

THE MARYLAND HEALTH CARE COMMISSION

FY 2013 BUDGET

PRESENTATION TO THE LEGISLATURE

M00R0101

Ben Steffen,

Acting Executive Director

Department of Health and Mental Hygiene

**MARYLAND HEALTH CARE COMMISSION
BUDGET PRESENTATION**

I. OVERVIEW

The mission of the Maryland Health Care Commission is to plan for health systems needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability cost, and quality of services to policy makers, purchasers, providers, and the public.

Our vision is a state in which informed consumers hold the health care system accountable, and have access to affordable and appropriate health care services through programs that serve as national models.

II. DETAILS-MAJOR ACCOMPLISHMENTS

The Commission's activities throughout the fiscal year focused upon collaborative initiatives related to broadening Marylanders access to high quality and cost effective health care services. Particular attention was given to areas such as Access to Health Care, Quality and Patient Safety, Innovative Health Care Delivery, Health Information Technology, and Information for Policy Development.

ACCESS TO HEALTH CARE

The Health Insurance Partnership – A Premium Subsidy Program for Low Wage Small Employers

Maryland has made important strides in providing health care coverage to uninsured citizens. During the 2007 Special Session, Governor O'Malley proposed and the General Assembly passed legislation that will extend medical coverage to more than 100,000 uninsured Marylanders – including low income adults and children.

The Working Families and Small Business Health Coverage Act created the Health Insurance Partnership Program, which assists small businesses in purchasing health insurance for their employees. The Partnership is specifically targeted at reducing the number of uninsured individuals in Maryland by providing subsidies to small, low and moderate wage firms with fewer than ten employees that have not previously offered insurance to their employees. The Maryland Health Care Commission (MHCC) is pleased to be administering this program in conjunction with four of the largest private health plans, CareFirst, Coventry Health Care, United Healthcare and Aetna.

As of December, 2011, the Partnership has enrolled 373 businesses and has 1,055 participating employees and 1,772 covered lives. The average annual premium subsidy per covered individual is \$2,343. In spite of the efforts, take-up has been slow. The primary reason has been and remains the economic downturn. Businesses with fewer than 10 workers and a low average annual wage are unlikely to offer health insurance in the face of economic uncertainty.

The Comprehensive Standard Health Benefit Plan (Maryland's Small Group Market)

The enactment of SB 637/HB 674 required the Commission to post on the MHCC website and update quarterly, premium comparisons of health benefit plans issued in the small group market. The Commission contracted with BenefitFocus to design, develop and host this web portal, called VIRTUAL COMPARE which became operational on May 3, 2011. VIRTUAL COMPARE provides information about select health plans available to small employers in Maryland, allowing a side-by-side comparison of benefits, premiums, and out of pocket costs. VIRTUAL COMPARE also includes guidance about choosing health insurance; information about federal tax credits and state subsidies for small, low wage companies; and assistance in finding an insurance broker to apply for coverage. Throughout FY 2011, more than 600 licensed insurance producers in Maryland have registered to be listed on VIRTUAL COMPARE to assist small employers with the group application process.

HEALTH CARE QUALITY AND PATIENT SAFETY

Reporting on the Quality of Long-Term Care

The Commission has worked collaboratively with long term care representatives in updating its performance reporting systems. The nursing home guide is a searchable database that makes available a broad array of information to help Marylanders seeking care for themselves or a loved one. It includes facility characteristics, quality measures, and the results of annual licensing surveys for the more than 200 comprehensive care nursing facilities and continuing care retirement communities in Maryland.

The new Consumer Guide is an expanded and comprehensive LTC web portal focusing on frequently used LTC services received in one's home, community, or facilities such as nursing homes with emphasis on community services. Service categories have been expanded to include: adult day care; assisted living; home-based care such as home health agencies, agencies providing non-skilled care (residential service agencies, and nursing referral agencies); hospice programs; and nursing and rehabilitation facilities. Key features of the expanded site include: planning for Long Term Care; information about home modifications to allow seniors and persons with disabilities to remain in their home; location of community support services including senior centers, meal programs, resources for family caregivers, and transportation; a resource section that includes links to federal, state, and local sites to assist in answering questions about prescription drugs, legal resources for seniors and persons with disabilities, a tool that can locate a physician near one's home, and local resources for health care such as county clinics; guidance on health insurance benefits, Medicare, special transportation for persons with disabilities, and resources for family members or friends who help seniors and persons with disabilities.

Reporting on the Quality of Hospital Services

The Hospital Performance Evaluation Guide enables Marylanders to review information on the characteristics of Maryland's hospitals, including the location of the hospital, number of beds, and accreditation status. The Guide also includes key performance data

on 27 core measures endorsed by the National Quality Forum (NQF) and adopted by the Centers for Medicare and Medicaid Services (CMS), The Joint Commission, (TJC) and the National Quality Alliance (NQA). The Commission utilizes the results of a national, standardized survey of hospital patients to obtain and report on measures of hospital performance.

Healthcare Associated Infections (HAI)

To assist in developing a plan for expanding the HAI data on the Hospital Performance Evaluation Guide, the Commission appointed an HAI Technical Advisory Committee (TAC). The purpose of the TAC was to study and develop recommendations to the Commission on the design and content of a system for collecting and publicly reporting on HAI data. The Commission has made significant progress towards the implementation of the Committee's recommendations. Based upon extensive discussions, it was recommended that HAI reporting be initiated with the reporting of measures on: (1) Central-Line Associated Bloodstream Infections (CLABSIs) in All Intensive Care Units; (2) Health Care Worker Influenza Vaccination; and (3) Compliance with Active Surveillance Testing for MRSA in all ICUs. The Committee also recommended that the second phase of the HAI public reporting system include Surgical Site Infections data. Further recommendations were to use the National Healthcare Safety Network (NHSN) as the vehicle for collecting these data where feasible.

Cardiovascular Data Collection Initiative

In order to assure high quality and timely data on specialized cardiac care (i.e., Percutaneous Coronary Intervention (PCI) or angioplasty) the Commission adopted two uniform data sets to be submitted by all hospitals that provide PCI services. Effective July, 2010, all hospitals that provide PCI services must participate in the following two data registries developed and maintained by the American College of Cardiology Foundation:

The National Cardiovascular Data Registry (NCDR) ACTION Registry-GWTG – This tool is used by all Maryland hospitals that provide primary angioplasty and seek designation by the Maryland Institute for Emergency Medical Services Systems (MIEMMS) as a Cardiac Interventional Center and; The National Cardiovascular Data Registry (NCDR) Cath/PCI Data Registry – This tool is used by all Maryland hospitals that provide primary and/or non-primary angioplasty and measures outcomes of patients undergoing diagnostic catheterizations and PCIs.

INNOVATIONS IN HEALTH CARE DELIVERY

The Patient Centered Medical Home

The Maryland Patient Centered Medical Home Program (PCMH), established by legislation enacted by the Maryland General Assembly in 2010 charged the MHCC to establish a program if it concluded that the program would likely result in the delivery of more efficient and effective health care services and is in the public interest. The statute requires that the program promote the development of patient centered medical homes (PCMHs) by adopting standards, forms and processes with consultation of stakeholders.

The PCMH is a model of primary care in which a team of health professionals, guided by a personal physician, provides continuous, comprehensive, and coordinated care. A PCMH practice provides for all of a patient's health care needs or appropriately collaborates with other qualified professionals to provide patient-centered care through evidence-based medicine, expanded access and communication, care coordination and integration, and care quality and safety.

Currently, the Commission has selected 53 practices from the 179 primary care practices that had applied to participate in the Commission's three-year Multi-payer PCMH Program (MMPP). In selecting the invited practices, the Committee utilized a ranking procedure weighing the practice's responses across 6 domains: 1. Special Requirements in legislation; 2) Existing NCQA Recognition; 3) Participation in quality initiatives, employee wellness, primary care residency; 4) Established business functions; 5) PCMH features such as the use of EHR; and 6) Adaptive reserve - the capabilities and resources that can be used to further the transformation to a PCMH.

The MMPP intends to test the following value propositions: 1) Enhanced primary care will improve health status and outcomes for patients; 2) The result will be fewer complications, ER visits, and hospitalizations; and 3) Savings from these improved outcomes can be used to fund increased payment to primary care practices.

Staff from the MHCC will be briefing the Senate Finance Committee on the progress of the program.

HEALTH INFORMATION TECHNOLOGY

Effective implementation of health information technology (HIT) will assure that clinicians have the right information available at the right time and place of care to improve treatment, prevent errors, and reduce health care costs. It will also help gather information to improve disease surveillance, to improve our understanding of what works in the real world, and to shape practice guidelines. Two crucial components are necessary for effective HIT: the implementation of a health information exchange (HIE) and the adoption of electronic health records (EHRs).

The Maryland Health Care Commission (MHCC) is the lead agency for developing an HIE and promoting the adoption of EHRs. The MHCC developed a Health Information Technology State Plan (Plan) that addresses the strategic and operational goals for advancing HIT in Maryland. The effort to expand EHR adoption and implement a statewide HIE is consistent with the established Plan.

Maryland is the first state to require certain state-regulated payers to provide incentives of monetary value to select health care providers who adopt and use EHRs. Staff modified COMAR 10.25.16, Electronic Health Record Incentives, to comply with House Bill 736 (HB 736), Electronic Health Records-Incentives for Health Care Providers, that was passed by the General Assembly during the 2011 session. The modifications to the

regulations include the requirement that incentives for adopting an EHR be paid in cash unless a primary care practice and a payor agree on an incentive of equivalent monetary value. The modifications also expand eligibility of an incentive for adopting an EHR to a hospital-owned primary care practice. Staff developed the EHR Incentive Application and EHR Incentive Payment Request form that is used by primary care practices to apply to the payers for the incentive.

Implementing a State-wide Health Information Exchange

Legislation was passed in 2009 that required the MHCC to designate a multi-stakeholder group to implement a statewide Health Information Exchange (HIE). The MHCC selected a non-profit organization, Chesapeake Regional Information System for our Patients (CRISP), which includes Johns Hopkins Medicine, MedStar Health, University of Maryland Medical System, Erickson Retirement Communities, and more than two dozen other groups, as the state designee to implement the HIE. Exchange activities are funded through Maryland's unique all-payor rate setting system and federally through the *State Health Information Exchange Cooperative Agreement Program* (\$9.3M). In 2011, the MHCC was awarded another \$1.6 million over a 3-year period to develop innovative and scalable solutions that will improve long-term care and post-acute care transitions by leveraging the state designated HIE.

Staff from the MHCC have briefed Health and Government Operations, Senate Finance and key representatives from the Administration on key milestones of the program.

INFORMATION TO GUIDE HEALTH POLICY

The Medical Care Data Base

During FY 2011, the Cost and Quality Analysis division added an additional year of professional services and prescription drug data to the MCDB, expanded the data submission to include claims for institutional health care services, and provided feedback on data quality to the submitting payers.

Each year the Commission analyzes the MCDB to produce the *Practitioner Utilization* report describing the use of privately insured professional health care services by Maryland residents and the associated payments by insurance companies and recipients for those services. This report summarizes trends in the volume and pricing of the services of physicians and other practitioners received by privately insured, nonelderly residents of Maryland.

Practitioner Utilization: Trends Among Privately Insured Patients, 2007–2008

This legislatively mandated annual study was completed in June, 2011. The analysis is based on the MCDB data, and the methods used for this report include the imputation of payments for services that lack payment information. Among the nonelderly (under age 65) who used professional services and were enrolled in the same insurance product for the entire year, the average expenditure for professional services in 2009 was \$1,238, 2% higher than in 2008. This growth was due to a 2% increase in the average payment rate

for the mix of services obtained by user. In contrast, the growth per user in 2008 was 5% driven mainly by a 3% increase in the number of professional services per user. The growth in per user spending from 2008 to 2009 varied by coverage type and was especially large, at 8% in the individual market

Study to Count the Supply of Physicians in Maryland in 2009-2010

The division oversaw an extramural study of physician supply in Maryland, conducted by Christopher Hogan, president of Direct Research, LLC. The study was jointly sponsored by the MHCC and HSCRC to resolve questions of physician supply in the state. The study analyzed the last data (2009-2010) from the Maryland Board of Physicians license renewal survey and compared the finding to the results from analyses of physician supply in Maryland based on the American Medical Association (AMA) Physician Masterfile data. The report, Maryland Physician Workforce Study: Applying the Health Resources and Services Administration Method to Maryland Data, was released in May, 2011.

After adjustments to make the Maryland license renewal data and the AMA Masterfile data comparable, the study found that the license renewal data yielded results very similar to those generated by the U.S. Health Resources and Services Administration (HRSA) and the Association of American Medical Colleges (AAMC) using the AMA data. The study estimates that Maryland has a 27 percent more active non-federal patient-care physicians per capita than the U.S. year 2000 average (HRSA's benchmark). This is nearly identical to the estimates of Maryland physician supply developed by HRSA and AAMC. In addition, after adjustment, the two data sources give nearly identical counts of active non-federal patient-care physicians in Maryland. These estimates demonstrate that Maryland's physician-to-population ratio is substantially above the U.S. average. These estimates demonstrate that Maryland's physician-to-population ratio is substantially above the U.S. average.

Healthcare Spending in Maryland's Individual and Small Group Markets

The mandated health care expenditure study compared annual spending for professional, institutional, and prescription drug services by privately insured Maryland residents with health insurance obtained in three different health insurance markets: the individual market, the small employer market - the Comprehensive Standard Health Benefit Plan (CSHBP), and the state's high-risk insurance program - the Maryland Health Insurance Plan (MHIP). The purpose of the study was to provide information that may be useful to state policymakers in implanting Maryland's Health Benefit Exchange.

III. BUDGET

The Commission's request for FY 2013 is \$31,944,172, which includes \$11,744,172 in operating funds, \$12 million for the Maryland Trauma Physicians Fund, \$2.3 million for expenditures associated with the Working Families and Small Business Health Coverage Act (Partnership Program), \$3,000,000 for the operating grant for R. Adams Cowley Shock Trauma Center, \$100,000 in reimbursable funds from the Community Health

Resources' participation in the PCMH Program, and lastly, \$2,800,000 in federal funds for the State Health Information Exchange Cooperative Agreement.

The FY 2013 budget request funds the costs associated with 62.70 permanent staff, and all statutory requirements. At the close of FY 2011, the Commission's surplus was \$2.5 million. The Commission will continue to utilize remaining reserves to fund the annual indirect cost assessment to the Department of Health and Mental Hygiene of approximately \$800,000, in lieu of assessing this fee to our industries.

THE HEALTH SERVICES COST REVIEW COMMISSION

FY 2013 BUDGET

***PRESENTATION TO THE BUDGET COMMITTEES OF THE
MARYLAND GENERAL ASSEMBLY***

MOOR0102

D. Patrick Redmon, Ph.D.
Executive Director, HSCRC

Department of Health and Mental Hygiene

HEALTH SERVICES COST REVIEW COMMISSION - FY 2012 BUDGET PRESENTATION

I. OVERVIEW

The Health Services Cost Review Commission (the “HSCRC,” or “Commission”) was established in 1971 with two principal responsibilities: to publicly disclose hospital financial data and trustee relationships, and to set payment levels for acute care hospital services.¹ Maryland is the last state to retain its all-payer hospital rate setting system, and as such, it has been able to address the issues of cost containment, access to care, equity in payment, financial stability, and accountability.

Under Maryland’s unique “All-Payer” system, all payers, including Medicare and Medicaid, pay hospitals on the basis of the rates established by the Commission. This “all-payer” nature of the system is made possible by the state’s Medicare Waiver that became effective in 1977. To retain this waiver, Maryland must pass a quarterly financial test, administered by the Medicare agency. An additional requirement is that all-payers continue to pay on the basis of the rates established by the Commission.

The Maryland Rate Setting System – Discussed as a Model of Cost Containment for the Nation

Given the general failure of the health care market place to contain costs in recent years, policy makers nationally are pointing increasingly to the Maryland All-Payer Rate Setting system as one of the most enduring cost containment systems in the U.S. over the past 35 years. From 1976 to 2009, Maryland experienced the lowest rate of increase in cost per admission of any state, as well as much slower hospital cost growth than that experienced in the nation as a whole. Had Maryland grown at the more rapid national rate of growth from 1976 to 2009, there would have been cumulatively \$44 billion more hospital expenditures (in nominal terms) than what resulted under rate setting. On the other hand, had the nation grown at Maryland’s slower rate of growth, cumulative U.S. savings would have been in excess of \$2.0 trillion.

Recent articles in national health policy journals, the *Wall Street Journal*, *Washington Post* and *Health Affairs*, identify Maryland as providing the nation with important lessons on how best to coordinate payment to providers, in order to achieve the multiple goals of: cost containment, expanded access to care, equity in payment, financial stability, accountability, and improved quality of care.

Important Commission Initiatives

While the Commission’s mandate is largely to constrain annual hospital rate increases and promote hospital efficiency, the payment system was also designed to achieve the following important objectives: 1) to provide universal financial access for hospital care; 2) to set rates that are equitable for all payers and thereby prohibit cost-shifting; 3) to make all parties accountable to the public, 4) to maintain solvency for efficient and effective hospitals and 5) ensure the provision of effective (high quality) hospital care.

In recent years, the Commission has evolved its rate methodology to: 1) promote hospital efforts to improve care quality; and 2) make available bundled payment options to hospitals to improve the financial incentives for better care coordination and cost reduction.

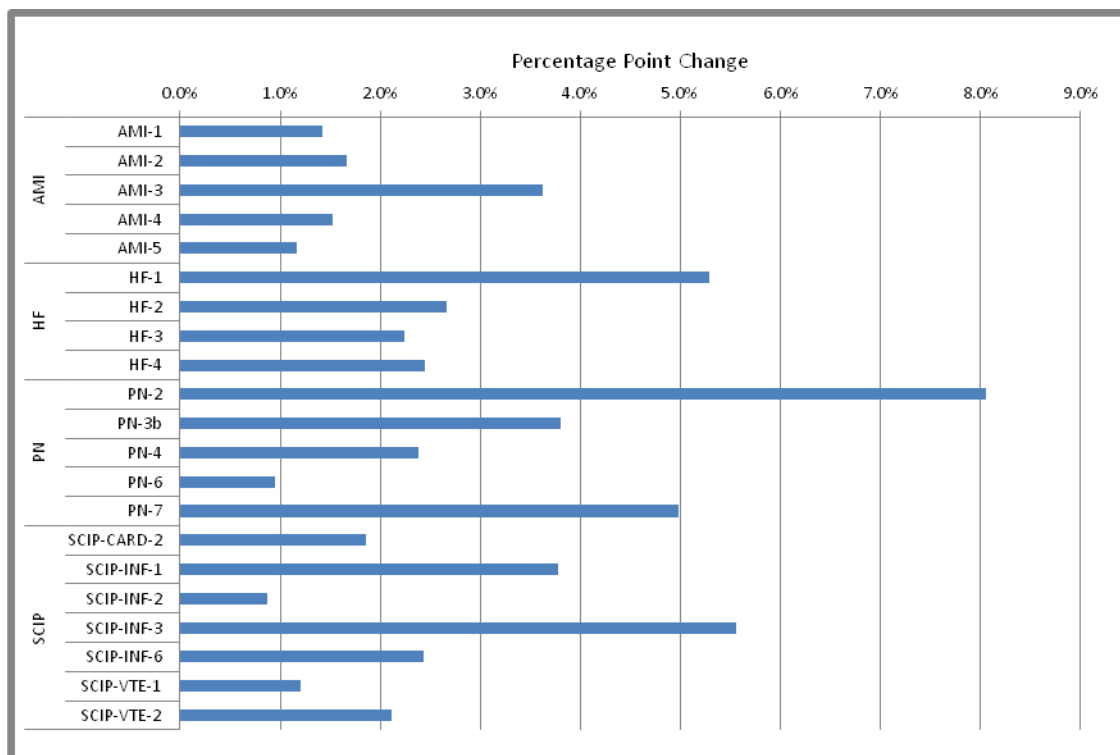
¹ The Commission consists of seven members appointed to four-year terms by the Governor and is staffed by 29 full-time positions. The Commission regulates an industry of 47 acute care hospitals, five private psychiatric hospitals, and three chronic care hospitals, with system revenues in excess of \$12 billion in gross charges.

Quality of Care Projects

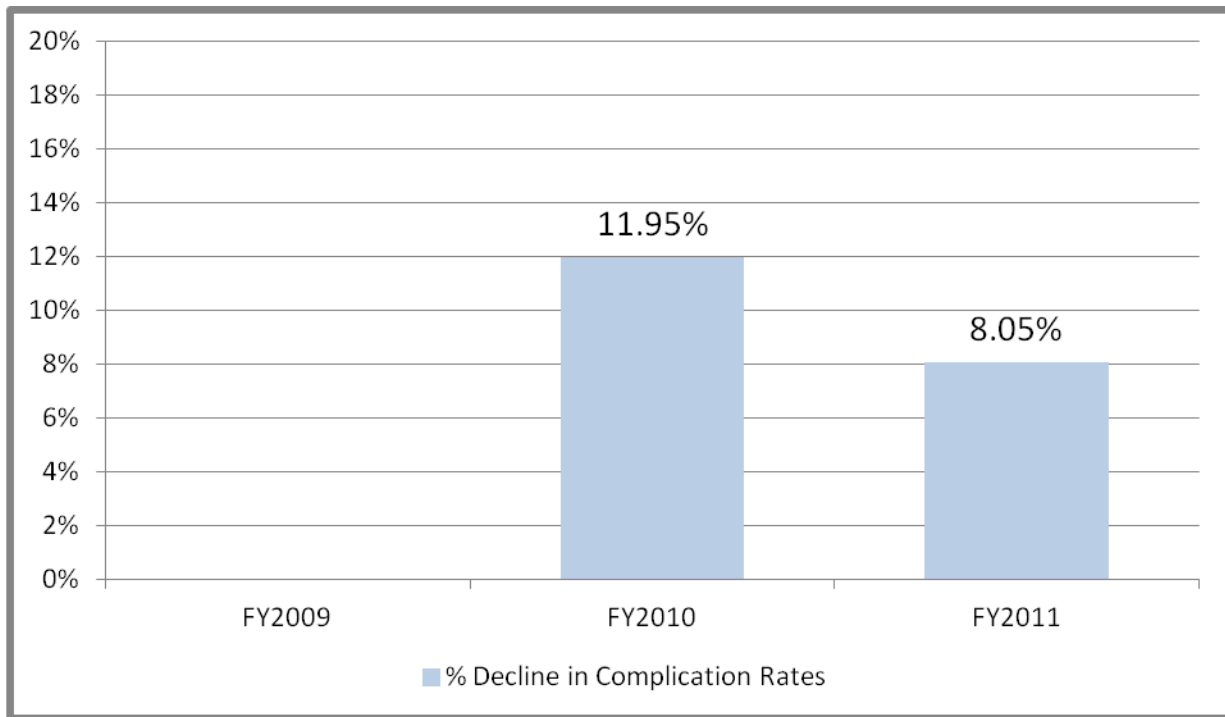
The Commission is in the process of implementing three initiatives relating to the quality of hospital care:

1. **“Quality-based Reimbursement”** which provides incentive payments to hospitals to promote the use of “Evidence-Based Processes of Care”;
2. **“Maryland Hospital Acquired Conditions”** which identifies and seeks to reduce preventable complications, acquired after a patient has been admitted to a hospital; and
3. Monitoring of **“30 Day All-Cause Readmissions”** to begin to reduce the number of readmissions that occur at hospitals.

With the first initiative, the HSCRC is building on the efforts of the Maryland Health Care Commission’s Hospital Performance Guide by implementing a system of rewards and incentives in the payment system to stimulate broad improvements in hospital quality of care and reduction in medical errors. The **Quality based Reimbursement** initiative recognizes performance on a series of process measures relating to acute myocardial infarction, pneumonia, heart failure and infection preventions. These processes of care are thought to be correlated with improved outcomes and higher quality of care. This year the Commission added a series of patient satisfaction measures the QBR program. Hospitals that perform these processes most frequently (or who show the largest year-to-year improvement in performance) receive rewards through the rate setting system. The Commission collected data hospital performance on the identified process measures from CY 2008 through CY 2010 and has adjusted rates accordingly in FY 2010, FY 2011, and FY 2012. Over this 2 year period, performance has improved on average by about 2% even though performance on many of the measures was already very high. The Chart below shows performance improvement by measure over the past two years.



In its second initiative, the Commission implemented the nation’s first broad-based program that links payment incentives to hospital performance on rates of **Hospital Acquired Complications** (including 11 categories of hospital-acquired infections). Beginning July 1, 2009, hospitals in Maryland have been measured on their rate of complications in 49 different categories. Relative performance on these complication measures is linked to rewards and penalties through the HSCRC’s rate setting system. The initiative provides strong incentives for Maryland hospitals to find ways of lowering the number of patients they treat who ultimately develop preventable complications. The Commission adjusted hospital annual rate updates based on relative performance for FY 2011 (effective July 1, 2010). In the second year of this pay-for-performance initiative, the State witnessed a 11.9% drop in the frequency of hospital acquired complications (or 6,691 fewer complications) after adjusting for differences in patient mix from year to year (this result includes over a 19% reduction in Hospital Acquired Infections as well). In the third year of data collection, these complication were reduced by another 8%. The Commission estimates that the overall improvement means that hospitals responded to the Commission’s system of quality incentive system, thereby removing approximately \$107 million of cost associated with preventable complications over 2 years.



In its third initiative, the Commission is collecting data regarding the total number of all-cause 30 day readmissions that occur in the State and the associated costs. This project is linked to the Admission Readmission Revenue (ARR) agreements that many hospitals have implemented with the Commission. Our monitoring of readmissions will help us evaluate whether this bundled payment structure is working as it was intended - to reduce readmissions.

Maryland is unique in the country in its implementation of pay for performance in that we are the only state that is able to provide financial incentives to hospitals for quality improvement through the rates of all patients and payers. Initiatives elsewhere in the U.S. suffer because they tend to be payer-specific (Medicare) or health plan specific and thus lack the broad based financial incentives of the Maryland system.

Bundled or “Global” Payment Initiatives

The U.S. health care system suffers from fragmented and uncoordinated care, which results in higher cost and lower quality than what is achieved in other developed countries. This fragmented health care delivery system is a reflection of our fragmented and episodic system for financing health care delivery. Private insurers and public programs like Medicare/Medicaid pay providers differently, and reimbursement is largely on a “fee-for-service” (FFS) basis - incremental payment for each and every service. Thus, there is no uniformity in payment nationally (in fact, there are often conflicting incentives across different providers) and the fee-for-service system adds to health care costs in that it rewards hospitals/physicians for providing more services. This fragmented payment system also creates financial barriers to providing the best possible care at the lowest price. As a result hospitals are reluctant to invest in extended care infrastructures that might reduce volume to their facility, reduce revenue and thereby erode their operating performance.¹

Bundled payments structures are a way that the HSCRC can both change, and better align, the financial incentives of providers and financially reward them for more efficient and higher quality care. Bundled payments also work to remove the existing financial barriers to providing more coordinated care. Development of these more “global” payment structures involves gradually transitioning the structure of payment away from a fee-for-service approach (to a more packaged approach), incrementally bundling in more health care services over longer periods of time, under a packaged price (or budget).

In the late 1970s, the HSCRC pioneered the transitioning of hospital payments from pure fee-for-service to a bundled payment per inpatient admission (a flat amount for each patient based on diagnosis). This gave hospitals incentives to control the services they provided for each inpatient case. The HSCRC is now implementing two broad bundled payment strategies – Total Patient Revenue (TPR) which is a global budget concept, and Admission-Readmission Revenue (ARR) which packages payment for both the inpatient admission and any subsequent readmission. Under these voluntary 3-year arrangements, hospital incentives are aligned around providing the most appropriate and cost-effective care for each patient. If these providers eliminate the unnecessary services previously incentivized under the FFS system – they can lower their cost (under a fixed payment) and thereby improve profitability. Under these approaches, hospitals have financial incentives to work with clinicians to provide the right care, to the right patient, at the right time, and improve the health of populations they serve. The Commission is also working on a population-based bundled payment strategy that will put the hospital at risk for the population within certain service areas around the hospital.

Maryland is uniquely positioned to lead the nation on bundled/global payment development – in large part due the existence of its “all-payer” hospital rate setting system, which provides a way of harmonizing financial incentives for all payers, as well as a platform for the development of these packaged payments. As noted, the HSCRC has simultaneously developed very broad and meaningful quality measurement systems to ensure that providers also have strong incentives to maintain and improve care quality. This equal emphasis on reducing health care cost and improving overall care coordination and quality is what sets Maryland apart from all other states and will allow the State to substantially improve the overall value of care received by Maryland patients for the health care dollars expended.

¹ Under a FFS payment structure, investment in better discharge planning, care managers, and less expensive outpatient capacity, all of which are proven to reduce unnecessary readmissions to a hospital, would mean both a large cost outlay by the hospital and the likelihood of significant reductions in hospital inpatient volume and associated revenue. Conversely, under a bundled payment that covered both admissions and readmissions, the hospital is given the opportunity to retain historical revenue levels, and an incentive to apply these resources in more effective ways from a cost and quality of care standpoint (i.e., invest in discharge planning, care managers, and outpatient capacity).

I. Response to the issue from DLS Budget Analysis

HSCRC should be prepared to update the committees on its discussions and any potential timeline to update the Medicare waiver to recognize the ongoing changes in payment structure.

Background

The Waiver Test

The waiver is at the core of the all-payer system, with private and government payers bearing similar charges for the same services. This waiver is subject to a financial test, and our current projections show that the relative waiver margin is declining dramatically.

As accurately described in the DLS analysis, while the most recent CMS waiver letter suggests that we have some room under the test, the letter is based on data that lags current events. The waiver letters typically lag current events by 15 to 18 months. The Commission's most recent publication of *Monitoring Maryland Performance* for year ending November 2011 shows that the Charge per Case is growing by 8.28%, far above the 4.3% budgeted under last year's update factor discussions (update factor plus the Medicaid assessment plus seed funding for ARR). A number of factors may account for this growth, including case mix, continued shifts of short-stay cases to observation, TPR shifts of services, activities to reduce readmissions under the ARR policy, and charging patterns.

Clearly, some of our difficulties result from HSCRC policies designed to improved incentives for the efficient delivery of care. The TPR and ARR policies are designed to improve the quality of care and reduce unnecessary utilization; however, the cases most likely to move from the inpatient setting are low-charge cases, leaving high-charge cases in the waiver measure. This erodes the waiver cushion.

Further, the policy to reduce 0 and 1 day stay cases has resulted in substantial erosion of the waiver. While the policy to reduce short-stay cases and increase the appropriate use of observation was desirable, this policy was executed by removing short stay cases at their actual charges (which are low by definition), and increasing the ability for hospitals to charge higher on those cases that remain on the inpatient side.

The DLS analysis shows that under a reasonable set of assumptions, the waiver cushion is deteriorating rapidly. Under the baseline model assumptions, we would end FY2012 with a relative waiver cushion of 1.48%. By FY2013, we expect the cushion to deteriorate to 0.77%.

Consequences of Failing the Waiver

The State's Medicare waiver is included in legislation, and the consequences are laid out in the Federal statute. If the State fails the numerical test, the statute allows three years for Maryland to return to compliance. However, the overpayments would have to be paid back as well, requiring tightening beyond what is necessary simply to get back into compliance.

An Alternative Waiver Test

Secretary Sharfstein, Chairman Colmers, and HSCRC staff have had numerous discussions with CMS regarding an alternative waiver test. The vehicle suggested for an alternative waiver approach is a forthcoming States' Initiative project. Maryland would submit an application for delivery system change with HSCRC proposing an alternative waiver methodology as part of the broader proposal. We expect a

request for Letters of Intent soon, with proposals to be submitted within a couple of months after the Letter of Intent. In anticipation of this process, the HSCRC has convened a workgroup of staff, provider representatives, and payer representatives to begin the process of developing a draft waiver proposal for this initiative.

Maryland Community Health Resources Commission

Senate Budget & Taxation Committee

Monday, February 6, 2012

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Creation of Maryland Community Health Resources Commission (CHRC)

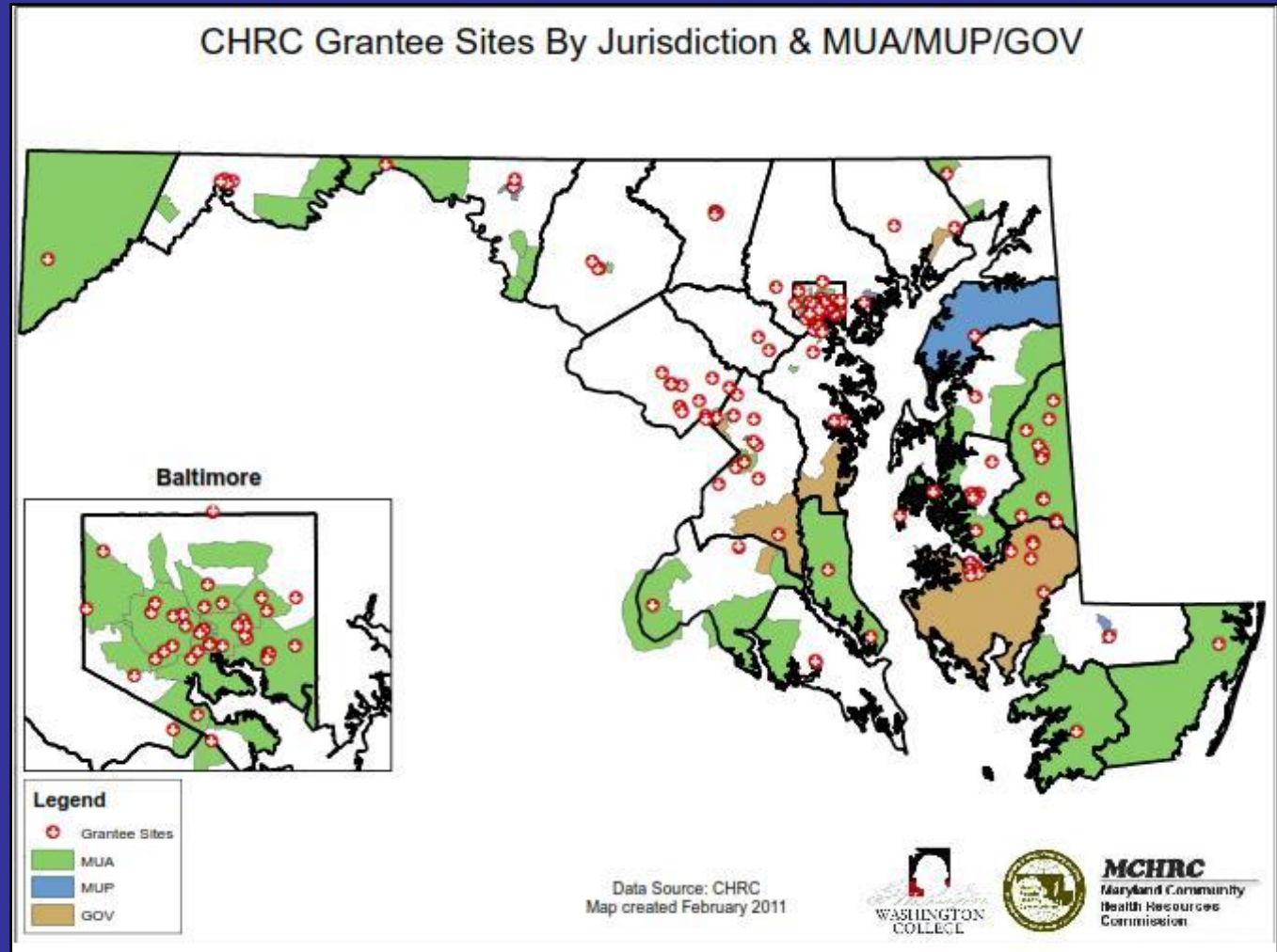
- The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 (HB 627/SB 775) to expand access to health care for low-income Marylanders and underserved communities in the state and bolster Maryland's health care safety net infrastructure.
- HB 627/SB 775 (2005) set forth broad policymaking functions for the Commission:
 - Identify a “medical home” for every Marylander;
 - Develop access to specialty care networks for uninsured and low-income Marylanders;
 - Reduce non-emergent visits to Maryland hospital EDs and establish “reverse-referral” programs; and
 - Develop a common HIT platform for community health centers.

Supporting Meaningful and Sustainable Programs

- Over the last 6 years, the Commission has awarded 93 grants totaling approximately \$22.6 million.
- These 93 grants/programs have provided services for more than 96,000 patients, resulting in more than 294,000 patient visits.
- The \$22.6 million awarded by the CHRC has enabled its grantees to leverage \$9.5 million in additional federal and private/non-profit resources.

Moving Health Care Forward in all 24 Jurisdictions in Maryland

The CHRC has supported programs in every jurisdiction of the state.



CHRC FY 2012 RFP: Targeting Health Priorities of DHMH

(1) Reducing Infant Mortality Rates;

(2) Building Primary Care Capacity;

(3) Expanding Dental Care Access for Children;

(4) Investing in Health Information Technology; and

(5) Integrating Behavioral Health Care Services.

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- The CHRC received 99 grant proposals this year, requesting more than \$35 million in support.

CHRC FY 2012 Grant Awards

Infant Mortality

- Harford County Health Department - Harford County (\$54,903)
- Tri-State Community Health Center - Allegany County (\$66,214)

Primary Care

- Community Clinic, Inc - Montgomery County (\$140,000)
- Catholic Charities - Esperanza Center - Baltimore City (\$109,700)
- Shepherd's Clinic - Baltimore City (\$60,000)

Dental Care

- Baltimore City Health Department - Baltimore City (\$14,174)
- Walnut Street Community Health Center - Washington County (\$45,000)
- Bel Alton Alumni Association - Southern Maryland (\$100,000)

Health Information Technology

- Prince George's Health Department - Prince George's County (\$75,000)
- Omni House Behavioral Health System - Anne Arundel County (\$50,000)

Behavioral Health Care

- Way Station, Inc. - Central Maryland (\$70,000)
- Mary's Center for Maternal and Child Health - Prince George's/Montgomery (\$66,492)
- Mobile Medical Inc. - Montgomery County (\$50,000)
- Lower Shore Clinic - Lower Shore (\$65,000)
- Walden Sierra, Inc. - Southern Maryland (\$70,000)

Supporting Health Care Reform Implementation

- The CHRC was tapped by the Health Care Reform Coordinating Council to lead the following activities:
 - (1) Develop a “business plan” outlining how the state and the CHRC would provide technical assistance and support to safety net providers; and
 - (2) Assist in the creation of Local Health Implementation Plans, as DHMH works to develop the State Health Improvement Process.

CHRC Business Plan- **Five Recommendations**

- (1) Provide technical assistance and support around the 'mechanics' of health reform implementation;**
- (2) Address workforce issues;**
- (3) Provide assistance interpreting and accessing data;**
- (4) Support expanded eligibility determinations; and**
- (5) Encourage innovative public-private partnerships that will leverage additional private resources.**

Health Enterprise Zones

- The FY 2013 Budget Allowance provides a new line item (\$4 million) in the CHRC's budget to support the Administration's Health Enterprise Zone (HEZ) Initiative.
- The HEZ Initiative is created in separate, stand-alone legislation (SB 234/HB 439) which will be heard later this month.



Maryland Community Health Resources Commission

- The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access to health care for low-income Marylanders and underserved communities in the state and bolster Maryland's health care safety net infrastructure. The CHRC is a quasi-independent commission within the Maryland Department of Health & Mental Hygiene (DHMH), and its 11 members are appointed by the Governor. In creating the Commission, the Maryland General Assembly recognized the need for having an independent commission that focused on strengthening Maryland's vibrant network of community health centers and addressed service delivery gaps in Maryland's dynamic health care marketplace.
- The Maryland General Assembly envisioned that the CHRC would play a unique role in terms of developing a statewide, comprehensive policy to strengthen Maryland's network of safety net providers. The CHRC's core mission is to articulate areas that are ripe for policy innovation (e.g., strategies to divert patients from emergency rooms to more appropriate sites of care, health information technology, and patient-centered medical homes) and work with multiple layers of government and regulatory agencies to develop grants that will generate the potential for systematic reform.
- The CHRC has developed a specific policy expertise with Maryland's safety net providers and it has forged interdisciplinary relationships with DHMH, other independent health regulatory commissions, Maryland's local health departments, local detention centers, and the judicial community, to develop and fund projects that expand access to health care, reduce health care costs, and improve quality of care for vulnerable populations.
- The \$21.6 million provided by the CHRC has enabled its grantees to leverage approximately 9.5 million in additional federal, private/non-profit resources and other resources.
- Over the last six years, the Commission has awarded 93 grants totaling approximately \$22.6 million. As shown in the table below, these 78 grants/programs have provided services for more than 96,000 patients, resulting in more than 295,000 patient visits. Over this same time period, the Commission has received 432 requests for consideration, totaling more than \$147 million in direct funding requests.
- In its most recent RFP, the CHRC awarded 15 grants totaling \$1 million in FY 2012 funds. The grants are fully aligned to support with the health priorities of the Administration and DHMH. These grants support expanding access to primary care in underserved areas of the state; helping to reduce infant mortality; increasing access to dental care for low-income children, integrating behavioral health treatment services in the community, and; assisting providers adopt health information technology.
- The CHRC has awarded 20 grants to Federally Qualified Health Centers, totaling \$6.5 million. These grants have helped to expand access to primary care services for vulnerable and underserved populations, provide comprehensive women's health care services to reduce infant mortality, and facilitate FQHC's adoption of health information technology and electronic medical records systems.

Maryland Community Health Resources Commission				
Focus Area	# of Projects Funded	Total Award Provided	Cumulative Total	
			Patients Seen/Enrolled	Visits Provided
Expanding Access to Primary Care at Maryland's safety net providers	25	\$5,930,812	36,629	114,407
Increasing Access to Dental Care for Low-income Marylanders	20	\$4,168,602	34,544	80,808
Addressing Infant Mortality	12	\$2,258,164	2,982	13,774
Reducing health care costs through ER Diversions	6	\$1,994,327	13,454	24,702
Promoting Health Information Technology at community health centers	9	\$3,088,035	Health Information Technology	
Providing Access to Mental Health and Drug Treatment Services	15	\$2,867,249	3,989	23,028
Addressing health care needs of Co-Occurring Individuals	7	\$2,364,737	4,913	37,397
Total Grant Funding Provided	93	\$22,671,926	96,643	295,003
Total Funding Requested	432	\$147,297,981		
Number of Patients Served/Enrolled	96,511			
Number of Patients Visits/Services Provided	294,116			
Additional federal and private resources leveraged	41	\$9,553,871		

Department of Health and Mental Hygiene

Health Regulatory Commissions

M00.R01

Response to Recommended Actions

Recommendation #1:

Delete 1 new position (NEW001) based on available vacancies. The fiscal 2013 budget includes 1 new regular position in the Maryland Health Care Commission to support the implementation of the commission's Patient Centered Medical Home initiative. However, as of January 1, 2012, the commission had 7 vacant regular positions. The commission should use 1 of those positions to support the initiative.

Response:

The Maryland Health Care Commission disagrees with the analyst's recommendation to eliminate our request for a Health Policy Analyst – Advanced position to assist in the ongoing implementation and evaluation of the patient centered medical home program. There is currently only one position that supports this important legislatively mandated program. The Commission did not receive a position when this program was piloted as requested; we have had to redeploy existing staff in order to support the program which has negatively affected other programs.

The Commission does agree with the analyst's note that its current vacancy rate is high; however, we have experienced a significant turnover in positions due to retirement, and recruitment difficulties, but mainly due to delays of several months in obtaining exemptions to the hiring freeze. These vacancies are not long standing.

We respectfully request that this position be left in the Commission's budget request.

Department of Health and Mental Hygiene

Health Regulatory Commissions

M00.R01

Response to Recommended Actions

Recommendation #2:

.provided that \$4,000,000 of this appropriation made for the purpose of funding Health Enterprise Zones may not be expended until the Maryland Community Health Resources Commission submits a report to the budget committees detailing how the funds will be spent. The report shall include, but not be limited to, specifics as to the criteria used in selecting Health Enterprise Zones, how funding is to be allocated, and what outcome measures and/or measurement system will be developed to monitor the progress in the Health Enterprise Zones. The budget committees shall have 45 days to review and to review and comment on the report. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall be cancelled if the report is not submitted to the budget committees.

Response:

The Maryland Community Health Resources Commission suggests that rather than \$4,000,000 of the appropriation be withheld, that \$3,750,000 be withheld. This would allow funding for the administration of the program to be available at the beginning of the fiscal year, while still withholding the bulk of the appropriation pending the report to the budget committees. The Commission looks forward to implementing this exciting initiative and to updating the budget committees on the progress of the initiative.



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

Testimony of Joshua M. Sharfstein, M.D.

Secretary, Department of Health and Mental Hygiene

Before the Health and Human Resources Subcommittee, House Appropriations Committee

Statement on the FY 2013 Budget for the Community Health Resources Commission

February 8, 2012

Thank you for the opportunity to testify in support of the disparities initiative included in the FY 2013 budget.

In May, 2011, Governor O'Malley signed an executive order continuing the Maryland Health Quality and Cost Council. In this Executive Order, Governor O'Malley required the Council to establish a workgroup to explore and develop health care strategies and initiatives to reduce and eliminate health disparities, and make recommendations regarding the development and implementation of these strategies.

As a result of the Executive Order, and with the leadership of Lt. Gov. Anthony Brown, the Maryland Health Quality and Cost Council established the health disparities workgroup. The workgroup was required by the Council to develop recommendations for best practices, monitoring, and financial incentives for the reduction of disparities in the health care system.

The workgroup was chaired by Dean Reece, Dean of the University of Maryland School of Medicine. The workgroup also included members of academia, local health officers, and health care providers.

The workgroup found that unacceptable health disparities exist in Maryland across a wide range of health conditions. In a number of communities, inadequate access to care exacerbates these disparities and contributes poor health outcomes.

As a central piece of its report to the Quality and Cost Council, the Disparities Workgroup recommended the establishment of Health Enterprise Zones, where funding opportunities will be available to address poor health outcomes. The Workgroup recommended passing legislation that defines Health Enterprise Zones and establishes a mechanism for a community to be certified as an HEZ.

SB 234 and HB 439 implement the recommendations of the Disparities Workgroup by establishing a process for areas to be designated as health enterprise zones. The budget provides \$4 million for pilot implementation.

The legislation requires non-profit community-based organizations or local government agencies to apply to the Community Health Resources Commission on behalf of an area to receive designation. The application must include a sustainable plan to reduce health disparities, reduce costs, and improve health outcomes. The plan must include a proposal to use available funding for loan repayment incentives for primary health care providers. The plan can include a proposal for use of tax incentives for primary care providers.

Priority will be given to applications that demonstrate support from key stakeholders, a plan for long-term funding, the support of the local health improvement coalition, and a plan for evaluation.

This design allows communities to tailor a plan to address disparities in their area in a manner that fits the specific needs of the community.

The DLS budget analysis recommends withholding the \$4 million budgeted for Health Enterprise Zones until additional detail is provided on how the funding will be used.

The Department and the CHRC suggest instead that \$3.75 million be withheld, rather than \$4 million. This would allow for funding needed to administer the program to begin.

Thank you for your consideration of this important initiative.