MCMS
MONTGOMERY COUNTY, MD
MEDICAL SOCIETY

MCMS Speaks Out on Patients' and Physicians' Behalf to the Health Services Cost Review Commission:

Patient Access, Quality of Care and Physician Viability

The letter below was sent to the Health Services Review Commission by Montgomery County Medical Society on February 3, 2025.

Dear Dr. Sharfstein & HSCRC Commissioners:

On behalf of our more than 1,600 physicians practicing in and/or residing in Montgomery County, Montgomery County Medical Society is pleased to respond to HSCRC's request for stakeholder feedback. Our members include physicians of all specialties, practice modes, and practice locations in the County, and we are committed to providing quality, accessible, equitable, and affordable healthcare for more than a million patients. We share our perspectives on behalf of our patients — the most important stakeholders — in mind.
We have worked collaboratively with MedChi, the Maryland State Medical Society, of which we are a chartered component, to share individual and collective physician concerns about the Total Cost of Care Model and now about AHEAD (States Advancing All-Payer Health Equity Approaches and Development) Model. As part of our feedback (and attached to this communication) are MedChi's positions on Healthcare Transformation, Population Health & Primary Care Investment. We support these positions and encourage the HSCRC to give serious consideration to the recommendations contained in these documents. These recommendations represent valuable insights into the challenges of providing patient care both in the hospital and outside the hospital and include proposed solutions.

There are several areas on which we want to provide additional feedback. These issues relate to significant concerns about the current Total Cost of Care (TCOC) Model. We want to ensure these issues are addressed and resolved and not repeated in the new AHEAD model.

At the foundation of our members' concern is that the focus on cost containment has adversely affected quality and access to care under the TCOC Model, and, if not addressed, will continue and be exacerbated in the new AHEAD model. Moreover, the statement "AHEAD envisions a health care system that empowers all Marylanders to achieve optimal health and well-being by ensuring high-value care, improving access to care, and promoting health equity" assumes that there is a system of and infrastructure for care to be provided, and the health care workforce necessary for Marylanders to "achieve optimal health and well-being." While we agree that we need to strive toward this vision, we feel strongly that Maryland lacks a coordinated and collaborative effort to address the foundational needs and building blocks to achieve this stated vision.

Below we have categorized our feedback according to HSCRC's formal request. We recognize that some of the issues raised may not be the purview of the HSCRC; however, they directly or indirectly impact the success of the TCOC and AHEAD models and must be addressed by appropriate legislative and regulatory bodies. Given the complexity of the funding mechanisms of the TCOC, it is often difficult to determine the appropriate process through which to raise quality and access concerns and to explore solutions.
Ensuring High Value Care.

The HSCRC's focus is on ensuring "high value care." Containment of costs is important; however, not to the detriment of access to and/or quality of care. The methodology used by HSCRC and/or hospitals to measure quality of care is likely different from how physicians who admit or consult at Maryland hospitals and/or inpatients measure quality of care.

Metrics used by hospitals to measure quality of care are often patient satisfaction scores post-discharge, mortality rate, readmission rate, length of stay, compliance with clinical guidelines, infection rates, patient safety incidents, average cost per patient, bed occupancy rate, and healthcare effectiveness data and information set (HEDIS) scores. While important factors, quality of care is also impacted by:

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-Inability of surgeons to schedule patients for procedures due to operating room suite closures attributed to staffing challenges or arbitrarily to diminish utilization and cost. Lack of access to surgical care negatively impacts patient care and the viability of surgical practice;

·Elimination of inpatient service lines which push patients to other hospitals in Maryland that provide the service, or into a community setting that isn't the most appropriate setting for that illness or disease treatment. The viability of such community providers is subject to market forces and reimbursement policy. Closure of outpatient services, such as dialysis, requires patients to drive long distances to receive care. In most physicians' opinions, these chronic diseases would best be treated in a community hospital for the best outcomes;

·Lack of call pay funding transparency. If used exclusively for hospital employed or contracted physicians to control costly admissions, access to cost effective, quality care provided to patients by outside specialists is undermined;

·Lack of adequate and adequately trained inpatient clinical staffing;[1]

·Unwillingness of hospitals to allow new and innovative treatments and surgical procedures because these treatments and procedures, while potentially financially profitable, could penalize hospitals under global budget models therefore denying access to such treatments or surgeries in Maryland; and

·Lack of adequate emergency room physician or hospitalist coverage to see patients resulting in additional patient care expenses from care provided by advanced practice providers and potentially greater liability;[2]

·Inability of patients and physicians to share their concerns about quality of and access to care because there is no third-party, nonbiased system for collecting and reviewing such data, and having findings addressed and factored into annual budget review.

These concerns, shared with us by our members out of concern for their patients, impact quality and cost and are unfortunately the symptoms of global budget cost constraints. We expect that many of these factors are not captured and are not a part of the HSCRC funding methodology as they are more qualitative than quantitative.

Furthermore, we have learned that many physicians and surgeons are admitting their patients to hospitals in DC and Northern Virginia to expedite patient care and diagnostic and surgical procedures. Our physician members have indicated that the care provided in those out-of-state hospitals is not affected by the cost-cutting decisions which are prevalent in Montgomery County and most of Maryland's community hospitals, including lack of access to OR suites, lack of innovative equipment and medications, and inadequate nursing and physician staffing. Contrary to HSCRC's effort to enhance health equity, patients in Maryland with Medicaid coverage are precluded from receiving care outside of the state and unable to access cutting edge technology which is offered outside of Maryland. These issues are worsened by the increasing volume of patients in Montgomery County at approximately 20% greater than pre-COVID rates (as reported by Suburban Hospital to the HSCRC), and without adequate adjustment of rates to Montgomery County hospitals to compensate for increased patient utilization. We encourage the HSCRC to look at the current volume methodology and make appropriate changes to ensure Montgomery County hospitals are appropriately compensated for increases in utilization.

Recommendations:

1)Modify the volume formula to reflect increased population utilization and fund hospitals accordingly using the "money should follow the patient" strategy. Community hospitals cannot be expected to provide care to more Maryland residents without additional resources. Free standing medical facilities and other lower acuity providers cannot provide the same services of full-service inpatient hospitals at a time of increasing population growth.

2)Evaluate the current funding methodology which has resulted in perverse incentives which ration patient care.

3)Incentivize hospitals financially to improve their offering of innovative procedures and surgeries which improve health outcomes, including requiring hospitals to pay call coverage to independent specialists.

4)Develop an independent complaint reporting system which will encourage patients and clinicians to share their feedback and concerns about inpatient care, and create a multi-disciplinary, non-biased committee to assess trends and address these complaints with specific hospitals and/or initiate improvements in hospital funding for those facilities which address complaints effectively.

5)Evaluate the disproportionate funding to hospitals within Maryland and reallocate funding to community hospitals where there is increasing demand and the need for community-based primary care which will help to achieve the goals of AHEAD. While it is understandable that funding is needed in our tertiary care facilities and trauma centers, population health strategies and improved outcomes will result from greater funding to community hospitals and community-based physicians and other outpatient services.

6)Improve the transparency of HSCRC funding strategies. It is complex and not easily understood. The general public is unaware of hospital funding methodology in Maryland or the impact it may have on their medical care.

7)Develop a publicly available and consistently applied transparent rating system for hospital quality and efficiency accessible to patients, physicians and other providers to inform consumers of quality health care.

8)Incentivize quality primary care rather than the number of visits. Physicians who care for patients with complicated health conditions should be compensated properly for the time and resources required to treat a patient effectively.

9)Medicare has established a rating system for hospitals, nursing homes, physicians and many other facilities called Medicare Compare. According to the medicare.gov website, "Medicare Compare uses a methodology that primarily relies on standardized quality measures, including process measures (what a provider does), outcome measures (results of care), patient experience measures, and sometimes structural measures (characteristics of the provider or facility), all gathered from patient medical records, claims data, and standardized surveys to generate a comparative rating for healthcare providers, allowing patients to compare quality across different facilities and doctors on the Medicare website; this often takes the form of a star rating system, where higher stars indicate better quality." Maryland's rating system could be based on similar measures but also on emergency room efficiency, acquisition of innovative equipment, staffing, etc. This rating system needs to be publicized. Hospitals should strive to achieve the highest level of quality and efficiency.

10)Consider "medical loss ratio" type reporting for hospitals. Medical loss ratios are a significant aspect of the Affordable Care Act.[3] They have been implemented in Maryland to hold health insurance companies accountable for the amount spent on medical care of every premium dollar and expose the amount spent on non-medical care expenses. The "medical loss ratio" concept applied to hospitals could limit the amount spent on administrative salaries, marketing, and non-medical projects including the building of non-patient care facilities. Hospital global budgets should be adjusted by the amount of administrative costs vs. actual costs of medical care. Hospitals should be incentivized to partner with community primary care physicians and urgent care centers to improve access to care, cost control and population health. By reporting both the resources spent on administration and health care to the HSCRC, hospitals will be held accountable for the medical care they are providing and be incentivized to meet certain targets of care. National and regional comparisons of administrative costs should be considered.

11)The payment structure for primary care physicians should move away from RVUs and toward high-quality care to compensate for time and resources needed to effectively use clinical guidelines and patient education to improve patient care and outcomes.
Improving Access to Care.

"AHEAD envisions a health care system that empowers all Marylanders to achieve optimal health and well being by ensuring high-value care, improving access to care, and promoting health equity."

Baked into the Total Cost of Care model and the new AHEAD model is the misguided assumption that there is an adequate physician workforce, both primary care and specialty care, to care for patients outside of the hospital. This is simply not true. [4]

While MCMS recognizes that health care professional workforce is not in the domain of HSCRC, without an adequate physician workforce, especially in primary and behavioral care, we will continue to witness the inability of Marylanders to "receive the right care in the right location at the right time" which is a fundamental and necessary aspect for the AHEAD model success. Longstanding and well-known physician and nursing workforce shortages in Maryland continue to challenge health care delivery, and have been studied by the State legislature, but few concrete steps have been taken to address the deficiencies.[5]

This lack of access to primary and behavioral health care is an element in Maryland's current ranking of 50th with the longest Emergency Department waiting time in the nation, a dubious distinction which Marylanders have shouldered for the past number of years. [6] Increasing use of observation status is recognized as a strategy to avoid compromising inpatient budget allocations of the TCOC model; however, observation status can contribute to clogged emergency rooms further exacerbating emergency wait times.

While MDPCP and other alternative payment models have demonstrated success in reducing cost and increasing value, there are still too many patients who have no access to primary care who may seek care in emergency rooms or urgent care centers or receive no treatment at all for chronic or acute conditions which result in costly hospital admissions. The Primary Care Model for patients with Medicaid will also make a difference; however, both rely on an adequate number of physician and advanced practice providers to participate in these care coordination programs. Effective strategies to ensure successful transitions of care from hospital to outpatient settings, continuity of care and "medical home models" have demonstrated considerable progress toward reducing hospital admissions.

A primary driver of diminishing supply of primary (and specialty) care physicians is the inability to sustain practices in Montgomery County and Maryland due to the unique private payor environment, with one dominant insurer, CareFirst, controlling the majority of non-Medicare individuals. Over 3.5 million patients are covered in the commercial insurance market by CareFirst, allowing the insurer to set lower prices, limit its provider panels, create its own network of practices (including the largest primary care practice in Montgomery County which has practice locations in D.C. and northern Virginia as well), and create cost-containing efforts that limit physician and patient access to care that would be considered routine.

By creating barriers to standard care, by requiring additional approvals called 'prior authorizations', physicians' time is used on needless red tape, when it could instead be used for patient care. By causing unnecessary delays, which are not based in science, patients are forced to either forego medications (some of which they have been used successfully for years) or pay for them outside of insurance.

As a result, physicians are leaving Maryland and moving out of state to practice elsewhere where the payor environment is less hostile to benefit from more insurance competition and higher payment rates, closing their practices and/or merging into larger groups, transitioning to concierge or direct membership practices, seeking employment in other medical environments such as NIH and FDA, and/or simply retiring early. A direct result of continual frustration with the status quo is a high rate of burnout.

When payors report network adequacy measures, the numbers do not reflect the reality of the situation. To understand the extent of the access problem, all one needs to do is to call a medical practice and see how long it takes to get a new patient appointment.

MCMS is so concerned about this issue that we launched our own workforce survey in the fall of 2024. The findings are:

- *·32 surveys received so far since survey was launched in late September which represents 164 clinicians including physicians and mid-levels and almost 38,000 patients under their direct care.*
- *·42% of primary care respondents report it takes 1-4 months to set up an appointment for an established patient for routine care. 44% of specialists report it takes 1-4 months for them to see an established patient.*
- *·67% of specialists note it takes 1-4 months to see a new patient. 1/3 of Primary care physicians report that it takes 1-4 months for a new patient.*
- *·For a referral, 42% of primary care physicians note it takes 3 to more than 6 months to get a specialist appointment for their patients.*
- *·42% of primary care physicians who answered our survey plan to retire in the next 5 years. 39% of specialists will retire in the next 5 years. This means almost 10,000 primary care patients will have to find a new physician and almost 8,000 patients of retiring specialists will as well.*

With all of these factors, Maryland has been ranked in one survey as the worst in which to practice Medicine and ranks 49th of 50 states in terms of physician payments by insurers.[7] Maryland is one of the few states where commercial insurance payments are lower than Medicare payments.

The answer is to make Maryland a more economically favorable environment in which to practice. The answer is not to expand scope of practice for advanced practice professionals which have been shown to increase cost and liability concerns.[8] Marylanders deserve to be treated by well-trained physicians. Physicians are most able to provide cost-effective quality care in the outpatient setting. Providing additional financial incentives to physicians to establish practices in Maryland, instead of hospitals, is what's needed to achieve "right care in the right location at the right time" as physicians are familiar with their patients' healthcare needs and can more effectively coordinate their care to avoid unnecessary hospitalizations.

According to our workforce survey 71.4% of primary care physicians note that they have considerable trouble or it's almost impossible to recruit a new physician to their practice, while 55.5% of specialists note the same concern. Inability to match competing compensation offers is the number one reason that it is difficult to recruit physicians to Montgomery County. According to several practices in Montgomery County, the only physicians who want to live in Maryland are those who have family connections, and it's our observation that these physicians often open practices in two or three jurisdictions – Maryland, Virginia and/or D.C. – once they recognize the economics of practice in Maryland are not sustainable given the high cost of practice and low commercial insurance payments.

Recommendations:

1)Expand facility fee payment policy to include additional medical care settings. By leveling the playing field, more cost-effective, high-quality care can be performed in the outpatient setting, including independent surgery centers and medical practices increasing patient access. HSCRC should institute policies to ensure the fees are supporting patient care.

2)Enhance access to and payment for remote patient monitoring for patients enrolled in MDPCP or Medicaid Primary Care Program. Remote patient monitoring has demonstrated success in management of the care for patients with long-term chronic conditions.

3)Create an environment which encourages, facilitates and rewards cooperation, not competition, among providers of care in the outpatient setting. Finding successful ways for hospitals and all physicians to align and work together to improve patient outcomes is critical. Acquisition of medical practices by hospitals often increases costs. Investing in independent primary care to improve outcomes through programs like MDPCP and the new Medicaid Primary Care Program are helpful to manage care at the local level, yet many physicians find that the administrative burdens of such programs limit their optimal success.

4)Create legislation that no payor operating in Maryland can pay less than Medicare to primary care and behavioral health physicians working exclusively in Maryland.

5)Expand Medicaid coverage and payments to be equivalent to Medicare for the Top 25 CPT codes in the outpatient setting. If the proposed budget for Maryland is approved, Medicaid E&M codes would once again be equivalent to Medicare. Unfortunately, patients have little or no access to medical or surgical care for chronic conditions.

6) Eliminate prior authorizations for all practices participating in MDPCP and the new Medicaid Primary care program. This would immediately increase interest in participation if administrative burdens could be reduced.

7)Eliminate duplicative credentialing requirements for participation in Medicare and Medicaid managed care plans (like Medicare Advantage) if clinicians are already credentialed by traditional Medicare and Medicaid. This will improve access and expedite care.

8)Enhance outreach services to and service for underserved communities by encouraging Medicaid to match the 10% incentive in payment to physicians who practice in Health Care Professional Shortage (HPSA) areas as designated by Medicare.

9)Encourage hospitals to collaborate with and support financially nonprofit clinics and organizations which provide medical care in the community to enhance outreach to underserved populations (e.g. Mobile Medical Care, Mercy Clinic, etc.)

10)Population-based payment methodology must include payments for care provided by community-based primary care physicians to ensure appropriate care for chronically ill patients to reduce hospital admissions.

Planning is underway to replicate the Maryland model to other states through the AHEAD Model. CMS's goal in the AHEAD Model is to "collaborate with states to curb health care cost growth, improve population health; and advance health equity." According to HSCRC, "The AHEAD Model is the multi-state CMMI model that builds upon the successes of the Maryland TCOC in reducing health care cost growth and improving statewide health care quality."

Physicians across the State have been raising concerns through our medical societies, and urgent action is needed. Access to care has been a longstanding goal for physicians, patients, elected officials, and other stakeholders. Access to high quality care provided by physicians is the mission of our state and local medical societies. Patient advocacy groups share our deep concern for the future of high-quality medical care in the state.

Montgomery County Medical Society and our members are available to participate with HSCRC to create solutions to the challenges faced by our physicians and patients.

Thank you again for the opportunity to provide feedback on behalf of our physician members and their patients.

Sincerely,

Brent Berger, M.D.
President

Aruna Nathan, M.D.
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Angela Marshall, M.D.
Immediate Past President

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