June 9, 2010

The Honorable Anthony G. Brown  
Lieutenant Governor  
State House  
100 State Circle  
Annapolis, MD  21401

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

Dear Lt Governor Brown and Secretary Colmers:

On behalf of the members of MedChi, The Maryland State Medical Society and the patients they serve, I would like to applaud this Administration’s commitment to proactively and comprehensively address the myriad of issues that face the State as it implements federal health care reform. The full impact of federal health care reform on the State, the provider community and the residents of Maryland will not be fully understood for a number of years. That being said, the physician community believes there are a number of critical components to the reform effort that present both significant challenges and opportunities. To that end, MedChi strongly urges the Council to address three specific issues that the physician community believes are critical if the current health reform efforts are to produce any meaningful improvement in access to care, quality improvement and cost containment.

1. Primary Care Access and Reimbursement Issues

MedChi requests that the Council establish a workgroup of relevant stakeholders to address issues relative to primary care access and reimbursement. The expansion of cover, both through the expansion of Medicaid and as a result of the obligation for individuals to acquire health care coverage will dramatically increase the demand for primary care physicians. In 2008, MedChi and the Maryland Hospital Association commissioned a physician workforce study to evaluate physician shortages across the State. That study which is attached for your review clearly demonstrated that Maryland has a significant shortage of physicians, most notably primary care physicians. The results of that study have been generally accepted in the marketplace and the ensuing two years has seen an exacerbation of the existing shortages.

While the study demonstrated a significant shortage of primary care physicians, the demographics of the shortage have not been fully evaluated. For instance, there are jurisdictions within the State where there appears to be sufficient physician capacity but upon
closer evaluation many of those physicians are no longer accepting new patients or do not participate in the Medicaid program. If the State is to effectively address the shortage of primary care physicians, it will need to do a more thorough analysis of the scope and demographics of the shortage. MedChi urges the Commission to charge any workgroup that may be appointed to conduct a thorough study of the primary care physician capacity and shortages issues in the State.

There are a number of factors contributing to the primary care shortage in the State, not the least of which is woefully inadequate reimbursement and significant barriers to recruitment and retention of physicians. If the State is to tackle its escalating primary care physician shortage, it will be essential for a workgroup to identify strategies for addressing access and enhanced reimbursement.

MedChi would caution the Council that the “patient centered medical home (PCMH) initiative” is not the answer to the challenges facing primary care physicians. While Med Chi is fully supportive of the development of the demonstration project and the ongoing dialogue of enhanced care management and reimbursement at the primary care level, the current demographics of Maryland’s primary care physician practices will not enable them to participate in any of the PCMH projects that are being proposed. For instance, CareFirst is about role out a PCMH program that has a “five physician practice” as one of the thresholds for participation. However, the CEO of CareFirst has publicly stated that 80% of the primary care practices that participate in their networks have fewer than five physicians and therefore will not qualify for participation. The same issue arises in conjunction with the PCMH demonstration project being advanced by the Maryland Health Care Commission.

Maryland’s primary care practices are predominantly small community based practices, including a large number of solo practices. This scenario is not likely to change appreciably in the next few years. The State must work within this framework as it plans for the increased demand for primary care services that will result from the expansion of coverage under federal reform. The Council should charge a workgroup with identifying initiatives that work within the framework. Primary care reimbursement, recruitment and retention initiatives should be a cornerstone of this Council’s efforts. Increased access to health care coverage will be meaningless if the State does not address assuring increased access to primary care services.

2. Health Information Technology (HIT)

The effective implementation of HIT across all health care settings, including small physician practices is a critical component of the ultimate success of the reform effort. MedChi is a full partner with the State and CRISP, and we appreciate the role that the State
has played to this point as a proactive partner in advancing access to and implementation of HIT, particularly for primary care practices. Investments in HIT are extraordinarily expensive and exceed the financial capacity of most physician practices. While the physician community appreciates the importance of moving in the direction of a fully integrated electronic health information delivery system, the resources to achieve that goal must come from the private insurance sector that stands to benefit from its efficiencies and from the public sector that has instituted penalties for failing to adopt HIT within defined timeframes.

To that end, MedChi requests that the Council commit itself to working with the federal government to roll back the implementation timeframes and penalties for HIT adoption to assure that they reasonably reflect the financial and time constraints that physicians face with implementation. Physicians should not be penalized for failing to adopt HIT if the government and insurers are not willing to be a financial partner with them in HIT implementation. Furthermore, MedChi requests that the Council ensure that the financial incentives for HIT adoption that the State has required the private sector to offer to physicians are direct front end monetary incentives and not more elusive, ill-defined backend rewards.

HIT adoption and implementation is complex, expensive and yet essential to ultimate success of system reform. To that end, the federal reform bill contains potential additional federal funds that State may be able to leverage to address some of these issues. MedChi urges the Council to establish a stakeholder workgroup to address HIT investment and implementation and to ensure the State is maximizing its potential to leverage federal funding opportunities.

3. Health Insurance Reform

There are a multitude of provisions in the federal health care reform bill regarding health insurance reform as it relates to the types of coverage that must be offered and the rules related to enrollment/subscription to coverage. These issues will undoubtedly be a central focus of this Council’s efforts. However, insurance coverage reform is not the only insurance reform that MedChi believes should be a focus of this Council. Insurance reform from the perspective of the administration of the insurance products is equally critical.

As discussed previously, there is a growing physician shortage in the Maryland marketplace which will have a real and direct impact on access to care. A significant factor that contributes to the growing physician shortage is the exodus of Maryland physicians to other jurisdictions. This exodus is often a reaction to the combination of inadequate reimbursement and the administrative burdens of participating with insurance carriers. The GAO report to the Honorable Paul Ryan titled “Competition and other factors linked to wide variation in health care prices” identified the Washington region as 316 out of 319 cities studied, and the
Baltimore region as dead last with respect to reimbursement. A recent survey of MedChi members indicated that the administrative burden and attendant overhead costs of complying with the administrative requirements of insurance companies was contributing to the financial instability of their practices, the exodus of physicians from the marketplace, and creating real barriers to assuring prompt and appropriate access to care.

Administrative simplification reduces overhead, decreases costs and increases access. It will be critical for the Council to focus on the identification and elimination of administrative hurdles to providing care as they implement the various private marketplace initiatives that are encompassed in the federal bill. MedChi urges the Council to incorporate this aspect of insurance reform in its deliberations on those components of the federal legislation.

MedChi appreciates the opportunity to provide input to the Council and looks forward to working with the various stakeholders on the issues it has identified in this letter as well as those issues identified by other stakeholders. Again we applaud the Administration for its proactive approach to health reform implementation and remain available as a resource to the Council as it moves forward with its work.

Sincerely,

Gene Ransom, III
Chief Executive Officer
MedChi, The Maryland State Medical Society

CC: Council Members