Health Care Reform Coordinating Council

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Final Report and Recommendations

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EXECUTIVE SUMMARY

Passage of the Affordable Care Act (ACA) earlier this year offered states an unprecedented opportunity to change the face of health care. While some states have responded with calls for obstruction, Maryland took bold action to build on the reforms already in place and our renowned health care system to develop a national model for the implementation of health reform. Under the auspices of the Health Care Reform Coordinating Council (HCRCC) established by Governor O'Malley in the immediate aftermath of Congress' enactment of the ACA, the State has spent the last nine months creating the blueprint for a well-planned and inclusive implementation of health care reform that is at once both visionary and realistic.

This final HCRCC report sets forth that blueprint. It provides an overview of the federal health care reform law; describes the already-established foundation for reform in Maryland; summarizes the work and process of the HCRCC; identifies the major challenges and opportunities presented by implementation; identifies the necessary investments to ensure success; and identifies 16 recommended short- and long-term action items on how federal reform can be implemented most effectively. With this roadmap, the State is better positioned than most states to comply with the requirements of the ACA and take full advantage of the once in a generation opportunity to lower costs, expand coverage, and improve health services.

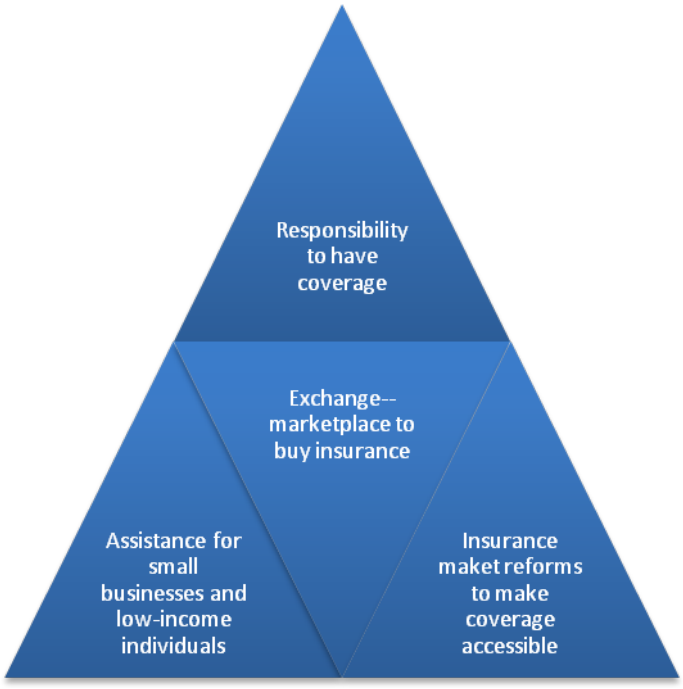
OVERVIEW OF HEALTH CARE REFORM

With comprehensive reforms to hold insurance companies more accountable, expand access to care and coverage, and enhance the quality of care, the ACA sets the stage for the transformation of health care in Maryland and across the country. Despite this broad reach, the law's goals at their core are built on essential and interrelated components:

- A responsibility to have coverage;
- Assistance for small businesses and low-income individuals.
- Market reforms to make coverage accessible; and
- A marketplace to buy coverage;

These building blocks of reform, shown below in Figure ES-1, work together to reduce the number of uninsured and improve health.

Figure ES-1: Essential Components of Health Reform



The first pillar - **the responsibility to have coverage or "individual mandate"** - spreads risk across the spectrum of all individuals, regardless of health status. It promotes affordability and paves the way for insurance market reforms necessary for everyone to be able to access and maintain coverage. The second pillar of reform - **federal subsidies providing assistance for small businesses and low-income individuals** - is necessary to enable those who cannot afford insurance on their own to fulfill their responsibility to purchase it. The third – **new insurance market rules which prohibit industry practices that have often resulted in people losing or being denied coverage just when they need it most** - ensure that no individual can be barred from accessing insurance and complying with the individual mandate. Finally, the ACA facilitates this coverage expansion through the fourth pillar - **a new marketplace or "Exchange"** - through which individuals and businesses can purchase insurance in an open, transparent and competitive environment.

In addition to these fundamental and interdependent building blocks of reform, the ACA includes additional features that will reshape the health care system, including:

- Supporting prevention and public health programs;
- Promoting initiatives designed to reduce racial and ethnic disparities;
- Shoring up primary care infrastructure through workforce development strategies;
- Protecting Medicare;
- Initiating changes in long-term care; and

- Cultivating payment reforms and other innovations designed to improve quality and slow the growth of costs.

HEALTH CARE REFORM COORDINATING COUNCIL'S WORK AND PROCESS

The HCRCC has been committed to conducting an open, transparent process designed to solicit and incorporate as much public input as possible. The Council initially conducted an assessment of the ACA and its potential impact on Maryland, submitting its findings to the Governor in its July 2010 Interim Report. A multi-faceted workgroup process followed in which six groups, open to all stakeholders and interested members of the public, focused on key implementation issues and developed options for consideration by the HCRCC. The Council solicited direct public input on proposed draft recommendations during five hearings held across the State. Finally, incorporating both public testimony and feedback from individual Council members, the HCRCC developed its final recommendations to be presented to the Governor in this report.

INTERIM REPORT'S FINDINGS ON THE IMPACT OF HEALTH REFORM IN MARYLAND

The HCRCC's Interim Report found that full ACA implementation will reduce Maryland's 700,000 uninsured by more than half, to just below 7%.[1] With respect to fiscal impact, Maryland's reform implementation will result in estimated savings of $829 million over the next ten years.[2] The HCRCC's financial model can be adapted and updated over time. The current estimate remains unchanged from the Interim Report as assumptions about implementation continue to be explored. That these savings reverse course and begin to decline in 2020, underscores the critical imperative that the State focus immediately on bending the cost curve to rein in spending growth and improve the long-term fiscal outlook.

MARYLAND'S FOUNDATION FOR REFORM

Most of reform's implementation will be left to states. Reforms already in place in Maryland position the state to enact the federal measures more successfully than other states. For example, Maryland has extended coverage to more than 250,000 Marylanders since 2007 by expanding Medicaid eligibility, helping small employers offer coverage, creating a high-risk pool for individuals unable to secure insurance because of their health conditions, and improving access to commercial insurance for young adults. In some areas, federal health care reform presents a

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[1] Health Care Reform Coordinating Council. (2010, July). *Interim report*. Retrieved from http://healthreform.maryland.gov/interimreport.html

[2] Health Care Reform Coordinating Council. (2010, July). *Interim report - Appendix F: Maryland Health Care Reform financial modeling tool: Detailed analysis and methodology*. Retrieved from http://healthreform.maryland.gov/documents/100726appendixf.pdf

logical extension of these and other current policy initiatives, while in other cases, federal mandates may require rethinking existing efforts.

Other features of Maryland's existing system and recent reforms will also affect implementation decisions. Examples include medical underwriting in its nongroup market; the Comprehensive Standard Health Benefit Plan and community rating in the small group market; the prominent role played in both markets by independent producers and third party-administrators; the hospital rate setting system used to finance uncompensated care; safety net programs for the State's uninsured and underinsured; and State and local public health infrastructure and systems.

IMPLEMENTATION ISSUES AND RECOMMENDATIONS

The HCRCC has developed 16 recommendations on how Maryland should undertake reform implementation. Public input was central to understanding critical implementation issues and shaping recommendations. The first two recommendations, relating to the health benefit exchange and entry into coverage, address the immediate building blocks of reform necessary to meet federal deadlines. The second group - recommendations 3 through 15 – responds to opportunities presented by reform to advance a sustained effort to strengthen the health care system and improve health. The last recommendation addresses the ongoing leadership and oversight necessary to achieve Maryland's goals for implementing health reform successfully, and for strengthening health and the health care system over the long term.

> **Recommendation One: Establish the basic structure and governance of Maryland's Health Benefit Exchange. This is a required building block of reform.** The HCRCC recommends that Maryland establish the initial structure and governance of a single health benefit exchange during the 2011 legislative session of the General Assembly to meet the March, 2012 federal deadline. The enabling statute should create an independent public entity, establish the Board and governing principles for transparency and accountability, ensure sufficient flexibility with respect to procurement and personnel practices, and confer authority to begin some federally-mandated implementation activities immediately while developing recommendations for the Governor and General Assembly on others.
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> The success of Maryland's Exchange will depend in large part on its ability to balance transparency, accountability, and the capacity to coordinate with state agencies on the one hand, with the flexibility and independence necessary to respond nimbly to market forces, attract expert personnel, and remain insulated from changing political environments and budgetary cycles on the other. The Exchange's influence over insurance markets, certification of qualified health plans, administration of publicly financed benefits, as well as its mandate to provide recommendations on the design of the Navigator program, selective contracting and a host of other critical functions all demand utmost transparency, stakeholder input, and accountability.

The Exchange will operate in the private sector and must be competitive and nimble in its hiring and procurement practices as well as nonpartisan in its administration and development of policy. In order to be a stable and credible marketplace capable of meeting the myriad challenges of functioning in both the public and private sectors, the Exchange will need some combination of all of these qualities.

The Exchange's start-up functions and wide-ranging influence over both public and private sector entities and markets require, at least initially, the transparency and accountability of an independent public entity. However, the Council recognizes that while the attributes of a public entity will be clear advantages in the early incubator phase of the Exchange, it may evolve into a nonprofit later on. Once the Exchange is established, has a self-sustaining funding stream, and has carved out independent relationships with other government agencies and private sector entities, the balance may shift and the benefits of a nonprofit may begin to outweigh the strengths of a public entity. As such, the HCRCC recommends that the Exchange study and report to the Governor and General Assembly by 2015 its findings and recommendations on whether it should be transformed into a nonprofit or should remain a public entity.

Recommendation Two: Continue development of the State's plan for seamless entry into coverage to meet federal implementation deadlines and to maximize federal funding for information technology systems and infrastructure. This is a required building block of reform. A critical component of expanding insurance coverage and reducing the number of uninsured will be the states' success in enrolling people in new and existing public and private coverage options. To address this challenge, the HCRCC recommends Maryland continue expeditious development of its plan for seamless entry into coverage. The plan should leverage federal funding to the full extent possible and be technically feasible by the 2014 implementation deadline. Under the plan, the new eligibility determination policies and processes should: 1) constitute a dramatic simplification with a new income-based methodology; 2) embrace a "no wrong door" approach, with seamless integration across both health and public assistance programs; 3) reflect a "culture of insurance" in which everyone is expected to have coverage; and 4) be integrated with actual enrollment rather than having two separate processes for eligibility and enrollment administered by distinct systems.

Recommendation Three: Develop a centralized education and outreach strategy. The success of health care reform will depend in large part on whether individuals and organizations understand and utilize its changes in the health care delivery system to improve their health and well-being. To this end, the HCRCC recommends that Maryland develop a centralized education and outreach strategy. Components should include formally establishing a public/private educational coalition and developing templates for

outreach materials. The strategy should also focus on incorporating cultural competence and taking other steps necessary to ensure that its messages connect with racial and ethnic minorities and special populations.

Recommendation Four: Develop State and Local Strategic Plans to achieve improved health outcomes. The HCRCC recommends that Maryland undertake interconnected state and local planning efforts to address opportunities to improve coordination of care for those remaining uninsured even after reform implementation. A State Health Improvement Plan (SHIP) should conduct a health needs assessment with identified priorities and set goals for health status, access, provider capacity, consumer concerns, and health equity. The SHIP should also designate public and private sector partners to work with the State and local health departments on implementation and to monitor performance metrics. Local Implementation Plans should involve collaborations led by local health departments to identify systemic issues which must be addressed to achieve SHIP goals. The Community Health Resources Commission should provide technical assistance in the development of these plans, piloting models and sharing lessons learned.

Recommendation Five: Encourage active participation of safety net providers in health reform and new insurance options. Even with the ACA's substantial coverage expansion, an estimated 400,000 or more Marylanders will remain uninsured. Given the ongoing need for their services, the HCRCC recommends that Maryland provide technical assistance to safety net providers to help them prepare for changes brought about by reform. This effort should assess the administrative infrastructure of small safety net providers, identify partnering opportunities among providers, and develop a roadmap for the sustainability of these efforts. In addition, in order to fully leverage opportunities for public-private partnerships to improve health care delivery, the HCRCC also recommends removing certain statutory and administrative barriers to contracting between local health departments and private entities.

Recommendation Six: Improve coordination of behavioral health and somatic services. Given the high prevalence of behavioral health needs and the ACA's implications for behavioral health, the HCRCC recommends that DHMH examine different strategies to achieve integration of mental health, substance abuse, and somatic services. Potential avenues to be explored include statewide administrative structure and policy, financing strategies designed to encourage coordination of care, and delivery system changes.

Recommendation Seven: Incorporate strategies to promote access to high quality care for special populations. Virtually the entire spectrum of ACA implementation decisions have potential consequences for special populations at high risk of encountering difficulties in accessing affordable, high quality care. The HCRCC recommends that

wherever possible, Maryland should incorporate strategies to promote improved access to high quality care for special populations in making these implementation decisions.

Recommendation Eight: Institute comprehensive workforce development planning. While more people will have health insurance when reform is fully implemented, coverage will mean little without access to health care providers. The HCRCC recommends that Maryland institute comprehensive workforce development planning to ensure sufficient providers able to meet the needs of the newly insured. Using a grant to the Governor's Workforce Investment Board as a resource, this planning effort should improve data collection to enable more accurate assessment of needs and should enhance coordination of various workforce development efforts throughout the State.

Recommendation Nine: Promote and support education and training to expand Maryland's health care workforce pipeline. The HCRCC recommends that Maryland expand and maintain a robust workforce pipeline through support for education and training initiatives. Strategies should include renewing efforts to secure federal approval of funding for the Maryland Loan Assistance Repayment Program, facilitating clinical training opportunities in community settings, and promoting non-traditional paths to participation in Maryland's health care workforce, including promotion and expansion of career ladder opportunities for existing allied health care professionals.

Recommendation Ten: Explore improvements in professional licensing and administrative policies and processes. The HCRCC recommends exploring ways in which licensing and administrative policies and processes could be streamlined and improved to ease entry into the health care workforce. Potential improvements include permitting reciprocity for health occupations licensed in other states, with certain safeguards; incentivizing volunteerism in underserved areas; promoting cultural competency training; and continuing efforts to streamline credentialing.

Recommendation Eleven: Explore changes in Maryland's health care workforce liability policies. The HCRCC recommends that Maryland explore changes in its approach to health care workforce liability. After federal guidance becomes available, the State should consider participating in the ACA's demonstration program to evaluate alternatives to current medical tort litigation. In addition, Maryland should encourage hospitals and health systems to provide medical malpractice coverage for volunteer providers in community settings.

Recommendation Twelve: Achieve cost savings and quality improvements through payment reform and innovation in health care delivery models. With current rates of health care spending unsustainable, the long-term success of reform depends on whether

we can transform the delivery system to control costs while also improving health. The HCRCC recommends that Maryland achieve cost savings and quality improvements through multiple payment reform demonstrations and innovations in health care delivery models throughout the health system. The HCRCC specifically encourages continued support of the Maryland Health Care Commission's Patient-Centered Medical Home pilot and encourages coordination with other models to facilitate participation by small practices and to align care coordination strategies. Maryland should also promote evidence-based practices by disseminating findings from comparative effectiveness research.

Recommendation Thirteen: Promote improved access to primary care. The HCRCC recommends that Maryland support improved access to primary care by working towards critical investment in Maryland's network of primary care providers. This investment should be pursued by promoting deployment of some savings achieved through delivery system reform to increase Medicaid's primary care provider reimbursement rates.

Recommendation Fourteen: Achieve reduction and elimination of health disparities through exploration of financial, performance-based incentives and incorporation of other strategies. While coverage expansion is important to reducing disparities, it is only a first step; disparities exist among both the insured and uninsured. Maryland must employ strategies to help translate coverage expansions into improved health outcomes for everyone, across the spectrum of racial and ethnic groups. Given the important role of incentives in driving systemic change, the HCRCC recommends that Maryland explore financial, performance-based incentives to reduce and eliminate health disparities. The State should enhance data collection to facilitate better assessment of both needs and performance metrics, and it should ensure that all reform implementation efforts incorporate and are aligned with the goal of reducing health care disparities.

Specifically, opportunities to address disparities include: 1) Using existing data and knowledge of incentives to craft programs that reward reductions in Maryland's racial and ethnic health disparities; 2) Using the SHIP and Local Implementation Plans to identify and address disparities and to monitor the performance of efforts to mitigate them; 3) Creating a more diverse workforce and strengthening the safety net through comprehensive workforce development planning; 4) Promoting cultural competency training; 5) Helping safety net providers leverage health reform opportunities to improve access and care for the diverse populations they serve; 6) Employing education and outreach efforts that ensure cultural sensitivity and engage community based organizations; and 7) Improving data collection and analysis through SHIP and Local Implementation Plans, as well as the Maryland Health Care Commission's ongoing work to encourage common reporting of race and ethnicity among health plans.

Recommendation Fifteen: Preserve Maryland's strong base of employer sponsored insurance. Recognizing that employer-sponsored insurance is the backbone and primary source of health coverage in this country and the State, the HCRCC recommends that Maryland seek to preserve its strong base of employer sponsored insurance through strategies that bend the cost curve and hold down the cost of premiums for employers. The State should also work towards simplifying employer enrollment in health coverage, and all reform implementation decisions affecting employers should seek to minimize potential disruption for those currently offering insurance to their employees.

Recommendation Sixteen: Ensure continued leadership and oversight of health care reform implementation by establishing a Governor's Office of Health Reform. Given the need for ongoing coordination of health reform implementation, the HCRCC recommends that the Council continue to function through 2014 to monitor progress on recommendations and provide input on implementation activities. Additional HCRCC members should be considered, including leadership from the new Health Benefit Exchange and representation from the Governor's Workforce Investment Board. The HCRCC should be an advisory body to the Governor's Office of Health Reform, which should be the focus of authority for health reform implementation.

The Office of Health Reform should direct reform policy and issue instructions for implementation, without duplicating the functions of other executive branch agencies involved in reform implementation. To the greatest extent possible, the resource needs for the Office of Health Reform will be addressed through federal and private grant funding and existing general fund resources. It is important to invest a modest level of resources in leadership and oversight in order to realize the full savings potential of reform.

ESSENTIAL INVESTMENTS

While the HCRCC's financial model estimates that health reform will generate substantial cumulative savings to Maryland over the next ten years, some individual components of health reform involve costs as well as savings. In many areas, the early phases of implementation require initial investments to build infrastructure and support administrative functions that will help the State fully realize potential savings down the road. The federal government will make available, for limited periods of time, financing for significant portions of many of these initial investments if states act early. Thus, Maryland must be vigilant in taking the steps necessary to obtain all available federal funds as soon as possible. For example, federal exchange planning and implementation grants will largely support the creation of Maryland's exchange if the State complies with federal deadlines. The federal government has also announced recently that it will provide 90% of the funding necessary for the development of the new Medicaid eligibility systems until 2015. In sum, the State must recognize that the investment of some limited

resources upfront will be needed to take full advantage of all the opportunities presented by health reform to achieve both substantial long-term savings and lasting improvements in our health system.

CONCLUSION

Maryland's blueprint for health care reform implementation is ambitious. Realizing its full potential will require sustained and collaborative effort on the part of all public and private stakeholders to preserve the best of Maryland's world-renowned health care system while transforming other areas. If we can rise to this challenge, we can change the face of health care. We can become a state in which everyone has access to high quality care at an affordable cost. Working together towards that day when no Marylander ever faces again the choice between health care and other basic human needs, we can achieve the full promise of reform. We will leave our children a healthier Maryland.