SB0734_SponsorAmendments

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Position: FAV

SB0734/663529/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

23 FEB 22
10:29:33

BY: Senator Lam
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 734
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 2, strike "**Health and Health Insurance**" and substitute "**Maryland Health Care Commission**"; in the same line, strike "**Reform Commission**" and substitute "**Spending and Improvement Report and Workgroup**"; in line 3, strike "establishing the Primary Care Reform" and substitute "requiring the Maryland Health Care"; strike beginning with "review," in line 3 down through "recommendations" in line 4 and substitute "provide an annual report to the Governor and the General Assembly"; in line 5, strike "by certain payors of health care services"; in line 6, after the semicolon insert "requiring the Commission to form a workgroup to develop the report;"; in lines 6 and 7, strike "Primary Care Reform" and substitute "Maryland Health Care"; in line 7, after "Commission" insert "and primary care spending and improvements"; and strike beginning with "20–2201" in line 10 down through "Commission"" in line 11 and substitute "19–108.4".

AMENDMENT NO. 2

On pages 1 through 6, strike in their entirety the lines beginning with line 17 on page 1 through line 8 on page 6, inclusive.

On page 6, after line 8, insert:

"**19–108.4.**";

in line 9, strike "**(K)**" and substitute "**(A)**"; in line 16, strike "**AND**" and substitute:

"**(2) RECOMMENDATIONS REGARDING:**

(I) WAYS TO IMPROVE THE QUALITY OF AND ACCESS TO PRIMARY CARE SERVICES, WITH SPECIAL ATTENTION TO INCREASING HEALTH CARE EQUITY, REDUCING HEALTH CARE DISPARITIES, AND AVOIDING INCREASED COSTS TO PATIENTS AND THE HEALTH CARE SYSTEM; AND

(II) MEANS OF REDUCING BARRIERS TO PRIMARY CARE ACCESS AND UTILIZATION IDENTIFIED BY THE COMMISSION; AND";

in line 17, strike "**(2)**" and substitute "**(3)**"; in the same line, after "**ANY**" insert "**OTHER**"; after line 17, insert:

"**(B) (1) THE COMMISSION SHALL FORM A WORKGROUP TO DEVELOP THE REPORT REQUIRED UNDER SUBSECTION (A) OF THIS SECTION, INCLUDING BY INTERPRETING THE RESULTS OF THE REQUIRED ANALYSIS AND MAKING THE RECOMMENDATIONS.**

(2) THE WORKGROUP REQUIRED UNDER THIS SUBSECTION SHALL INCLUDE REPRESENTATIVES FROM THE MARYLAND PRIMARY CARE PROGRAM, THE HEALTH SERVICES REVIEW COMMISSION, THE MARYLAND INSURANCE ADMINISTRATION, THE PRIMARY CARE COMMUNITY, AND HEALTH SERVICES RESEARCHERS WITH EXPERTISE IN PRIMARY CARE.";

strike in their entirety lines 18 through 22, inclusive; and in line 23, strike "3." and substitute "2.".

SB0734_with_183127_1.rtf.docx.pdf

Uploaded by: Clarence Lam

Position: FAV

Senate Bill 0734 as amended by SB0734/183127/1 (02/22/22 at 1:40 p.m.)
MLIS "Instant Reprint" System (version 5.0) - NOTE: This is not an official copy of the bill

UNOFFICIAL COPY OF SENATE BILL 734

SENATE BILL 734

J1, J5 2lr2423

By: **Senator Lam**
Introduced and read first time: February 7, 2022
Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **~~Health and Health Insurance~~ Maryland Health Care Commission- Primary Care ~~Reform Commission~~** Spending Report and Workgroup

3 FOR the purpose of ~~establishing the Primary Care Reform~~ requiring the Maryland Health Care Commission to ~~review, examine,~~
4 ~~and make certain determinations and recommendations~~ provide an annual report to the Governor and the General Assembly regarding primary care
5 spending ~~by certain payors of health care services and improvements to the quality~~
6 ~~of and access to primary care services~~; requiring the Commission to form a workgroup to develop the report; and generally relating to the ~~Primary Care~~
7 ~~Reform~~ Maryland Health Care Commission and primary care spending.

8 BY adding to
9 Article - Health - General
10 Section ~~20-2201 and 20-2202 to be under the new subtitle "Subtitle 22. Primary~~
11 ~~Care Reform Commission"~~ 19-108.4
12 Annotated Code of Maryland
13 (2019 Replacement Volume and 2021 Supplement)

14 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,
15 That the Laws of Maryland read as follows:

16 **Article - Health - General**

17 ~~**SUBTITLE 22. PRIMARY CARE REFORM COMMISSION.**~~

18 **~~20-2201.~~**

19 ~~**(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS**~~
20 ~~**INDICATED.**~~

21 ~~**(B) "COMMISSION" MEANS THE PRIMARY CARE REFORM COMMISSION.**~~

1 (c) "PRIMARY CARE" MEANS HEALTH CARE PROVIDED IN THE FOLLOWING
2 FIELDS OUTPATIENT SETTINGS:

3 (1) FAMILY PRACTICE;

4 (2) GENERAL PEDIATRICS;

5 (3) PRIMARY CARE INTERNAL MEDICINE; AND

6 (4) PRIMARY CARE OBSTETRICS AND GYNECOLOGY.

7 (D) "PRIMARY CARE SPENDING" MEANS ANY EXPENDITURE OF FUNDS MADE
8 BY THIRD-PARTY PAYORS, PUBLIC ENTITIES, OR THE STATE FOR THE PURPOSE OF
9 PAYING FOR PRIMARY CARE SERVICES OR SUPPORTING PRIMARY CARE PROVIDERS,
10 REGARDLESS OF PAYMENT METHODOLOGY.

11 **20-2202.**

12 (A) THERE IS A PRIMARY CARE REFORM COMMISSION.

13 (B) (1) THE COMMISSION CONSISTS OF THE FOLLOWING MEMBERS:

14 (I) THREE MEMBERS APPOINTED BY THE GOVERNOR;

15 (II) FOUR MEMBERS APPOINTED BY THE PRESIDENT OF THE
16 SENATE;

17 (III) THREE MEMBERS APPOINTED BY THE SPEAKER OF THE
18 HOUSE;

19 (IV) ONE MEMBER DESIGNATED BY THE MARYLAND HOSPITAL
20 ASSOCIATION;

21 (V) ONE MEMBER DESIGNATED BY THE MARYLAND NURSES
22 ASSOCIATION; AND

23 (VI) ONE MEMBER DESIGNATED BY MEDCHI, THE MARYLAND
24 STATE MEDICAL SOCIETY.

25 (2) TO THE EXTENT PRACTICABLE, THE MEMBERSHIP OF THE
26 COMMISSION SHALL:

~~(I) HAVE EXPERIENCE IN HEALTH CARE FINANCING, REIMBURSEMENT, AND REGULATION;~~

~~(II) BE COMPOSED OF:~~

~~1. PRACTICING PRIMARY CARE PROVIDERS;~~

~~2. REPRESENTATIVES OF FEDERALLY QUALIFIED HEALTH CENTERS;~~

~~3. PROVIDERS FROM PROFESSIONAL PRACTICE GROUPS;~~

~~4. PRIMARY CARE ADVOCATES;~~

~~5. PRIMARY CARE CONSUMER ADVOCATES;~~

~~6. REPRESENTATIVES OF BUSINESSES;~~

~~7. HEALTH PLAN REPRESENTATIVES; AND~~

~~8. REPRESENTATIVES OF HOSPITALS OR HEALTH SYSTEMS; AND~~

~~(III) REFLECT THE GEOGRAPHIC DIVERSITY OF THE STATE.~~

~~(C) A CHAIR OF THE COMMISSION SHALL BE SELECTED BY A VOTE OF THE MEMBERS OF THE COMMISSION.~~

~~(D) THE MARYLAND INSURANCE ADMINISTRATION AND THE DEPARTMENT SHALL PROVIDE STAFF FOR THE COMMISSION.~~

~~(E) (1) THE TERM OF A MEMBER OF THE COMMISSION IS 4 YEARS.~~

~~(2) THE TERMS OF THE MEMBERS ARE STAGGERED AS REQUIRED BY THE TERMS FOR MEMBERS OF THE COMMISSION ON OCTOBER 1, 2022.~~

~~(3) A VACANCY IN THE COMMISSION SHALL BE FILLED IN THE SAME MANNER AS THE MEMBER BEING SUCCEEDED WAS APPOINTED.~~

~~(F) (1) THE COMMISSION SHALL MEET AS OFTEN AS ITS DUTIES REQUIRE, BUT NOT LESS THAN QUARTERLY.~~

1 ~~(2) THE CHAIR OF THE COMMISSION SHALL PROVIDE ALL MEMBERS~~
2 ~~WITH NOTICE OF A MEETING AT LEAST 1 WEEK BEFORE THE DATE OF THE MEETING.~~

3 ~~(3) THE CHAIR OF THE COMMISSION SHALL CALL A MEETING AT THE~~
4 ~~REQUEST OF A MAJORITY OF THE COMMISSION MEMBERS.~~

5 ~~(4) SEVEN MEMBERS OF THE COMMISSION CONSTITUTE A QUORUM.~~

6 ~~(5) ACTION BY THE COMMISSION REQUIRES THE AFFIRMATIVE VOTE~~
7 ~~OF A MAJORITY OF THOSE PRESENT ONCE A QUORUM IS MET.~~

8 ~~(G) A MEMBER OF THE COMMISSION:~~

9 ~~(1) MAY NOT RECEIVE COMPENSATION AS A MEMBER OF THE~~
10 ~~COMMISSION; BUT~~

11 ~~(2) IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE~~
12 ~~STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.~~

13 ~~(H) THE COMMISSION SHALL:~~

14 ~~(1) REVIEW, EXAMINE, AND MAKE DETERMINATIONS REGARDING~~
15 ~~PRIMARY CARE SPENDING BY ALL PAYORS IN THE CONTEXT OF OVERALL HEALTH~~
16 ~~CARE SPENDING IN THE STATE; AND~~

17 ~~(2) MAKE RECOMMENDATIONS REGARDING:~~

18 ~~(I) WAYS TO IMPROVE THE QUALITY OF AND ACCESS TO~~
19 ~~PRIMARY CARE SERVICES, WITH SPECIAL ATTENTION TO INCREASING HEALTH CARE~~
20 ~~EQUITY, REDUCING HEALTH CARE DISPARITIES, AND AVOIDING INCREASED COSTS~~
21 ~~TO PATIENTS AND THE HEALTH CARE SYSTEM;~~

22 ~~(II) MEANS OF REDUCING BARRIERS TO PRIMARY CARE ACCESS~~
23 ~~AND UTILIZATION IDENTIFIED BY THE COMMISSION;~~

24 ~~(III) PROPOSED CHANGES TO THE DEFINITION OF "PRIMARY~~
25 ~~CARE" FOR THE PURPOSES OF THE COMMISSION'S FUTURE WORK; AND~~

26 ~~(IV) RECOMMENDATIONS TO INCREASE SPENDING ON PRIMARY~~
27 ~~CARE BY THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND HEALTH INSURERS,~~
28 ~~NONPROFIT HEALTH SERVICE PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS.~~

~~(I) (1) (I) EACH MANAGED CARE ORGANIZATION PARTICIPATING IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM SHALL PROVIDE THE FOLLOWING INFORMATION TO THE COMMISSION:~~

~~1. FOR 2017, 2018, 2019, 2020, AND 2021, AND FOR EACH SUBSEQUENT YEAR ON THE REQUEST OF THE COMMISSION:~~

~~A. THE AMOUNT THE MANAGED CARE ORGANIZATION SPENT ON PRIMARY CARE SERVICES FOR ENROLLEES; AND~~

~~B. THE TOTAL AMOUNT THAT THE MANAGED CARE ORGANIZATION SPENT ON HEALTH CARE SERVICES FOR ENROLLEES; AND~~

~~2. ANY OTHER INFORMATION REQUESTED BY THE COMMISSION.~~

~~(II) THE SECRETARY SHALL:~~

~~1. ENFORCE THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH; AND~~

~~2. ADOPT REGULATIONS TO PROTECT THE CONFIDENTIALITY OF ANY PROPRIETARY INFORMATION PROVIDED TO THE COMMISSION UNDER THIS PARAGRAPH.~~

~~(2) (I) EACH INSURER, NONPROFIT HEALTH SERVICE PLAN, AND HEALTH MAINTENANCE ORGANIZATION THAT PROVIDES HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS UNDER HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE DELIVERED IN THE STATE SHALL PROVIDE THE FOLLOWING INFORMATION TO THE COMMISSION:~~

~~1. FOR 2017, 2018, 2019, 2020, AND 2021, AND FOR EACH SUBSEQUENT YEAR ON THE REQUEST OF THE COMMISSION:~~

~~A. THE AMOUNT THE ENTITY SPENT ON PRIMARY CARE SERVICES FOR ENROLLEES; AND~~

~~B. THE TOTAL AMOUNT THAT THE ENTITY SPENT ON HEALTH CARE SERVICES FOR ENROLLEES; AND~~

~~2. ANY OTHER INFORMATION REQUESTED BY THE COMMISSION.~~

~~(II) THE MARYLAND INSURANCE COMMISSIONER SHALL:~~

~~1. ENFORCE THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH; AND~~

~~2. ADOPT REGULATIONS TO PROTECT THE CONFIDENTIALITY OF ANY PROPRIETARY INFORMATION PROVIDED TO THE COMMISSION UNDER THIS PARAGRAPH.~~

~~(J) THE COMMISSION MAY ACCEPT FUNDING OR GRANTS TO AID IN THE WORK OF THE COMMISSION.~~

19-108.4.

~~(K)~~ **(A)** **ON OR BEFORE DECEMBER 1 EACH YEAR, BEGINNING IN 2023, THE COMMISSION SHALL PROVIDE A REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2-1257 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY THAT INCLUDES:**

(1) AN ANALYSIS OF PRIMARY CARE SPENDING OVER THE IMMEDIATELY PRECEDING YEAR, INCLUDING DATA STRATIFIED BY ZIP CODE AND COUNTY, IN RELATION TO TOTAL HEALTH CARE SPENDING OVER THE PREVIOUS YEAR; AND

(2) ANY FINDINGS AND RECOMMENDATIONS OF THE COMMISSION.

(B) (1) THE COMMISSION SHALL FORM A WORKGROUP TO DEVELOP THE REPORT REQUIRED UNDER SUBSECTION (A) OF THIS SECTION, INCLUDING BY INTERPRETING THE RESULTS OF THE REQUIRED ANALYSIS AND MAKING THE RECOMMENDATIONS.

(2) THE WORKGROUP REQUIRED UNDER THIS SUBSECTION SHALL INCLUDE REPRESENTATIVES FROM THE MARYLAND PRIMARY CARE PROGRAM, THE HEALTH SERVICES REVIEW COMMISSION, THE MARYLAND INSURANCE ADMINISTRATION, THE PRIMARY CARE COMMUNITY, AND HEALTH SERVICES RESEARCHERS WITH EXPERTISE IN PRIMARY CARE.

~~SECTION 2. AND BE IT FURTHER ENACTED, That the terms of the initial members of the Primary Care Reform Commission shall expire as follows:~~

~~(1) four members in 2024;~~

~~(2) four members in 2025; and~~

~~(3) five members in 2026.~~

SECTION ~~3.~~ 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2022.

SB0734-183127-01.pdf
Uploaded by: Clarence Lam
Position: FAV

SB0734/183127/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

22 FEB 22
13:30:34

BY: Senator Lam
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 734
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 2, strike "**Health and Health Insurance**" and substitute "**Maryland Health Care Commission**"; in the same line, strike "**Reform Commission**" and substitute "**Spending Report and Workgroup**"; in line 3, strike "establishing the Primary Care Reform" and substitute "requiring the Maryland Health Care"; strike beginning with "review," in line 3 down through "recommendations" in line 4 and substitute "provide an annual report to the Governor and the General Assembly"; strike beginning with "by" in line 5 down through "services" in line 6; in line 6, after the semicolon insert "requiring the Commission to form a workgroup to develop the report;"; in lines 6 and 7, strike "Primary Care Reform" and substitute "Maryland Health Care"; in line 7, after "Commission" insert "and primary care spending"; and strike beginning with "20–2201" in line 10 down through "Commission"" in line 11 and substitute "19–108.4".

AMENDMENT NO. 2

On pages 1 through 6, strike in their entirety the lines beginning with line 17 on page 1 through line 8 on page 6, inclusive.

On page 6, after line 8, insert:

"**19–108.4.**";

in line 9, strike "**(K)**" and substitute "**(A)**"; after line 17, insert:

"**(B) (1) THE COMMISSION SHALL FORM A WORKGROUP TO DEVELOP THE REPORT REQUIRED UNDER SUBSECTION (A) OF THIS SECTION, INCLUDING**

(Over)

BY INTERPRETING THE RESULTS OF THE REQUIRED ANALYSIS AND MAKING THE RECOMMENDATIONS.

(2) THE WORKGROUP REQUIRED UNDER THIS SUBSECTION SHALL INCLUDE REPRESENTATIVES FROM THE MARYLAND PRIMARY CARE PROGRAM, THE HEALTH SERVICES REVIEW COMMISSION, THE MARYLAND INSURANCE ADMINISTRATION, THE PRIMARY CARE COMMUNITY, AND HEALTH SERVICES RESEARCHERS WITH EXPERTISE IN PRIMARY CARE.";

strike in their entirety lines 18 through 22, inclusive; and in line 23, strike "3." and substitute "2.".

SB734_LAM_FAV.pdf
Uploaded by: Clarence Lam
Position: FAV

Clarence K. Lam, M.D., M.P.H.
Legislative District 12
Baltimore and Howard Counties

Education, Health, and Environmental Affairs Committee
Chair, Environment Subcommittee

Executive Nominations Committee

Joint Committee on Ending Homelessness

Senate Chair
Joint Audit and Evaluation Committee
Joint Committee on Fair Practices and State Personnel Oversight

Vice Chair
Baltimore County Senate Delegation
Chair
Howard County Senate Delegation
Chair
Asian-American & Pacific-Islander Caucus

THE SENATE OF MARYLAND
Annapolis, Maryland 21401

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11 Bladen Street, Room 420
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410-841-3653 · 301-858-3653
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Support SB 734:
Health and Health Insurance – Primary Care Reform Commission

Background Information:

- Primary care is defined as outpatient family practice, general pediatrics, primary care internal medicine, and primary care obstetrics and gynecology.
- Primary care physicians provide patients with continuity of care that focuses on disease prevention, early detection, management of illnesses, and patient health education.
- Primary care is the foundation of the healthcare delivery system. Often the "first contact" for patients, primary care physicians serve as conduits for more specialized medical services when appropriate.
- Patients that see a primary care physician frequently are in a more advantaged position to identify and address health issues earlier.
- Geographical areas with a greater primary care physician supply are associated with lower cardiac, cancer, and respiratory death.[1]

The Issue:

- On average, the United States spends 5%-7% on primary care as a percentage of total health care spending.
- Compared to these national averages, Maryland primary care expenditures constituted only about 4.6% of all medical and outpatient prescription drug spending in 2018.[2]
- As Maryland's population continues to grow, age, and become increasingly insured, the current primary care physician shortage will continue to accrue over time.

[1] JAMA Internal Med (2019)
[2] Maryland Health Care Commission (2020)

- It is estimated that the state needs to increase the number of primary care physicians by 23% by 2030 to meet the needs of our evolving population.[3]
- Primary care is both undervalued and underfunded, despite the evidence that it both improves health outcomes and reduces costs.[4]

What SB 734 does with Sponsor Amendment 183127/1:

- SB 734 is being introduced with a sponsor amendment that is the result of collaboration between the Maryland Health Care Commission, the Department of Health, and MedChi to introduce the most effective bill without sacrificing the intent of the original language.
- SB 734 as amended will establish a workgroup within the Maryland Health Care Commission comprised of representatives from the Office of the Maryland Primary Care Program (MDPCP), the Health Services Cost Review Commission, the Maryland Insurance Administration, representatives of the primary care community, and health services researchers with expertise in primary care.
- The workgroup will analyze spending on primary care services in the state and provide a report to the Governor and the General Assembly with findings and recommendations on an annual basis.
- The workgroup will be additionally tasked with analyzing considerations of health equity, disparities in health outcomes, and barriers to primary care access.

What SB 734 Accomplishes:

- SB 734 establishes a workgroup within the Maryland Healthcare Commission that will provide to the General Assembly and the Governor recommendations to enhance patient outcomes, mitigate health disparities, and reduce barriers to primary care.
- SB 734 ensures that the General Assembly will be better appraised of primary care spending in the state to inform policy decisions in subsequent years.
- SB 734 aligns Maryland with numerous other states that have established similar workgroups, task forces, and commissions to analyze primary care services and make subsequent recommendations.[5]
- SB 734 affirms the legislature's commitment to facilitating the best quality of life for Marylanders.

[3] Robert Graham Center
[4] Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care
[5] State Legislation: PCMH and Advanced Primary Care

SB0734 primary care reform commission.pdf
Uploaded by: Dan Martin
Position: FAV

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

Heaver Plaza
1301 York Road, #505
Lutherville, MD 21093
phone 443.901.1550
fax 443.901.0038
www.mhamd.org

Senate Bill 734 Health and Health Insurance – Primary Care Reform Commission
Finance Committee
February 23, 2022
Position: SUPPORT

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). We appreciate the opportunity to provide this testimony in support of Senate Bill 734.

SB 734 establishes the Primary Care Reform Commission to review, examine, and make determinations regarding primary care spending across Maryland. The Commission must also make recommendations for ways to improve the quality of and access to primary care services, with special attention to increasing health equity, reducing health disparities, and avoiding increased costs to patients and the health care system.

Studies have shown a marked decrease in primary care spending. Estimates are that only five percent of total healthcare spending goes to primary care, down from 6.5 percent fifteen years ago. This has resulted in a corresponding decline in access to care felt across Maryland. All of Western Maryland, nearly all of the Eastern Shore, and a sizeable portion of Southern Maryland have been designated as Primary Care Shortage areas.

This is a particular concern given efforts to improve the quality of behavioral health treatment delivered in primary care settings. Most individuals experiencing mild to moderate symptoms of anxiety or depression will never seek care from a behavioral health specialist. More often than not, they will turn to their primary care provider for treatment. For this reason, MHAMD and our partners have been working for several years to increase uptake in Maryland of the Collaborative Care Model (CoCM), which is a validated, evidence-based approach for integrating physical and behavioral health care in primary care settings.

We’ve made much progress, but we still have ways to go. We need to ensure our primary care providers are funded appropriately to deliver CoCM and other treatment modalities that can improve the quality of health care for Maryland residents. **For this reason, MHAMD supports SB 734 and urges a favorable report.**

For more information, please contact Dan Martin at (410) 978-8865

MRHA SB734- Primary Care Commission- Support.docx.

Uploaded by: Kathleen Hays

Position: FAV

Statement of Maryland Rural Health Association

To the Health and Government Operations Committee

February 23, 2022

Senate Bill 734- Primary Care Commission

Position: SUPPORT

Chair Kelly, Vice Chair Feldman and members of the Finance Committee, the Maryland Rural Health Association (MRHA) wishes to provide supportive testimony for SB 734-Primary Care Commission. This bill would establish a commission to ultimately improve access to quality, affordable primary care throughout the state of Maryland. The number of primary care providers are declining in our state.[1] This is especially true in rural communities. Rural Maryland represents almost 80 percent of Maryland's land area and 25% of its population.

This bill responds to a recommendation of the 2018 Maryland Rural Health Plan which states:

> One of the largest barriers to rural health is the recruitment and retention of providers. Virtually all data sources emphasized the difficulty of both finding qualified providers to work in rural areas and then retaining them once hired. This problem exists across disciplines, affecting primary care providers, specialists, behavioral health physicians, and oral health providers. To correct the problem, policy makers, administrators, rural health professionals, and others need to study barriers to recruitment and retention and identify best practices. After completion, an action plan to make changes should be developed and enacted to improve Maryland's rural health.[2]

MRHA's mission is to educate and advocate for the optimal health and wellness of rural communities and their residents. Membership is comprised of health departments, hospitals, community health centers, health professionals, and community members in rural Maryland.

Supporting initiatives that respond to rural health care workforce needs is our top advocacy priority for this year. MRHA urges the committee's favorable review.

Board President, Jenifer Berkman, 443-783-0480

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[1] Maryland Department of Health. https://health.maryland.gov/pophealth/Documents/Rural%20Health/MDRH-Plan-2018.pdf

[2] Maryland Department of Health, Maryland Rural Health Association, Rural Maryland Council and Robert Wood Johnson Foundation (2018) Recommendations – Maryland Rural Health Plan (mdruralhealthplan.org)

P.O. Box 475 • Centreville, Maryland 21617

SB 734 - Primary Care Reform Commission - Letter o

Uploaded by: Steven Chen

Position: FAV

Maryland
Hospital Association

February 23, 2022

To: The Honorable Delores G. Kelley, Chair, Senate Finance Committee

Re: Letter of Support- Senate Bill 734 – Health and Health Insurance – Primary Care Reform Commission

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 734.

SB 734 would establish the Primary Care Reform Commission (Commission) to review, examine, and make determinations regarding primary care spending in Maryland. The Commission would recommend ways to improve the quality of and access to primary care services, with special attention to increasing health care equity, reducing health care disparities, and avoiding higher costs to patients and the health care system. To inform the Commission recommendations, all payers, including Medicaid Managed Care Organizations, will be required to provide the Commission with information regarding the amount each payer spent on primary care services and the total amount each payer spent on health care services for enrollees.

Maryland hospitals support efforts to expand access, improve quality, and reduce unnecessary health spending. We are also focused on promoting equity and addressing social determinants of health. As part of our commitment to racial equity, we work with members of our Diversity, Equity & Inclusion Advisory Group and Health Equity Task Force to identify partners and opportunities. Maryland hospitals are committed to embracing responsive strategies to address disparities in health outcomes and ensure all Marylanders can be as healthy as possible.

Access to primary care is vital for patients. People without a source of primary care are more likely to be hospitalized, visit emergency departments, delay needed care or preventive services, have higher health care costs, and experience poorer health outcomes. Conversely, access to primary care has been shown to lower health care costs, improve outcomes, and reduce health inequity.

For these reasons, we urge a ***favorable*** report on Senate Bill 734.

For more information, please contact:
Steven Chen, Director, Policy
Schen@mhaonline.org

SB 734 - Letter of Support wAmendments (Amendments

Uploaded by: Ben Steffen

Position: FWA

MARYLAND
Health Care
Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

MHCC Amendments SB 734

AMENDMENT NO. 1

On pages 1 through 6, strike in their entirety the lines beginning with line 16 through line 8 on page 6, inclusive.

AMENDMENT NO. 2

On page 6, in lines 10 and 17, in each instance, strike "**COMMISSION**" and substitute "**MARYLAND HEALTH CARE COMMISSION**".

AMENDMENT NO. 3

On page 6, strike in their entirety, lines 18 through 22, inclusive, and substitute "**SECTION 2. AND BE IT FURTHER ENACTED THAT THE MARYLAND HEALTH CARE COMMISSION SHALL FORM A WORKGROUP TO DEVELOP THE STUDY, INTERPRET THE RESULTS,AND MAKE RECOMMENDATIONS. THE WORKGROUP SHALL INCLUDE REPRESENTATIVES FROM THE DEPARTMENT INCLUDING THE PROGRAM OFFICE OF THE MDPCP, THE HEALTH SERVICES COST REVIEW COMMISSION, THE MARYLAND INSURANCE ADMINISTRATION, REPRESENTATIVES OF THE PRIMARY CARE COMMUNITY, AND HEALTH SERVICES RESEARCHERS WITH EXPERTISE IN PRIMARY CARE.**"

mhcc.maryland.gov

Toll Free: 1-877-245-1762
TTY Number: 1-800-735-2258
Fax: 410-358-1236

4160 Patterson Avenue,
Baltimore, MD 21215

SB 734 Letter of SWA - MHCC (2-23-2022)Final.pdf

Uploaded by: Ben Steffen

Position: FWA

MARYLAND
Health Care
Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

February 23, 2022

The Honorable Delores Kelley
Chair, Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: SB 734 - Health and Health Insurance – Primary Care Reform Commission

Dear Chair Kelley:

The Maryland Health Care Commission (the "MHCC") is submitting this letter of support with amendments on *SB 734 – Health and Health Insurance – Primary Care Reform Commission ("SB 734").* The MHCC endorses the aims of SB 734 but believes formation of a new single-purpose Commission to study primary care issues is not needed.

SB 734 establishes a Primary Care Reform Commission composed of 13 members; three appointed by the Governor, four appointed by the President of the Senate, three appointed by the Speaker of the House, and one member each appointed by the Maryland Hospital Association, MedChi, and the Maryland Nurses Association. The primary responsibility of the Commission is to review and make recommendations on the level of primary care spending relative to overall health care spending for all payors. The Commission is also to make recommendations on expanding access to primary care, lowering overall costs, and increasing health equity and in parallel reducing health disparities. The Commission would apparently develop a uniform definition for primary care, a question on which the clinical care and health services research communities have produced multiple definitions.

The MHCC believes that examining primary care spending as a percent of total health care spending can be a valuable tool for assessing access to primary care and for measuring the overall effectiveness of a health care system. Primary care experts beginning with Dr. Barbara Starfield documented that increased investment in primary care could have a beneficial effect on the quality of care, access to care, and mortality. Starfield and colleagues went on to document that the effectiveness of health care systems in the United States and across developed countries could be measured by the percent of health care dollars

mhcc.maryland.gov

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Setting spending floors for primary care is one such approach. Rhode Island, Oregon, and Connecticut have taken a direct approach to rectifying under investment in primary care.[9] These states have established minimum thresholds for primary care spending expressed as a percent of total health care spending.

MHCC supports studying access to primary care and developing recommendations to improve access. MHCC believes that a better approach to examining these questions is to direct the MHCC in consultation with the Health Service Cost Review Commission, with the Maryland Department of Health (MDH) and the Maryland Insurance Administration (MIA) to develop a workgroup to study these issues and develop recommendations by the end of 2023. The MHCC has experience with primary care models as MHCC launched the first PCMH program in 2012 after the General Assembly passed legislation establishing a Patient Centered Medical Home (PCMH) pilot. Most notably that program is the primary care program that required the five largest commercial carriers and the Medicaid MCOs to participate.

More recently, the MHCC has been engaged with the MDPCP program since its inception and currently manages the MDPCP Advisory Council, a blue-ribbon workgroup composed of 20 members including some of the leading primary care experts in the country, local experts, payor representatives, and primary providers participating in the MDPCP. Other key participants on the Council include the MDPCP Program Management Office (PMO) and HSCRC. HSCRC's participation is essential because it has developed care transformation programs that complement the MDPCP. HSCRC's participation has ensured that transformation made in the delivery of primary care services align with current and future Total Cost of Care contracts between Maryland and CMS.

MHCC and HSCRC possess analytic and actuarial staff necessary to conduct the assessment of primary care spending relative to total health care spending. MHCC has responsibility for building the Medical Care Data Base (MCBD), which is Maryland's version of an All-Payer Claim Database. The MCDB is used by the HSCRC, MIA, Medicaid

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Administration, and the Maryland Health Benefit Exchange. MHCC released a study of primary care spending as a percent of total spending that mirrors the types of analyses needed to determine possible spending floors for primary care.[10] More recently, MHCC's MCDB contractor worked with six states in New England to develop a comparative report on primary care spending for those states.[11] Other researchers have sought to assess the level of primary care spending using different data sources [12] [13] The MHCC contends that establishing a new commission and directing it to assemble claim data from commercial payors and MCOs is unnecessary and likely duplicative.

MHCC supports the objectives of SB 734. A more cost-effective approach is to ask the agencies already engaged in this work to form a workgroup, study the issue, and report recommendations back to the Committees in December 2023. A letter from the Chairs of Senate Finance and the House Health and Government Operations Committee to MHCC, HSCRC, the Department, and the MIA would be sufficient to engage the respective organizations if the Committee believes legislation is not necessary. Please see the attached amendments.

We hope this information is helpful. If you would like to discuss this further or have any questions, please contact Tracey DeShields, Director, Policy Development and External Affairs at tracey.deshields2@maryland.gov.

Sincerely,

Andrew Pollack
Chair, MHCC

Ben Steffen
Executive Director, MHCC

cc:

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[13] Reiff J, Brennan N, Biniek J, Primary Care Spending in the Commercially Insured Population, JAMA December 10, 2019,vol 322,No. 22. https://jamanetwork.com/journals/jama/fullarticle/2757218

The Honorable Clarence Lam, Senator
Howard Haft, M.D., Senior Medical Advisor, MDH
Heather Shek, Director, Office of Governmental Affairs, MDH
Tracey DeShields, Director, Policy Development and External Affairs, MHCC

12 - SB 734 - FIN - MHCC - LOSWA.pdf
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MARYLAND
Health Care
Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

February 23, 2022

The Honorable Delores Kelley
Chair, Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: SB 734 - Health and Health Insurance – Primary Care Reform Commission

Dear Chair Kelley:

The Maryland Health Care Commission (MHCC) is submitting this letter of support with amendments on *SB 734 – Health and Health Insurance – Primary Care Reform Commission (SB 734).* The MHCC endorses the aims of SB 734 but believes formation of a new single-purpose Commission to study primary care issues is not needed.

SB 734 establishes a Primary Care Reform Commission composed of 13 members; three (3) appointed by the Governor, four (4) appointed by the President of the Senate, three (3) appointed by the Speaker of the House, and one (1) member each appointed by the Maryland Hospital Association, MedChi, and the Maryland Nurses Association. The primary responsibility of the Commission is to review and make recommendations on the level of primary care spending relative to overall health care spending for all payors. The Commission must also make recommendations on expanding access to primary care, lowering overall costs, and increasing health equity while reducing health disparities. The Commission would develop a uniform definition for primary care, a question on which the clinical care and health services research communities have produced multiple definitions.

The MHCC believes that examining primary care spending as a percent of total health care spending can be a valuable tool for assessing access to primary care and for measuring the overall effectiveness of a health care system. Primary care experts, beginning with Dr. Barbara Starfield, documented that increased investment in primary care could have a beneficial effect on the quality of care, access to care, and mortality. Starfield and colleagues went on to document that the effectiveness of health care systems in the United States and across developed countries could be measured by the percent of health care dollars

dedicated to primary care.[1] [2] [3] Starfield articulated the four pillars of primary care practice: contact care, continuity of care, comprehensive care, and coordination of care. These pillars have been the foundation for all elaborations of the key primary care attributes that provide the basis for launching multiple primary care interventions. Drs. Thomas Bodenheim, Kevin Grumbach and colleagues posited 10 building blocks of high-performing including four foundational elements — engaged leadership, data-driven improvement, empanelment, and team-based care that assist the implementation of the other six building blocks — patient-team partnership, population management, continuity of care, prompt access to care, comprehensiveness and care coordination, and a template of the future.[4] Greater primary care physician supply was associated with lower mortality, but primary care providers per capital have decreased from 2002 to 2016 and prospects for greater supply in the future without major interventions appear dim.[5] Other experts have voiced alarm as the percent of total health care spending attributed to primary care continues to decline. [6]

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Heather Shek, Director, Office of Governmental Affairs, MDH
Tracey DeShields, Director, Policy Development and External Affairs, MHCC

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MARYLAND
Health Care
Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

MHCC Amendments SB 734

AMENDMENT NO. 1

On pages 1 through 6, strike in their entirety the lines beginning with line 16 through line 8 on page 6, inclusive.

AMENDMENT NO. 2

On page 6, in lines 10 and 17, in each instance, strike "**COMMISSION**" and substitute "**MARYLAND HEALTH CARE COMMISSION**".

AMENDMENT NO. 3

On page 6, strike in their entirety, lines 18 through 22, inclusive, and substitute "**SECTION 2. AND BE IT FURTHER ENACTED THAT THE MARYLAND HEALTH CARE COMMISSION SHALL FORM A WORKGROUP TO DEVELOP THE STUDY, INTERPRET THE RESULTS,AND MAKE RECOMMENDATIONS. THE WORKGROUP SHALL INCLUDE REPRESENTATIVES FROM THE DEPARTMENT INCLUDING THE PROGRAM OFFICE OF THE MDPCP, THE HEALTH SERVICES COST REVIEW COMMISSION, THE MARYLAND INSURANCE ADMINISTRATION, REPRESENTATIVES OF THE PRIMARY CARE COMMUNITY, AND HEALTH SERVICES RESEARCHERS WITH EXPERTISE IN PRIMARY CARE.**"

mhcc.maryland.gov

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TTY Number: 1-800-735-2258
Fax: 410-358-1236

4160 Patterson Avenue,
Baltimore, MD 21215

ISSUE BRIEF

PRIMARY CARE SPENDING RELATIVE TO TOTAL MEDICAL AND OUTPATIENT PRESCRIPTION DRUG SPENDING IN MARYLAND'S PRIVATELY INSURED MARKETS, 2018

Maryland Health Care Commission

CENTER FOR ANALYSIS AND INFORMATION SYSTEMS

August 2020

ISSUE BRIEF

Primary Care Spending Relative to Total Medical and Outpatient Prescription Drug Spending in Maryland's Privately Insured Markets, 2018

Takeaways

- The primary care spending percentage in Maryland was less than half the average spending on primary care in over 20 industrialized nations (14%).
  - Major contributors to this finding include increased health care costs, reduced primary care service utilization, and a reduction in primary care workforce.

- In Maryland, primary care alone constituted about 4.6% of all medical and outpatient prescription drug spending in 2018, which was comparable to national benchmark percentages of 6.0 (4.6 - 7.6) for PPO plans and 6.5 (3.1 - 9.2) for HMO plans.

- MHCC commenced tracking of primary care spending in the "*Spending and Use among Maryland's Privately Insured,* 2018" (PI Report). Key findings from the report are as follows:
  - Privately insured enrollees ages 0-18 years are more likely to receive primary care services (12%) compared to other age groups (less than 6%).
  - In 2018, PPO and EPO plans spent 4.2% and 4.6%, respectively on primary care while HMO plans spent 5%. These data were comparable to national benchmark percentages reported by the Milbank Memorial Fund.

- Recommendations for increased spending on primary care include:
  - Increased reporting and tracking of primary care spending
  - Enactment of legislation that will promote utilization of primary care services
  - Mandating fully insured health plans to set higher measurable targets for primary care spending

The Issue

The United States spends about **50%** less on primary care services out of total medical spend compared to other industrialized nations, and this is one of the reasons why the cost-effectiveness of US health systems continues to lag.[1, 2] Recent studies have shown that relatively high investment in primary care spending is associated with more top-quality care and a reduction in the overall cost of care.[3] A dozen states track primary care spending in the private market and in Medicaid. Among this group, several states have set floors on primary care spending on private health insurance contracts issued in their states.[4] Key factors relating to the availability and utilization of primary care services are described below.

- **Increased Cost**: The rising cost of care has impacted access to primary care health services. In 2007, only 15% of the US population were enrolled in high deductible health plans (HDHP) compared to **43%** in 2017.[5] The number of visits to primary care physicians are lowest for members enrolled in high deductible plans compared to enrollees with low or no deductible health plans.[5]

- **Reduced Utilization:** The number of individuals with a primary care provider **dropped** by two percent between 2002 and 2015.[6] For adults who consult with primary care providers, the proportion of individuals that received all high-priority recommended preventive services remains low. Studies based on the 2015 Medical Expenditure Panel Survey (MEPS) reported that only **eight percent** of US adults ages 35 and older received all high-priority recommended preventive services.[7] Visits for primary care services among the privately insured declined from 170 to 134 per 100 member-years between 2008 and 2016.[6] During the same study period, the proportion of adults who did not visit a primary care provider increased by 8%. Conversely, visits to urgent care facilities increased by 47% while specialists' visits remained stable.[8]

- **Reduction in Primary Care Workforce**: Even though the demand for primary care is projected to grow with time, the number of primary care physicians dropped from 47 per 100,000 in 2005 to 41 per 100,000 in 2015.[3] Studies show that the number of primary care physician jobs grew by **eight percent** from 2005 to 2015; however, the number of jobs for specialist physicians grew about six times that of primary care physicians. Career dissatisfaction or burnout has also been

[1] Koller, C.F., Khullar, D. (2017) Primary Care Spending Rate — A Lever for Encouraging Investment in Primary Care, NEJM, 377:1709-1711. Retrieved 05/28/2020 from: https://www.nejm.org/doi/10.1056/NEJMp1709538
[2] OECD, (2019). Deriving Preliminary Estimates of Primary Care Spending under the SHA 2011 Framework. P.10. Retrieved 06/03/2020 from: https://www.oecd.org/health/health-systems/Preliminary-Estimates-of-Primary-Care-Spending-under-SHA-2011-Framework.pdf
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[5] Editorial (2019). Prioritizing Primary Care in the USA. Vol 394, (10195), p.273. Retrieved 06/04/2020 from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31678-2/fulltext
[6] Levine,D.M., Linder, J.A., Landon, B.E. (2019). Characteristics of Americans With Primary Care and Changes Over Time, 2002-2015. JAMA Intern Med. 2020;180(3):463-466. doi:10.1001/jamainternmed.2019.6282
[7] Borsky, A., Zhan, C., Miller, T. (2018). Few Americans Receive All High-Priority, Appropriate Clinical Preventive Services. Health Affairs, Vol 37 (6). Retrieved 05/28/2020 from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1248
[8] Ganguli, I., Shi, Z., Orav, J., Rao, A., Ray, K.N. (2020). Declining Use of Primary Care Among Commercially Insured Adults in the United States, 2008–2016. Annals of Internal Medicine from: https://www.acpjournals.org/doi/10.7326/M19-1834

reported in recent studies which showed that **approximately 25% of internists and 46% of pediatricians** stated that they would opt for an alternative specialty if they could choose again.[9]

Policy Implications: Most states recognize the importance of enhancing primary care service delivery and have instituted different strategies to promote primary care. Many states have established multi-payer patient-centered medical home programs. Some states and payers have sought to elevate primary care by creating programs that incentivize primary care and specialists to work together; the best known of these models is the Centers for Medicare and Medicaid Services' Accountable Care Organizations (ACOs). In Maryland, the Total Cost of Care Model aims to engage hospitals and health care practitioners in a broad program to improve quality and slow the growth of total costs. Regardless of a program's scope – narrowly focused on primary care or encompassing the entire health care economy - increasing use of primary care is seen as a driver to slow the growth of total health care spending. Many advocates contend that a more significant investment in primary care will pay for itself over time by reducing the use of expensive specialty and inpatient hospital care, thereby lowering overall health spending.[10]

A pivotal strategy for promoting primary care delivery is measuring and reporting primary care costs and services. Reporting primary care spending encourages clear financial accountability for insurers, the public, or members of an integrated health care delivery system. It also creates a learning opportunity for all stakeholders and provides an evidence base for making critical policy decisions. Until recently, little or no information is available on tracking primary care spending in the privately insured market in Maryland.

MHCC's Initiative

A priority of the Maryland Health Care Commission (MHCC) is to support advanced primary care and practice transformation to improve coordinated care delivery and health outcomes. For the first time, MHCC commenced the tracking of primary care costs in its annual report titled "*Spending and Use among Maryland's Privately Insured, 2018."*[11] In this report, primary care spending is defined as the cost (including provider reimbursement and insured member out of pocket amounts) of preventive services, including wellness programs, and the treatment of common illnesses rendered by physicians in an office or an outpatient facility setting. As noted in the report, spending was reported on a per capita basis for 2018. This report also showed primary care spending as a percentage of total per capita expenditure (all medical outpatient facility services and professional services, and prescription drugs). Results from the report found that the proportion of spending on primary care in Maryland was comparable to other states in the nation. Further details of the report and Milbank Memorial Fund definitions of primary care are included in the appendix.

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[9] Primary Care Collaborative. Spending for Primary Care. Retrieved 06/04/2020 from: https://www.pcpcc.org/resource/spending-primary-care-fact-sheet

[10] Phillips, R.L., Bazemore, A.W. (2010). Primary Care And Why It Matters For U.S. Health System Reform. Health Affairs vol. 29, no. 5. Retrieved 07/01/2020 from: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0020

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Findings:

Primary care spending constituted about 4.6% of all medical and outpatient prescription drug spending in 2018. This was comparable to national benchmark percentages reported by the Milbank Memorial Fund.

- Annual primary care spending for all products combined increased substantially from 2017 to 2018, by about 6%, compared to a 2.5% increase from 2016 to 2017. (Exhibit 3).
- There was a steady decline in spending on primary care in the individual market from 3.8% in 2016 to 3.4% in 2018 (Exhibit 1). This may be attributed to the exit of relatively healthier enrollees who are more likely to use mostly primary care services.
- The percent annual spending on primary care was highest (12.4%) for ages 0-18 years compared to any other age group (Exhibit 2). Compared to adults, the higher primary care spending percent observed among this age group could be attributed to more primary care services required for brief recurrent illnesses and preventive care. Adults seek care mostly when there are significant morbidity or risk factors of concern.
- There were no remarkable differences in primary care spending by gender.
- The average annual expenditure for primary care services increased modestly from the 19 to 64-year age group throughout the study period. However, the percentage of primary care spending compared to overall spending declined with age, from 12.4% to 3.0% (Exhibit 2).
- When total spending was broken down by product, in 2018 PPO and EPO plans spent 4.2% and 4.6% respectively on primary care while HMO plans spent 5% on primary care (Exhibit 3). These data are comparable to national benchmark percentages reported by the Milbank Memorial Fund.

Exhibit 1: Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending by Market: 2016 – 2018

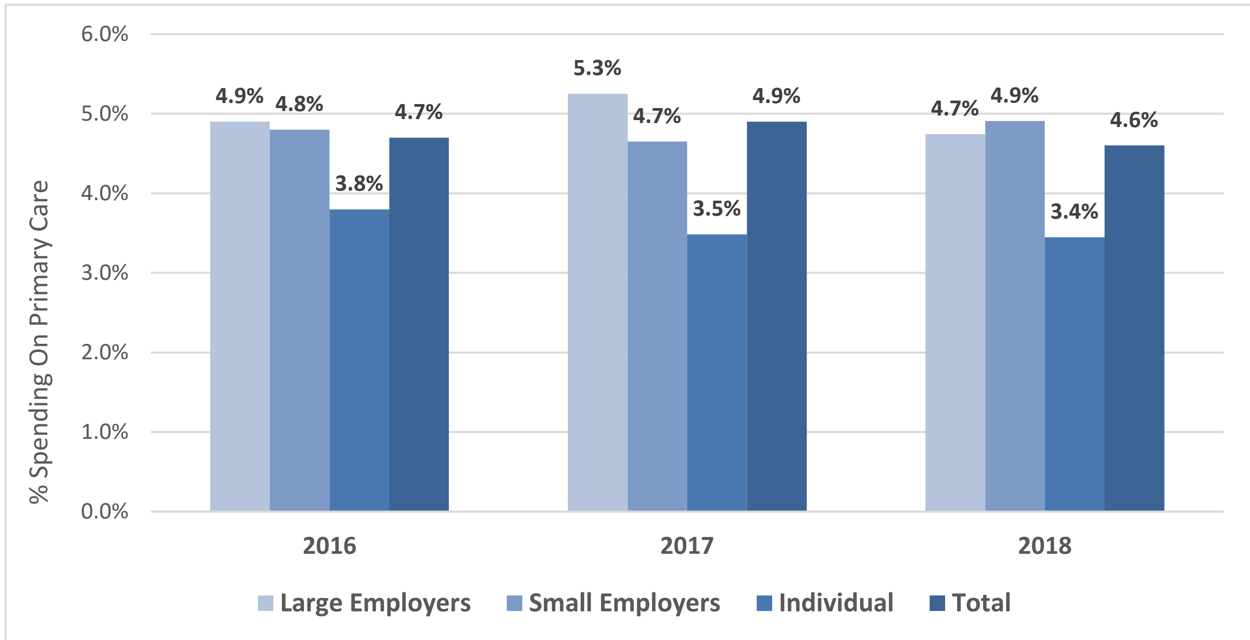

Exhibit 2: Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending by Age Group, 2018

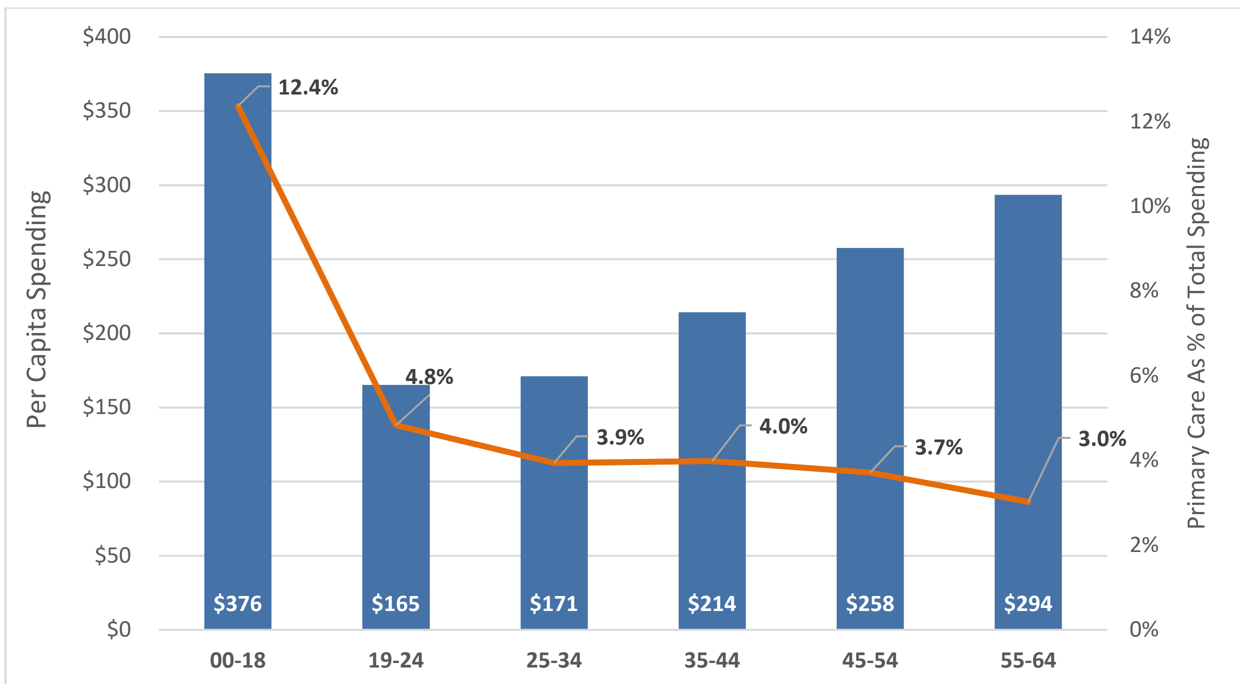

Exhibit 3: : Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending by Product: 2016 – 2018

Product	2016	2017	2018
Annual Primary Care Spending Per Member			
PPO	$258	$262	$276
EPO	$208	$230	$199
HMO	$233	$238	$261
POS	$258	$244	$257
All Products	**$240**	**$246**	**$261**
Annual Primary Care Spending as a % of Total Spending			
PPO	4.5%	5.0%	4.2%
EPO	4.4%	5.2%	4.6%
HMO	5.1%	5.0%	5.0%
POS	4.4%	4.4%	4.9%
All Products	**4.7%**	**4.9%**	**4.6%**

Experiences from other States that Track Primary Care Spending:

- **Connecticut**: The average percentage of the expenditure on primary care in Connecticut from 2014 to 2018 was 5%. This result was also comparable to the Maryland rate of primary care investment. In January 2020, Connecticut's governor issued an executive order which directs the Office of Health Strategy to establish statewide healthcare cost growth and quality benchmarks and a primary care spending target of 10% by calendar year 2025.[12]
- **Delaware:** In 2018, Delaware passed legislation that requires insurers to participate in the state's Primary Care Reform Collaborative. In 2019, this Collaborative issued a recommendation for a target of 12% investment in primary care.[4]
- **Oregon:** In 2017, Oregon passed legislation that sets a minimum primary care threshold for all commercial and public payers of at least 12% of total medical expenditures by 2023.
- **Rhode Island**: In Rhode Island, the state measured and increased its primary care spending from 5.7% in 2008 to 9.1% in 2012.[13]. In June 2020, Rhode Island updated its health care affordability standards. Under the new regulations, insurance carriers are required to spend at least 10.7% of total health expenditures on primary care.[14]
- **Maine**: The percentage of spending on primary care in Maine was 5.8 - 6.8% in 2018. While a floor on primary care spending has not been set, in June 2019, Maine passed legislation titled "An Act to Establish Transparency in Primary Health Care Spending," requiring insurers to report primary care expenditures to the Maine Health Data Organization, and for the Maine Quality Forum to use these data to report annually to the Department of Health and Human Services and the Legislature.[15]

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[12] Milbank Memorial Fund, (2020). How Connecticut is Moving to Control Health Care Cost. Retrieved 05/28/2020 from: https://www.milbank.org/2020/03/how-connecticut-is-moving-to-control-health-care-costs/

[13] PCC Primary Care Investment. Retrieved 05/26/2020 from: https://www.pcpcc.org/primary-care-investment

[14] Rhode Islands Updated Affordability Standards Support Behavioral Health and Alternative Payment Models (2020). Milbank Memorial Fund. Retrieved 07102020 from: https://www.milbank.org/news/rhode-islands-updated-affordability-standards-to-support-behavioral-health-and-alternative-payment-models/

[15] Main Quality Forum. Measuring to Improve (2020). Retrieved 05/28/2020 from: https://www.pcpcc.org/sites/default/files/resources/MQF%20Primary%20Care%20Spending%20Report__Jan%202020.pdf

- **Washington**: The percentage of spending on primary care in Washington was 4.4% in 2018. This rate was comparable to Maryland. In 2019, Washington appropriated $110,000 for the fiscal year 2020 to determine annual primary care medical expenditures using the state's all-payer claims database and other existing data.[16]

Other states that have passed legislation to support or increase the proportion of spending allocated to primary care include Colorado, Vermont, West Virginia, Hawaii, and Massachusetts.[4]

Conclusions: Primary care spending as a percent of total spending in Maryland is comparable to other states that have tried to measure spending. All the state rates fell well behind the average expenditure on primary care (14%) in over 20 countries of the Organization for Economic Cooperation and Development (OECD).[17] In order to increase primary care services, policymakers must support the development of advanced primary care programs, report and track primary care spending, enact legislation to promote the utilization of primary care services, and set minimal levels of primary care spending for fully insured products. Increasing spending on primary care is possible. Rhode Island saw spending climb from 2008 to 2012 after the Insurance Commissioner ordered insurance carriers to elevate funding. Recent legislation sets even stronger targets: insurance carriers are required to spend 10.7% of premiums on primary care services. Providing incentives to specialize in primary care could also increase the attitude of medical students towards specializing in primary care[18].

Appendix

Primary Care Definitions and Measurement Methodology: Since the definitions and measurement of primary care providers and services are not yet standardized across institutions, MHCC deferred to methodologies used in a report published by the Milbank Memorial Fund in 2017.[19] The Milbank report classified four types of primary care definitions, "A through D", based on provider specialty only and provider specialty plus services rendered. MHCC evaluated the Milbank methodologies and selected the narrow PCP-B definition as that most closely aligned with how primary care in Maryland is conceptualized. Qualified providers were identified using industry-standard taxonomy codes. All data used in this report were retrieved from Maryland's Medical Care Database (MCDB), which contains health insurance enrollment, health care claims, and encounter data for Maryland residents.

Inclusion Criteria: Primary care providers include physicians in family medicine, general internal medicine, pediatrics, nurse practitioners, physician assistants, nurse non-practitioners, and homeopathic specialties. Services categorized as primary care include immunization, health risk assessment, office visits for new or established patients, telephone or home visits, smoking cessation, or health screening. Point

[16]Office of Financial Management, (2019). Primary Care Expenditures. Summary of Current Primary Care Expenditures and Investment in Washington. Retrieved 05/28/2020 from: https://www.ofm.wa.gov/sites/default/files/public/publications/PrimaryCareExpendituresReport.pdf
[17] Primary Care. Retrieved 05/27/2020 from: https://www.oecd.org/health/health-systems/primary-care.htm
[18] Beverly E.A., Reynolds S., Balbo, J.T. et. Al (2014). Changing first-year medical students' attitudes toward primary care. Family Medicine 46(9):707-12. Retrieved 1/24/2020 from: https://pubmed.ncbi.nlm.nih.gov/25275282/
19. Bailit, M.H., Friedberg, M.W., Houy, M.L. (2017). Standardizing the Measurement of Commercial Health Plan Primary Care Spending. (Retrieved 01/27/2020: https://www.milbank.org/publications/standardizing-measurement-commercial-health-plan-primary-care-spending/)

of service locations included rural health clinics, primary health clinics, federally qualified health centers, physician offices, and hospital outpatient departments.

Exclusion Criteria: Obstetrics and gynecology, geriatric, and psychiatry specialties were excluded. Claims incurred in emergency rooms and inpatient services were also excluded.

Qualified medical encounters for this analysis include all products (HMO and non-HMO) offered in the individual, small employer, and large employer markets.

Appendix Exhibit 1 - Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending: 2016 – 2018

	2016				2017				2018			
	Total	Large Employers	Small Employers	Individual	Total	Large Employers	Small Employers	Individual	Total	Large Employers	Small Employers	Individual
Annual Primary Care Spending Per Member												
Age												
00-18	$344	$351	$328	$317	$354	$361	$340	$314	$376	$382	$367	$329
19-24	$142	$144	$136	$136	$148	$152	$134	$137	$165	$167	$162	$152
25-34	$159	$162	$152	$157	$162	$165	$152	$157	$171	$176	$162	$159
35-44	$199	$205	$183	$188	$202	$211	$179	$186	$214	$224	$189	$190
45-54	$239	$248	$219	$217	$247	$259	$218	$219	$258	$272	$227	$216
55-64	$273	$286	$245	$245	$278	$293	$239	$247	$294	$313	$255	$250
Total	$240	$249	$221	$219	$246	$257	$221	$219	$261	$272	$237	$221
Annual Primary Care Spending as a % of Total Spending												
Age												
00-18	13.1%	13.5%	12.4%	11.3%	13.1%	13.8%	11.6%	10.3%	12.4%	12.6%	12.7%	9.9%
19-24	4.5%	4.6%	4.3%	4.3%	4.8%	5.1%	4.1%	4.0%	4.8%	5.0%	4.8%	4.0%
25-34	4.0%	4.2%	4.3%	3.0%	4.0%	4.3%	4.2%	2.7%	3.9%	4.1%	4.4%	2.8%
35-44	4.1%	4.3%	4.4%	3.2%	4.2%	4.5%	4.2%	2.9%	4.0%	4.1%	4.3%	3.0%
45-54	3.8%	3.8%	3.8%	3.4%	4.0%	4.2%	3.7%	3.2%	3.7%	3.8%	3.8%	3.2%
55-64	3.1%	3.2%	3.1%	3.0%	3.3%	3.5%	3.0%	2.8%	3.0%	3.0%	3.1%	2.9%
Total	4.7%	4.9%	4.8%	3.8%	4.9%	5.3%	4.7%	3.5%	4.6%	4.7%	4.9%	3.4%

Note: (1) Some calculations in the above exhibit might not be exact due to rounding.
(2) The large employer market includes the State of Maryland employees (self-insured non-ERISA) and other self-insured non-ERISA plans.
(3) Results exclude Kaiser health plans.

This issue brief was created by Center for Analysis and Information Systems staff (Kenneth Yeates-Trotman, Shankar Mesta, Oseizame Emasealu and Janet Ennis, Editor). Questions about the report should be directed to Oseizame Emasealu (Email: Oseizame.Emasealu@maryland.gov).

The Maryland Health Care Commission is an independent regulatory commission administratively located within the Maryland Department of Health.

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director
Maryland Health Care Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215
Telephone: 410-764-3570, Fax: 410-358-1236, Web: https://mhcc.maryland.gov/

SB 734_R.Jones 1199SEIU FAV with Amendment.pdf
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Position: FWA

Testimony of Ricarra Jones, Political Director of 1199SEIU on

SB 734 Health and Health Insurance – Primary Care Reform Commission Act

Position: FAVORABLE WITH AMENDMENT

February 23, 2022

Dear Chairwoman Delores G. Kelley and Members of the Finance Committee:

1199SEIU Healthcare Workers East is the largest healthcare union in the country with, with over 450,000 members throughout Massachusetts, New York, New Jersey, Maryland, Florida and Washington, D.C. **We fully support SB 734 with amendment.**

SB 734 The Health and Health Insurance – Primary Care Reform Commission Act ("PCRC Act") would positively impact Marylanders by establishing a commission which will review and issue recommendations on improving primary care spending by all payors, and issue recommendations on improving crucial areas of the health care system.

The PCRC Act would create a commission tasked with undertaking an in-depth review of primary care spending by all payors in the context of overall health care spending in the State. The commission will also issue recommendations on the following key areas:

- improving the quality of and access to primary care services, with special attention to increasing health care equity;
- reducing health care disparities;
- avoiding increased costs to patients and the health care system
- means of reducing barriers to primary care access and utilization;
- proposed changes to the definition of "primary care" for the future; and
- regarding recommendations to increase spending on primary care by the Maryland Medical Assistance Program and health insurers, nonprofit health service plans, and health maintenance organizations.

The commission created by the PCRC Act would be composed of industry experts and leaders in government, and should also include representation of health care workers. 1199SEIU has provided an Amendment with this testimony for the purpose of adding representatives of healthcare employee unions to the membership of the commission. 1199SEIU would gladly serve on this commission.

The PCRC Act establishes a means to obtain important insight and guidance on how to improve many significant aspects of health care in the State, to the great benefit of Marylanders.

For these reasons, we **SUPPORT SB 734** and ask for a **FAVORABLE WITH AMENDMENT** report.

Sincerely,

Ricarra Jones
Maryland/DC Political Director
1199SEIU United Healthcare Workers- East
Cell: 443-844-6513

Senate Bill 734

By: **Senator Lam**
Introduced and read first time: February 7, 2022
Assigned to: Finance

AMENDMENT TO SENATE BILL 734

On Page 3, after Line 14, add:

9. REPRESENTATIVES OF HEALTHCARE EMPLOYEE UNION.

MCHI TESTIMONY FOR SENATE BILL 734.pdf
Uploaded by: Suzanne Schlattman
Position: FWA

2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM

TESTIMONY FOR SENATE BILL 734

Primary Care Reform Commission

By Suzanne Schlattman, MSW, MPH, Deputy Director
of the Maryland Citizens' Health Initiative, Inc.

February 23, 2022

SUPPORT WITH AMMENDMENT

Chair Kelley and Members of the Senate Finance Committee, thank you for the opportunity to testify in support of Senate Bill 734. Thank you Senator Lam for introducing this important bill.

The Maryland Citizens' Health Initiative, Inc. was established in 1999 to advocate for policies which expand access to quality affordable health care for all Marylanders. Since that time our state has achieved historic coverage gains, reducing the rate of uninsured from 13 percent to 6.5 percent in 2018. This year, over 180,000 Marylanders have enrolled in coverage through the Maryland Health Connection! High rates of insurance coverage are associated with better health outcomes and a stronger health care system. These indicators are a testament to the vision and leadership on this committee which has taken decisive policy action to enact reinsurance and pilot subsidies for low-income young adults.

While coverage plays an important role, it is not synonymous with access. The members of our coalition—hundreds of faith, business, professional and community leaders across the state—have expressed concern about difficulties accessing primary care. Primary care plays a critical role in our state's efforts to prevent and better manage chronic diseases. Primary care providers are often the face of the health care system and being able to establish a long-term, trusting relationship with these providers is critical to achieve our ambitious Statewide Integrated Health Improvement Strategy.

SUGGESTED AMMENDENT: We are committed to supporting the work of this commission to the extent practicable and are pleased to see the inclusion of a consumer health advocate among the list of commission members. **We suggest the addition of a representative of health care workers on the commission to further strengthen representation of affected stakeholders**.

Thank you for your careful consideration of this issue. We urge a favorable review.

Suzanne Schlattman, suzanne@healthcareforall.com, (410)235-9000

MMCOA SB734 02 23 2022 OPPOSE.pdf

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Position: UNF

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Senate Bill 734 – Health and Health Insurance – Primary Care Reform Commission

OPPOSE

Senate Finance Committee

February 23, 2022

Thank you for the opportunity to submit testimony in opposition to Senate Bill 734 – Health and Health Insurance – Primary Care Reform Commission.

The Maryland Managed Care Organization Association's (MMCOA) nine member Medicaid Managed Care Organizations (MCOs) that serve over 1.5 million Marylanders through the Medicaid HealthChoice program are committed to identifying ways to improve quality and access to care for all Medicaid participants.

While we strongly support efforts to improve member access to- and utilization of- primary care services, SB 734 contains several problematic provisions and requirements.

The information that is required to be reported by the MCOs to the Commission created by the legislation is already reported to the Maryland Department of Health. Requirements surrounding the submission of information on primary care spending and utilization and other data pertaining to the care of our members is contained in our contracts executed annually with the State. Any information requested by the Commission should be compiled and submitted by our regulator – not by nine separate organizations- in order to avoid any variations in data collection or create any regulatory or antitrust concerns.

In addition, as part of the enhanced focus on primary care delivery throughout Maryland's health care system, the MCOs, in close partnership with the Department of Health, have worked to assist in the design of the HealthChoice alignment to the Maryland Primary Care Program, which is on-track to be fully implemented for the HealthChoice program by January 2023. The MCOs have worked with MDH and other stakeholders for the past year developing a program framework that best serves our members and the goals of the Program, and our work continues to ensure a timely and successful program start. For these reasons, this legislation is duplicative to efforts well underway by the State and the MCOs serving the HealthChoice program.

Furthermore, if passed in its current form, we believe that the omission of a MCO Representative to serve on the Commission will present challenges as the group begins its work. It is necessary to include a representative of the MCOs on the Commission to discuss the unique structure of the HealthChoice program, the delivery of care to our members, and to speak to the data which is required to be submitted to the Commission. If the bill were to advance, we respectfully request that a MCO Representative be added to the membership of the Commission.

For these reasons, we **respectfully oppose Senate Bill 734**.

The MCOs welcome the opportunity for continued engagement in policy discussions surrounding primary care initiatives and look forward to continued collaboration with the State as we work to identify ways to improve access to affordable high-quality care for all Medicaid participants.

Please contact Jennifer Briemann, Executive Director of MMCOA, with any questions regarding this testimony at jbriemann@marylandmco.org.