningful information, UNITEDHEALTHCARE shall use the most current

claims or other data to measure physician performance, consistent with the time period needed to attain adequate sample sizes and to comply with the requirements of this Agreement. UNITEDHEALTHCARE shall use its best efforts to ensure that the data it relies upon is accurate, including a consideration of whether some medical record verification is appropriate and necessary.

29. As part of its reporting to the oversight monitor described below, within 3 months of this Agreement, UNITEDHEALTHCARE shall provide the oversight monitor a plan to use aggregated (pooled) data, validated as appropriate, as a supplement to test its own claims data, within 6 months of this Agreement. The OAG may in its sole discretion grant an extension of time in this regard.

Oversight

30. To assure compliance with the terms of this Agreement, and to facilitate the collection and presentation to consumers and physicians of information about UNITEDHEALTHCARE's processes and methodologies used in its physician performance reporting program, UNITEDHEALTHCARE agrees to the appointment of an oversight monitor to be known as the Ratings Examiner ("Rx"). The Rx shall be a nationally-recognized standard-setting organization, nominated and paid for by UNITEDHEALTHCARE, and approved by the OAG. UNITEDHEALTHCARE shall promptly complete and maintain in good standing a review of its physician performance measurement and reporting process by the Rx. The review conducted by the Rx shall encompass all of the elements described in this Agreement.

UNITEDHEALTHCARE also agrees to obtain review by the Rx of such additional national standardized review processes as may be necessary to assure compliance with this Agreement, including fully disclosing UNITEDHEALTHCARE's procedures for consumer and physician grievance or appellate rights.

UNITEDHEALTHCARE agrees to make the results of these review processes prominently accessible in all locations that describe the physician performance reporting program. The Rx shall report and make recommendations to the OAG every six months regarding the details of the methodologies used and the extent to which they reflect national standards and compliance with this Agreement.

31. For the purposes of this Agreement, a "national standard setting organization" shall be national in scope, independent, and an Internal Revenue Code § 501(c)(3) organization, and shall have existing standards and collection processes that would enable the transparency and accuracy terms of this Agreement to be satisfied.

SUMMIT MEETINGS

32. UNITEDHEALTHCARE agrees to participate in any summit meetings the Attorney General convenes for the purpose of working on issues related to evaluating physician performance.

CONSISTENCY WITH STATE LAW

33. As applicable, this Agreement shall be interpreted consistently with §4406-(d)(4) of the Public Health Law, § 4803 of the Insurance Law and any other New York State law or regulation.

ATTORNEY GENERAL'S AUTHORITY

34. Nothing in this Agreement shall in any way limit the Attorney General's ability to investigate or take other action with respect to any non-compliance at any time by UNITEDHEALTHCARE with respect to this Agreement. The parties hereby agree that this is an evolving field and as new technology and information becomes available, the parties may wish to refine this Agreement by mutual agreement in a signed writing.

VALID GROUNDS AND WAIVER

35. UNITEDHEALTHCARE hereby voluntarily accepts the terms and conditions of this Agreement and waives any right to challenge it in a proceeding pursuant to Article 78 of the Civil Practice Law and Rules or in any other action or proceeding.

CORRESPONDENCE

36. All correspondence UNITEDHEALTHCARE submits to the Attorney General pursuant to this Agreement shall be sent to the attention of:

Henry S. Weintraub, Esq.
Assistant Attorney General
Health Care Bureau
120 Broadway, 25th Floor
New York, N.Y. 10271

SUCCESSORS

37. This Agreement, including, but not limited to, all obligations imposed on or undertaken by UNITEDHEALTHCARE herein, will be binding upon and enforceable against any subsequent owner or operator (whether by merger, transfer of control, contractual arrangements, or other means) of all or any substantial portion of UNITEDHEALTHCARE.

PRIVATE RIGHT UNAFFECTED

38. Nothing herein shall be construed to deprive any consumer or other person or entity of any private right under the law.

MISCELLANEOUS PROVISION

39. It is further understood and agreed that the acceptance of this Agreement by the Attorney General shall not be deemed or construed as an approval by the Attorney General of any of the activities of UNITEDHEALTHCARE, its successors, agents or assigns, and none of them shall make any representations to the contrary.

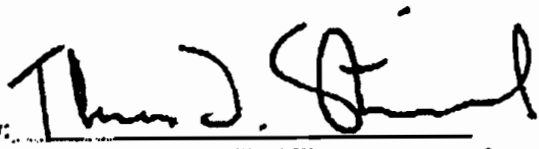
EFFECTIVE DATE

40. This Agreement shall be effective upon the date of the last signature to the Agreement, which may be executed in common parts.

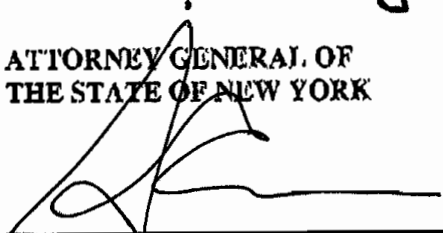
IN WITNESS THEREOF, the undersigned subscribe their names:

Dated: November 15, 2007

**UNITEDHEALTHCARE OF NEW YORK, INC.,
UNITED HEALTHCARE INSURANCE
COMPANY OF NEW YORK, OXFORD
HEALTH PLANS, INC., OXFORD HEALTH
INSURANCE, INC.**

By: 
THOMAS L. STRICKLAND
CVP, Chief Legal Officer

**ATTORNEY GENERAL OF
THE STATE OF NEW YORK**


ANDREW M. CUOMO



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