Patient First
Neighborhood Medical Centers

TO: The Honorable Shane Pendergrass, Chair
Members, House Health and Government Operations Committee
The Honorable Nicholaus R. Kipke

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Richard A. Tabuteau
410-244-7000

DATE: February 20, 2020

RE: **SUPPORT** – House Bill 970 – *Health Insurance – Reimbursement of Primary Care Providers – Bonus Payments – Applicability*

Patient First, a provider of primary care and urgent care services throughout Maryland, strongly supports House Bill 970, which ensures that providers of both services receive bonus payments for providing after hours care. To accomplish this, House Bill 970 defines a "primary care provider" as a licensed physician assistant, a certified nurse practitioner or a licensed physician certified in family practice, internal medicine, or pediatrics or otherwise identified as a provider of primary care in an applicable insurance contract who provides basic health care or urgent care services, including diagnostic, treatment, consultative, referral, and preventative services.

Maryland law requires carriers to pay a bonus payment to "primary care providers" for services provided after 6 P.M. and before 8:00 A.M. and on weekends and national holidays. Because the legislation failed to define "primary care provider," carriers have alleged that only "designated primary care providers" are included under the bill and not providers of urgent care services. We disagree. The purpose of the existing law is to increase access to primary care services in order to reduce emergency room utilization. Regardless of whether these services are provided in an office or in an urgent care setting, the same purpose is achieved, and both should be eligible for the same bonus payment. As discussed below, we believe that this position aligns with legislative intent not to exclude urgent care settings or other providers.

The issue of emergency department overcrowding has been a topic of concern in Maryland for over two decades, resulting in numerous studies and recommendations. A 2006 report from the Maryland Health Care Commission,[1] which examined the use of Maryland hospital emergency departments, recommended:

> *Strategies should be developed and implemented* ***to encourage the use of primary care and urgent care services in the community*** *rather than emergency departments. Effective strategies will combine efforts to improve the availability and convenience of services and to provide incentives to both patient and provider.*

A sub-recommendation of this recommendation further concluded:

---

[1] Maryland Health Care Commission, *Use of Maryland Hospital Emergency Departments: An Update and Recommended Strategies to Address Crowding*. December 22, 2006.

Private and public payers should examine ways ***to compensate providers for improving access to primary care services****. These might include differential rates for providers' success in decreasing emergency department utilization, for providing prompt appointments for emergent conditions, for having evening and weekend hours, and for developing innovative service programs.* (emphasis added)

This recommendation did not limit "provider" to one setting and, in fact, directly included urgent care services in the reference to providing differential rates for evening and weekend hours. Following the 2006 report, the General Assembly created the Task Force on Health Care Access and Reimbursement and, in 2008, the General Assembly amended the legislation to include two additional areas:

(8) Whether there is a need to provide incentives for physicians and other health care providers to be available to provide care on evenings and on weekends; and

(9) The ability of primary care physicians to be reimbursed for mental health services performed within their scope of practice.

Ironically, the General Assembly used the term "primary care physician" as it related to mental health services but did not use it when discussing incentives for physicians and other health care providers. The Task Force report concluded that insurance carriers and health plans should pay primary care providers a premium for visits after the 5:00 PM end of the workday and on weekends for scheduled and unscheduled appointments. However, while using the term "primary care provider," the report did not discuss that the terminology was to be limited to one setting.

Again, the primary purpose of the legislation has been to increase access to primary care services to reduce emergency room utilization. As noted in the Task Force report "[l]imited availability of **after-hours primary care** is most likely a contributing problem to the overburdened emergency medical system in Maryland. Almost 35% of Maryland emergency department visits in 2005 were classified as either nonemergency or emergency (i.e., requiring care within 12 hours), **but could have been treated in primary care settings**." (emphasis added).

Services provided under the designation of primary care and urgent care are virtually synonymous but are being differentiated as a mechanism for not paying the bonus payment. For example, of the top 20 diagnoses treated under each designation of primary care and urgent care services, 12 of them are identical, such as respiratory infections, flu, bronchitis and pneumonia. For the remaining diagnoses, these are diagnoses that would typically not be seen in a physician office and would require emergency services (but can be handled by many urgent care centers) due to the need for additional diagnostic measures. Urgent care centers are being utilized as an extension for other, in-office, primary care providers. Medical records are shared, and care is coordinated among the two. As such, given that urgent care centers are achieving the basic purpose of reducing emergency utilization and work with other primary care providers on the coordination of care, they should be equally compensated under the bonus payment statute.

Therefore, for the above reasons and to recognize the community benefit provided by urgent care settings in providing care when designated primary care providers are not available, we urge a favorable vote on House Bill 970.