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Report of the Task Force on Health Care Access and Reimbursement (SB 107)

Final Report and Recommendations

December 2008

DRAFT

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Executive Summary

Chapter 505 of the 2007 Acts of the General Assembly established the fourteen-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 of 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 fourteen 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. It was told that fees for services in Maryland were below the national average, there was also evidence that 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 HMO and non-HMO products.

The Task Force spent considerable time analyzing the 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 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, as noted by Barbara Starfield, Johns Hopkins School of Public Health. Recommendation 1 begins to address supply problems by expanding loan programs in the state and promoting practice development, particularly in primary care.

Recommendation 2 aligns credentialing documentation to the extent possible within the State and with the private sector entities that are responsible for gathering and sharing physician information needed for credentialing. An objective the Task Force believes important is to allow a single organization to conduct all primary and secondary source verification on behalf of health plans and hospitals. This is an important step. Medical societies and MHA agreed to encourage private entities to conduct primary source verification. State agencies will advocate that NCQA and the JCAHO accept information from a single private entity when that is the physician'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 CMS to adjust fees of underpaid services have had limited success. 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. Some hospital-based physicians were supportive of the concept, but there was little consensus among specialties. The Health Services Cost Review Commission 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.

The Task Force developed Recommendation 3 for resolving the long-standing problem of reimbursement for non-contracting 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 non-contracting payment floor for medical inflation. The Task Force estimates that non-par payments will increase about 25 percent if this proposal is adopted. Increases to HMO health plans will vary, but HMO-wide payments to all hospital-based physicians will be grow about 3 percent, assuming no significant changes in contracting behavior by physicians.

Recommendation 4 recommends that Maryland establish requirements on carriers and plans for physician performance and tiering systems. Plans operating in New York have already committed to such an agreement. Similar agreements should be adopted with plans operating in Maryland to protect consumers and providers. These agreements will also legitimize the new systems and speed adoption.

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 that 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 paying a premium for after-hours and weekend care. In

addition, it recommends that eVisits be reimbursed in certain situations. These services have the potential for preventing expensive emergency room visits. It seems appropriate that primary care providers benefit for providing care during off hours. The Task Force did not make a specific recommendation on the amount of the premium for after-hours care as the premium will likely need to be incorporated into established reward programs offered by plans.

The Task Force examined whether primary care physicians should be reimbursed for mental health services. A study conducted on behalf of the Task Force identified confusion among payers and PCPs on 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 physicians supply is quite limited and data on non-physician providers is 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 workforce issues in a coherent way.

Table 1-EX lists each of the eight options 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 would also 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

Description	Type of Action Required
1. Recommendations On Approaches To Promote Practice Formation In Maryland	Changes to § 18-501-18-502
2. Recommendations 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. Recommendations for Changing the Formula for Reimbursing Non-Participating Providers that Treat HMO Patients	Modification to Health General § 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
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. Recommendations On Improving Data on Physician Supply	Changes to COMAR 10.25.14

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 be allowed to receive reimbursement for mental health services?

While the issues cover a vast amount of territory, many of them stem from problems related to physician supply and reimbursement. The discussions of the Task Force have, therefore, been wide-ranging with a general focus on examining approaches to improving primary care through changes in the delivery of services or in physician compensation. Bearing in mind that a broad picture of the health care marketplace and the incentives and consequences facing different players helps in understanding how the legislative issues have arisen and evolved provides a framework within which to view the recommendations of the Task Force. In this introduction to the Task Force report, we describe certain aspects of the structure and workings of the insurance market and the market for physician services, examining how proposed changes

might impact reimbursements, access to care, quality of care, or health care costs. We then present an overview of selected major policy initiatives that aim to address the issues raised by the legislation, with a brief discussion of how these efforts may resolve or fail to resolve identified problems.

Chronology of Task Force Meetings

The Task Force held fourteen 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 University School of Public Health, MedChi, the American Academy of Physicians, the American College of Emergency Medicine, the Maryland Hospital Association, the Rural Roundtable, Aetna, CareFirst, United Health Care, and several independent consultants under contract to MHCC. Table 1 identifies issues discussed at each meeting.

Table 1 Issue Areas Discussed by the Task Force September 2007 through November 2008

	Meeting Date												
Issue as Identified in Senate Bill 107 and Senate Bill 744	Sept 20th	Oct. 15	Nov. 14th	Dec. 14th	Jan 28th	Feb 25th	Apr 25th	May 12th	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 primary care physicians 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.[1] 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, the influence of insurers on physician compensation and access to health care services is substantial.

Health insurance markets in the U.S. 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 health maintenance organization (HMO)/preferred provider organization (PPO) market.[2]

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

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[1] Maryland Health Care Commission, *Health Insurance Coverage in Maryland Through 2007*, forthcoming January 2009.

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

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 as 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.

Based on the central role that insurers play in the health care marketplace, almost all of the issues facing the Task Force relate in some way to the provision of insurance and, specifically, 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 non-participating 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 2-physician practices has experienced an 8 percent drop since 1997. Even with this drop, in 2005, close to two-thirds of physicians that were self-employed or employed by a physician-owned group were in practices of 5 or fewer physicians.[3] There is limited evidence as to whether physician practice size differs in Maryland compared to the U.S. 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 not clear 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 (IPAs) are precluded from forming for the sole purpose of rate negotiations with

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

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 RVU output than physicians in a large practice.[4] 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.

Table 2 – Distribution of Maryland Practices By Number of Physicians 2005-2006

Practice Size (# of Full time Physicians)	Practices
Under 6	4,707
6 to 10	143
11+	52
Total	**4,902**

Source: MHCC analysis of 2006-2007 unaudited physician license renewal files

Limited access to capital also inhibits practices from competing for new physicians, as 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.

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[4] Pope, Gregory and Burge, Russell, "Economies of Scale in Physician Practice," *Medical Care Research and Review,* Vol. 53, No. 4, 417-440 (1996)

Specific questions raised include:

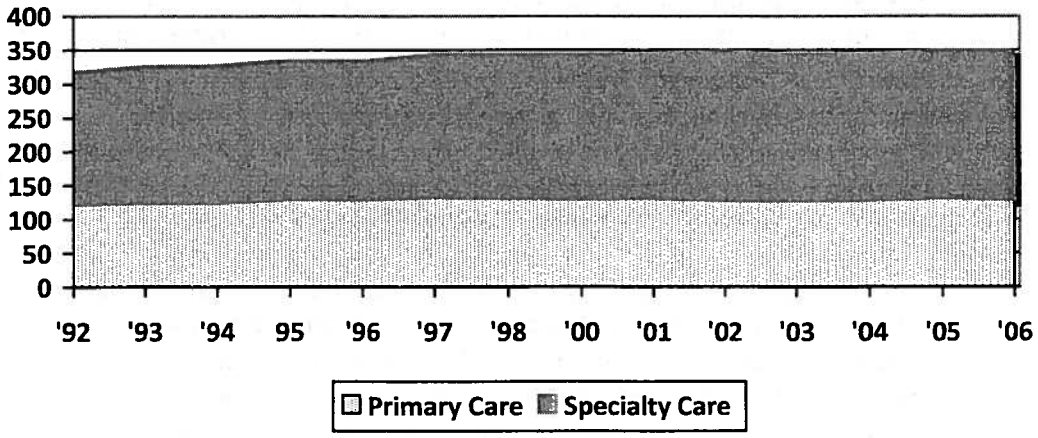
- Are physician practices smaller in Maryland than nationally and, if so, are there state-level barriers to practice formation?
- What are the mechanisms that could be used to encourage formation of larger practices?
- Would larger practice sizes increase the ability of physicians to negotiate effectively 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 workforce at the national level, reported that the U.S. possessed an oversupply of physicians, particularly specialists. However, in its 2005 report, COGME reversed course; it estimated that the U.S. could have a deficit of 85,000 to 96,000 physicians in 2020 if current demand and service utilization patterns continued. 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 1990's.

For primary care, the situation could be even more dire. Assuming that generalist medicine will continue to lose favor among young physicians, the COGME projects that the generalist-physician-to-population ratio will fall 9% from 2005 to 2020. Some experts point to non-physician providers as the solution to shortages in primary care. Nurse practitioners (NP) and physician assistants (PA) alone are not likely to close the generalist gap. Almost 42 percent of patient visits to NP/PAs are in offices of specialists, not primary care (COGME and Bodensteimer). Figure 1 presents Maryland 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 U.S. overall.

Figure 1 --Maryland Physicians in Patient Care 1992-2006



Source AMA Masterfile 1992-2006, Physicians in Patient Care

It is unlikely that new non-physician graduates will reduce the looming national shortages in primary care. Nurse practitioners' annual graduate numbers are projected at 4,000 by 2015; about 65% 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 that 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 primary care physician, NP, and PA numbers for 2020, the primary care clinician-to-population ratio will fall by 9% from 2005 to 2020. In contrast, the specialist-physician-to-population ratio will rise by 14% during those years. There is no evidence that distributions in Maryland will be any different than the national forecasts.

The American Association of Medical Colleges (AAMC) in 2006 called for a 30 percent increase in total medical school enrollment over the next decade, a goal physician workforce 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. Other researchers have looked at COGME and Cooper's estimates with a skeptical eye. 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. Other researchers have sought to distinguish between supplies of primary care and specialty care physicians. Barbara Starfield and her colleagues at the Johns Hopkins School of Public Health found that a greater supply of primary care physicians was generally associated with lower county mortality rates, while a greater specialist supply was associated with higher mortality.

The Maryland Hospital Association (MHA) and MedChi, the Maryland State Medical Society commissioned a study to examine physician work force needs to 2015. 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 Health Care Access and Reimbursement Task Force in December 2007. The report finding sparked considerable comment in the Task Force given that the Health Resources and Planning 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 percent 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 primary care physicians 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 primary care physicians 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 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.[5]

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 by primary care physicians (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 primary care physicians.

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[5] Medical Group Management Association (MGMA) *Physician Compensation and Production Survey: 2007 Report*, based on 2006 data; tabulations are provided by MGMA from the survey database.

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.[6] 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 matches 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.[7]

How reimbursement rates and total payments to health care providers affect physician recruitment and retention and, ultimately, access to health care services was a major focus of the Task Force. 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?

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."

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[6] *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

[7] 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.

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 of 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.[8]

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 decision-making among patients; patients were sometimes rewarded with lower premiums or co-pays for seeking out top-tier providers, but payment to providers was not directly affected.

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 re-admission 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

[8] Institute of Medicine, *Crossing the Quality Chasm,* 2001

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 a 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 (UHC) has a P4P program that is being piloted in selected jurisdictions across the country, as of early 2008, UHC had not implemented a P4P program in Maryland in which physicians were financially rewarded for meeting specific quality standards. Instead, UHC relies on a physician tiering program where 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 where consumers face a lower co-payment 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.[9]

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 (APR-DRGS) 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 pay for performance 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 above Medicare fees for the same service, are not sufficient to subsidize uncompensated care losses. Table 1 presents physician-reported uncompensated care hours per month for the principal hospital-based specialties.

[9] 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.

Which specialties have the most uncompensated care?

Table -1 Reported Hours of Uncompensated Care per Month (charity + non-collectible)

Specialty	Physician reported Hours	
Primary Concentration	Hrs 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

Results from 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 (source 2007 HSCRC Annual Filings). Care needs to be taken in interpreting these losses; however, as 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:

- 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. Par/non-par debate would disappear;
- Encourage increased 'systemness' between payers ,hospitals , and providers;
- 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 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 Health Services Cost Review Commission 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.

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,' 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. Developed by the American Academy of Family Practitioners (AAFP) and the American College of Physicians (ACP), payment for the medical home may include multiple components, such as a prospective bundled component, a 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 rewards primary care physicians for those aspects of care not fully recognized by the current reimbursement system with its service-by-service focus.[10]

The interest in expanding after-hours care stems from increased overcrowding of emergency departments, the high costs of treating non-emergent patients in the ED, and the Institute of Medicine's focus on timely care as an essential pillar of quality care.[6] 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.[11]

While practices are slowly changing, most commercial payers in Maryland and across the country do not compensate PCPs for phone 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.

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[10] The medical home concept is discussed briefly in *Paying for Physician Care in Maryland: What Are the Factors Contributing to Differences Across Specialties?* See also Berenson, R.A. and colleagues, "A House is Not a Home: Keeping Patients at the Center of Practice Redesign," *Health Affairs* Volume 27, Number 5, pp.1219-1230.

[11] 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.

The issue of the provision of mental health care by primary care physicians 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 isolated from the overall insurance and covered in a separate contract between the payer (insurer or employer) and a mental health vendor with a distinct provider network and financial incentive arrangement. 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 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.[12] PCPs may also avoid use of extended service codes that compensate them for the longer visits required to manage mental health problems in order to reduce the risk of claim denials.

Recent passage by the U.S. Congress of the 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 co-payments 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; employers who offer these products will no longer be allowed to deny payment to PCPs for treatment of mental health issues.

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:

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[12] Kautz C, Mauch D, & Smith SA. (2008). *Reimbursement of Mental Health Services in Primary Care Settings.* HHS Pub. No. SMA-08-4324. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Rockville, MD.

- 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 primary care physicians be improved?
- Will enhanced payment for after-hours care reduce overall costs through reductions in use of more costly emergency department care?

1. Recommendations on Approaches to Promote Practice Formation in Maryland

1. Establish an Expanded Loan Program

a. The Health Services Cost Review Commission ("The Commission") should establish a program (LARP-State Only [LARP-SO]) to allow physicians in physician shortage areas as defined by the Office of Primary Care at DHMH to access the LARP –PCS program administered by DHMH and MHEC. Under the program, primary care physicians practicing in a shortage area should be eligible for loan repayment in exchange for a commitment to practice in the shortage area. 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 Commission 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 18-501 to include for-profit physician settings. (Note that under the current LARP program, this is not possible due to federal funding; however, this would not be an issue if funds come from the HSCRC); and
- That allows other physician specialties to participate in loan forgiveness as long as the specialty has been identified has being in shortage in the area by DHMH.

Rationale: Generating additional revenue from all payers for the state portion of Loan Assistance Repayment Program (LARP) funding could be used to draw down 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 .1% 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 Commission currently has the authority to implement such a plan. A second source of funding comes from reallocating the portion of physician license fees currently assigned to loan assistance programs for non-physician providers. In parallel, license fees for other allied health professionals may need to be increased modestly to sustain loan repayment programs in those professions once the physician license fees are reallocated.

Total Funds Available: A surcharge of up to .1% 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% of the physician license fees are dedicated to loan repayment and split between two programs: 1) grants under the Health Manpower Shortage Incentive Grant Program; and 2) the Loan Assistance Repayment Program for primary care physicians. For FY 2008, the grants awarded under the Health Manpower Shortage Incentive Grant Program totaled $499,098 and were split among 39 different postsecondary institutions in a number of health professional occupations. The LARP for primary care physicians in FY 2008 totaled $432,500, with an average of $25,441 provided to 17 physicians.

2. Maryland government should establish a program that allows medical schools to offer tuition assistance and admission preference to qualified in-state applicants who agree to stay and practice in underserved areas 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 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 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.

2. Recommendations for 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 a national nonprofit alliance of health plans and trade associations. The Office of Health Care Quality (OHCQ) and the Maryland Insurance Administration (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.

The Office of Health Care Quality should align information on its Standard Credentialing Form to be consistent with information collected by a nonprofit alliance of health plans and trade associations.

The Office of Health Care Quality and the Maryland Hospital Association should work collaboratively with the Joint Commission on the Accreditation of Healthcare Organizations (Joint Commission) to permit hospitals to use primary source information held by a nonprofit alliance of health plans and trade associations.

The Office of Health Care Quality and the Maryland Insurance Administration 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).

The Maryland Health Care Commission and the Maryland Insurance Administration, in consultation with the Office of Health Care Quality and the Maryland Board of Physicians, 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 Workgroup gathered information from the Maryland Board of Physicians, the Office of Health Care Quality, the Maryland Hospital Association, Maryland Association of Life and Health

Insurers, and the CAQH. Senator Garagiola asked the OHCQ and MIA to explain their credentialing requirements. Both organizations 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 Maryland Board of Physicians (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 Maryland Board of Physicians as the primary source for licensure information. The Board holds the following information for credentialing: practitioner's name, license number, graduation date, license status, date license issued, license expiration, and Maryland disciplinary actions. The NCQA allows health plans to use the educational credentials held by the Board of Physicians in provider credentialing, but the Joint Commission does not. DEA numbers are not held by the Board of Physicians and medical liability carriers change frequently and could not be easily tracked by the Board.

The Workgroup concluded that establishing a central repository for credentialing at the Board of Physicians is not viable. The representative from the Maryland Life and Health Insurers provided information on the failure of a similar initiative in Florida under the Board of Physicians (CoreStat). That effort 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. The representative from the Maryland Life and Health Insurers stated that the large national carriers, including Aetna and CIGNA, oppose any Maryland credentialing initiative because it adds expense.

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 consider implementing a primary source verification function in the spring of 2009. The members of the Workgroup 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, will 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.

3. Recommendations for Changing the Formula for Reimbursing Non-Participating Providers that Treat HMO Patients

Note these recommendations apply only to services provided by Non-Participating Providers with HMO Plans

1. 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 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 the Centers for Medicare and Medicaid Services 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 is a classification developed by the Centers for Medicare and Medicaid Services that groups procedures codes together by clinical consistency.

2. A health care practitioner providing an evaluation and management service as defined in the Berenson-Eggers Type of Service definition developed by the Centers for Medicare and Medicaid Services, is reimbursed at the greater of:

a. 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid services, for the same covered service to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year; or

b. 125% of the average rate the health maintenance organization paid to similarly licensed providers under written contract in the same geographic area, as defined by the centers for Medicare and Medicaid services, for the same covered service as of January 1 of the previous calendar year.

3. For any other service at 125% of the average rate the health maintenance organization paid to similarly licensed providers under written contract in the same geographic area, as defined by the Centers for Medicare and Medicaid services, for the same covered service as of January 1 of the previous calendar year.

4. The Maryland Health Care Commission shall annually review the payment to providers not under written contract with the health maintenance organization to determine compliance with this section and report its findings to the Maryland Insurance Administration. The Maryland Insurance Administration shall take appropriate action, including conducting an examination under Title 2 Subtitle 2 of the Insurance Article, to ensure compliance with this section.

5. No recommendation 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 (Health General §19-710) since the late 1980s.

The prohibition on balance billing and the reimbursement floor established for non-contracting providers covers only HMO health plans. Patients enrolled in preferred provider organizations, 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 non-emergency 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 HMOs' networks must accept as payment in full the rate they negotiated with the HMO as payment. (See, 89 OAG 53 (2004)). Out-of-network providers must accept an amount defined in statute. Providers have voiced the following complaints about the current law, as follows:

- Non-Par rates are too low;
- Some plans do not pay what is required;
- Non-par rates serve as the ceiling on reimbursement, not the floor as was intended by the current statute;
- Enforcement has been difficult due to the lack of clarity in the statute.

Rationale for Recommendations

The Task Force has received significant testimony over the past year regarding the inadequacy of the current fee-for-service reimbursement. Current fee schedules are particularly inadequate for evaluation and management services that are most often rendered by primary care physicians, emergency medicine physicians, hospitalists, and critical care specialists. All of these specialties provide principally cognitive services that are defined in the evaluation and management category of service.

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 the table below 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. Although the data shown in the table is based on national averages, the pattern of earnings among specialties likely looks the same in Maryland.

The Workgroup 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 would also benefit to the extent they provided evaluation and management services.

The Workgroup also examined current payment levels relative to Medicare and as a portion of billed charges. Average non-par reimbursement (including the carrier and assumed patient reimbursement) was about 200 percent of Medicare and were about 55 percent of billed charges. Evaluation and management services were paid approximately 167 percent of the comparable Medicare fee. Although this percent may suggest private non-par reimbursement is adequate, the Medicare Payment Advisory Commission (MedPAC) has recommended significant increases in evaluation and management reimbursement. Relative to other broad categories of service, evaluation and management reimbursement is a smaller share of Medicare fees.

Non-par fees 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 38 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 1 Average Income for Selected Specialties

	Annual Income	Income Relative to Radiation Oncologist's Income
Radiation Oncology	$489,765	100%
Orthopaedic 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%

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 2, non-par services constitute from less than 1 percent to over 30 percent of total 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 more aggressively negotiate price.

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, as non-par rates are pegged to a health plan's contracting rates. The percent of services paid out-of network is only weakly linked to the percent 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 changed. Reimbursement for non-par services would increase by over 27 percent if the formula was set at 125 percent of the comparable Medicare fee.

Table 2 Implications on Payers of a Change in Non-Par Law

Percent of Non-Par Services Paid Under 125% of Medicare

	% of Payer's Hospital-based Services Paid Out-of Network	Share of all Maryland Total Non Par Services Paid Below 125% of Medicare	% of Payer's non-Par services Paid below 125% of Medicare	% increase in Cost of Non par Services Due to the proposed changed, 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 not possible to show changes in costs without violating the anonymity of specific payers.

Table 3 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.

The overall impact on payers would be quite modest. Total reimbursement for hospital-based care would increase by about 3 percent. The cost impact to a 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 3 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 parallel increases in contracting rates would be necessary to maintain adequate networks, particularly in more rural areas where a single practice may dominate.

Table 3 Implication of a Change in the Non-Par Law (§ 19.710.1)
Reimburse Evaluation and Management at the Greater of 140% of Medicare or 125% of In-Network Fees, All Other Non-Par Services at 125% of the In-Network Average

BETOS Aggregate Service Category	NonPar Payments as a Share of Current Law HMO payments	% increase in Total Non Par Payments as a Result of Proposal	NonPar 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%
Non-Classified	8.5%	36.2%	11.2%	3.1%	1.2%

PAR/NON-PAR PAYMENTS FOR HMO PLANS 2006 MARYLAND PROVIDERS

Services Paid By HMOs In Hospital Inpatient, Outpatient, and ER Settings

		Service/ Procedures	Less Than 125% of Medicare	125% to 200% of Medicare	200%+ of Medicare	Average Ratio of Private Payment to Medicare Payment	Average Ratio of Private Payment to Billed Charges	Average Medicare Payment	Average Private Payment	Median Ratio of Private Payment to Medicare	Median Ratio of Private Payment to Billed Charges
Participating	Total	1,297,502				1.32	0.43	131.49	170.76	1.07	0.39
	Evaluation and Management	427,185	67%	28%	6%	1.24	0.56	96.3	116.96	1.11	0.52
	Procedures	261,168	55%	19%	26%	1.67	0.45	410.74	556.74	1.2	0.43
	Imaging	429,367	84%	12%	4%	1.09	0.3	34.48	37.89	0.95	0.27
	Tests	160,228	55%	27%	18%	1.55	0.4	34.3	47.71	1.2	0.36
Non Participating	Total	165,746				1.97	0.62	98.32	187.77	1.77	0.56
	Evaluation and Management	84,081	39%	36%	25%	1.67	0.62	102.79	161.5	1.49	0.58
	Procedures	29,814	14%	21%	65%	2.45	0.58	205.79	490.13	2.42	0.54
	Imaging	18,348	28%	17%	55%	2.22	0.67	32.74	68.88	2.5	0.78
	Tests	31,967	25%	27%	48%	2.2	0.59	23.76	44.94	1.95	0.53

4. Recommendation 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 in Maryland 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 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 (NQF) 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 Attorney General's office every six months; 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 Maryland Health Care Commission will promulgate regulations in consultation with the Office of the Attorney General and the Maryland Insurance Administration to implement 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 supports provider efforts to improve their performance. Complete information provided to the consumer better educates all parties.

Physician performance is relatively new, complex, and rapidly evolving. The need for transparency, accuracy, and oversight in the process is significant. Potential conflicts exists 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 healthcare decisions, such as choosing a primary care physician or specialist. The independence, integrity, and verifiable nature of the rating process are paramount to building trust in the new systems.

5. Recommendation for Enhancing Delivery of Primary Care and Development of the Medical Home Model

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 that 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 as been developed and a recognition program is underway (See Appendix 2). Proponents have great aspirations: reduce cost, increase access, and improve quality. Evidence that the medical home can meet these great aspirations is very limited. Demonstrations are underway in 22 states to test the medical home concept of which twelve are multi-stakeholder. The demonstrations are shown in Table 1.

TABLE 1 – Medical Home Demonstrations Now Underway
Multi-stakeholder Demos in Italics

UnitedHealth Group PCMH Demonstration Program (AZ)	MediQhome Quality Project: Patient-Centered Advanced Medical Home Quality Improvement Initiative (ND)
Colorado Multi-Stakeholder Multi-State PCMH Pilot (CO)	CDPHP Patient-Centered Medical Home Pilot (NY)
Wellstar Health System (GA)	EmblemHealth Medical Home High Value Network Project (NY)
Quality Quest Medical Home (IL)	***New York Hudson Valley p4p/Medical Home Project (NY)***
Louisiana Health Care Quality Forum Medical Home Initiative (LA)	Cincinnati Medical Home Pilot Initiative (OH)
Maine Multi-Payer Patient-Centered Medical Home Pilot (ME)	***Greater Cincinnati Aligning Forces for Quality Medical Home Pilot (OH)***
Aligning PCMH Stakeholders in Michigan (MI)	***Southeastern Pennsylvania Rollout of the Chronic Care Initiative (PA)***
Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP) (MI)	***Rhode Island Chronic Care Sustainability Initiative (CSI-RI) (RI)***
CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot (NH)	***Memphis Multi-Payer Patient-Centered Medical Home (TN)***
NH Multi-Stakeholder Medical Home Pilot (NH)	***Texas Patient-Centered Medical Home Demonstration Project (TX)***
Patient-Centered Medical Home—Diabetes Management (ND)	Patient-Centered Medical Home—Vermont (VT)

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

Maryland does not currently have any medical home demonstrations underway. CareFirst has made recognition as a medical home a component of their primary care reward program. Although about 60 Maryland physicians have received recognition through the NCQA Practice Connection programs for electronic health records, no Maryland practice has yet achieved recognition as a NCQA Advanced Medical Home.

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 FTE and the American Academy of Family Practice puts on-time expenses at up to $75,000 per physician.[13,14] 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 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 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. To further promote early adoption of the medical home model, the Task Force Recommends the following steps.

1. The Secretary of DHMH, with the assistance of the independent commissions, should establish a multi-stakeholder coalition of providers, payers, patients, purchasers, academics, and state policymakers to promote medical home demonstrations.

2. MedChi, with the assistance of the primary care specialty societies including AAFP, ACP, AAP, 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 CME credit.

   a MedChi should set ambitious goals for primary care practices in the State – 100 Maryland practices obtain NCQA medical home recognition at Level II or above by 2011.

   b. MedChi should work to effectively leverage existing demonstrations such as the CMS electronic health record program now underway so that practices migrate to a medical home.

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[13] Deloitte Consulting, Center for Health Care Solutions, "The Medical Home, Disruptive Innovations", Washington DC, 2008 accessed at http://www.deloitte.com/dtt/cda/doc/content/us_chs_MedicalHome_w.pdf

[14] America Academy of Family Practice, "The Future of Family Medicine", 2004 accessed at http://www.annfamed.org/cgi/reprint/2/suppl_3/s1.

3. The Maryland Department of Business and Economic Development (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.

6. Recommendation on Elevated Payment for After-Hours and Weekend Care

1. Encourage insurance carriers and health plans to pay primary care providers a premium for visits after the end of the 5:00 p.m. work day 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 [E/M] codes), or .
    b. Award PCPs bonus points in a payer's performance payment system, if a PCP offers after-hours appointments.

2. Encourage insurance carriers and health plans to compensate primary care providers for telephone and electronic (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 U.S., where 60 percent of primary care physicians report not offering arrangements in which patients can be seen by a physician or nurse if needed when the practice is closed.[15] An equal number of adults (60 percent) report having difficulty getting care on nights, weekends, or holidays without going to the emergency department.[16] 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 non-emergent or emergent (i.e., requiring care within 12 hours) but could have been treated in primary care settings.[17]

Inappropriate use of emergency departments leads to not only misuse of scarce services, but also scarce healthcare dollars. In 2006, the median emergency department expense, including facility and physician expense, was over 6 times greater than an office-based visit ($72 vs. $460).

Most commercial payers in Maryland and across the country do not compensate PCPs for phone or e-mail communications (eVisit) or pay a premium for after-hours face-to-face visits. This

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[15] Schoen C, Osborn R, Huynh P, Doty M, Peugh J, & 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.

[16] How KH, Shih A, Lau J, & Schoen C. (2008). "Public Views on U.S. Health System Organization: A Call for New Directions." 1158, vol. 11. The Commonwealth Fund Commission on a High Performance Health System.

[17] Maryland Health Care Commission. (2007). *Use of Maryland Hospital Emergency Departments: An Update and Recommended Strategies to Address Crowding.*

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.[18]

Enhanced access with open scheduling, expanded hours , and non face-to-face modes of communication is identified as an integral component to the medical home construct.[19] 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 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 towards transforming their practice into a medical home with after-hours care as one component of coordinated care that is worthy of incentives.

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[18] Committee on Quality of Health Care in America. (2001). "Crossing the Quality Chasm: A New Health System for the Twenty-first Century." *Institute of Medicine*, National Academy Press. Washington.

[19] "Joint Principles of the Patient-Centered Medical Home" (2007), published by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association

7. Recommendation for 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 primary care physicians that 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 regarding 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:
    - Studying and correcting claims coding issues associated with services provided by primary care providers; and
    - 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 primary care physicians (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 healthcare services. A study conducted on behalf of the Task Force by MHCC and consultants developed three recommendations:

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

Rationale:

The United States 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 the Employee Retirement Income Security Act of 1974 ("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 co-payments 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 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 such as:

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

8. Recommendations on Improving Data on Physician Supply

The Maryland Board of Physicians' licensure data are the primary source for analyzing physician supply in Maryland as it is the most comprehensive source of information on physicians actively practicing 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.

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 on-line 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 & related activities, overall and by practice site;
    - Hours per week spent in "primary/preventive care" (as a percent 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 should direct the MBP and MHCC to establish a workgroup consisting of MBP, MHCC, Office of Health Policy & Planning, MedChi, MHA, CareFirst, and other payers, to plan analyses and improvements in data collections and plan 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 non-physician clinical supply with the Office of Primary Care and MHCC for workforce planning needs in the State.

An issue of particular importance to examine. A finding of the MHA/MedChi study was the lower share of time spent in patient care among Maryland physicians. Factors that contribute to lower clinical practice hours in Maryland compared to the United States need to be better understood, especially as high market concentration means less complexity dealing with numerous plans. Fewer hours delivering patient care means that the same number (head count) of physicians in Maryland and the U.S. will produce a lower number of FTE clinical care physicians in Maryland. Increasing physician clinical productivity could contribute to resolving supply problems in some areas.

APPENDIX 1 – Status of Recommnendations 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 Board of Physicians. These standards should be accepted by all licensed providers, insurance carriers and hospitals in Maryland. This credentialing can be based on national standards and adopted state wide.	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 above	HCAR staff
Give MIA authority to permit plans to have more flexibility with payment, penalize providers that perform poorly, 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 non-participating 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
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	NA	Delegate Costa

Recommendation	Reason Not Recommended	Offered By
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.		
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 phone and e-visit 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% if they provide a service in a population defined 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 end of the 5:00 pm work day and on weekends. Compensate PCPs for phone 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
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 non-participating health care providers in shortage areas		Delegate Costa
Payment Reform		
Establish a pilot project under the auspices of the Maryland Health Care Commission 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	Expanded hours concept Included in Recommendation 6.	MHA

Recommendation	Reason Not Recommended	Offered By
upgrades/medical home development/expanded hours.	Health IT initiatives already underway by CMS and several private payers. Medical home development is at the demonstration stage – not yet clear what savings will be to system	
Apply For CMS Medical Home Demonstration	Assume in recommendation 5	MHA
Establishment of a primary care demonstration project under the auspices of the Maryland Health Care Commission with health insurer support of primary care practices with increased E and M fees for doctors who take part in a "medical home" practice.	Concepts included in Recommendation 5	MedChi
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 Maryland Health Care Commission, the Maryland Insurance Administration, 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 advanced in writing by the health insurance carriers.		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.	No action	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-payor 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	Secretary will work with	MHA

Recommendation	Reason Not Recommended	Offered By
and expand MUA /HPSA designations, increase J-1 Visa programs, expand National Health Services Corps, and CMS support for Telemedicine.	Congressional delegation to raise awareness and assess approaches for developing HRSA programs that better meet Maryland's needs	
Establish a five-year loan forgiveness program for medical school debts to any graduate of an American medical school who agrees to practice primary care in a Maryland shortage area. Debt will be remitted at the rate of 20% per year until extinguished.	Included in Recommendation 1. MHCC exploring feasibility of including all medical schools.	MedChi
Establish a rural residency training program at eligible Maryland hospitals. An "eligible hospital" means with respect to a loan, a non-profit hospital that, as of the date of the loan submission application, meets each 4 of the following 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 Department of Health and Mental Hygiene, 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. MH providers oppose expansion of PCP scope of practice.	Delegate Costa
Professional Liability		
Enactment of "Good Samaritan" protection for physicians practicing/providing consultation in emergency department.	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

APPENDIX 2 - 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 decision making. 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 assure 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 decision making. Non-adherence 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 decision-making, 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.