Health Care Reform Coordinating Council Workgroup White Papers

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1. Exchange and Insurance Markets Workgroup:
Report to the Health Care Reform Coordinating Council

October 31, 2010

Introduction

The Co-Chairs of the Exchange and Insurance Markets Workgroup hereby submit this report of the workgroup's efforts to the Health Care Reform Coordinating Council (HCRCC).

The workgroup sought input from the public to guide Maryland's implementation of the Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), commonly referred to as federal health reform. A discussion document was created to request public comments on the following issues: whether the Exchange should perform functions beyond the federal minimum functions; the form of governance; the competencies and location of Navigators; whether there should be more than one Exchange and whether the individual and small group markets should be merged; strategies to encourage take-up and avoid selection bias; whether Maryland should phase in reforms prior to 2014; and how the Exchange operations should be financed once federal start-up funding ends. Individuals were also encouraged to provide comments on other topics if they wished.

Throughout the workgroup's activities, which included five meetings (held on August 10, August 26, September 15, October 1, and October 22), these issues were refined and additional issues emerged.

The workgroup focused its attention on the specific elements of its charge, based on both the Interim Report submitted to Governor O'Malley on July 26, 2010, and on the letter of direction provided by HCRCC Co-Chairs DHMH Secretary Colmers and Lt. Governor Brown.

This report summarizes the public input that was received. It identifies areas where common themes and suggestions—as well as differences of opinion—emerged.

As the workgroup's efforts proceeded, it became clear that only a handful of decisions require specific actions in the next 12 months, including the governance approach taken during the 2011 legislative session and whether Maryland should phase in certain reforms prior to January 2014 (e.g., begin moving the individual market to a modified community rating approach or require small groups to move toward benefit packages that may resemble the forthcoming federal "Essential Benefits"). Many other decisions can and should be made later. To determine which time-sensitive issues require a recommendation by the HCRCC, the Co-Chairs relied on a timeline developed by the State Coverage Initiatives (see the Appendix).

Even if certain issues do not require immediate decisions by policymakers, the Co-Chairs greatly value the thoughtfulness in the public input. Thus, the Co-Chairs will ensure that this full report—with the breadth and depth of the helpful public comments—will be presented to the

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successor entity of the HCRCC in order to inform future policymaking.

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Summary of Shared and Differing Perspectives

Shared Perspectives

Because most contributors shared a similar perspective in several topic areas, common themes and recommendations emerged. Contributors generally provided the following suggestions and recommendations:

- A single Exchange that will facilitate the purchase of health insurance in both the individual and small group markets should be created.

- The Exchange should not be located within a traditional executive branch agency.

- The Exchange should offer standalone single-benefit plans, such as dental plans, when necessary to offer all Essential Health Benefits required by Qualified Health Plans.

- The Board of the Exchange should include broad representation. Specific suggestions for members of the Board included public officials, consumer representatives, members of racial and ethnic minority groups, individuals with knowledge and understanding of commercial insurance, and individuals with knowledge and understanding of public health insurance.

- Navigators should be trained and certified to understand public sector programs such as Medicaid and CHIP, and also commercial insurance markets and products.

- Navigators should be culturally competent to work with populations with low health literacy, and assure that translated materials and interpreting services are available.

- The Exchange Plans should collect and analyze quality data to identify any disparities related to race, ethnicity, and language.

- Eligibility and enrollment into the Exchange (and Medicaid) should be simplified—using new technology—in order to alleviate some of the challenges in the current Medicaid eligibility process.

- The external individual market should not be eliminated.

- The Exchange should permit regional contracting within the state.

- The Exchange should not limit its contracting in the individual market to insurers and managed care organizations (MCOs) that also participate in HealthChoice; commercial insurers should be allowed to sell through the Exchange without a requirement that they participate in Medicaid.

- The Exchange should be financed by fees that do not influence individuals' or small groups' decisions to buy coverage inside vs. outside the Exchange. These fees should be designed in a way that creates a level playing field between individuals' and small groups' decisions to purchase insurance inside the Exchange vs. outside the Exchange. The Exchange should not be financed with state general revenue.

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Differing Perspectives

Although there were many shared perspectives, different opinions emerged in the following major areas:

- Whether the Exchange should perform functions beyond those required under federal law
- Whether the Exchange should be created as a nonprofit entity or as an independent or quasi-independent public entity like a commission or authority
- Whether the individual and small group markets should be combined into a single purchasing pool, or whether they should remain separate purchasing pools in separate rating groups
- Whether Medicaid should require that all Medicaid MCOs in HealthChoice offer a product in the Exchange, or whether Medicaid MCOs should have the right to choose to participate in Medicaid alone
- Whether Navigators should be employees of, or contractors to, the Exchange
- Whether employers of 51 to 100 employees should be considered "small employers" under state law prior to 2016 (thereby permitting them to purchase insurance through the Exchange), or whether Maryland should specify that from 2014 to 2016, small employers are limited to employers of 2-50 employees
- Whether or not certain federal reforms should be phased in before 2014

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Governance Structure and Location

The most pressing issue to be decided on in the next legislative session is the governance structure of the Exchange. Most future decisions regarding the Exchange will depend on the governance structure, as well as on the leadership team and Board of the Exchange.

Further, the entity created in 2011 will be responsible for creating the process (including ongoing public input) for the work that needs to continue after the governance model is established.

Almost universally, contributors recommended that the Exchange not be housed in a traditional executive branch agency, given state personnel systems, pay scales, the potential politicization of the Exchange, and the risk that individuals, carriers, brokers, and small groups would not perceive a traditional executive branch agency as a credible business partner. For example, one contributor said that if the Exchange's employees were subject to state furloughs, then the external market would be more responsive and would have a natural advantage, and the participation in the Exchange would suffer.

Public support was divided between locating the Exchange in either a public sector commission/ authority or in a nonprofit organization. Those who desire to see the Exchange created as a governmental entity stressed a number of reasons: the Exchange would be performing "inherently governmental" roles (under OMB Circular 76), such as distributing governmental funds (advanceable tax credits), promulgating rules and regulations on plan participation, and coordinating with state agencies and programs—such as Medicaid, the Maryland Insurance Administration (MIA), and state licensure boards; the Exchange would be handling sensitive information, such as individual income and citizenship status; and a publicly accountable governmental entity would be seen as more accountable to the needs of consumers.

Those who support creating the Exchange as an independent nonprofit organization also recognized that the state would need to be intricately involved in its organization, establishment, and functioning. These contributors explained that situating the Exchange in a nonprofit would isolate it from changes in the political and economic climates while taking pressure off of already overburdened state agencies and the state budget. It would allow the Exchange to be consumer-oriented and publicly accountable, and more independent from political influence. In addition, the Exchange would not necessarily be subject to state procurement laws, which would allow it more flexibility in hiring and salary decisions (though some contributors pointed out exceptions to procurement laws in state agencies: one example being the stadium authority). They believe an organization dedicated solely to the Exchange would ensure that it is run as adequately, effectively, and efficiently as possible. Some contributors believe locating the Exchange in a nonprofit agency would help increase enrollment by attracting individuals and small groups who may otherwise be unenthusiastic about the idea of purchasing insurance through a government entity.

No matter which location contributors supported, the majority of public comments agreed that representation on the Board of the Exchange needs to be broad and include a variety of stakeholders and experts. State officials should be welcome onto the Board for their expertise and experience (the most cited state official fitting this criterion being a representative from the

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Maryland Medicaid office). The following stakeholders were suggested for representation on the Board: insurers [note: this is not allowed under the ACA], consumer advocates, and employers. Contributors suggested that individuals with expertise in the following areas should also be on the Board: marketing, education and outreach, legislation, research, public programs, vulnerable populations, health care delivery, insurance markets, sales, and regulation. Contributors felt that the Board must also have representation from racial and ethnic minorities. Some contributors believe the Board could, at least in part, be appointed by the Governor. Another suggestion was that the Board could be appointed by a consumer protection agency official.

The majority of public comments stressed the need for the governance to be transparent and for Board members to be free from conflicts of interest. The Board of the Exchange should take advantage of existing infrastructure and expertise whenever possible.

The governance structure is a decision that needs some form of recommendation and resolution in the next 12 months, and legislative action is necessary during the 2011 session.

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Functions of the Exchange

The precise functions of the Exchange do not need to be resolved in the next 12 months, and a recommendation is not necessary. The Governor and legislature could define these functions in 2011, but there is no need to resolve the precise functions that soon; these decisions could be made later by the Exchange in the form of regulations, or in later legislation in the 2012 session.

Public comments revealed support for an Exchange that performs only the minimum functions required under federal law, as well as for an Exchange that performs functions beyond those that are required.

The Exchange should not perform additional functions

The contributors who articulated that the Exchange should act as a clearinghouse and not assume additional responsibilities cited a variety of reasons:

- The Exchange has many complex functions clearly outlined by the ACA and the focus should be on executing these basic functions before adding more.

- Many of the additional functions proposed are already duties of existing agencies; the Exchange should not waste resources replicating these functions.

- Adding functions has the potential to compromise participation in the Exchange. For example, limiting the number of insurers in an Exchange by imposing purchasing standards may limit consumer choice and cause both insurers and consumers to remain in the outside market; instead, the Exchange should encourage what one contributor called "a farmer's market approach."

- The Exchange will most likely be under constant pressure to expand and assume more responsibility once in place; therefore, Maryland should make the simplest, most efficient Exchange possible to leave room for future growth.

- The needs of the public and the challenges of the Exchange will be better understood once the Exchange has been implemented; therefore, additional duties should be allocated to the Exchange only after implementation and only once the additional duties become apparent on the basis of experience.

- The state budget is unsure and, given that the Exchange will not receive any federal financial support starting in 2015, Maryland should minimize the potential that the state general fund would have to shoulder the cost of expansive services. This risk is mitigated if the Exchange only performs the minimum tasks required by the ACA.

The Exchange should perform additional functions

Contributors who recommended that the Exchange take on additional functions explained that this would mean taking advantage of the opportunity to strengthen Maryland's health care delivery system. One contributor noted that the failure of the Exchange to capture a sizable number of individuals and small businesses and provide them with affordable, high-quality health care could result in the overall failure of the Exchange. Therefore, it should take on as

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many additional responsibilities as necessary to ensure its success. Another contributor observed that the experience in Massachusetts proves that an Exchange performing only clearinghouse functions is insufficient for controlling health care costs. The following additional functions were suggested:

- Control the quality of insurers within the Exchange: Most contributors who believe that the Exchange should take on additional functions also believe that controlling the quality of insurers is necessary. One frequent recommendation in this area was a requirement that the Exchange only contract with insurers that promote a patient-centered medical home model of care. Some other recommendations included establishing minimum outcome standards; requiring transparency and report cards; and requiring the adoption of electronic health records. Contributors disagreed on whether the Exchange should select insurers through competitive bidding or whether it should negotiate with insurers. Even the majority of those who do not support the Exchange performing additional functions believe insurers need to have uniform price and quality reporting to allow for easy comparison by consumers.

- Education and outreach: While the ACA outlines that the Exchange must provide some education and outreach, such as a telephone hotline, some contributors believe it should go further to ensure that it reaches out to and educates as many people as possible. Many of these comments focused on cultural competency, meeting the needs of people with disabilities, and providing resources in multiple languages, all through multiple media. These processes should be sensitive to underserved populations, like individuals with low literacy, limited English proficiency, mental illness, or those without access to a computer. Contributors said that an extensive approach would maximize participation in the Exchange and the purchase of health insurance by populations to whom the Exchange is available. Many who believe education and outreach are a necessary function believe this responsibility, in part, belongs to Navigators.

- Single portal to eligibility: The ACA requires that the eligibility transition between the Exchange and public programs like Medicaid and CHIP be seamless. There must be a "single portal to eligibility" that would allow individuals to apply for Medicaid and CHIP using the same application. Contributors suggested that the Exchange—rather than another entity— operate this single portal for eligibility; this would be an additional function, because the Exchange could receive a list of Exchange-eligible individuals from another entity. Throughout the comments, there was significant support for building a relationship between the Exchange and these public programs beyond the minimum requirements. Contributors suggested that the Exchange coordinate billing with Medicaid and CHIP or aggregate premiums from multiple employers. These additional functions could simplify the application and eligibility processes and reduce costs.

- Incentivizing: Some public comments focused on the possibility that the Exchange could incorporate incentives in order to accomplish a variety of goals. Such goals include: encourage use and availability of primary care facilities; encourage use and availability of medical homes; ensure adequate reimbursements; adopt new, cost-effective technology; enroll low-risk members; manage chronic conditions; enroll underserved populations; make high-performance, high-quality insurers available; increase patient satisfaction;

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decrease labor and administrative costs; promote healthy consumer lifestyles; and ensure good clinical outcomes.

- Support for small groups: A few contributors said that the Exchange should provide services to small groups that are available outside the Exchange, including the purchase of additional coverage; Section 125 administration; COBRA or state continuation administration; wellness or health advocate programs; and employee assistance programs.

The majority of contributors emphasized the importance of the Exchange not duplicating existing functions.

Whether or not the Exchange is to take on additional functions, where appropriate, it should utilize the services and expertise of public and private entities.

The decision regarding whether the Exchange should take on additional functions does not need to be resolved in the next 12 months, and a recommendation is not necessary.

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Basic Organization and Market Structure

The precise role of the Exchange in the broader market does not need to be resolved in the next 12 months, and a recommendation is not necessary. The Governor and legislature could make these decisions in 2011, but there is no need to resolve these issues that soon; these decisions could be made later by the Exchange in the form of regulations, or in later legislation in the 2012 session.

The specific issues that define the role of the Exchange in the overall insurance market include selection and take-up, existence of the external market, and the relationship between the individual and small group markets.

Selection and Take-Up

Many of the comments relevant to plan selection and take-up were more appropriately addressed in other sections of this document. For instance, many contributors noted the influence on selection and take-up of the existence of the external market, training of Navigators, and additional functions the Exchange may take on, such as education and outreach and controlling the quality of insurers sold within the Exchange. Further, some comments regarding selection and take-up were not suggestions for Exchange policy but, rather, for Maryland policy. A few comments pertained to selection and take-up independent of other sections and represented action that could be taken by the Exchange.

The main consistent recommendation was that all insurers selling in the external market offer a product inside the Exchange. As one contributor said, "Insurers that don't participate in the Exchange should be prohibited from offering catastrophic coverage outside the Exchange." Another contributor noted that requiring an insurer to offer products inside the Exchange in order to offer products outside the Exchange is forcing the Exchange to be the main market and provider.

Another frequent recommendation was that the Exchange make enrollment and plan comparison simple and clear. Most contributors who discussed participation believe that simplification and ease of enrollment combined with versatile, aggressive education and outreach would maximize participation. A variety of options for simplifying enrollment and plan comparison were presented. One suggestion was the implementation of an electronic verification system that would direct individuals to the appropriate portal of care: the Exchange, Medicaid, CHIP, or other public programs. Also, having one enrollment form for all public programs would reduce administrative costs and prevent individuals from having to understand and fill out different forms. Lastly, the Exchange should use simple language in its communication pieces.

Additional suggestions for how to mitigate adverse selection and encourage enrollment through the Exchange include:

- Limit open enrollment periods
- Encourage plan participation

- Encourage low-cost coverage options to participate

- Encourage broad provider networks

- Allow enrollment through multiple sources (online, by telephone, by mail, or in person)

- Assist consumers with not only enrollment, but also renewal and other subsequent issues

- Develop low-literacy materials and services

- Develop non-English materials and services

- Encourage value-based insurance design

- Encourage the inclusion of additional coverage, such as dental and emergency care

Existence of the External Market

Some contributors support the idea of eliminating the external market and selling all individual insurance through the Exchange. These contributors believe this would ensure the practicality of the Exchange because individuals would have to go through the Exchange for insurance. They pointed out that insurers would be more accountable to consumers as the Exchange may act as an active purchaser and impose more stringent quality and cost requirements on the insurers and products offered. Further, the Exchange could be in the position to control costs as it would only allow high-value insurers and products to be sold. Some contributors believe that the risk would be lowered in the Exchange if the external market were eliminated.

The majority of the public, however, does not support eliminating the external market. First, contributors pointed out that, because insurers would be required to pool inside and outside the Exchange, rates would be the same whether or not there was an external market. Second, the additional functions of the Exchange have not yet been determined, so the regulatory assumptions being made in the above argument are not yet certain. Third, eliminating the external market would eliminate a market through which many people currently purchase insurance. It would most likely cause much political turmoil as all participants in the individual market are forced into the Exchange. Lastly, the external market provides a source of competition that may help lower costs and increase efficiency in the Exchange. Contributors who support the coexistence of the Exchange and the external market argue that there are numerous disadvantages and few—and even in that case uncertain—advantages to insisting that all individual insurance be sold through the Exchange.

Individual and Small Group Markets

The public agreed that having one Exchange for both the individual and small group markets was the best option. The establishment and administration of one Exchange is already complex; there is no need to establish two Exchanges that would have significant overlap. Creating just one Exchange would limit administrative costs and burden, as well as reduce confusion for consumers.

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The comments were divided as to whether Maryland should combine the individual and small group markets or leave them separate. However, the majority of comments recommended keeping the markets (rating groups) separate.

Contributors who think the two markets should be combined stressed that the success of the Exchange lies in creating the largest, most viable market possible. Combining the two markets, these contributors said, would increase the size of the rating pool and could stabilize both markets while maximizing enrollment and lowering premium costs. Further, these contributors believe combining the two markets could encourage competition, create efficiencies, and encourage innovation.

Contributors who think the two markets should remain separate admitted that a larger pool generally does create more stability; however, this may not be necessary given Maryland's markets. The individual and small group markets may be fundamentally different, thus requiring distinct marketing, administrative functions, and plan design. In addition, the individual market is going to go through many changes over the next few years, and the small group market should not be destabilized by combining the two rating groups. In addition, some contributors pointed out that some insurers participate only in one of the two markets. These insurers may be at a disadvantage if the two markets are combined.

The precise role of the Exchange in the broader market does not need to be resolved in the next 12 months, and a recommendation is not necessary.

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Coordinated Contracting with Medicaid

Medicaid and the Exchange must coordinate in certain areas, such as the design of the entry point and eligibility, to ensure that a single, seamless process is used to enroll eligible individuals in the appropriate program: Medicaid for adults below 133 percent of the federal poverty level (FPL); Medicaid or MCHIP for children below 300 percent of the FPL; and the Exchange for adults above 133 percent of the FPL and children above 300 percent of the FPL.

Another potential area of coordination between Medicaid and the Exchange is the contracting policies utilized by either or both programs. For example, Medicaid could require the MCOs that have HealthChoice contracts to also offer products in the Exchange (as a condition of receiving a HealthChoice contract), in order to enable Medicaid beneficiaries to remain with the same insurance company as they transition from Medicaid to the Exchange (e.g., when adults experience income increases, or when children "age out" of MCHIP into the Exchange as they reach adulthood). Similarly, the Exchange could choose to only allow carriers to sell products in the Exchange if those carriers participated in Medicaid, as a condition of selling products in the Exchange.

Whether the Exchange and Medicaid coordinate contracting practices in either or both of these manners is not a decision that must be made within the next 12 months, so a recommendation is not required. Nevertheless, public input was requested on this topic, and very thoughtful comments were received.

Contributors consistently opposed the possibility that the Exchange limit its contracts to insurers that participate in HealthChoice. The comments uniformly stressed that commercial insurers should be allowed to participate in the Exchange without being required to participate in HealthChoice as a Medicaid MCO.

Regarding the suggestion that Medicaid MCOs be required to offer a product in the Exchange, the comments were much less uniform.

Several individuals asserted that Medicaid MCOs should be required to offer a product in the Exchange for the following reasons:

- It would promote continuity in care and provider networks when an individual moves from Medicaid to an Exchange product. Contributors who support this approach emphasized the disruption that would occur if Medicaid beneficiaries with complex health care needs (and who see many specialists) had to change insurers, networks, and providers simply because their income changed.

- Medicaid's purchasing power in the HealthChoice program (worth several billion dollars a year) would expand choices in the individual and small group markets if Medicaid MCOs were required to enter the commercial market.

- Medicaid MCOs already cover children up to 300 percent of the FPL (in the MCHIP program), and family enrollment in the same insurance company would be promoted by having Medicaid MCOs in the Exchange; thus, households between 133 and 300 percent

of the FPL would not have parents in one insurance company (in the Exchange) and their children in another (a Medicaid MCO).

- Adoption of the Basic Health Plan option in Maryland (which is a provision in the federal health reform law that would allow a state to cover adults up to 200 percent of the FPL in Medicaid, outside the Exchange) would not solve the problem of a "seam" between the Exchange and Medicaid; the transition between the programs would then occur at a different income level but would still exist.

Others endorsed the recommendation that Medicaid MCOs not be required to offer products in the Exchange for the following reasons:

- Medicaid MCOs have core expertise in a given model and program, and these MCOs should be entitled to select their markets and business models, and to continue focusing on public programs if that is their core strength and preferred business model.

- Unless state law changes, Medicaid MCOs would need an insurance license or health maintenance organization (HMO) license, and this requirement should not be imposed on Medicaid MCOs as a condition of contracting in HealthChoice.

- Maryland could and should adopt the Basic Health Plan[1] option, which would allow Medicaid MCOs to cover adults up to 200 percent of the FPL in Medicaid rather than the Exchange. This income cohort is likely to be less familiar with commercial insurance and more likely to need the specific specialty services of Medicaid (e.g., behavioral health) and the safety net provider network of Medicaid MCOs (e.g., FQHCs), whereas the cohort above 200 percent of the FPL is likely to be more familiar with commercial insurers and seek the networks offered in that market.

- Transitions from Medicaid and MCHIP to commercial insurance products occur now, and these transitions do not create continuity of care problems if enrollment workers (and Navigators in the future) work closely with families to select the best insurance carriers and products.

This issue does not require an immediate recommendation.

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[1] Under the "Basic Health Plan" option, states may contract with MCOs to provide health insurance coverage, outside of the Exchange, to certain nonelderly individuals below 200 percent of the FPL who may move in and out of the Medicaid program. The purpose of the Basic Health Plan option in federal law is to ease the transition in and out of Medicaid, and to improve access to care and continuity of care, for certain individuals familiar with Medicaid. The Basic Health Plan receives significant federal financial support; HHS will annually transfer 95 percent of Basic Health Plan enrollees' expected federal subsidies (e.g., premium tax credits and cost sharing subsidies) if the individuals instead are covered in the Exchange to Maryland via a state-established trust. The federal financial support for the Basic Health Plan option is not time-limited.

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Regional Contracting

Contributors stated that consumer choice of insurance carriers would be promoted by allowing the Exchange to offer products from carriers that do not offer insurance products on a statewide basis. For example, if an HMO has a licensed service area that is not statewide, or if another insurance carrier has a statewide license for a preferred provider organization (PPO) but is only allowed by MIA to sell insurance within a limited region of the state (due to the scope of its provider network), then the Exchange should allow those HMOs and other carriers to be options for individuals and small groups (through the Exchange) in exactly the same regions of the state where they offer insurance outside the Exchange.

These comments indicated that choice would be promoted through these regional contracts within the state, because regional HMOs and PPOs would be available choices. One contributor said that carriers should be "all in or all out," meaning the regions of the state in which these companies sell insurance outside the Exchange should be identical to the regions in which they sell inside the Exchange. That is, these companies should not be allowed to offer products in the Exchange in a *smaller* region of their state than their external market. The regions inside the Exchange and outside the Exchange should be co-extensive.

One Medicaid MCO asserted that if Maryland requires Medicaid MCOs to offer a product in the Exchange for continuity of coverage, then the Medicaid MCO's region in the Exchange should be limited to the counties in which the MCO is available to Medicaid beneficiaries in HealthChoice. That is, the MCO should not be forced to have a larger region in the Exchange than its region in Medicaid.

This issue does not require an immediate recommendation.

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Navigator Function

The location of the Navigator function, as well as licensure and training requirements, are very important decisions to be made in the establishment of the Exchange. While these issues do not require a policy decision in the next 12 months, they must continue to be pursued by the governance entity created during the 2011 session. Some informed and pertinent perspectives are presented below to help future policymakers design the framework for the Navigator function.

The majority of public comments stressed the need for the Navigator function to be free of financial relationships with insurers and other conflicts of interest. The comments also uniformly said that the Navigator function must closely coordinate with the enrollment broker in Medicaid's HealthChoice program in order to facilitate transitions as people change programs.

There was support for locating the Navigator position inside the Exchange, in which case Navigators would be employees of the Exchange. There was also support for locating the Navigator position outside the Exchange, in which case Navigators would be contractors to the Exchange.

Almost everyone who commented on the Navigator function asserted that Navigators need to be well-trained, not only in enrollment in private insurance, but also in Medicaid, MCHIP, and other public programs. One contributor noted that the Navigator function should "build on the current system in the commercial and public programs." Another contributor noted that the broad range of expertise needed by the function could be considered an "elevated form of licensure."

Many contributors indicated that the Navigators will be dealing with sensitive situations and people will be relying on them for guidance for as long as they have health insurance through the Exchange. Therefore, Navigators need to be able to present information clearly, concisely, and in simple language (as well as in multiple languages). Navigators need to provide forms of post-enrollment service to the insured, and follow through and facilitate enrollment with individuals and small groups.

Contributors said that this type of full-service support from Navigators is essential for the Exchange to be a credible source of coverage—especially when compared to the external market. If Navigators inside the Exchange fail to be as knowledgeable, accommodating, and customer-oriented as agents, brokers, and health departments in Medicaid and the external insurance market, then the viability and credibility of the Exchange is at risk as people may turn to the outside market for their insurance needs.

A few contributors said that the salaries of Navigators should be comparable to (or above) the salaries of brokers for many reasons, including the expansive skills and training required of Navigators.

Contributors pointed out that it is impractical to expect every Navigator to have full expertise in every public and private program, for every individual and small group, across all languages and the diversity of the population, and in every region of the state. Instead, contributors said that the Exchange must retain Navigators (inside or outside the Exchange) who collectively fulfill these

duties. One contributor suggested having general and expert Navigators. General Navigators could be licensed in the commercial market and have general knowledge about other topics, including where individuals can go to get further information. Expert Navigators could be more knowledgeable about public programs and could be responsible for the more vulnerable populations passing through the Exchange. Another contributor pointed out that the more successful the Exchange is at being a clear, simple way to purchase insurance, the more Navigators can focus on assisting disadvantaged populations.

The precise role and location of the Navigator function does not need to be resolved in the next 12 months, and a recommendation is not necessary.

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Phase In Reforms

Maryland could choose to phase in certain reforms prior to January 2014 in order to avoid the potential shock of numerous changes affecting the market all at once. For example, Maryland could elect to gradually phase in a form of community rating in the individual market prior to 2014, or modify the mandated benefit rules in the small group market to conform to the federal Essential Health Benefits (once those are clarified by the federal government).

Strong arguments were made on both sides of this issue. Contributors who believe phasing in federal reform is the best course of action seek to mitigate the sudden "sticker shock" that individuals might experience in 2014 when underwriting practices end in the individual market, all individual products are subject to federal benefit design rules (thereby ending catastrophic-only insurance), and MHIP is combined with the current individual market.

In the small group market, phasing in reform is supported by some contributors in order to "gradually modify the CSHBP and adjusted community rating."

Supporters of a phase-in argued that incremental changes are easier to handle than drastic changes. Also, some of the changes that need to be made could take a significant amount of time and effort. Some contributors feel that getting a head start on these changes would ensure an effective system by the time the reforms should be in place.

On the other hand, some contributors believe that insisting individuals pay higher premiums sooner for the sake of incrementalism could create unintended problems that are economic, social, and political. As one contributor expressed, phasing in federal reform would "ease the shock but accelerate the pain." Others said that incremental changes would simply add to the underlying confusion about health care reform, and that the state should not create more confusion by adding new deadlines and changes in law, all with varying effective dates. These contributors believe that the benefits of phasing in the reform are unknown and are outweighed by the potential negative consequences.

Because a decision to phase in reforms likely would require statutory changes in the individual and/or small group rating rules and benefit requirements, it is appropriate to begin the policy discussion in the 2011 legislative session. The HCRCC should further discuss this issue.

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Definition of Small Employer

Some contributors believe defining "small employer" as "an employer with 1-100 employees" as soon as possible is the best course of action. These contributors believe the Exchange needs to be as large as possible to ensure its success.

Others believe the definition of "small employer" should remain "an employer with 2-50 employees" until it is federally mandated to change to "1-100 employees" in 2016. First, changing the definition would be an additional responsibility the Exchange does not need to take on before 2014. Letting the definition change when the ACA has designated it to change would reduce the use of resources. Employers with 51-100 employees have options available to them, so including them in the Exchange may not be necessary and may lead to adverse selection. Second, expanding the definition of "small employer" would encourage self-funding and thus may also contribute to adverse selection.

This issue does not require an immediate recommendation.

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Self-Sustaining Financing for the Exchange

Though a short-term budget needs to be decided on, the availability of planning grants and a deadline that is more than four years away allow the topic of self-sustaining financing to be considered long-term. Self-sustaining financing implies that the Exchange must be functional without federal funds by 2016.

Almost all contributors agree that the Exchange should be self-financed without resorting to state funds, both because of the state's ongoing structural deficit and because reliance on state funds might negatively affect the operations and stability of the Exchange. A few dissenting contributors said that the state should apply some of its savings from health reform to help finance the operations of the Exchange once federal support ends. Contributors also noted that utilizing state funds would only make sense if the Exchange were created as a public sector entity.

Most contributors believe the Exchange should not be subject to changes in the state budget and should instead be funded by user fees to insurers, consumers, or both. However, some contributors noted that assessing fees on insurers may mean they are paying twice. Built into premium rates are fees to finance the external market, such as broker commissions. To add a fee to fund the Exchange on top of set premium rates may mean insurers and consumers in the Exchange are paying fees to finance both markets. A few contributors voiced support for the Massachusetts model; in this case, instead of assessing a fee on top of premium rates, insurers in the Exchange would be required to give the Exchange a percentage of the premium that would have gone to finance the external market.

A few contributors pointed out that licensure fees for Navigators could also be used to partially finance the Exchange. Other contributors suggested charging fees not only to users and insurers, but also to stakeholders who benefit from the implementation of the ACA. Such stakeholders include self-insured employers, pharmaceutical companies, and medical supply manufacturers. Many contributors said the fees should be broad-based (i.e., apply to brokers and carriers outside the Exchange just as they apply to Navigators and insurers inside the Exchange). Comments universally supported the view that the financing strategy should not create an uneven playing field between coverage sold inside and coverage sold outside the Exchange; the financing approach should not influence individual or small group purchasing decisions.

The Exchange should be financed with the goal of minimizing the effect of the financing strategy on individual, small group, and plan participation decisions. The fees need to be low enough so that no one is discouraged from participating in the Exchange. Further, user fees would need to be low enough so that identical products would not be more expensive inside the Exchange than in the external market. However, as premium costs in the outside market include fees and commissions, a fee of the same magnitude to purchase a product through the Exchange in order to retain overall pricing comparability is a plausible outcome. This may mean that assessing smaller fees on multiple parties, consumers, insurers, and stakeholders is the best means of self-sustaining financing to avoid high costs to any one party. Contributors agree that financial

information should be transparent and broad-based. Most contributors agree that user fees should be excluded in the medical loss ratio calculation.

One contributor said that the ideal model—both for governance and self-sustained financing—is the Maryland Stadium Authority because of its capacity to issue bonds and borrow money. This would enable the Exchange to make long-term capital investments (such as information technology) and secure the financing for future revenues.

The precise strategy to ensure that the Exchange is self-sustaining after federal funding ends does not require an immediate recommendation.

Conclusion

The Co-Chairs of the Exchange and Insurance Markets Workgroup suggest that deliberation on the decisions that do not require an immediate recommendation be conducted by the governing body of the Exchange when appropriate. They wish to thank everyone who tendered comments for their invaluable contributions to this process. The Co-Chairs hope the HCRCC can utilize the perspectives presented in this document to begin to construct an Exchange that best serves the needs of Marylanders.

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Contributors

Alliance of Maryland Dental Plans
America's Agenda: Health Care for All
American Federation of Labor and Congress of Industrial Organizations (AFL-CIO)
American Federation of State, County, and Municipal Employees, Maryland (AFSCME)
American Hospital Association
America's Health Insurance Plans
Amerigroup Community Care of Maryland, Inc.
The Arc of Maryland
Baltimore Association of Health Underwriters
Baltimore HealthCare Access
Beilenson, Peter
Christian Science Committee on Publication for Maryland
Connecture
Evangelical Lutheran Church in America
Frank, Jon
Group Benefit Services, Inc.
Health Insurance Buyers and Brokers Coalition of Maryland
Homeless Persons Representation Project
Kaiser Permanente
League of Life and Health Insurers of Maryland, Inc.
Legal Aid Bureau, Inc.
The Maryland Alliance of Dental Plans
Maryland Catholic Conference
Maryland Chamber of Commerce
Maryland Citizens' Health Initiative Education Fund, Inc.
Maryland Citizens' Health Initiatives: Health Care for All!
Maryland Hospital Association
The Maryland Women's Coalition for Health Care Reform
MAXIMUS
MD Association of Health Underwriters
MedChi
MedStar Family Choice
MedStar Health
Mental Health Association of Maryland
Middaugh, Susan
National Association of Dental Plans (NADP)
Naumburg, Eric
Office of Minority Health and Health Disparities
Patient First
Pharmaceutical Research and Manufacturers of America (PhRMA)
Public Justice Center
Schumann, Deborah
University of Maryland, Baltimore

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Appendix

Major Exchange Timeline Tasks from "Health Benefit Exchanges: An Implementation Timeline for State Policymakers"

State Coverage Initiatives
Robert Wood Johnson Foundation
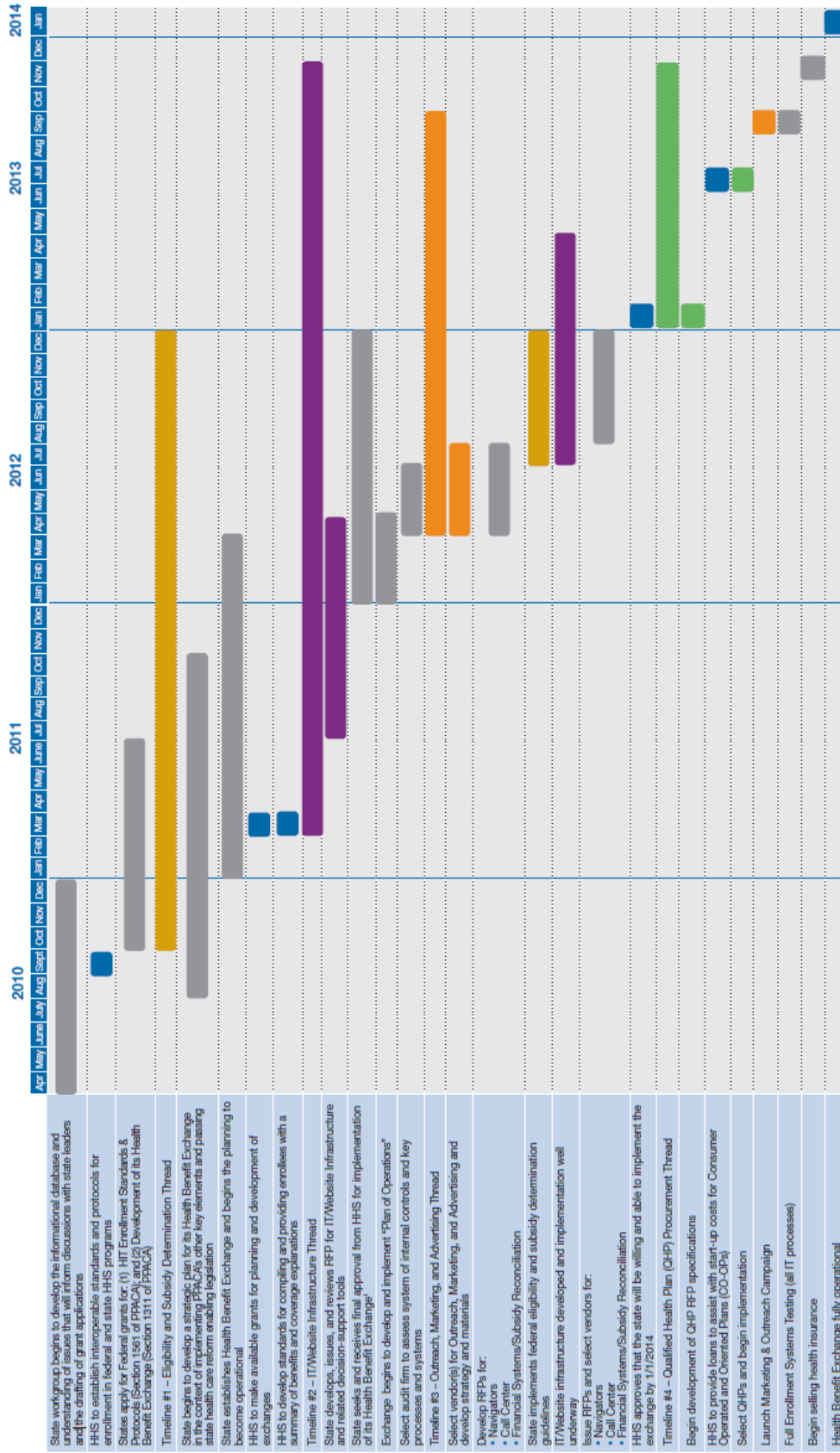
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2. Entry into Coverage Workgroup:
Report to the Health Care Reform Coordinating Council

Charge

One of the fundamental goals of the Affordable Care Act (ACA) is to reduce the number of the uninsured.   Health care reform expands insurance coverage though several different strategies: it expands Medicaid[2]; offers premium subsidies to individuals with incomes above the Medicaid level[3]; imposes a requirement that individuals maintain health insurance enforced by a federal tax penalty[4]; and creates new health insurance exchanges to facilitate the purchase of insurance.[5] There are also subsidies for some small employers and penalties for employers that don't offer insurance. Together, these strategies create a "culture of insurance" where virtually everyone is expected to have health insurance through public or commercially available health insurance.

Estimates are that these combined strategies will cut the number of uninsured by half in Maryland.[6]   But achieving these goals depends largely on the State's ability to enroll people in the new and existing coverage options available to them.   Many implementation decisions are left to states.   Some of these decisions will create the foundation for how Maryland will connect people to coverage and the extent to which ACA's goals of expanding insurance coverage and reducing the number of uninsured are met.   In its Interim Report, the Health Care Reform Coordinating Council (HCRCC) charged the Entry into Coverage Workgroup with identifying options for Maryland to consider in its approach of Entry into Coverage.   These encompass both eligibility and plan enrollment:

1. Eligibility -- The structure, process and policies to determine eligibility for individuals in Medicaid, the Maryland Children's Health Program (MCHP) and income-based premium credits offered through an Exchange; and

2. Enrollment - The point of access for individuals and small businesses to enroll in health plans offered through the Exchange.

The structure and goals of the Exchange are within the purview of a separate workgroup, Exchange and Insurance Markets.   There are a number of decisions about the Exchange that are fundamental to developing options for Entry into Coverage: What will be the goals of the

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[2] P.L. 111-148: §2001 as modified by §10201; P.L. 111-152: §1004 and §1201

[3] P.L. 111-148: §1401-15, §10105, as amended by §1001 and §1004 of P.L. 111-152

[4] P.L. 111-148: §1501(b) as amended by §10106 (b) of and by §1002 of P.L. 111-152

[5] P.L. 111-148: §1311(b)(1)(B) discusses a state option to operate two exchanges (an individual exchange and a SHOP [Small Business Health Options Program]exchange) or consolidate as one.

[6] Health Care Reform Coordinating Council (July 2010). *An Interim Report*. Retrieved from http://healthreform.maryland.gov/documents/100726appendixf.pdf

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Exchange? What functions will actually be performed by an Exchange or be left to the current private sector mechanisms for enrolling people into coverage? The Exchange and Insurance Markets Workgroup is beginning a process to examine options, but it is likely that much uncertainty will remain about how Maryland will choose to implement an Exchange. In its Interim Report, the Council called for a consumer-centric approach to both care and coverage that provided seamless transition between eligibility determinations and enrollments. Achieving this goal will require that eligibility and plan enrollment process are connected. The Council will need to evaluate the Entry into Coverage options presented in this paper in the context of options being considered by the Exchange and Insurance Market Workgroup. The on-going health reform implementation efforts will need to align the future decisions in these areas.

Process

The Entry into Coverage Workgroup was co-chaired by Brian Wilbon, Interim Secretary of the Department of Human Resources, and John Folkemer, Deputy Secretary of Health Care Financing, Department of Health and Mental Hygiene. There was no assigned membership. In an effort to be as inclusive as possible, participation in the workgroup was open to any interested party.

The workgroup met four times between August 2010 and October 2010. The goal of the first meeting was to review the charge, provide background information and overview of current enrollment system, and present an overall work plan. The co-chairs solicited feedback, to include any gaps in the conceptualization of the enrollment system or focus of the work plan. The goal of the second meeting was to listen to oral and written testimony from various stakeholders to highlight issues to be taken into consideration when framing the enrollment system to new federal standards in 2014. The goal of the third meeting was to present the first draft of the white paper, which reflected the public comments as well as a basic structure of Maryland's new enrollment and eligibility system. Feedback was solicited to ensure the draft white paper accurately reflects the scope of the public input. The goal of the fourth meeting was to present an updated iteration of the report and to solicit any remaining comments.

Background on Issues

Federal guidance is still pending on a number of issues that are important to state implementation efforts. Federal regulations on eligibility issues were expected by the Fall of 2010, but have not been released to date. Until regulations are released, states do not know the essential requirements of the new systems. One of the most significant outstanding federal decisions is whether the states will be required to track Medicaid eligibility under current rules as well as the new streamlined rules for 2014. If the federal government requires states to track this information for the purposes of federal matching formulas, efforts to streamline eligibility could be thwarted.

Federal policy makers are considering the possibility of providing either standards for eligibility system development or possibly components of an eligibility system to states through the use of open source software or common systems. While this could significantly assist state efforts, the uncertainty about what assistance will be offered is complicating state planning efforts. Even if

the federal government provides some systems, states would still be required to complete significant information system changes as well as implement and integrate a 'common system' with existing systems.

The data exchange standards and details of how verifications will be streamlined through connections to the IRS and other federal databases have yet to be determined. In addition, a simplified common application form across health programs is to be developed by the federal government.[7] The data elements and structure of this application will also impact information system development.

Although there are a number of uncertainties about implementation, the development of eligibility and enrollment systems takes significant lead time and state implementation efforts must begin immediately. The Entry into Coverage Workgroup is basing its planning efforts on the assumption that the streamlined connections to the IRS and other federal databases will be realized so that the possibility of real time eligibility determinations through a simplified process is achievable.

Options

This section of the paper summarizes the options proposed by public comments as well as options developed by Agency staff for which guidance is needed despite a lack of comment. The majority of comments focused on the process for determining income based eligibility for Medicaid, MCHP and premium credits. Several common themes emerged as goals for Maryland's Entry into Coverage implementation.

- Income based eligibility determination policy and process should be dramatically simplified relative to the current policy and process for Medicaid and MCHP;
- Eligibility determinations should be integrated and seamless (across both health and public assistance programs);
- Eligibility policy and process should reflect the culture of insurance (where all individuals have insurance coverage as required by the federal mandate) envisioned by ACA and called for in the Interim Report of the HRCCC;
- There should be a "No Wrong Door" approach to applying for coverage (across both health and public assistance programs).
- Eligibility and enrollment into health plans should be part of a continuous process rather than distinct systems.

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[7] P.L. 111-148: §1413

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Eligibility Determination for Medicaid, MCHP and Premium Subsidies for Plans Offered through Exchange

ACA requires State Medicaid and CHIP programs and the Exchange to coordinate enrollment procedures to provide seamless enrollment for all health programs.[8] State Exchanges have the option to contract with State Medicaid agencies to determine income based subsidies under the Exchange. Regardless of where the function is housed, Maryland has two basic structural options: Create a point of entry for consumers to health programs, managing eligibility determinations for Medicaid, CHIP and Premium Credits for Exchange products in one place; or Build on the existing health and public assistance model for Medicaid and public assistance and coordinate with eligibility determination for Premium Credits through the Exchange.

Maryland's current process for determining eligibility for Medicaid has evolved over a 40 year history of changing public assistance programs and Medicaid expansions. Today, about 1,600 staff at 24 local Departments of Social Services, 24 Local Health Departments and at Maryland's Department of Health and Mental Hygiene (DHMH) review and approve applications. The Client Automated Resource and Eligibility System (CARES) supports the eligibility determination for the majority of Medicaid and MCHP enrollees, but some groups' eligibility is determined outside of the CARES system. In addition, the CARES system determines eligibility for other social programs sucs as food, cash and energy assistance, and provides an integrated care for those individuals with eligibility in multiple programs. Local Departments of Social Services, Health Departments, and DHMH all use CARES system to support current operations

The Service Application and Information Link (SAIL) system is a web-based system that is available via the Internet to the public. Today, 8.5 percent of all Medicaid applications and 17.8 percent of all MCHP applications are received through SAIL. The SAIL system is a tool available to consumers to apply for benefits electronically for most Medicaid programs, food assistance, cash assistance, and energy assistance. SAIL has an interface with the CARES system, providing a transfer of the application data into the eligibility system without the re-entry of data. Some comments said that in its current state, SAIL is insufficient as a screening tool and simplified enrollment tool. .

Virtually all comments to the Entry into Coverage Workgroup called for seamless eligibility determinations through an integrated eligibility system. Some even called for a co-locating of eligibility staff. The challenge for Entry into Coverage implementation is how to achieve seamless enrollment to health coverage programs across the income scale as envisioned by ACA as well as coordinating eligibility determination process for related health and public assistance

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[8] P.L. 111-148: §2201

programs (Chart 1). Many comments urged the state to coordinate eligibility for all of these programs at the start of any new system.

Chart 1. Coordination of Eligibility Determinations

Overall Eligibility and Enrollment Schema

No eligibility determination	Small Employers Enrolling through Exchange	
	Individuals Enrolling through the Exchange (non-subsidy)	
400%FPL	Non-group market with subsidy	
Eligibility determination required	MCHP	Special health care programs with varying eligibility requirements
133%FPL	Medical Assistance	Social services programs with varying eligibility requirements

ACA requires Seamless Eligibility Determination

- - - - - No wrong door

Central vs. Local Eligibility Determinations

Today, Medicaid and MCHP applications are accepted by mail, in person and through web-based applications. The applications are processed by 1,600 staff in 24 Local Departments of Social Services, 24 Local Health Departments and DHMH.   There was consensus that there will continue to be a need for a local eligibility and enrollment assistance; however, the role of the traditional case worker may change as more automated systems proactively determine eligibility. This local role may be able to focus on assisting with more complicated Medicaid eligibility cases, such as long term care and home and community-based waiver eligibility, and connecting individuals to a broader range of services and public assistance programs. The local role would need access to tools, such as a health portal or more comprehensive access to the eligibility

system of record, to facilitate enrollment into Medicaid, Maryland Children's Health Program (MCHP), or Premium Credits.

A centralized administrative system could manage eligibility determinations that are based on applications that come in other than in person (mail, fax, phone, and web). This centralized system could manage data-driven eligibility determinations such as automated feeds of IRS information on prior-year income data.

These options will need to be more fully vetted when federal guidance is provided and more is known about what eligibility determinations will actually be supported by automated systems. Maryland is estimated to have over 1 million individuals enrolled in Medicaid by 2015.   Even with new automated strategies, this new caseload as well as current staffing levels will likely mean that new staff will be required.

Use of Modified Adjusted Gross Income Standards (MAGI)

Today, states use a number of different standards to calculate income for the purpose of Medicaid eligibility.   States use different policies to calculate income and use different income disregards in setting their eligibility thresholds. ACA requires all states to use Modified Adjusted Gross Income (MAGI) as the way to calculate income for eligibility determinations for Medicaid, MCHP and subsidies through the Exchange.[9] All states are required to apply a standard 5% disregard so that income disregards are also standardized. In some respects, this will simplify the eligibility determination process because MAGI can be calculated from Adjusted Gross Income which is a line item on an individual's tax return. ACA assumes electronic verification of income will occur through linkages with the IRS.   These new requirements will change the concept of eligibility determinations with computer systems providing more ability to make real-time determinations based on electronic sources of verification.

In other respects, the change to MAGI will complicate eligibility determinations. MAGI provides household income in the prior year, but may not reflect current circumstances. Therefore, processes to gather current information will need to be established.   Some low-income individuals do not file taxes and systems will need to consider how to process their eligibility. Some stakeholders called for standardized eligibility rules and income definitions across programs.   The use of MAGI will support the standardization across health programs (Exchange, Medicaid and MCHP), but it would be more difficult to standardize income definitions across public assistance programs and even within some Medicaid eligibility groups.[10]

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[9] P.L. 111-148: §2001 as modified by §10201; P.L 111-152: §1004.

[10] Per P.L. 111-148: §2001; certain groups are exempted from income eligibility determinations based on MAGI. They are (1) individuals who are eligible for Medicaid through another federal or state assistance program, such as

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Although there was little comment from stakeholders, one of the challenges of the eligibility process will be the interface with a federal tax credit process. The federal tax credit is advanceable[11], meaning that applicant can elect to receive the tax credit immediately, which will have the effect of reducing the upfront premium costs. How an individual will agree to accept the advanceable credit will be important to consider because it will affect the eligibility determination process.

Websites
ACA maximizes the role of the internet in applying for and renewing coverage. HHS launched a website on October 1 that provides information on health plans available in each state and links to enrollment information on Medicaid and MCHP.[12] This website will be refined and ultimately linked to Exchanges for enrollment information. By 2014, States are also required to operate an internet website that links the Exchange, Medicaid and CHIP. This website must allow individuals to compare plans and apply for and renew coverage.[13]

Today, Maryland has a web-based application for Medicaid and MCHP and public assistance programs, but some other health programs are not currently supported by a web-based application. Maryland is developing a web-based health application that combines applications for Medicaid, MCHP, the Primary Adult Care Program and local health initiatives and links to SAIL and CARES for eligibility determinations. A website that supports consumers in applying for coverage is both required by federal law and advocated for by most stakeholders.

The website will be an important way to reach consumers and could serve many functions: providing information about health programs and a means to apply, screening tools and decision tools that give consumers real time information, comparative information about health plans and choices.

Some comments expressed a concern that implementation of Entry into Coverage strategies could not rely solely on web-based strategies because many low-income and vulnerable populations do not have access to internet. Computer literacy varies tremendously and websites need to be developed in accessible formats. Web resources need to be written at no more than a

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foster care; (2) the elderly; (3) certain disabled individuals eligible for SSI; (4) the medically needy and (5) enrollees in a Medicare Savings Program.

[11] P.L. 111-148: §1412(a)(3).

[12] P.L. 111-148: §1103, as amended by §10102

[13] P.L. 111-148: §2201

4th grade reading level and include translation into prominently spoken languages. The website should be tested with diverse consumers before launching the site.

Assistance with Eligibility

ACA calls for states to provide assistance to individuals to apply for and enroll in health plans. ACA requires Exchanges to set up Navigators[14] to provide fair and impartial information regarding enrollment in health and subsidies.   States are required to establish procedures for conducting outreach and providing enrollment assistance to vulnerable and underserved populations.[15]

There is broad consensus that Maryland should use a diverse network of existing community based organizations with a track record of trust in their community to assist individuals to enroll in health coverage programs. Massachusetts' experience with small grants to community based organizations was cited as a model that many wanted to pursue. This concept is thought to be particularly important for special populations that may rely on specific community based organizations for assistance. Some commented on the need for on-going stable financing to support the community assistor activity. Effective training and tools (health portals) to support community based organizations will be necessary.

Some suggested the use of out-stationed eligibility workers to facilitate enrollment. As systems are developed and it becomes clearer what the role of eligibility workers will be in a new technology enabled system, this option should be evaluated.

As health coverage is expanded both through Medicaid and new products offered through the Exchange, additional strategies to assist people with eligibility should be considered. Implementation plans should consider how to coordinate the different roles of assistors: case workers, brokers and agents, community based organizations, and ombudsman and care coordinators.   It is important that these assistors represent the communities they will serve.

Hotline/Helpline

Many stakeholders called for a well staffed and trained hotline or helpline to be available to consumers for information on programs and how to apply.   The telephone helpline/hotline could serve as an important resource for consumers in answering questions about availability of benefits.   ACA also cites the telephone as one of the mechanisms for individuals to apply for

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[14] P.L. 111-148: §1311(i)

[15] P.L. 111-148: §2201

coverage.[16]   The hotline/helpline is an important compliment to outreach and education strategies. This hotline/helpline needs to be well trained and staffed to support the outreach and education efforts that may precede plan enrollment and may need enhanced staffing at peek times. The helpline/hotline staff also need to be trained to provide culturally appropriate services and have the capability to link individuals with limited English proficiency with needed resources.   Consumers should have a variety of ways to get follow-up information, including the telephone and website.

Strategies to Achieve No Wrong Door Goals

No Wrong Door refers to a service system that welcomes people in need and assists them to connect with desired services regardless of the agency where they try to gain access. In simple terms, it means that consumers should be able to get information and apply for programs wherever they are – at a local health department, department of social service or when they are seeking health care services or other services.

ACA requires a "no wrong door" approach to eligibility determinations for income based health programs (Medicaid, MCHP, Exchange Subsidies).[17]   Some changes to the eligibility determination process for health programs will make the linkage with public assistance more challenging. However, there are opportunities to use the changes to the eligibility determinations process for health to make it more seamless with related public assistance programs. These include:

    a. Effective and simple screening tool for programs (health and public assistance) – A screening tool that enables consumers to input basic information and be prompted to ask questions that would allow a determination of eligibility for a broad range of programs is an important tool for case workers, community assistors or consumers to get the information they need about a broad range of programs and their potential eligibility. An effective screening tool could empower consumers, community assistors and case workers for a range of programs to provide information and assistance to the consumer. The SAIL system already provides this screening tool for many programs through its "Am I eligible" calculator, which determines potential eligibility based on consumer responses to a few questions.

    b. Document Management and Verifications – One of the barriers to enrollment in both health and public assistance programs is the difficulty individuals have collecting and providing documentations of income, immigration status, citizenship or other

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[16] P.L. 111-148: §1311(d)(4)(B)

[17] P.L. 111-148: §1413

required materials. A shared document management system could ease the barrier to enrollment by allowing information to be provided once and shared among health and public assistance programs.   There are other states that use data driven document verification strategies and these should be explored. It is also assumed that new avenues will be available to verify income for health programs through linkages with the IRS that will reduce barriers to enrollment related to income verification.

c. System to Check Status of Eligibility Determinations –   Some stakeholders proposed a system that would allow consumers or community assistors access to real-time information on the status of their eligibility determination for health and public assistance programs. This system could provide information on documentation that is missing or information that is needed to complete the eligibility determination process.   This concept applies to both health and public assistance programs.

d. Single Streamlined Application - ACA requires HHS to develop a single streamlined application form that can be used for applying for subsidies under the Exchange, Medicaid or MCHP.[18] States may develop their own single form as long as it meets the same standards.   Some suggested the advantage of having a common application between health and public assistance programs. The federal requirements regarding the streamlined health subsidy application may make it challenging for health and public assistance to share the same application form; however, the concept that the health application could be the basis of an application and other programs would develop modules for information specific to their program is worth pursuing once more is known about what the Federal application will require.

e. Express Lane Eligibility - Prior federal law (CHIPRA) gave states the option to allow children express lane eligibility, allowing Medicaid and CHIP eligibility requirements to be satisfied based on the data from other government agencies. This means states could deem children eligible even if there are technical differences in how income is evaluated across programs. ACA preserves this opportunity, exempting express lane strategies from the new MAGI income definition.[19]   Express lane strategies could allow children who are eligible for SNAP to be automatically deemed eligible for Medicaid or MCHP. Express lane strategies should be evaluated as another approach to achieving no wrong door policies.

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[18] P.L. 111-148: §1413

[19] P.L. 111-148: §2001 and §2002 as modified by §10201

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The General Assembly approved budget language requiring a study of No Wrong Door policies across a broad range of public assistance programs. The implementation of health reform should work in collaboration with the efforts of this group.

Policy Issues to Expedite Eligibility Determinations or Maintain Coverage

Current federal law allows states to use presumptive eligibility for pregnant women and children. ACA extends this definition, giving states the options to allow this option for additional populations.[20] In addition, it allows hospitals to conduct presumptive eligibility.[21] This is an option to consider and some stakeholders called for this strategy to maximize coverage options. Clear and simple criteria for determining a person's eligibility for Medicaid, based on readily accessible information, will facilitate hospitals' ability to accurately determine eligibility.

One of the challenges with Medicaid is that individuals churn on and off of coverage as their income and other circumstances change. A number of stakeholders called for 12-month guarantee of eligibility to reduce churning of individuals on and off of Medicaid, MCHP, or Exchange subsidy coverage. Some called for implementing this prior to 2014 reforms. Under Maryland's current eligibility policy, when an individual is determined Medicaid eligible, they are enrolled for 12 months. However, individuals are required to notify their case worker when they have a change in circumstance which may affect their eligibility. There is an annual redetermination process which verifies their continued eligibility. Medicaid enrolled individuals who are eligible for other programs such as Supplemental Nutrition Assistance Program are required to reapply for coverage more frequently. A 12-month guarantee of eligibility would maintain individuals on Medicaid regardless of whether they continue to meet eligibility requirements. Until 2004, Maryland guaranteed eligibility for 6 months for all individuals enrolled in HealthChoice except those who were paying premiums through MCHP premium. This policy was discontinued for cost containment reasons. A policy to guarantee eligibility for 12 months just for children has been estimated to be $58 million.[22]

Under federal rules, individuals who are incarcerated are not eligible for Medicaid services. However, they may be eligible for Medicaid after they are released and

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[20] P.L. 111-148: §2001 as modified by §10201

[21] P.L. 111-148: §2202

[22] Maryland Department of Health and Mental Hygiene (December 2009). *2009 Joint Chairmen's Report: Report on Barriers to Enrollment at the Community Level*. Retrieved from http://www.dhmh.state.md.us/reports/pdf/2009/dec09/Medicaid/100_MA_Enrollment_Barriers.pdf

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Medicaid coverage can play an important role in re-entry programs, including maintaining their access to mental health or addictions treatment. The current Maryland eligibility system requires individuals to re-apply for Medicaid after they are released from incarceration, which can be a long and cumbersome process. Another option to facilitate continuity of care and support re-entry efforts is to "suspend" Medicaid eligibility during a period of incarceration. This would ease the administrative barriers to health care for those who were previously enrolled in Medicaid and who were incarcerated for a short period of time. If they were released within their Medicaid eligibility span (normally one year), the suspension would be lifted and Medicaid eligibility continues for the remainder of the span. Another suggestion was made that Medicaid work with Public Safety and Correctional Services to screen all prisoners released for Medicaid eligibility. A screening for the Primary Adult Care program already occurs. This would ensure health coverage and support re-entry efforts.

Strategies to improve retention during the recertification process were suggested, including pre-populating recertification forms.

Data Driven Enrollment

ACA requires linkages with the IRS to streamline eligibility determinations for subsidy programs, Medicaid and MCHP.[23] This will streamline the application process, making determinations more real-time. More federal guidance is needed about how this will work. Consensus among stakeholders was that in addition to linkages to the IRS, other data driven strategies in which consumer are determined eligible based on existing data should be pursued. These data matching efforts could help identify all available coverage options for individuals. In addition, it was noted that legislation may be necessary to give DHMH authority to use all necessary state administered data files (such as the state wage files, and Motor Vehicles records) for electronic verifications of individuals applying for Medicaid, the subsidized exchange, or other state health programs.

Empowering Consumers

Effective Entry into Coverage strategies require that consumers know how to use the system. They need clear information on the availability of assistance, the value of the benefits that coverage programs provide, and how to apply on their own or get help when they want it. The Entry into Coverage outreach efforts will need to include consumers, providers, insurers, non-profits and the general public. The communication and outreach strategy should be addressed early in the planning process and adequately funded. Racial and ethnic minorities should be active participants in the planning process.

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[23] P.L. 111-148: §1311(c)(3-6), (d)(4)

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The importance of clear communications and the need for materials on 4th grade reading level and translations at the 4th grade level were cited. Other comments focused on the need for local input on media strategies because different strategies work in different communities. Furthermore, there was an emphasis on ensuring racial and ethnic minorities are part of the planning and development process. This involvement would greatly facilitate the cultural competency and assuring that materials are culturally appropriate and sensitive

The web resources discussed above will be an important part of reaching consumers. There are a number of additional creative strategies identified by stakeholders that hold the potential to make it easier for individuals to apply for coverage. Many of these could be low-cost and low-tech solutions to making eligibility determinations more accessible. They include:

a. Kiosks at diverse locations that provide information on health programs, applications for coverage and a way to submit the application.

b. Applications, Copiers and Drop Boxes located at public assistance offices and other locations would allow consumers to apply quickly without meeting with a case worker. This strategy was successfully employed by Delaware.

c. Fee waivers for documentation make it feasible for low-income consumers to gather necessary documentations.

d. Mobile offices in low income neighborhoods or rural areas could provide information and application assistance on programs.

Early Expansion of Medicaid

Some stakeholders called for an early expansion in Medicaid (such as an expansion to 50 percent of the FPL for childless adults to reduce the ramp-up of this population in 2014). An early expansion t would let the state phase-in what is likely to be a significant expansion and would simplify the eligibility process for individuals with disabilities even before health reform is fully implemented. Others cautioned that restoring prior provider reimbursement reductions is important before expanding coverage further.

Address Broad Medicaid Eligibility Issues

The workgroup focused on eligibility for individuals whose eligibility is affected by reform. This includes the Families and Children Medicaid groups, MCHP and individuals eligible for premium credits through the Exchange. There are about 150,000 individuals enrolled in Medicaid as Aged, Blind and Disabled (ABD) groups. Eligibility for ABD Medicaid can be

complicated because it may require a disability determination process, which can be lengthy. Health care reform may provide some relief to eligibility backlogs for ABD because some individuals will now be determined eligible based on their income and will no longer have to demonstrate their disability. Several comments were provided that urged improvements in the eligibility process for the Aged, Blind and Disabled categories of Medicaid. Placing more out-stationed eligibility workers in hospitals was suggested. The current systems for determining eligibility for nursing home care was cited as flawed and not meeting the goals of the ACA.

Immediate Issues (Next 12 Months)

Maryland stakeholders have identified a number of encouraging options and strategies that could be part of an overall approach to Entry into Coverage that achieves the goals of simplifying the eligibility process; making eligibility integrated and seamless; embracing a culture of insurance; advancing no wrong door efforts; and connecting eligibility and plan enrollment. Many of these issues are inter-related and will depend largely on federal guidance and state decisions related to the goals and functions of an Exchange.

The challenge for Maryland and all states is that many implementation activities require significant systems changes which have long lead times in planning, procurement and implementation. The Entry into Coverage Workgroup was asked to focus on the immediate issues that Maryland will need to address for successful implementation in the next 12 months. While this paper identifies many issues that will ultimately need to be considered, there are two fundamental decisions that will need to be made in 2011 because they are foundational to reform implementation: 1. the goals and functions of information systems; and 2. structural decisions related to eligibility determination and plan enrollment.

The timeline below illustrates these foundational decisions need made regarding IT systems and structure in 2011 because they impact procurement decisions or FY 2013 budget issues.

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Chart 2. Timeline of Decisions for IT Systems and Structure
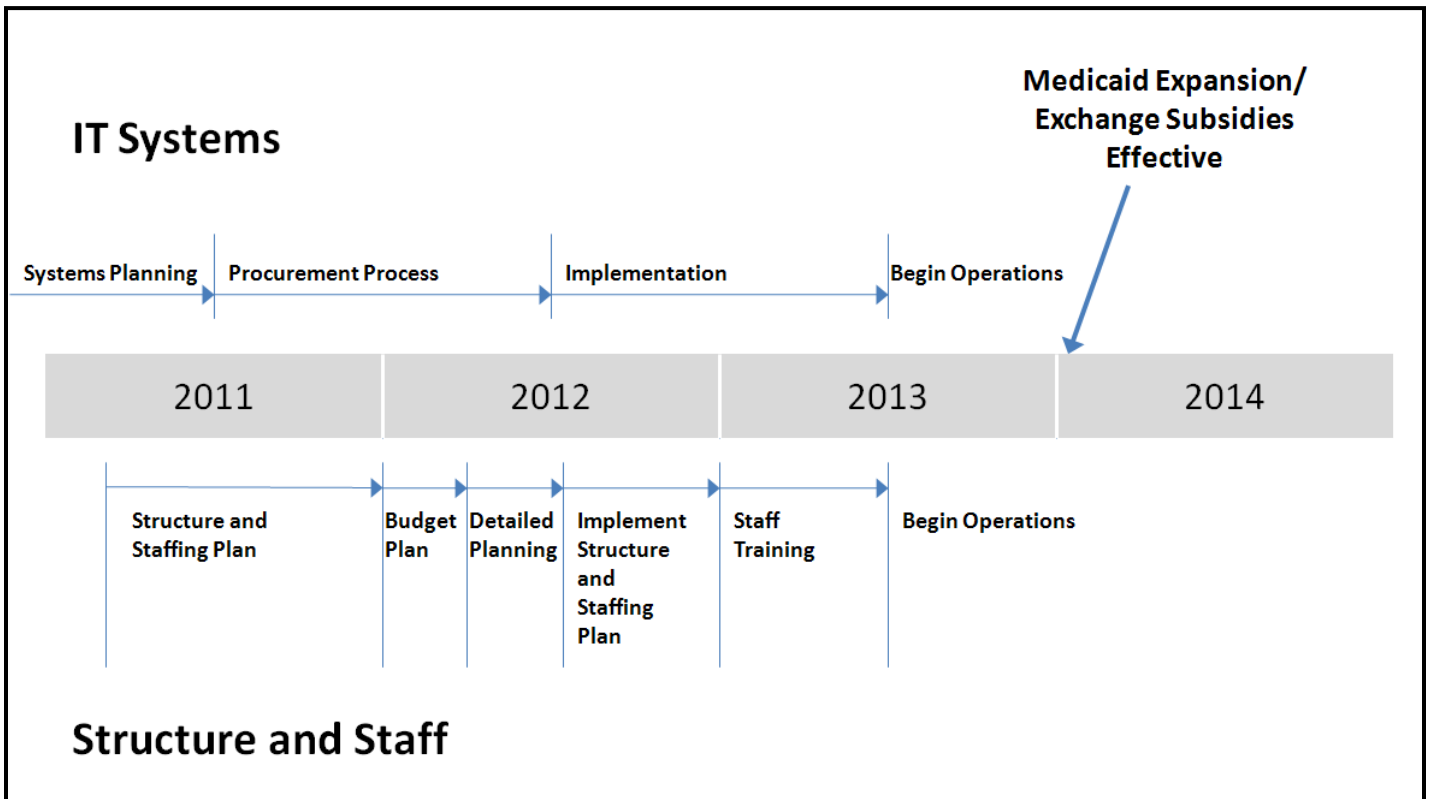
More information about federal requirements and the feasibility of technical options are needed before decisions can be made on IT systems and the structure for eligibility systems. On September 30, 2010 Maryland received a federal planning grant that will contribute to Maryland's effort to further develop these options. The $999,227 Health Insurance Exchange Planning grant will be largely allocated to evaluating different technical options available to Maryland. These resources will allow Maryland to fully examine technical options, including

the best practices and systems from other states. The first phase of this planning work is planned to be completed by July 2011 so that necessary procurement processes can begin.

These federal planning funds will support some of Maryland's implementation efforts, but there will be a potentially significant cost to implementing these system changes.   It may be challenging to ensure that sufficient funds are available to build and maintain a modified system. With uncertainty about necessary system changes and how much the federal government will contribute, it is impossible to predict the implications for the state budget.

The workgroup has provided invaluable direction in guiding the continued planning process. This paper provides a direction for the ultimate goals for Entry to Coverage:

1. Income based eligibility determination policy and process should be dramatically simplified relative to the current policy and process for Medicaid and MCHP;
2. Eligibility determinations should be integrated and seamless (across both health and public assistance programs);
3. Eligibility policy and process should reflect the culture of insurance (where all individuals have insurance coverage as required by the federal mandate) envisioned by ACA and called for in the Interim Report of the HRCCC;
4. There should be a "No Wrong Door" approach to applying for coverage (across all health and public assistance programs).
5. Eligibility and enrollment into health plans should be part of a continuous process rather than distinct systems.

Achieving all of these goals by 2014 is a tall order. Given our current information on federal rules, potential federal systems and more detailed technical analysis, it is premature to decide what system changes should be made. In the next several months, Maryland can use these federal grant resources to evaluate what is technically feasible to accomplish by 2014. With this assessment we will better understand how far Maryland can progress towards achieving these goals or how immediate system changes could be a part of longer term strategic vision for Entry to Coverage.

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3. Education and Outreach Workgroup:
Report to the Health Care Reform Coordinating Council

October 31, 2010

Charge

Much of the success of health care reform will depend on how individuals and organizations respond to and use the new health care delivery system. Engaging the public in health care reform implementation is essential. However, the volume and complexity of the Affordable Care Act create communication challenges. A critical component of the Health Care Reform Coordinating Council's (HCRCC) role must be to provide information about how reform may affect different individuals and stakeholders, and how they may participate in the implementation process.

Critical questions this group should address include:

(1) How should the state communicate to various constituencies the significant changes that will occur as health care reform unfolds at both the federal and state level?
(2) What type of plan for a coordinated and comprehensive outreach and education strategy should be developed to meet the needs of different groups, including consumers, providers, insurers, employers, and others?
(3) How will Maryland assure that efforts are effective and culturally and linguistically appropriate?
(4) How should the state address current needs for information on reform implementation and its implications, as well as develop a long-term strategy for ongoing effective communication about the new health care system?

Process

The Education and Outreach Workgroup was co-chaired by Marilyn Moon, Commission Chair, Maryland Health Care Commission, and Joy Hatchette, Associate Commissioner, Maryland Insurance Administration. There was no assigned membership; in an effort to be as inclusive as possible, participation in the workgroup was open to any interested party.

The workgroup met three times between September 2010 and October 2010. The goals of the first meeting were to review the charge and provide background information on existing State and federal health reform outreach resources, key health reform implementation dates, and basics on developing a communications plan. A panel of speakers discussed lessons learned from past experience with Medicare Part D implementation. The co-chairs solicited feedback to inform short-term and long-term needs assessments. The goal of the second meeting was to delve deeper into discussions of (1) who are the audiences that we need to reach, (2) what are the topics we need to communicate, and (3) what are the channels of communication we should use.

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Three break-out sessions were organized to discuss these questions. Written comments were also accepted via the HCRCC website. The second meeting included information on Massachusetts' communications campaign for state health reform, and Maryland's past experience conducting outreach to businesses to promote the Health Insurance Partnership. The third meeting was devoted to reviewing and gaining public input on the draft white paper of options.

Inventory of Some Government Outreach Resources

Most people rely on friends and family for information when making health care decisions. In addition, health reform is receiving significant media attention, which shapes public opinion about the new law from a variety of perspectives. As more provisions of the law are implemented, information will be increasingly communicated from health care providers, insurers, brokers, and employers.

The government may not be the initial source of information to which people turn. However, the many current public efforts in Maryland to educate consumers, businesses, health care providers, and others about health coverage and reform can be leveraged to conduct outreach and serve as a basic source of accurate information. Public outreach efforts in Maryland include products, such as publications and web resources, as well as individual contacts, including on-the-ground outreach staff and staffed hotlines. While some public outreach efforts target audiences for income-based programs or other subsets of the population, others are more general. Some examples of State outreach efforts follow.

- **Maryland Insurance Administration Consumer Education and Outreach**

  Staff conducts outreach at many community events/locations to help consumers with insurance questions and provide information.

- **Office of the Attorney General Health Education and Advocacy Unit**
  Helps consumers with denied referrals or claims.

- **Maryland Health Insurance Plan**
  State and Federal health insurance for individuals unable to obtain private coverage.

- **Maryland Department of Aging Senior Information and Assistance**
  120 local Senior Information and Assistance offices throughout the state are staffed to provide assistance in determining need for services, make referrals to appropriate agencies, and offer case management/coordination for persons requiring ongoing services. The Maryland Department of Aging (MDoA) recently received federal funding through the Affordable Care Act to provide outreach and assistance to Medicare beneficiaries regarding benefit coverage, including coverage for preventive services; and provide options counseling through Aging and Disability Resource Centers (ADRC).

  Options counseling helps people understand, evaluate, and manage the full range of services and supports available in their communities.

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- **Maryland Department of Disabilities Constituent Services**
  Staff provides information and assistance to individuals as they navigate the human services system.

- **Maryland Health Care Commission Resources**
  Resources include the Health Insurance Partnership, a premium subsidy program for small businesses; and the Comprehensive Standard Health Benefit Plan (CSHBP) for small businesses, which requires all carriers to offer the same health benefits to all small employers and establishes cost sharing for various delivery systems. The "Consumer Guide" provides information on CSHBP eligibility, benefits, and cost-sharing, as well as information on small business tax credits now available under the Affordable Care Act.

- **Department of Labor, Licensing and Regulation (DLLR) One-Stop Career Centers**
  One-Stop Career Centers are located in each county to match people with jobs. Other DLLR activities also interface with employers throughout Maryland.

- **Department of Health and Mental Hygiene "Get Health Care"**
  Hotlines, contact information for applications for Medicaid, Primary Adult Care (PAC), Maryland Children's Health Program (MCHP), Medical Assistance for Families, Local Health Department resources, and other health-related programs. Local Health Departments have multiple building locations in each county where information can be provided.

- **Department of Human Resources Economic Assistance Programs**
  Online services, call centers, local Departments of Social Services to determine eligibility for Medicaid, MCHP, and other health and non-health programs and entities such as County Commissions for Women.

- **Department of Business and Economic Development**
  Technical assistance for existing and start-up non-profit health care organizations.

The federal website www.healthcare.gov provides a clearinghouse of factual information on health reform. Its "Information for You" is targeted by audience, to families with children, individuals, people with disabilities, seniors, young adults, and employers. The "Find Insurance Options" feature links to State resources. The website is available in Spanish, www.cuidadodesalud.gov, and other languages are under development. The website will continue to be populated with additional information over time, for example insurance product pricing.

In addition, many private foundations and community-based organizations are producing materials on health reform and/or actively conducting outreach. For example, the Kaiser Family Foundation recently released a short web video, "Health Reform Hits Main Street,"[24] which explains the basics of the law. The National Institutes of Health also provides templates that

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[24] Available at http://healthreform.kff.org/the-animation.aspx.

could be modified and reproduced for educational materials. University of Maryland's Small Business Development Center Network counsels and trains aspiring and existing small businesses to resolve regulatory and other issues. Maryland's hospitals help patients understand reform through their websites, newsletters, and more, and the Maryland Hospital Association (MHA) links to information about reform from its website. Health insurance carriers also have a range of outreach activities to provide information to their members and providers. The Maryland Citizens Health Initiative has hosted press conferences, informational forums, and participated in numerous community events to conduct outreach on health reform. Maryland must determine how best to leverage federal, State, local, and private resources.

Lessons from Prior Initiatives

Health reform is unique in terms of its scope and complexity, as well as its incremental approach to implementation and the many key unknowns that still exist. For example, critical decisions yet to be made regarding the structure of the exchange, entry to coverage, and the nature of the safety net will drive outreach messages. Despite the uniqueness of health reform, there are lessons to be learned from past efforts to communicate changes in health care. The lessons highlighted below are gained from experience with Maryland's implementation of Medicare Part D and the Health Insurance Partnership, as well as Massachusetts' experience implementing state health reform. It is important to note the very different funding levels for past initiatives. Massachusetts' outreach campaign had a budget of $7.3 million over three years. Major costs consisted of media buys and a public relations firm procurement. In contrast, there was no formal budget when the Maryland Health Insurance Partnership was rolled out.

- It takes a community effort.
- Build partnerships and keep them alive.
- Partner with elected officials to help gain media attention.
- Maintain message consistency through train the trainer approaches.
- Continue education and training as programs evolve.
- Segment the audience.
- Communicate "news you can use" to an individual.
- Ensure messages are simple, and linguistically and culturally appropriate.
- Be accessible to answer questions, even when answers are not yet known.
- Use venues that are appropriate to the target audience, and adapt materials to the site and audience.
- A variety of approaches is critical.
- There is a need for basic information, as well as more detailed reference information.
- Opportunities for outreach are everywhere, from ballparks to churches, pharmacies to grocery stores.

Needs Assessment

The co-chairs sought input from workgroup participants on a needs assessment for education and outreach. Discussions were structured around three primary questions: (1) who are the

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audiences that we need to reach, (2) what are the topics we need to communicate, and (3) what are the channels of communication we should use. Public input provided to the workgroup at meetings and via the HCRCC website is synthesized below under these three categories. While outreach to consumers garnered most of the attention of the workgroup, Maryland's health reform communications strategy will need to address outreach to providers, employers, insurers, brokers, and others affected by reform. The need to tailor approaches to different jurisdictions or geographic areas was emphasized.

Audiences: Who are the audiences that we need to reach?

There was agreement on the need to segment audiences according to their information needs and motivators. Messages, collaborations, and outreach approaches would then need to be tailored by audience. The major categories defined by federal outreach efforts include families with children, individuals, people with disabilities, young adults, seniors, and employers. These groups made sense to workgroup participants, but there was much emphasis on the additional needs of vulnerable populations.

Vulnerable populations are characterized by low income, low health literacy or illiteracy, individuals with developmental or other disabilities, behavioral health needs, lack of stable housing, involvement with the criminal justice system, limited English proficiency, citizenship status, or racial or ethnic groups experiencing health disparities. Notably, 62% of Maryland's uninsured population is made up of individuals from racial and ethnic minority groups. Strategies for outreach will need to be tailored to the diverse needs of different racial and ethnic minorities. There is a need for cultural sensitivity, which requires much more than simply translating materials into additional languages. Translation into more languages than just Spanish will be needed.

People need to be reached whether they are residing in their homes in the community, or other settings such as assisted living facilities and nursing facilities. It was noted that many individuals from vulnerable groups may have never had health coverage previously, and may distrust the health system. Some groups, such as undocumented immigrants, will remain without coverage even after the full implementation of the Affordable Care Act, and will need information about available options and how to access services. Families with undocumented parents may include citizen children who are fully eligible for benefits.

The need for distinct messages was identified for insured versus uninsured populations. Individuals with insurance may fear change, and need to understand that they will not see a change in coverage. Segmentation by geography—urban, suburban, rural—was also raised. Strategies might target women, as the health care decision makers of most households. Self-employed individuals were also identified as having specific information needs. Information needs and motivators will vary greatly among consumers, health care providers, large and small employers, insurers, and brokers.

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Topics: What are the topics we need to communicate?

There was agreement on the need for clear, concise, simple, and up to date information communicated from a trusted source. There is a need for consistency in all communications and by all communicators. Information should be factual and apolitical. Given the level of misinformation circulating, there is a need to dispel common myths, but this may be viewed as politically charged. It is important to not over-promise what reform will deliver, and to communicate the new responsibilities and penalties for individuals and employers. People need information that is relevant to their individual situation. Important topics cited were eligibility and enrollment, effective dates of changes, appeals processes, and coverage of behavioral health benefits. In addition, the promotion of wellness and prevention, to reflect an integration and balance between medical care and public health, is important. Information should have emotional meaning if it is to resonate. The use of personal anecdotes is useful for this.

A culture of health care needs to be emphasized, particularly for individuals who may have never had insurance previously. Efforts will need to be taken to communicate the value of coverage, how to use insurance coverage and find providers, and the importance of seeking preventive care and early treatment. It is also important to help people understand how to maintain seamless access to coverage, which is a currently challenge due to the need to redetermine eligibility, or as people's eligibility for different programs changes.

It was suggested that health care providers be informed of incentives for serving underserved areas, and of resources for development of medical homes that are welcoming to all racial, ethnic, and language groups. Health care providers should also be educated about available and required behavioral health benefits.

Given the incremental nature of implementation of the different provisions of the law, it is important to carefully sequence communications. People need information that is timely. A balance needs to be struck between disseminating information early enough to allow for multiple contacts, but not so far ahead that people cannot yet act on the information. The prioritization of messaging is also important; there needs to be a balance between providing useful information without overwhelming the audience.

Channels of Communication: What are the channels of communication we should use?

Information should be provided in venues appropriate to the audience. It is necessary to understand where people get information. Materials should be adapted to the site and audience. It was agreed that a communications strategy should have a layered approach, not relying on any single vehicle. Extensive input was provided listing potential partners for outreach and the format that outreach might take.

Potential partners and venues include health care providers, particularly in urgent care and emergency settings; community health workers; health care settings such as Federally Qualified Health Centers, community health centers, and school-based health clinics; a wide array of social services providers, such as shelters; elementary and secondary school systems and institutions of

higher education; churches, synagogues, and faith-based organizations; a wide array of community-based and advocacy organizations; elected officials; government sites such as the Motor Vehicle Administrations and post offices; grocery stores; laundromats; business groups; brokers; labor unions; libraries; and senior centers. Local Health Departments are a key partner. It was noted that Maryland's Local Health Departments have extensive reach into each jurisdiction of the State, and already provide health education as one of their essential services. Maryland's existing coalitions can help connect numerous individual organizations. Some examples of existing coalitions include Maryland Health Care or All! Coalition, Maryland Alliance for the Poor, MANO Maryland Nonprofits, and the Maryland Mental Health Coalition.

Partners must be seen as trusted sources by the target audience. Peer outreach and education models were recommended. Partners should represent diverse communities and geographic areas. The many public and private workers who currently interface with the public will need to be well-educated about reform.

Comments encouraged the HCRCC to consider a number of elements to determine the optimum location and role for an ombudsman's office, including the needs and diversity of Maryland's residents; the past and future role of public and private organizations that provide education, outreach, and ombudsman services; and the role of navigators within the new exchange.

The many suggestions related to the format of outreach agree that a multi-faceted approach is necessary. Suggestions include print materials such as brochures, flyers, and posters; hotlines; features for organizational newsletters or the media; web-based media such as a Facebook page and Youtube videos, without over-relying on the internet given the divide between those who have access and those who do not; smart phone applications; in-person fairs and public events such as community forums, trainings, and seminars; television; radio; bus ads; digital and traditional billboards, and others. The importance of having trusted, one-on-one interpersonal contacts was emphasized as essential to help people get questions answered and navigate the complex health care system. Staff working to conduct outreach should have cultural competency training.

Options

Different options for the HCRCC to communicate about health reform are described below. They are divided into shorter-term and longer-term options, although planning for even longer-term options should begin soon. The numbering of options does not reflect order of priority. Maryland's outreach strategy should be scalable, depending on the level of available funding.

Shorter-Term

1. Continue to Coordinate Government Outreach Activities
Maryland has already begun to coordinate the State's health care coverage and health reform information through the HCRCC website, www.healthreform.maryland.gov. This website has Maryland-specific updates on reform, as well as links to existing State resources for coverage. Individual State agency websites link back to the HCRCC website. A web resource is in no way sufficient to conduct outreach, but as a starting point it can provide a

valuable means of sharing information. As more provisions of the law are implemented it will become even more important to continue to coordinate Maryland's State and local government resources.

2. *Further Develop a Maryland Asset Inventory*

The inventory of government outreach resources listed above is only the beginning of an effort to coordinate potential channels of communication at the State and local levels. It does not begin to delve into the many community-based, faith-based, and larger private organizations as well as business groups and health care provider associations that will be crucial to communicating effectively about reform. We need to understand where the different public and private resources exist in order to build upon existing strengths, coordinate outreach efforts, and assess where gaps still remain.

3. *Formalize a Public/Private Coalition*

Maryland is fortunate to have an existing infrastructure of public and private entities at the State and local levels to help conduct education and outreach. Organizations are already conducting outreach, and have volunteered to help through the workgroup process. Formalizing a public/private coalition can help clarify roles, ownership of the message, information flow, and can help coordinate resources efficiently. A central calendar could track different outreach events conducted by members of the coalition.

Community-based organizations can help Maryland deliver the message on health reform; they have the trust on the ground with targeted groups, particularly for vulnerable populations. Information must flow up as well as down. It is equally important that grassroots organizations provide input into the communications strategy, for example by helping the State understand how to motivate different audiences and by testing messages with audiences. The coalition would provide a forum to share best practices and continually evaluate and evolve outreach and education activities. A coalition could also create some economies of scale, for example by providing the volume to facilitate more affordable contracts for printing materials. The point was raised in the workgroup that community-based organizations need financial support to take on new activities or expanded roles.

4. *Develop Template Materials*

Given the agreement around the importance of having a consistent, fact-based message, there needs to be a common set of high-level materials that can be used as a starting point by the coalition of organizations conducting education and outreach. Different templates would be needed for the very different audiences to be targeted by outreach: consumers, providers, employers, and others. Development of materials should include early and ongoing input from a variety of stakeholders and communities to help ensure that they are suited to the target population, culturally and linguistically appropriate, and follow health literacy principles. It was suggested that community-based organizations and other partners have some flexibility to customize materials. An organization could use template materials to

conduct outreach but also provide additional, more detailed information depending on its mission and focus. Materials should be translated into commonly spoken languages.

5. *Fully Leverage Federal Communications Tools*

Maryland should fully leverage federal tools such as www.healthcare.gov when developing its materials. The federal website provides a clearinghouse of factual information, and effectively simplifies and communicates complex information about the law. Maryland should use these descriptions as the basis for common messaging. Maryland may also advocate for further outreach support from the federal level, for example national public service announcements prior to implementation of major provisions of the law.

6. *Establish Partnerships to Communicate Immediate Changes*

Changes to the health care system have already been implemented as a result of the Affordable Care Act. Some of the changes include:

- Young adults can stay on their parents' health insurance until age 26 (one year later than current Maryland law);
- Insurers cannot deny coverage to children with pre-existing conditions or exclude their conditions from coverage;
- Insurers cannot rescind coverage when people become sick;
- Insurers cannot cap lifetime coverage;
- Restrictions are placed on annual limits to insurance;
- Preventive care is covered without cost-sharing;
- Tax credits are available for small businesses offering coverage;
- A new temporary federal high-risk pool provides coverage for people with pre-existing conditions.

Marylanders need information about these changes immediately. Efforts have already been undertaken to communicate the effects of recently implemented provisions. For example, the Maryland Health Insurance Plan (MHIP) which operates the temporary federal high-risk pool ran radio advertisements and held media events publicizing the new program.

Key partnerships could help Maryland reach target audiences most likely to benefit from some of these provisions. For example, a partnership with two- and four-year institutions of higher education in Maryland could help publicize the ability of young adults to stay on their parents' coverage. Partnerships with elementary and secondary school systems could help publicize coverage protections for children with pre-existing conditions. Partnerships with health care provider associations and employer groups could help publicize new free coverage for preventive care.

7. Promote Existing Programs

The provisions of the law expanding Medicaid coverage don't take effect until 2014. However, many Marylanders are currently eligible for but not enrolled in existing health coverage programs, including Medicaid, MCHP, and PAC. Maryland can leverage the attention on health care resulting from reform to connect people to existing programs. Efforts to educate different groups about health reform can promote existing resources.

Longer-Term

1. Fund and Procure Communications Strategy Expertise

Maryland needs the expertise to develop a comprehensive strategy for how to communicate about health reform to the many groups who will be affected—consumers, providers, employers, insurers, brokers, and others. The needs identified in this white paper should inform the comprehensive strategy. Maryland recently received a $1 million grant from the Department of Health and Human Services to plan and develop consumer tools that will help Marylanders purchase affordable health insurance under the forthcoming Health Insurance Exchange. This grant includes close to $80,000 to procure expertise to plan a comprehensive outreach and communications strategy to reach the public in general, and small businesses in particular. While this is not on the scale of Massachusetts' investment in a communications strategy, it represents an invaluable opportunity to gain needed communication expertise.

There was agreement within the workgroup that funding for education and outreach beyond the currently available $80,000 is a priority to support a well-coordinated, effective statewide campaign. It was suggested that strategies to maximize the effect of funding include partnering with community-based organizations for material development and field testing, and focusing tasks for consultants.

2. Coordinate Outreach with Exchange; Entry to Coverage; and Public Health, Safety Net, and Special Populations Decisions

Many of the tactics for a communications strategy hinge on decisions to be made on the structure of the exchange and the nature of entry to coverage. For example, messages cannot be developed to encourage uninsured individuals to gain coverage through the exchange until there is a mechanism to do so. Thus, the direction of a communications strategy must closely track decisions about the exchange and entry to coverage, as well as the nature of the health care safety net and services for special populations. It was noted that building a simple, modern enrollment infrastructure will simplify messaging and help Marylanders maintain coverage year to year. Needs identified through this workgroup should inform exchange; entry to coverage; and public health, safety net, and special populations decisions.

3. Centralize Outreach Strategy

Coordinating public and private outreach activities will require significant attention. While education and outreach activities will be decentralized in order to leverage the many public, private, State-level, and local partners, ownership of the strategy and messaging should be

centralized. The entity or structure charged with health care reform on a longer-term basis should have responsibility for coordinating education and outreach. There should be efforts to evaluate the effectiveness of education and outreach among different populations. Community-based organizations stated that having a centralized point of contact will help them engage in outreach, by creating a clear path to get information and connect to the health reform outreach campaign.

4. *Pursue Private Funding*
As discussed above, mobilizing Maryland's many community-based organizations will be essential to promote a culture of health care, connect people to the health system, and empower them as health care consumers. Community-based organizations will need resources to do this. Maryland should consider ways it can partner with community-based organizations to pursue private funding in support of education and outreach activities. It may also be possible to obtain foundation support for Maryland to be a role model for other states.

4. Public Health, Safety Net, and Special Populations Workgroup: Report to the Health Care Reform Coordinating Council

October 31, 2010

Introduction and Charge to the Workgroup

The Patient Protection and Affordable Care Act of 2010 (ACA), commonly referred to as federal health reform, has significant potential to transform Maryland's health care delivery system. More Marylanders will have access to affordable health insurance through an expansion of Medicaid and new federal subsidies will help others purchase health insurance through new Health Insurance Exchanges. The federal government will develop an Essential Benefit Plan that will shape what health care services are covered by health insurers. The ACA creates new funding opportunities and demonstration projects to make changes to the health care delivery system to improve health outcomes and promote wellness, prevention, and health equity. These shifts in coverage status and other changes will affect the traditional role and functions of safety net programs for special populations as well as the public health infrastructure. Proactive planning to shape the future of the health care safety net and services for special populations in Maryland in anticipation of these changes is critical.

The Public Health, Safety Net, and Special Populations workgroup was charged with addressing the following questions:

> (1) How will Maryland ensure that populations that remain without adequate insurance coverage obtain the health care they need?
> (2) How will the safety net prepare for the likely changes in benefits that are covered by commercial or public insurers?
> (3) How should the public health infrastructure leverage the demonstration projects, grant opportunities, and other features of reform to augment its resources, increase its effectiveness, and enhance its impact?
> (4) What changes should occur in how behavioral health services are provided and how will these changes interface with new mental health parity rules and other changes in insured benefits?
> (5) How will Maryland facilitate the coordination of safety net services in the reformed health care system while identifying both persistent and new unmet needs and coordinating safety net care delivery?
> (6) What should be expected of traditional safety net providers in an environment in which more individuals have insurance coverage, and how can the capacity of these providers be leveraged and fostered?
>
> (HCRCC Interim Report, 2010, p.17-18).

Workgroup Process

The workgroup sought input from the public through a series of public meetings and by

disseminating materials via the Health Care Reform Coordinating Council (HCRCC) website (www.healthreform.maryland.gov). The Public Health, Safety Net, and Special Populations workgroup was co-chaired by Delegate James Hubbard, House Health and Government Operations Committee, Fran Phillips, Deputy Secretary, Department of Health and Mental Hygiene - Public Health Services, and Renata Henry, Deputy Secretary, Department of Health and Mental Hygiene - Behavioral Health and Disabilities. There was no assigned membership; in an effort to be as inclusive as possible, participation in the workgroup was open to any interested party. Specifically, this workgroup requested public input regarding options to consider in designing a comprehensive, proactive approach to integrating public health infrastructure and initiatives, behavioral health services and supports, and health care safety net and services for special populations in Maryland. This report summarizes the public input and outlines the common themes identified in the workgroup process.

The workgroup met three times between September 2010 and October 2010. The goals of the first meeting were to review the charge, the work plan, and provide background information on newly insured, the uninsured, and existing community health resources. A panel of speakers provided an overview of safety net as well as the behavioral health services system. The goals of the second meeting were to explore issues related to public health and special populations and to receive public comment. Written comments were also accepted via the HCRCC website. The third meeting was devoted to gaining feedback on the white paper of options based on public comment.

Issues for Workgroup

This section provides background information and summarizes public comments around the main issues addressed by the workgroup. Although this section is divided into three categories, there is significant overlap among these issues as the public health infrastructure and the safety net are essential components of caring for special populations and promoting health equity.

Public Health

Public health serves the health of a community as a whole. It encompasses health promotion, disease prevention, health education, community coalition building, environmental health, epidemiology, public health surveillance, and gap-filling clinical services not available through private providers. Over 80% of the increase in life expectancy experienced in the 20th century is the direct result of public health interventions (Improving Health: Measuring Effects of Medical Care. Milbank Quarterly, 1994).

Public health is the science and practice of protecting, promoting, and improving the health and well-being of individuals and communities through control of communicable diseases, application of sanitary measures, monitoring of environmental hazards, health education and prevention, addressing health disparities, and policy development. Public health interventions, through organized community efforts aimed at the prevention of disease and the promotion of health, assure conditions in which people can be healthy [Institute of Medicine]. Federal, state, territorial and local governmental agencies, working with public and private entities, comprise the nation's broad public health system. Collectively, the system prevents disease, injury and

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disability, protects against environmental hazards, promotes physical and mental health, responds to disasters and emerging diseases, and ensures access to healthcare services. Within this broader public health system, governmental public health – composed of federal, state, and local health agencies – carries out an exceptional and fundamental role. It is uniquely accountable to the public and elected representatives for the responsible use of tax dollars that fund its activities. The U.S. Constitution reserves to the states the primary authority and legal responsibility to protect the health of the population within their borders. Still, no single component of the government's public health system can function to maximum effectiveness without the other components. Local health departments are one of these governmental entities.

The major elements of ACA expand health insurance coverage and care through changes to the health care financing and delivery system. These changes affect how and whether individuals receive health care services. These reforms affect public health, but do not replace it. The workgroup discussion demonstrated a consensus that the public health infrastructure, including Local Health Departments (LHDs) and population-based programs, provide unique functions that will not be replaced by the health insurance coverage aspects of reform.

The core functions of public health are:

1. Assessment:
    i. Monitor health status to identify community health problems;
    ii. Investigate community health problems and hazards;
    iii. Evaluate effectiveness, accessibility, and quality of health services;
2. Policy Development:
    iv. Develop policies and plans that support individual and community health efforts;
    v. Enforce laws and regulations that protect health and ensure safety;
    vi. Develop new insights and innovative solutions to health problems;
3. Assurance:
    vi. Link people to needed personal health services and assure the provision of health care when otherwise unavailable, including the provision of gap-filling services;
    viii. Assure a competent public health and personal health care workforce;
    ix. Inform, educate, and empower people about health issues; and
    x. Mobilize community partnerships to identify and solve health problems.

To that end, the ACA provides for an array of initiatives to improve quality and encourage prevention and wellness that are particular to public health. The Prevention and Public Health Fund is a historic investment in public health programs that prevent illness and injury before they occur, thereby resulting in significantly lower health care costs. For example, the Fund authorizes funding for the Community Transformation Grant Program which will provide competitive grants to reduce chronic disease rates, address health disparities, and develop a stronger evidence base of effective prevention programming (HCRCC Interim Report, 2010, p.2). However, it remains unclear the extent to which federal funds will actually be appropriated, how Maryland will fare in competing for these funds, and to what extent Community Transformation and other ACA funds will reach all LHDs.

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The ACA also provides the opportunity for significant investment in training programs to increase the number of primary care doctors, nurses, and other public health care professionals in an effort to improve access to affordable health care. Other funding opportunities include the establishment of a public health workforce loan repayment program, training for mid-career professionals in public health or allied health, expanded public health fellowship training programs, and training for general, pediatric, and public health dentistry (HCRCC Interim Report, 2010, p. 2). The ACA also includes provisions for research on optimizing the delivery of public health services and understanding health disparities.

One of the themes that emerged from comments was that public health and LHDs have an important role with unique community-based resources and expertise. Therefore, LHDs should be a fundamental part of strategic planning efforts to ensure that all Marylanders receive appropriate health services. Some public comments focused on the need for LHDs to be well represented in both future statewide health reform oversight activities and the development and monitoring of performance measures. Other comments focused on integrating population measures into all workgroup activities.

A recommendation was made to develop a strategic plan that integrates and coordinates the work of LHDs, community health centers, Federally Qualified Health Centers, school-based health clinics, and community-based organizations. It was also noted that not all jurisdictions have community health centers or community-based organizations and that strategic planning efforts should include all providers, not just those that receive grant and charity support.   This plan should address how local providers can reach all segments of the population, including special populations, the uninsured, and the newly insured. Particular attention should be paid to gaining input from populations who experience health disparities. It was recommended that the HCRCC, or a successor oversight group, convene a diverse group of representatives to develop this strategic plan.

The role of information technology (IT) in public health was raised. Some comments related to eligibility and enrollment into Medicaid and Exchanges, and others related to Health Information Exchange – both are issues for other workgroups. The antiquated and duplicative IT systems throughout the sectors of public health were identified as barriers to coordination and effective care. It was also noted that while improvements to the state's IT systems will be expensive at the outset, they would likely result in long-term savings. Comments urged continued efforts to support LHDs in grant processes to support health IT innovation and implementation.

Finally, budget reductions and staff shortages were cited as serious barriers for LHDs in fulfilling their unique mission. Comments urged Maryland to pursue funding opportunities through ACA's Prevention and Public Health Fund and Community Transformation Grant Program. Others advocated for greater flexibility in current State funding, recognizing that the current specific funding categories for LHDs do not reflect the unique needs of local areas and prevent local health departments from making more locally coordinated and allocated resource decisions. Finally, others supported funding for the State's tobacco prevention and cessation program.

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Additional comments focused on the opportunities for the fields of Aging and Public Health to collaborate to develop the definition of primary prevention for seniors. Another area of concern was that policy considerations on reducing teen pregnancy should not be overwhelmed by the controversial issue of abortion. Other suggestions were made that the focus on primary care and prevention under health reform is an opportunity to include issues such as food security, environmental hazards, housing and workplace conditions, and violence in a comprehensive plan to improve the overall health of the people of Maryland.

Safety Net

The workgroup was charged with considering two different issues related to the safety net. First, how Maryland should ensure that populations without adequate health insurance get the health care they need; and second, how the role of traditional safety net providers may evolve under health reform.

Access for Remaining Uninsured

It has been estimated that when ACA is fully implemented, Maryland's uninsured rate will be reduced by half (from 14.0% to 6.7% by 2017) [HCRCC Interim Report, 2010]. These shifts in coverage status and other changes will affect the traditional role and functions of safety net providers and programs. The workgroup recognized that even after full implementation over 400,000 Marylanders are estimated to remain uninsured either by choice or circumstance and agreed that Maryland should maintain support for programs that serve uninsured individuals. Further, the Massachusetts' experience of increased emergency room use following coverage expansion was cited as an example of the potential of what might be expected in Maryland. The workgroup was cautioned that funding for safety net programs or providers should not be reduced until it is clear that the private sector has demonstrated a commitment to and capacity for serving the existing and newly insured. Some suggested that, at a minimum, there should be a period of transition built in that ensures continuity of care until new systems demonstrate functionality and sustainability.

Additional comments focused on how to improve care delivery for this group who will remain uninsured. Current models were discussed to improve care management through the provision of navigators that help coordinate follow-up care for uninsured individuals. Patient navigators and integrated primary care networks hold the promise of improving outcomes and reducing emergency department and hospital admissions due to unmanaged care. The workgroup recognized that an effective and integrated infrastructure, such as patient navigators or case managers, is important to the success of current models.

Coverage of Special Services

Some individuals have health care needs that are not met by traditional health insurance products. Today, many of these individuals rely on safety net providers and programs to get the care they need. It is unclear whether or how health reform will address this issue. ACA requires the federal government to define Essential Health Benefits to be covered by all health plans

offered through the Health Exchange. States may require additional benefits, but must fund the marginal cost of additional services. Comments expressed concern about access to a number of services that may be likely to fall outside the federal Essential Benefit Package, including adult dental care; wraparound services to prevent institutionalization; Rare and Expensive Case Management Programs (REM); interpreter services (foreign languages and sign language); and other wrap around services. Federal policy decisions about the essential benefits will be important to understand before decisions about gap filling safety net programs can be made.

The workgroup recognized the critical importance of Medicaid's current comprehensive benefit package, particularly for individuals with disabilities or other special needs. With uncertainty about the federal benefits requirements, other comments urged that Maryland maintain the full Medicaid benefit package for the Medicaid expansion under a Secretary-approved benchmark option.

Role of Safety Net Providers

The Institute of Medicine defines safety net providers as "providers that deliver a significant level of health care to uninsured, Medicaid, and other vulnerable patients." (IOM, America's Health Care Safety Net: Intact but Endangered, June 2000). Maryland has a broad network of safety net providers. Public comments maintained that Maryland should build on the strengths that already exist and also offered examples of safety net providers that include community health centers, school-based health centers, LHDs, behavioral health providers, emergency room departments and other community-based organizations. Today, these safety net providers are an important source of health care for the uninsured as well as for many with health insurance. Under health reform, safety net providers will continue to be an important source of care for both the insured and uninsured. Some individuals will likely move in and out of Medicaid and Exchange products and their continuity of care is dependent upon safety net providers participating in both Medicaid and Exchange products.

There was consensus that as more individuals gain access to health insurance and services previously provided to the uninsured on a sliding fee scale are now reimbursable, the traditional business model and operational practices of many safety net providers may need to change. Safety net providers may need to implement or enhance their IT systems to ensure that they are able to bill public health and commercial insurance networks for services provided. This transition may present enormous challenges for many safety net providers, and it was suggested that the State may want to consider providing technical assistance and other supports to safety net providers as they undergo this transition. The Community Health Resources Commission was recognized as being capable and well positioned to provide this support. The following specific items were raised as potential areas for assistance: (1) IT/billing capacity; (2) grant writing; (3) an 'incubating' function that positions safety net providers to tap into new resources now available under reform; (4) GIS mapping services to better match supply and demand and identify gaps in service delivery, and (5) promoting and providing resources for cultural, linguistic and health literacy competency.

Some urged that the State ensure sustainability of the non-profit safety net programs after reform and others urged the State to continue funding for safety net providers during the transition

period as they are an important source of care that Maryland will likely need to draw on even as more Marylanders are insured. Without funding during the transition period, these safety net providers may not be able to sustain efforts until private sector capacity is demonstrated.

Health reform includes a number of investments in safety net programs. The ACA authorizes $11 billion to fund community health centers. There is an opportunity to improve collaboration so that Maryland communities effectively compete for new funds and efficiently use current resources. Maryland's diverse network of safety net providers today have to compete for scarce resources. With collaboration and strategic planning, safety net providers can work together to meet the challenge of health care reform. There was discussion of a strategic plan that integrates and coordinates the work of LHDs, community health centers, school-based health centers, faith-based safety net providers, other safety net providers and community-based organizations. Some jurisdictions may not have these providers, and it was suggested that all providers participate in the strategic planning effort. These local strategic plans would help identify critical gaps in health care services, foster collaborations with the private sector to fill those gaps, and identify those services which continue to be unmet where public providers must fill the gap.

Some comments suggested that Maryland should address through regulation or statute the current barriers for LHDs to contract with private insurers and bill allowable costs to Medicaid Managed Care Organizations (MCOs), commercial payers, and the Primary Adult Care (PAC) program, if eligible. The rationale for this comment was that is some areas LHDs are the only providers or are necessary because the private sector capacity is not adequate to serve the need for substance abuse treatment. Other comments recognized that some individuals are likely to transition in and out of Medicaid and Exchange products and that all types of safety net providers, including LHDs, need to be able to participate with Medicaid or other commercial products to maintain continuity of care.

Behavioral Health

National estimates are that one in five individuals has a behavioral health need. (President's New Freedom Commission on Mental Health, May 2003) Of all disability groups, individuals with mental health problems reported the highest rates of lack of health insurance. The implementation of health reform has implications for how behavioral health services are provided and how care is ultimately received by those with need. Health reform expands the number of individuals that have health insurance and will mean that Medicaid and commercial insurance will have a bigger role in financing mental health and substance abuse treatment services.

The ACA requires the federal government to develop Essential Health Benefits. These Essential Health Benefits must include behavioral health services and must be offered by all health plans participating in the Health Insurance Exchange. States may require benefits in addition to the Essential Health Benefits but must also pay the marginal cost for these additional benefits. As such, this federal decision is critically important to which benefits will be covered by health insurance and how they will be financed. To date, there has been little guidance from the federal government on when these decisions will be made and which benefits may be included or excluded. Some comments recognized Maryland as a leader in mental health coverage and urged

the State to advocate to the federal government to ensure mental health coverage in the Essential Health Benefits. Further, comments suggested that Maryland's public mental health system should maintain behavioral health services at existing levels if the level of behavioral health coverage mandated by the federal government in the Essential Benefit Package is less than what is currently required in Maryland. Other benefit and coverage issues identified focused on the use of Addiction Medicine Patient Placement (ASAM) Criteria. Medicaid MCOs are required to use ASAM criteria when determining the appropriate level of care for individuals seeking alcohol and drug addiction treatment. Comments urged that Maryland mandate the use of ASAM by all payers, including insurance products offered through the Exchange.

Maryland's current Public Mental Health System was described by some commenters as one of the best in the nation. Maryland's Public Mental Health System is largely financed by Medicaid through a carve-out administered by an Administrative Services Organization. Attributes that were sited were its comprehensiveness and the growing use of evidence-based practice. These comments suggested that Maryland preserve and strengthen the current system. Another comment suggested health reform presents an opportunity to reevaluate its current system citing the current carve out of mental health services as an example of the fragmentation that exists in the system. This comment suggested an approach that would move mental health into a more coordinated structure with substance abuse disorders and other health care services.

There was consensus that behavioral health care services should be integrated and coordinated with somatic services at the point of delivery for the patient. This means that Maryland's delivery system should have a greater capacity to treat individuals with co-occurring mental health and substance abuse treatment disorders, and somatic services should be effectively coordinated with behavioral health services.

The need to strengthen regulatory oversight and compliance functions were raised in the workgroup as it related to individuals with behavioral health care needs as well as other special populations. The complaint procedures for commercial and Medicaid MCOs were described as barriers rather than sincere efforts to resolve concerns. Suggestions were made to conduct a thorough review and audit of all government-administered quality and oversight functions so that duplicative and inefficient programs could be eliminated and cost effective mechanisms that ensure proactive complaint resolution could be identified. Other comments recommended that resources at the Maryland Insurance Administration, Office of Health Care Quality, Alcohol and Drug Abuse Administration (ADAA) and Mental Hygiene Administration be increased to address their regulatory oversight.

Several fiscal issues were raised by comments. First, one comment called for no less than the current funding for ADAA regardless of an increase in the number of insured individuals. This recommendation was made because there are likely to remain uninsured individuals who are seeking treatment and many services to support recovery (e.g., residential services, housing supports, continuing care, and some prevention services) which are often unreimburseable by Medicaid and commercial insurance. Second, others said the budget for the public mental health system should reflect the inevitable growth in new users of the system as a result of more individuals gaining coverage. Third, comments called on the State to invest in community-based

mental health services citing the alternative as costly hospital care. Finally, assuring adequate reimbursement for behavioral health providers was cited as an issue.

Past experience has demonstrated that individuals enrolled in Medicaid churn in and out of coverage as their financial circumstances as well other factors change. This issue is particularly important for special populations to ensure continuity of care during critical transitions. Several comments focused on the need to ensure coordination of coverage and care for individuals with behavioral health needs who are transitioning out of jail. Re-entry programs that support efforts to fill the gaps in services are needed. Additionally, the fact that Medicaid individuals who are incarcerated lose their Medicaid eligibility, rather than having their coverage suspended, was cited as a barrier to effective re-entry efforts.

Special Populations

Health care reform will make health insurance available to many currently uninsured Marylanders. For many special populations, the ACA will create new opportunities to get health insurance. For others who already are covered, a comprehensive approach to implementation holds the potential to improve their access to care and their outcomes. Establishing available and affordable services is necessary but not sufficient to ensure that special populations who confront a myriad of personal, socio-cultural, and logistical barriers receive the care they need. Experience shows that traditional delivery models may not reach some populations.

The term "special populations" is broad. Comments suggested that the State needs the capability to identify those populations at highest risk for difficulty in accessing affordable, high quality care. Many different groups of individuals, both insured and uninsured, were identified through comments as special populations. Insurance status, immigration status, employment status, socioeconomic status, health status, disability status, age, English language proficiency, housing status, involvement with the criminal justice system, and health literacy level are all factors which potentially contribute to risk for barriers to access. Concerns were raised that the State should include in its definition of special populations those individuals not traditionally recognized by public programs, including undocumented persons, persons who are homeless, farm workers and other migratory workers in agricultural and non-agricultural jobs, racial and ethnic minorities, and recent immigrants.

Health reform implementation should address the barriers to care that some special populations face, including issues that affect access to care, language and literacy issues, cost issues and continuity of care. Some comments called for an evaluation of existing and new provider networks to see if they adequately meet the needs of adults and children with disabilities.

Other Issues

Some comments related to Medicaid reimbursement. Some said that annual updates should reflect the full inflation-driven cost of providing care. Others related to Hospital Averted Uncompensated Care, expressing concern with the averted uncompensated care assessment. They called for the current prospective reductions in hospital payments to end until all prior averted uncompensated care reconciliations have been completed to the satisfaction of

policymakers and reconciled with actual hospital experience. Others called for Medicaid and MCHP reimbursement rates to be increased to incentivize physician participation in these programs because they are important vehicles for expansion.

Other comments said the State should consider incrementally expanding Medicaid for single, childless adults before the 2014 federal requirement. This expansion would begin to integrate special populations into health insurance and end the lengthy disability determination process for many individuals. Other perspectives were that Maryland should not expand Medicaid early because if funding is available a higher priority would be to restore Medicaid cuts.

A suggestion was made to create a commission or taskforce to address the ethical issues that may be generated by reform implementation. These issues include problems of confidentiality that may arise from a greater use of technology, informed consent, client self-determination, and conflict of duties for professionals.

Immediate Issues

The workgroup was directed by the HCRCC to focus on issues that require immediate attention. These are issues that require action in 2011 or that lay the ground work for future efforts. Many of the critical issues to the safety net depend on other State implementation decisions or the outcome of federal decisions on Essential Health Benefits which are not likely to occur in the immediate future. The ACA does not require State action on issues discussed by the workgroup, but careful planning to prepare for the changes ACA should begin immediately.

Options

The workgroup participants discussed a number of strategies for consideration in health reform implementation. Some of the options presented here are a melding of different suggestions received that relate to public health, safety net and special populations – the areas of focus for this workgroup. Although the options are divided into different categories, the workgroup recognized there is significant overlap between them and should be considered together.

Underlying these options were several general areas of consensus.

Areas of Consensus

1. Health insurance coverage is necessary, but not sufficient to improve health outcomes. Health care reform is an opportunity to embrace a "culture of care" where not only do individuals have health insurance, but are also able to access to health care services. Maryland heath reform implementation efforts should recognize that some individuals may

not be able to access the health care for reasons such as racial or ethnic disparities, geographic, cultural, or linguistic barriers and/or provider shortages. Achieving a culture of care requires that these issues are addressed.

2. Maryland should maintain support for safety net programs because some individuals will continue to be uninsured or may have needs that are not met by their health insurance.
3. Continuity of care is particularly important for special populations. Some individuals are likely to transition in and out of Medicaid and Exchange plans and may have periods when they are uninsured. Assuring continuity of care requires that a safety net continues to exist and that it is fully integrated to Medicaid and Exchange plans.
4. There is an opportunity to improve the coordination and delivery of care for uninsured individuals.
5. The traditional business model and operating practices of some safety net providers may need to change to take full advantage of the opportunities of reform.
6. There is an opportunity for Maryland to improve collaboration between public and safety net providers to effectively compete for new funds and efficiently use current resources.
7. Federal decisions on Essential Health Benefits will be critically important. Maryland may need to maintain funding for services excluded from this definition. Comprehensive benefits are particularly important for individuals covered by Medicaid.
8. Behavioral health services should be integrated and coordinated to improve patient care.
9. The public health infrastructure, including LHDs, and population-based health programs provide unique functions that will need to continue following reform implementation.
10. Health reform implementation should address the barriers to care that some special populations may face.

Public Health

1. State Health Improvement Plan - The State should work collaboratively with LHDs and other partners to develop a statewide heath improvement plan (SHIP), based on a data-driven state health needs assessment. The plan should identify statewide health priorities, with corresponding quantitative indicators of both baseline and future targets, which can be monitored at the State and local level to track performance and support continuous quality improvement processes. These indicators and benchmarks should include state goals for health status, access to quality health services, provider capacity, consumer concerns and health equity. The SHIP should also indicate public and private sector partners that will work with state and LHDs on implementation of the SHIP. The plan developed should also include identification of gaps and barriers to plan implementation, areas of responsibility, evaluation, and a funding strategy that supports and sustains the work outlined in the plan. In addition, the State should explore approaches other states have used to fund statewide and local public health initiatives.

2. Local Implementation Plans - Local Health Departments should lead the development of Local Implementation Plans in collaboration with safety net providers, community health centers, hospitals, and other community based organizations. The goal of the Local Implementation Plan should be to ensure local achievement of SHIP goals for health status, health services, provider capacity, consumer concerns, and health equity by way of local collaboration and planning. The Community Health Resources Commission could provide technical assistance in local implementation planning, pilot models of local implementation planning in a few jurisdictions, and work to resolve implementation barriers identified by local planning groups. The Local Implementation Plan could identify issues which should be addressed in the statewide plan or through other statewide efforts.

3. Pursue ACA funding opportunities to modernize the health IT systems at both the state and local level and provide on-going technical and other supports to fully integrate community-based prevention and public health projects. Funding may be available through the Prevention and Public Health Fund and Community Transformation Grant Program.

Safety Net

4. Access for uninsured: Once more information is known about the federal benefit package, a plan for coordination of safety net services should be developed. This plan should address how to facilitate enrollment in health insurance for those who are eligible as well as coordinate the follow-up care for those who remain uninsured.

5. Preparing Safety Net Providers for Opportunities of Reform
    a. Technical Assistance - The State should assist safety net providers prepare for the changes that may result from reform. Further consideration should be given to whether common administrative systems and technical assistance would be successful in helping small safety net providers to contract with Medicaid and commercial insurers and be reimbursed by these third party payers. The Maryland Community Health Resources Commission is capable and well positioned to provide this assistance. A plan could assess the administrative infrastructure of small safety net providers, identify opportunities to partner to more efficiently support these activities, and develop a business plan for the sustainability of these efforts.

    b. Local Health Department Contracting – In the event that there is no private capacity to provide clinical services in some areas of the State, LHDs should be able to effectively finance gap filling services. Further, LHDs should have the

flexibility required to enter into innovative partnerships, such as contributing to patient- centered medical homes, in order to improve local service delivery. Currently, there are certain statutory and administrative barriers to the contracting with private entities that impede innovation and efficiency. These barriers should be removed to fully leverage opportunities for public-private partnerships to improve health.

Behavioral Health

6. Study the integration of mental health, substance abuse treatment and somatic services – The State should study different strategies to achieve the integration of mental health, substance abuse treatment and somatic services to a greater extent than was achievable through the workgroup. The study should address the statewide administrative structure, policy, and budget necessary to encourage coordination of care; the local resource planning activities needed to encourage collaboration; and the delivery system changes that can improve coordination and patient care.

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Special Populations

7. Oversight Assessment - The State should conduct an assessment of how government administered quality and oversight functions work for special populations, such as individuals with behavioral health needs. In the workgroup's three meetings, this option was not fully developed and more work would need to be done to understand the implementation and cost issues.

Further, the workgroup recognized the public health, safety net, behavioral health, racial and ethnic disparities, and special populations are all key components of health reform and should be considered in all health reform implementation activities. The workgroup developed a list of implementation considerations (see Table 1) for other workgroups. These cross cutting issues were identified through comments from workgroup participants, but were not discussed in detail by the workgroup. These considerations should be considered and evaluated by organizations implementing different aspects of reform, and the wide range of organizations representing special populations should participate in the resolution of these issues as reform implementation progresses to more detailed issues.

Appendix H. Workgroup White Papers

Table 1. Considerations for Other HCRCC Workgroups and Reform Implementation Activities

Entry into Coverage Workgroup

- Facilitating entry into coverage is essential
- System needs the capability to suspend coverage for those transitioning in and out of institutional settings
- Eligibility for Medicaid, MCHP, Exchange and social service programs should be integrated.
- Use community based organizations to facilitate enrollment.
- Current enrollment practices, procedures and infrastructure should be examined and improved to meet the expanded needs by both individuals seeking coverage and for the entities responsible for eligibility determination.
- Processes should be streamlined into a consumer friendly eligibility model and expedited to allow for seamless enrollment, re-enrollment, or for those that have a change in eligibility status.

Health Care Workforce Workgroup

- Conduct a needs assessment of behavioral health workforce capacity and develop a plan in conjunction with behavioral health community to mitigate shortages
- Increase the network of health care providers through visiting physicians, advanced practice nurses, and partnerships though higher education in the context of reaching the developmental disability community
- Create opportunities for better continuing education and training to medical providers to better understand the needs of developmental disability community, including informed consent and medical decision-making
- The State should consider funding through ACA to support the Primary Extension Care Center, which provides funding for states to develop primary care learning communities to support community health teams
- Incentivize more providers to participate in Medicaid, including specialists.
- Expand role of nurses and physician assistance in primary care
- Better compensation for primary care is needed

Health Care Delivery System Workgroup

- Behavioral health providers should be considered as Medical home
- Emergency room visits provide opportunity for brief screening tool for substance abuse disorders and provider education about tools and referrals is needed
- Create more capacity to treat individuals with co-occurring disorders
- Better coordinate services between primary care providers and specialists
- Facilitate the establishment of nurse-managed health centers at locations with concentrations of vulnerable populations
- Explore collaborative agreements between primary care and specialists where majority of care is provided by primary care physicians and telemedicine and telehealth strategies used for specialists to review and consult with primary care providers
- Facilitate the establishment of nurse-managed health centers at locations with concentrations of vulnerable populations
- Explore collaborative agreements between primary care and specialists where majority of care is provided by primary care physicians and telemedicine and telehealth strategies used for specialists to review and consult with primary care providers
- Unleash the potential of nursing workforce to serve as part of safety net by removing current barriers, e.g., collaborative agreements and attestations, reimbursement parity, advocacy for federal Medicare reimbursement for reimbursement of home care by specified advanced practice nurses and physician assistants
- Local health department staffing needs also should be included in any examination of health care workforce issues. If local health departments move out of direct service provision, they will lose the infrastructure that is needed for emergency response and the wrap-around services that are necessary in a public health emergency. The staff that remains will require additional training and support in order to carry out the local health department functions

Education and Outreach Workgroup

- Public education is needed for individuals not currently covered understand the benefits
- Public education on mental health parity needed
- If the new system is to work and special populations are to be reached greater emphasis must be placed on educating the citizenry on the upcoming changes and how they will impact health care delivery in the future
- Health literacy should be adopted as a principle in all health reform efforts

Exchange and Insurance Markets Workgroup

- There should be a State subsidy for individuals with income between 133%-200% FPL in the Exchange
- Evaluate new and existing provider networks to see if they meet the needs of adults and children with disabilities
- Broaden coverage in Exchange to include individuals over age 65 who are not enrolled in Medicare
- Exchange should coordinate with Medicare to meet the needs of Maryland seniors

Long-Term Care

- Community First – focus on the follow-up and services necessary to keep individuals out of nursing homes and in their home
- Shift Maryland's long-term care program to more community-based care
- Integration of long-term care and health care should be a goal
- CLASS Act – Maryland should evaluate the potential to provide assistance for CLASS premiums below a certain income to increase uptake
- Also consider whether it would be cost effective to use State funds to buy-in some individuals to CLASS

Other

- Nurse informaticians should be a part of Health Information Exchange
- Public health surveillance and monitoring of diseases and health conditions should be integrated into Statewide and regional health information exchange
- Local Health Departments should be integrated into Maryland's Health Information Exchange and receive sustainable funding to do so.

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5. Health Care Workforce Workgroup:
Report to the Health Care Reform Coordinating Council

October 31, 2010

Charge

Recently released projections of physician supply and demand identify a national shortage of 90,000 physicians in ten years.[25] While more individuals will have health insurance when federal reform is fully implemented, their coverage will be meaningful only if they have access to health care providers able to meet their needs. Shortages in Maryland's health care workforce already exist, and will be exacerbated in the future by the increased demand for services resulting from reform, coupled with the increasing need for health services by an aging population. At the same time, there are trends in the health delivery system attempting to shift from acute to primary care, and from institutional to community-based settings, which may affect future workforce needs.

The Health Care Workforce Workgroup is charged with considering strategies to prepare the workforce for the future. The workgroup was directed to partner with the Governor's Workforce Investment Board (GWIB) to identify areas best addressed through collaboration with existing programs and initiatives.

Critical questions for this workgroup include:

1) What steps should Maryland take to ensure sufficient capacity in the health care delivery system to meet increased demand?

2) To what extent should Maryland use a broad range of tools to increase capacity and assure an adequate workforce, including fostering **educational and training** programs designed for the workforce of the future, changing **licensing policies**, supporting **recruitment and retention** strategies, and changing **liability laws and regulations**? Key themes that emerged from public comment are outlined below.

3) How can Maryland effectively compete for new federal funding opportunities, particularly for underserved areas?

Given the breadth of these issues, the workgroup was to first focus on the most immediate issues that Maryland will need to address for successful reform implementation in the next 12 months, particularly the issues that require legislation during the 2011 session of the General Assembly. In addition, the workgroup was to identify issues requiring further attention and decision-

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[25] Physician Shortages to Worsen without Increases in Residency Training. Association of American Medical Colleges. September 30, 2010.

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making.

Process

The Health Care Workforce Workgroup was co-chaired by Thomas McLain Middleton, Chairman of the Senate Finance Committee, and Wendy Kronmiller, Chief of Staff and Assistant Secretary of Regulatory Affairs, Department of Health and Mental Hygiene. There was no assigned membership. In an effort to be as inclusive as possible, participation in the workgroup was open to any interested party.

The workgroup met three times between September 2010 and October 2010. The goals of the first meeting were to review the charge and provide background information on recent efforts in Maryland to strengthen workforce capacity. The co-chairs solicited feedback on these recent efforts, including the gaps that this workgroup should address, and where additional momentum might be needed to advance past recommendations. The goal of the second meeting was to hear from panels of educators, professionals, consumers, and providers hiring or contracting with professionals regarding potential tools for strengthening workforce capacity. In addition to the panels, individuals provided public comment on these topics. Written comments were also accepted via the HCRCC website. The third meeting was devoted to reviewing and gaining public input on the draft white paper of options based on input received.

Background

Multiple public entities in Maryland address workforce issues, including the Governor's Workforce Investment Board (GWIB), the Department of Health and Mental Hygiene (DHMH), the Maryland Higher Education Commission (MHEC), and the Department of Business and Economic Development (DBED). GWIB defines the chronic ailments of the health care workforce as the continuous need for trained workers, faculty capacity, lack of clinical sites, physical space, demographic changes, cultural competency, and funding.

The table below shows that between 2007 and 2010, health care and social assistance jobs grew in Maryland while there were declines in jobs in all other industries.

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Cumulative Job Growth in Maryland: December 2007 - July 2010
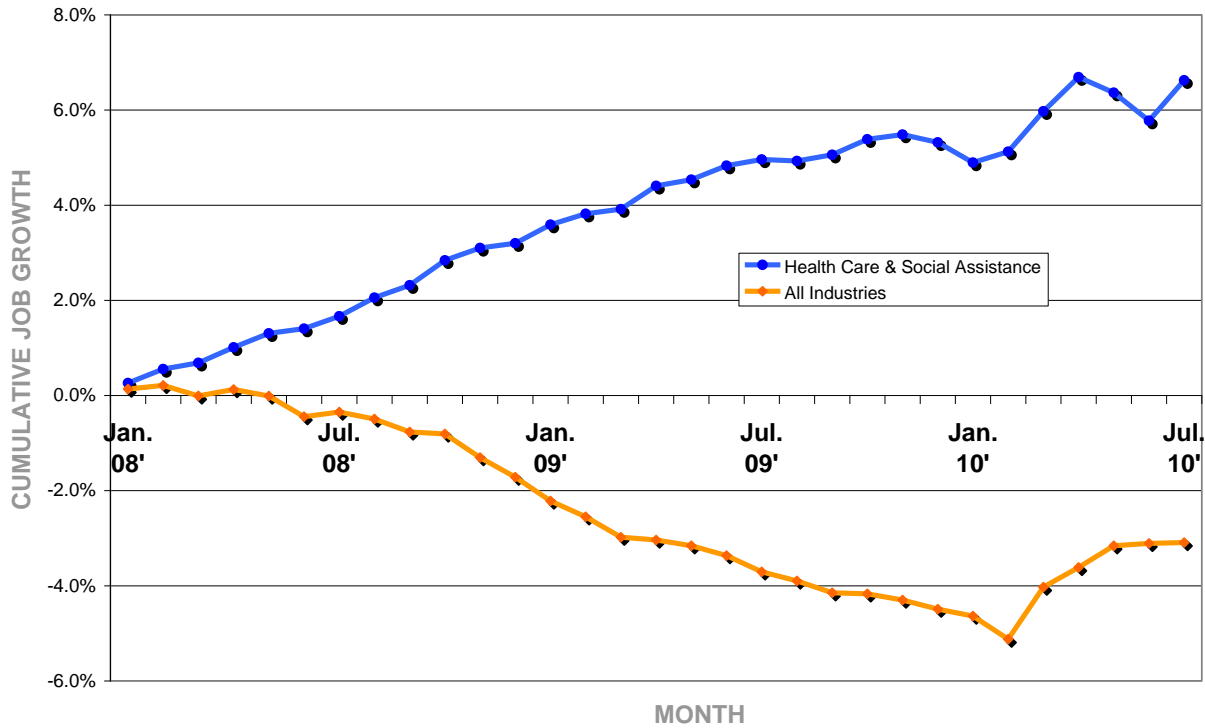
Data Source: Maryland Department of Labor, Licensing and Regulation

Despite these gains, Maryland's aging population puts pressure on the health care system from two ends: the overall population is aging and as a result requiring a greater volume of health services, at the same time that health care professionals are aging and retiring from the work force.

Data from the Maryland Department of Labor, Licensing, and Regulation (DLLR) show the health care professions with the greatest projected need between 2008 and 2018. These projections do not take increased demand from health reform implementation into account, and therefore likely understate need. The following table describes these trends.

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Health Care Practitioner and Technical Occupations with the Most Projected Openings, 2008 to 2018

Title	Jobs in 2008	Projected Annual Openings	Projected Growth (2008-2018)
Registered Nurses	51,290	2,042	22.3%
Licensed Practical and Licensed Vocational Nurses	10,975	554	19.1%
Pharmacy Technicians	5,865	317	28.8%
Physicians and Surgeons, All Other	9,790	256	8.5%
Pharmacists	5,175	199	16.2%
Physical Therapists	3,905	180	33.9%
Radiologic Technologists and Technicians	4,220	141	19.0%
Medical and Clinical Laboratory Technologists	4,345	137	12.4%
Dental Hygienists	2,405	112	26.0%
Emergency Medical Technicians and Paramedics	3,840	110	8.2%

Source: Maryland Department of Labor, Licensing, and Regulation

In particular, there is a need for greater diversity in Maryland's health care workforce. The chart below shows the percentage of Black/African American, Native American, and Hispanic/Latino health profession graduates in 2008, compared to the percentage of Blacks/African Americans, Native Americans, and Hispanics/Latinos in Maryland's overall population. These populations are under-represented in the health professions relative to their proportion of Maryland's general population.

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**Representation of Minorities Among Health
Profession Graduates in Maryland (2008)**

URM Population *

Baccalaureate Nursing

Associate Degree Nursing

Pharmacy

Dental

Medical

40%
35%
30%
25%
20%
15%
10%
5%
0%
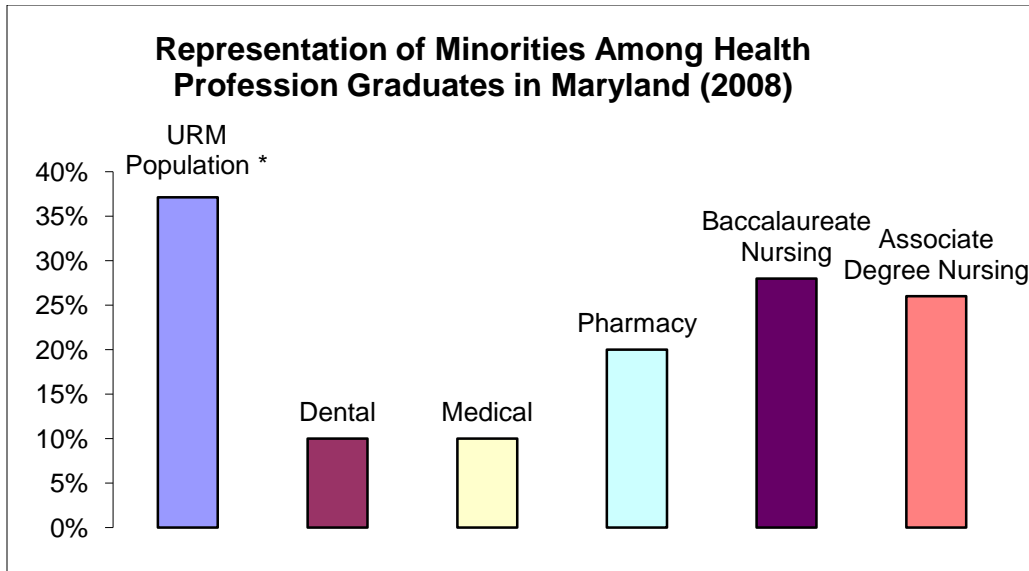
* The term "under-represented minorities" (URM) refers to Black/African American, Native American and Hispanic/Latino health profession graduates.

Source: Maryland Vital Statistics, ADEA, AAMC, AACP, MHEC.

Health care workforce capacity has been studied previously in Maryland, with multiple past task forces and reports. The goal of the workgroup is to build upon previous efforts. Some of the key reports include the Task Force on Health Care Access and Reimbursement (HCAR)[26], established by Senate Bill 107 and issued in December 2008; the Task Force to Review Physician Shortages in Rural Areas[27], established by Senate Bill 459 and also issued in December 2008; the Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals, established by House Bill 524 and issued in November 2007; and the Maryland Physician Workforce Study[28], commissioned by the Maryland Hospital Association and MedChi, and issued in April of 2008.

These reports focused on physician workforce, and shared the following commonalities. Critical areas of concern statewide include primary care, emergency medicine, and obstetrics. Urban areas have more adequate overall physician supply, but within urban areas special attention is needed for populations with limited access. Rural areas and outer suburban areas require special attention to primary care and specialty care capacity. Concerns were raised about the adequacy of reimbursement, and the need for administrative simplification. Better medical management and new models of care, such as the patient centered medical home, were viewed as having the potential to alleviate shortages. Better data are needed on workforce supply. Lastly, there was a call for better coordination of existing resources. The 2007 Annual Report of the Statewide

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[26] www.dhmh.maryland.gov/hcar/pdf/jan09/HCAR_Final_Report.pdf

[27] www.mlis.state.md.us/2009rs/misc/ReviewPhysicianShortages.pdf

[28] www.mhaonline.org/workforce/physicians

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Commission on the Shortage in the Health Care Workforce[29] also highlighted the importance of coordination, and addressed the need to develop faculty, consider reciprocity, and promote diversity in the health care workforce. This Commission sunset in 2008.

Diversity in the health workforce was also addressed by the recommendations set forth by the Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals. The Workgroup's recommendations related to the need to facilitate the licensure or certification of foreign-born and foreign-trained mental health professionals to the full scope allowed by State and Federal law; and development of training programs and educational materials and other initiatives to enhance the cultural competency of all mental health professionals and enhance consumer access to culturally-appropriate mental health services.

Maryland's attention to health care workforce capacity has resulted in the implementation of multiple initiatives in recent years. Legislation has expanded the roles of nurse practitioners, physician assistants, pharmacists, and dental hygienists, and has addressed reimbursement by providing primary care bonus payments for after-hours and weekend care, and setting floors on HMO payments to non-contracting providers. Legislation in the past Session created a patient centered medical home pilot, to be launched in 2011. In the past Session the General Assembly passed Assignment of Benefit legislation that allows a patient's out-of-network provider to be paid directly (assignment of benefits) if that provider does not balance bill the patient. The bill also provides for increased reimbursement for non-preferred providers that fall under this agreement. In 2009, a Maryland loan assistance repayment program (LARP) was authorized, but State funding has been unavailable and implementation has stalled.

Financial support for nursing recruitment, retention, and education capacity continues to be provided through the Nurse Support Programs, funded through hospital rates. This initiative is administered by MHEC. The Nurse Support Program II provides approximately $17.7 million for multiyear projects from 2007 through 2012.[30] MHEC administers a number of additional student financial assistance programs, including the Workforce Shortage Student Assistance Grant Program to support students going into the fields of human services, nursing, public service, and physical and occupational therapy; the Loan Assistance Repayment Program for practicing nurses; the Graduate Nursing Faculty Scholarship and Living Expenses Grant Program to assist graduate nursing students to become nursing faculty at a Maryland higher education institution; and the Health Personnel Shortage Incentive Grant Program to support post-secondary institutions to enhance or expand programs in health occupations experiencing personnel shortages in Maryland. Other smaller MHEC programs target physician assistants, nurse practitioners, nurses, and optometrists. In recent years the Workforce Shortage Student Assistance Grant Program has experienced reductions in funding; annual funding fell from approximately $3 million FY 2008 to $1.25 million in FY 2011.

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[29]www.dhmh.maryland.gov/mscshw/pdf/MSCSHW_2007Annual%20Rpt_Jan2008.pdf

[30] A Quick Guide to Nurse Support Programs I and II.
http://www.hscrc.state.md.us/documents/HSCRC_Initiatives/NurseSupportPrograms/NSP_QuickGuide.pdf.

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Increases to Medicaid physician and dental fees in past years have improved the reimbursement environment. Other efforts to strengthen workforce capacity have focused on telemedicine, transitioning military health care providers to the civilian workforce, physician quality reporting, and improved physician workforce data collection. The Maryland Health Quality and Cost Council is overseeing a multi-agency initiative leading to the establishment of a comprehensive telemedicine system in Maryland. A new Maryland Alliance to Transform the Health Professions is working to expand the diversity of the health care workforce. The DHMH Office of Minority Health and Health Disparities (MHHD) is developing and strengthening partnerships with Maryland's health occupations boards, hospital systems, community colleges and universities to address workforce diversity and cultural competency under a federally-funded State Partnership Grant.

Additional initiatives include the Welcome Back Center, a program of the Montgomery County Department of Health and Human Services, which helps foreign-trained nursing professionals enter the Maryland health care workforce. The Maryland Hospital Association is leading the development of a Baltimore regional pilot adapted from this program. The Maryland Hospital Association's *Who Will Care?* Campaign has raised more than $17 million in private donations to help double the number of nursing graduates by 2016. In addition, the Maryland State Department of Education, the Maryland Area Health Education Centers (AHECs), local workforce investment boards, and other programs promote technical and health care training throughout the education system.

Public Input

The workgroup received close to 50 sets of comments, from individuals as well as coalitions. Workgroup comments echoed issues raised in public comments provided to the full HCRCC and summarized in the July 2010 Interim Report. The synthesis of workgroup comments is organized according to the major tools available to strengthen workforce capacity.

Perspectives were provided from across the health care delivery system, including physicians, nurses (advanced practice nurses, registered nurses, and others), physician assistants, dentists, occupational therapists, hospitals, community health centers, mental health providers, addictions providers, providers for people with developmental disabilities, public health workers, and others. The Workgroup also received comments from groups representing consumer and community interests.

It is essential to take into consideration the diverse needs of Maryland's population. The scope of the workgroup includes general health care workforce needs, as well as areas or populations for which shortages are exacerbated. These include rural areas, vulnerable populations such as those with low income, limited English proficiency, or racial and ethnic minorities experiencing health disparities.

Education and Training

The same key barriers to educating and training the workforce of the future were identified by a number of groups. These were limited financial assistance for full-time and mid-career part-time

students, and graduate and professional students, including loan assistance repayment, tuition remission, and scholarships; the need for more faculty, and the competitive salaries and incentives to attract them; limited physical capacity of schools; and the need for more clinical training sites and incentives to attract more preceptors. These were cited as barriers to training a variety of health professions, including physicians, nurses, physician assistants, dentists, pharmacists, social workers, and allied health professionals.

There was agreement that support is needed for new models of training to advance the goals of health reform. These should emphasize multidisciplinary, coordinated team approaches, enhance understanding of the roles of team members, and train professionals to leverage health information technology. Team approaches support optimal delivery of care by fully using the skills and knowledge of each team member. It was also suggested that public health principles be integrated into health professional education programs.

Strategies for education and training can target almost the full life spectrum. Educational planning to attract individuals to health fields could begin in elementary and secondary education. "Grow your own" programs may be especially important to develop workforce in rural areas, given that students are more likely to be committed to those areas. The Maryland Area Health Education Centers (AHECs) provide some models for this approach. Training programs are needed for health workers in the field to upgrade skills and advance up a career ladder. Initiatives to attract health professional retirees from health professions to work as instructors are one means to address needs for faculty.

Special attention was paid to the need for a health care workforce that is culturally and linguistically representative of the communities served. Studies show that health professionals from racial and ethnic minority groups are much more likely to practice in underserved areas. It was suggested that historically black colleges and universities would play a key role in training health professionals if enhanced support were available.

The Affordable Care Act provides funding opportunities to increase educational capacity. Smaller schools may need technical assistance on grant writing and project implementation in order to leverage these funds.

Efficient Use of Workforce Resources and Changes to Licensing Policy

More efficient use of existing workforce resources was raised by many as a way to meet increased demand for health care. Promotion of a team approach to providing care was cited as one means of increasing efficiency. The team approach recognizes the important role of the professional and graduate degree health care workforce as well as allied health providers, including speech therapists, occupational therapists, respiratory therapists, case managers, and patient navigators/community health workers. Other suggestions included fostering development of larger community-based integrated delivery systems, and investment in integrated and interoperable information technology systems that incorporate public health. There was interest in incentives for all primary care providers to adopt electronic health records. It was recommended that telehealth be recognized as a solution to respond to workforce shortages in rural and underserved areas, particularly for mental health services, and that any reimbursement

or legal impediments to telehealth be explored.

Several groups advocated for regulatory and structural changes to allow nurse practitioners and physician assistants to practice at the full extent of competencies and current licensure. The participation of nurse practitioner-managed practices in patient centered medical home pilots, and changing Medicaid policy to increase the role of physician assistants, were examples. A key message of a recent Institute of Medicine Report, *The Future of Nursing: Leading Change, Advancing Health*[31] is that nurses should be allowed to practice to the full extent of their education and training**.**

Credentialing practices were cited as barriers to practice for nurse practitioners, physician assistants, and behavioral health providers. It was suggested that insurers be encouraged or required to credential nurse practitioners as primary care providers. Beyond credentialing, claims payment and utilization authorizations were described as lengthy, time-consuming, and burdensome. It was suggested that administrative requirements be streamlined, with greater uniformity across payers.

Other ideas included increasing the number of hospital and school based primary care clinics, with the goal of reducing unnecessary use of emergency rooms. It was suggested that current trends in the health care market, such as retail clinics, increase fragmentation and raise a danger of reducing efficiency by running counter to the medical home model.

Some raised concerns about the effect of "degree creep" and increasing licensure requirements on limiting access, for example for respiratory therapists. Representatives of nurse practitioners, physician assistants, dental hygienists, and pharmacists expressed interest in revisiting scope of practice to expand their responsibilities. There was discussion of the current structure to resolve scope of practice differences among the professional Boards, and the need to consider an evidence-based, neutral manner to evaluate competing scope of practice decisions. The need for new training and licensure for anesthesiologist assistants was suggested. It should be noted that the Maryland State Board of Dental Examiners' initiatives to expand dental workforce capacity include new responsibilities for dental hygienists, and the Board is considering support of licensure reciprocity across states for volunteer dentists. The Board of Social Work is promulgating regulations permitting "licensure by endorsement" under many circumstances for social workers licensed in other states. There was a call for cross-state licensure reciprocity or endorsement for more professions, specifically for short-term needs such as call coverage.

Others counseled more caution with scope of practice changes. It was recognized that while a change in scope of practice may be appropriate in some instances, it is imperative that any change in scope of services to be provided also articulates how these services are coherently delivered in the context of the patient's total care requirements. It was suggested that clear delineation of roles is needed.

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[31] www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx

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The complexity and length of time to licensure were cited as current barriers to expanding the health care workforce.

Recruitment and Retention

The need to attract more individuals to primary care professions, and to retain professionals in Maryland, was the subject of much discussion. Given national shortages in primary care, it was stated that Maryland has to compete nationally to attract and retain primary care physicians. Maryland's high cost of living, low level of reimbursement, and challenging liability climate were cited as barriers. Reimbursement was a major issue raised by many types of health care professionals. It was noted that services follow the dollar in health care delivery systems, and primary care providers face an income gap because the current system favors specialty procedures over primary care. Inadequate Medicaid reimbursement levels and the uncompensated cost of case management contribute to the income gap. Concerns were raised about the ability to recruit Medicaid providers once the Medicaid expansion is fully implemented. When individuals cannot access Medicaid providers they use local health departments and other public health programs to obtain care. It was suggested that therefore there is a need to maintain funding for public health safety net programs until it becomes clear that Medicaid has sufficient capacity to serve existing and newly eligible enrollees.

The nurse practitioner and physician assistant communities stated that the differentiation in reimbursement levels between those professions and physicians acts as a major barrier to access. For example, nurse practitioners are limited from opening their own practices because reimbursement at 85% of the rate of physicians is not a financially viable business model.

In addition to increased reimbursement levels, potential solutions to attracting and retaining providers in the primary care field include enhancing practice environments through practice expense reductions, administrative streamlining, support for health information technology, and greater access to telehealth.

Input regarding recruitment and retention of allied professions identified additional challenges, beyond just the adequacy of wages. Particularly in rural areas, allied professionals may need support for transportation or childcare. Many allied workers are uninsured, and face difficulties accessing pre-employment physicals or general preventive care.

Special attention is needed for the field of behavioral health. The mental health and addictions fields have faced high turnover and vacancy rates because of uncompetitive salaries and stigma. Because of new federal parity requirements and the expansion of Medicaid eligibility, a large increase in demand for behavioral health services is anticipated. This will exacerbate existing pressure on the behavioral health workforce, particularly for adults and children in need of the type of high-intensity care currently provided by the public behavioral health system, and for a workforce which can meet the needs of individuals with co-occurring mental health, substance abuse, and other chronic conditions. It was suggested that certain behavioral health providers be reimbursed for preventive and in-home services. Better information is needed on the current

supply of and demand for a range of behavioral health providers by geographic area.

Advocate for Federal Change

It was suggested that Maryland advocate for federal change to increase the role for nurse practitioners, others in the nursing profession, and physician assistants. Current areas of limitation include the ability to prescribe buprenorphine and to order Medicare home health services. Maryland could also advocate for federal funding to advance education and training programs, including clinical simulation and targeting of diverse populations, and health information technology.

Options

Different options for the HCRCC to strengthen Maryland's health care workforce capacity are described below. These options are shaped in part by the Committee's charge to focus on the most immediate issues presented by health care reform. Some of the options entail specific activities that could begin in the short term, and others require further input from stakeholders and additional review. Options are organized around these two categories. They are *not* numbered by order of priority. The options tend not to have a firm deadline for implementation, but it is in the best interests of successful health reform implementation to begin work on these options quickly. The timeline for increasing the number of practicing health care professionals can be lengthy, particularly when talking about education and training approaches to develop future providers.

Short-Term Activities

1. *Revisit Maryland Loan Assistance Repayment Program Funding*

Given the substantial student debt incurred by new physician graduates and the income gap between primary care and specialty physicians, there is wide support for financial assistance incentives to attract more physicians to primary care. As noted above, in 2009 the Maryland General Assembly authorized MHEC and DHMH to establish a new physician loan repayment program. Physicians practicing in a variety of settings in a DHMH-defined health professional shortage area would be eligible. Because the program would rely on state and not federal funds, the State would have flexibility to define shortage areas. The original plan for funding required federal approval, which Maryland has not received. One option for the HCRCC is to revisit the funding plan with the federal government, given the new context created by health reform. Stakeholders expressed interest in expanding this program beyond physicians to other health care professional students, as well as exploring additional sources of funding, for example a small portion of licensure fees.

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2. Comprehensive Workforce Planning

Many different past initiatives have studied Maryland's health care workforce needs and provided recommendations for strengthening capacity. These efforts have tended to focus on specific categories of health professionals or geographic areas within Maryland. Health reform provides the impetus for a more comprehensive approach to planning. There is a need for better data to identify primary care shortage areas and target strategies, and for evaluation of efforts to understand the effectiveness of different strategies. Data and evaluation needs should be addressed through the planning process. It was suggested that information is needed on the numbers, types, and diversity of health professionals currently employed, where they are employed, and in what roles and what types of activities they perform. Data are also needed on the numbers, types, and diversity of health professional students in the educational pipeline, including allied health training programs.

The planning process should ensure the inclusion of stakeholders who represent and serve the needs of diverse communities, health professionals, health professions students, and institutions to adequately address the primary care shortage issues that exist in underserved areas in the state. Attention to behavioral health is important to these efforts. Retired health professionals would provide an additional perspective to the planning process. Local Health Departments, Community Health Centers, Federally Qualified Health Centers, School-Based Health Clinics, and community based organizations could also be incorporated in the planning process. It was suggested that this effort coordinate with existing efforts to develop a "Primary Care Access Plan" to identify the populations in need of services as well as the current resources available to meet the needs and the resources required to improve access to primary care services, as well as diagnostic, ancillary and specialty care services. To the extent possible, behavioral health workforce assessments and regional variations should also be a part of this process.

GWIB was recently awarded a one-year, $150,000 State Health Care Workforce Development Planning Grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), through funding made available via the Affordable Care Act. The purpose of the grant is to establish a high-level health care workforce steering committee composed of GWIB Board Members that will undertake a rigorous planning process leading to development of the ten-year health care workforce expansion blueprint, "Preparing for Reform: Health Care 2020," which is designed to increase the primary care workforce by ten to 25% over a ten year period. Building on its well-established sector initiatives model, the GWIB will collaborate with a broad network of health care industry leaders, the education community, including two- and four-year institutions of higher education, graduate and professional schools, and the public workforce system to train new workers to meet the primary care workforce need resulting from the federal legislation.

The year-long GWIB grant should be the beginning of the comprehensive planning process for assessing how health reform affects workforce supply and demand within Maryland, particularly for primary care. Information on workforce supply and demand may inform consideration of how to increase the efficiency of the workforce through structural, policy, and regulatory changes, as well as considering evidence for licensing changes. The GWIB grant is one of several efforts to strengthen the health care workforce in anticipation of health reform.

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3. Improve Coordination of Existing Resources

As mentioned above, a number of State entities are active in addressing health care workforce capacity needs. Recommendations to coordinate ongoing health care workforce issues in Maryland have been issued previously. There is a continued need for this, especially as the climate changes with health reform. The GWIB planning grant may provide a natural opportunity for better coordination.

Coordination efforts should also facilitate development of viable partnerships among both governmental and non-governmental entities engaged in health care workforce initiatives. Increased partnership-building could allow for increased efficiency in utilization of existing resources and greater prospects of successful grant awards through public and private funding sources.

Health care institutions should be heavily involved in any efforts to coordinate existing resources and develop partnerships that have the potential to improve the health outcomes of the local communities being served. For example, publicly-funded health care institutions' fulfillment of community-benefit obligations pertaining to diversity and cultural competency could provide an impetus for greater development of meaningful institutional partnerships with other entities and resources in the community. Health care institutions and other local entities are engaged in serving the needs of the same communities and populations.

4. Explore Licensure Process Improvements

Several ideas arose for strengthening the workforce through the licensure process and approaches at the level of the individual professional boards. These are listed below. There is also a need to convene the different professional boards together in an effort to review evidence for scope of practice changes. Additional staffing would help with coordination, but it is feasible that existing resources would be sufficient with greater prioritization and accountability.

- Explore Shortened Licensure Process or Reciprocity: A review of professional licensure laws could explore options for greater efficiencies in licensure processes, including options for the implementation of reciprocity for individuals licensed in other States. Licensure qualifications may not be standardized across states, and these efforts must take care to protect patient safety and standards of quality.

- Incentivize Volunteerism: The number of health care professionals volunteering in underserved areas could be increased through the provision of incentives. One potential incentive is fulfillment of requirements for continuing education. The professional boards could promulgate regulations encouraging volunteer work in underserved areas as a means of fulfilling continuing education requirements.

- Require Cultural Competency Training: Promoting cultural competency can help to address disparities in health experienced by racial and ethnic minorities. The professional boards could require cultural competency training. Training programs should be evidence-based.

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5. *Pursue Demonstration Program to Evaluate Alternatives to Current Medical Tort Litigation*

One of the factors cited in attracting and retaining primary care physicians to Maryland is the liability climate. The Affordable Care Act creates state demonstration programs to evaluate alternatives to current medical tort litigation. Each state applying for a grant must demonstrate how the proposed alternative:

- makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;
- encourages the efficient resolution of disputes;
- encourages the disclosure of health care errors;
- enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;
- improves access to liability insurance;
- fully informs patients about the differences in the alternative and current tort litigation;
- provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;
- would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and
- would not limit or curtail a patient's existing legal rights, ability to file a claim in or access a State's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim.

States must establish a scope of jurisdiction for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative. The scope cannot be based on a health care payer or patient population. The federal government will give preference to states that develop the proposed alternative through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing patients and health care providers, medical malpractice insurers, and patient safety experts. Preference will also be given to proposals that are likely to enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; and that are likely to improve access to liability insurance.

The HCRCC has established a process for coordinating Affordable Care Act funding opportunities among State agencies. Applying for and initiating this demonstration program may help make Maryland more competitive nationally when vying for primary care physicians. Suggestions related to medical tort litigation received by the workgroup include strengthening apology provisions, enacting Good Samaritan provisions, and creating a pilot medical care track within the judicial system.

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6. Facilitate Medical Malpractice Coverage for Volunteers

Medical malpractice coverage can create barriers for providers to volunteer in community settings. One solution may be to encourage hospitals, health systems, and insurance carriers to provide coverage for volunteer providers in community settings. This currently takes place on an ad hoc basis. A more structured system could increase the volume of volunteer providers in underserved areas.

Need for Further Input and Additional Review

1. Streamline Credentialing

Past steps have been taken to streamline provider credentialing, and further progress is needed. One option is to convene public and private insurers in Maryland with provider groups to review current credentialing practices and identify opportunities to further minimize unnecessary administrative burdens. It was suggested that a council of all stakeholders be established to recommend revised credentialing practices.

2. Facilitate Clinical Training in the Community

Steps can be taken to increase clinical training and residency opportunities in the community. This could address undergraduate and master's level training as well as post-licensure and post-graduation residencies. Opportunities might include physician residencies, nurse practitioner preceptorships, social work internships, and clinical training placements for all health care professions.

Increasing the availability of clinical training opportunities in the community for health professional students early in their educational careers may cultivate the interest of medical, nursing, and other health professional students in practicing in primary care and underserved areas. Community-based providers sometimes find it challenging to accommodate students, as it can be resource-intensive to create meaningful learning opportunities and provide appropriate supervision and coaching. The HCRCC may choose to initiate discussions with educational institutions and community-based providers, including behavioral health providers, on ways to increase clinical training opportunities and overcome obstacles to clinical training placements, for example by developing a standardized agreement between community-based providers and schools.

The Affordable Care Act provides funding for "Teaching Health Centers" which are defined as ambulatory care programs with primary care residencies. This funding could represent a promising opportunity for community-based providers to establish their own residency programs. Currently, only hospitals can directly receive Graduate Medical Education (GME) payments through Medicare. However, in order to receive funds, providers must already be

accredited by the Accreditation Council for Graduate Medical Education. The accreditation process is extensive and resource intensive. Support is needed for efforts to identify and obtain sources of funds that allow community-based providers to become accredited. Partnerships between community-based providers and hospitals accredited for GME offer another path to establishing more primary care residency rotations. While there is already activity in this area, an option is to convene a larger group of community-based providers and hospitals to create a more structured process for developing partnerships.

The Affordable Care Act promotes the establishment of "residency" style training for advanced practice nurses by establishing five demonstration projects. The projects award funds to qualified nursing schools and hospitals. There is also a provision for grant funding for a one-year training program for family practice nurse practitioners at a Federally Qualified Health Center (FQHC). Both of these grant opportunities may offer Maryland the opportunity to expand training opportunities for advance practice nurses. The HCRCC may encourage partnerships with schools of nursing and health organizations to pursue these opportunities.

Resources and partnerships also could be identified to increase the integration of pharmacists, dentists, and behavioral health professionals in community-based primary care settings, through residencies and other training opportunities.

Such training programs should include education and clinical experience aimed at facilitating health professionals' development of skills in cultural competency and sensitivity, and the ability to navigate patient-provider discordance in language and health literacy. Inter-professional training models should also be encouraged. Special effort should be made to ensure that these clinical training opportunities are extended to health profession students who reside in rural and other medically-underserved areas, and students who are from racial and ethnic minority communities.

3. Maximize Opportunities for Non-Traditional Paths to Health Workforce Development

Increased effort could be made to identify and maximize the utilization of non-traditional channels to increase the health professions pipeline and practicing workforce. Many Marylanders are living longer in good health and have valuable contributions as retired health professionals. A well-organized program to bring these individuals back into the health care workforce could be beneficial to all.

Additional resources and partnerships could be identified to scale up and expand current programs dedicated to facilitating foreign-trained health professionals to enter Maryland's health care workforce. A large pool of potential participants in Maryland's health workforce currently reside in Maryland and have a full range of health professions skills that are not being utilized due to barriers and challenges related to navigating the licensure and certification process.

As an extension of community-based clinical providers (whose training is discussed above), opportunities for establishing a lay network of community-based health workers could be considered to effectively link consumers to health information and services. Such a network of

lay health workers recruited from within the respective communities being served would help to increase the likelihood that medically underserved residents gain access to appropriate and timely health information and primary care services. Lay health workers also represent a potential pool of future clinical and allied health providers.

Efforts to establish non-traditional paths into the health care workforce should consider educational needs to promote expertise and appropriate skills mix across the workforce. Partnerships developed to address Maryland's health care workforce issue could heavily involve the state's system of community colleges, particularly as they play a key role in moving students along the health professions and allied health pipelines. Increased efforts are needed to expand and/or create beneficial and effective partnerships between community colleges, historically black colleges and universities, and other universities in the state. Such partnerships also would be valuable in developing solutions to address a major problem in the health professions pipeline—high school drop-out and low performance issues. Solving problems that are impacting the foundation of the health professions pipeline requires a statewide effort to address this crisis in Maryland. A concerted effort to address Maryland's education and health professions pipeline crisis can best be handled through a coordinated partnership of State agencies, community organizations, and institutions dedicated to addressing the issues of education, health, employment, housing, public safety, criminal justice, and others.

4. Continue to Improve Medicaid Reimbursement Rates

Significant progress has been made in recent years to increase levels of Maryland's Medicaid reimbursement rates, in both the fee-for-service and managed care systems. The Health Care Provider Rate Stabilization Fund created in 2005 allocated funds to the Medicaid program to increase rates annually. For FYs 2006 through 2009, the Medicaid program convened stakeholders to discuss how best to apply rate stabilization funds to increase Medicaid fees. The group first identified areas experiencing access problems or where there were equity issues, and then recommended fee increases across all procedure codes. By FY 2009 Medicaid rates had been raised to approximately 83% of Medicare rates. Due to budget restrictions, certain physician fees were reduced in FY 2010 and FY 2011. Medicaid fees are currently at 80% of Medicare rates for almost all procedure codes. Fees for procedures that are commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency medicine physicians pay greater than 80% of the Medicare rate in order to maintain access to care. As Medicaid expands under the Affordable Care Act, covering a larger portion of the population, it will be even more important to have adequate Medicaid reimbursement. Part of workforce planning should include a plan for improving Medicaid reimbursement rates as the economy improves. It should be noted that effective January 1, 2013 through December 31, 2014, the Affordable Care Act increases Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate, financed with 100% federal funding.

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6. Health Care Delivery System Workgroup:
Report to the Health Care Reform Coordinating Council

October 31, 2010

Introduction

The Co-Chairs of the Health Care Delivery System Workgroup hereby submit this report of the workgroup's efforts to the Health Care Reform Coordinating Council (HCRCC).

The workgroup sought input from the public to guide Maryland's implementation of the Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), commonly referred to as federal health reform. A discussion document was created to request public comments on the following issues: primary care reimbursement and access; patient-centered medical homes (PCMHs); payment reform; electronic health records/health information technology; evidence-based practices; behavioral health; controlling health care costs; regulated insurance products; health care professional schools; and grants, demonstrations, and pilot programs in Maryland. Individuals were also encouraged to provide comments on other topics if they wished.

Throughout the workgroup's activities, which included four meetings (held on August 25, September 24, October 7, and October 25), these issues were refined and additional issues emerged.

The workgroup focused its attention on the specific elements of its charge, based on both the Interim Report submitted to Governor O'Malley on July 26, 2010, and on the letter of direction provided by HCRCC Co-Chairs DHMH Secretary Colmers and Lt. Governor Brown.

This report summarizes the public input that was received. It identifies areas where common themes and suggestions—as well as differences of opinion—emerged.

As the workgroup's efforts proceeded, it became clear that no decisions are required in the next 12 months. Yet, even if certain issues do not require immediate decisions by policymakers, ongoing work must continue to be pursued in order to bend the cost curve; promote quality, access, and affordability; build collaborative models across providers, insurance carriers, employers, and public sector payers; and develop innovative models in Maryland.

Thus, the Co-Chairs present this report to the HCRCC with a concise statement on behalf of the individuals who offered public input: ***It is imperative that Maryland continue to work on these issues in 2011 and beyond to foster innovation and make a collective commitment to work toward cost-effective health care that delivers quality and access.***

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Shared Perspectives

In several areas, the majority of contributors shared a similar perspective, and common themes and recommendations emerged. Contributors generally provided the following suggestions and recommendations:

- Medicare and Medicaid provider reimbursement levels must be adequate to provide access, and should be increased, if possible.

- Provider reimbursement rates should include financing to support the costs of case management and care coordination.

- In order to effectively launch the PCMH initiative, payment rates should cover the start-up (and ongoing) costs related to electronic medical records, expanded office hours, development of care plans, medication management, and other activities.

- PCMHs should have a strong focus on patients with multiple chronic conditions.

- Bundled payments must be allocated fairly among providers, including both community-based and hospital-based providers.

- Because electronic health records and health information technology systems are very expensive, the state should provide funding for these.

- Evidence-based practices can be promoted through the use of health information technology.

- The public mental health system should receive more funding and behavioral health should be incorporated into medical homes.

- Maryland should promote the establishment of cultural and linguistic competency programs in health care systems and provider settings, such as organizational cultural competency assessments, implementation of linguistic service standards, and training of health care providers and support staff.

The majority of the themes and recommendations pertain to seeking funding for innovations and reforms, such as electronic health records systems, expansions in access, payment reforms, and the costs associated with PCMHs. Other concepts—such as the release of public information regarding insurance rate reviews and payment reform policies—require Maryland to change or implement new state policies.

Appendix H. Workgroup White Papers

Primary Care: Provider Reimbursement and Access

A primary care provider is a health care provider located in the community who serves as the first point of contact when an individual is in need of non-emergent medical care. Primary care providers are responsible for patients with a broad range of health issues, including patients who need assistance in managing a chronic illness.

A common theme among public comments was the need to address the shortage in the primary care workforce. Contributors said that, due to low provider reimbursement rates, Medicaid beneficiaries are finding it increasingly difficult to locate private providers willing to care for them. The contributors said that this causes unnecessary emergency room visits and expensive hospitalizations. These comments emphasized the fact that primary care providers who serve Medicaid beneficiaries face severe financial stress. Many contributors stressed that the primary care shortage will further reduce access to health care after the ACA expands health care coverage to more individuals in 2014.

One contributor said that urgent care clinics are available to provide after-hour and urgent services when patients have difficulty getting into their primary care providers for an urgent appointment, and that urgent care clinics are very cost effective relative to hospital emergency rooms. This contributor suggested that the state and payers better incorporate urgent care clinics. However, another contributor said that supporting urgent care clinics could be contradictory to moving toward a PCMH model; episodic urgent care services from different providers might undermine a patient's medical home.

A number of contributors suggested the following to address primary care reimbursement and access issues:

- Increase Medicare and Medicaid reimbursement levels
- Stabilize Medicaid funding
- Have reimbursements cover the costs of case management and care coordination
- Use funds gained from the decrease in uncompensated care costs to pay primary care providers
- Compensate nurse practitioners at the same rates as physicians for the same services
- Support funding for primary care residencies in rural areas
- Establish nurse-managed health centers in areas with high concentrations of vulnerable populations, such as family and juvenile courts and low-income housing sites
- Develop a Primary Care Access Plan that is updated regularly and identifies the populations in need of services, the resources to meet the needs of patients, and the resources needed to improve primary care access

Appendix H. Workgroup White Papers

Patient-Centered Medical Home

A patient-centered medical home (PCMH) model can help bend the cost curve. This model offers ongoing, complete, and coordinated care to patients. Maryland has recognized the benefits of PCMHs and is beginning its own medical home pilot.

Most comments were very positive and supportive of PCMHs. Many agreed that PCMHs should help control costs and increase access to care, quality, and efficiency. Some mentioned that CareFirst's primary care medical home is a good model to follow. Others expressed concerns that CareFirst's model might be problematic because it excludes nurse practitioners from leading a PCMH and because operationally it is hard to reconcile with the multi-payer model (e.g., the locus of care coordination in the multi-payer model resides with the provider, whereas the locus of this function in the CareFirst model resides with CareFirst).

However, some comments raised concern about the use of PCMHs. Some were worried that PCMHs will be expected to provide a fast fix to the health care delivery system challenges, even though these models are largely untested and many unanswered questions remain, including operational ones. Another concern was that the state's PCMH model is focused on large medical practices, although much of the primary care workforce in the state works in groups of fewer than five providers. Contributors said that if small group practices formed joint ventures in order to participate in the state's PCMH model, then these joint ventures might themselves raise legal and operational problems about HIPAA (sharing protected health information), billing, user control, and medical records, for example. To make the PCMH model available to the vast number of small primary care practices around the state, these issues would need to be addressed. Marketing and enrolling patients into a PCMH was another topic of concern; primary care providers do not have the time or the resources to be responsible for this aspect of PCMHs.

Contributors suggested that for PCMHs to be successful, they would need these components:

- In addition to a leading physician or nurse practitioner, a PCMH would need a support team of pharmacists, dentists, social workers, nurses, case managers, and other health workers to achieve the best patient outcomes

- The reimbursement rates to create PCMHs would need to cover upfront and ongoing costs associated with electronic medical records, expanded office hours, development of care plans, medication management, and other activities

- PCMHs would need to create a strong focus on patients with multiple chronic conditions

- PCMHs would need to coordinate and/or integrate treatment for behavioral health needs and meet SAMHSA's "bi-directional" model of PCMH

- Culturally and linguistically appropriate services, as well as transportation services, should be addressed

Appendix H. Workgroup White Papers

Payment Reform

In the United States, health care providers are paid mainly on the amount of services they deliver, not on the quality of the services or their role in improving health. Also, primary care and preventive services are reimbursed at low levels (relative to specialty and inpatient care) even though they provide much value. To amend this, payment methods could be changed to encourage highly effective care that advances patients' health, promotes care management and prevention, and creates efficiency in the delivery system.

Payment reform—specifically bundled payments and accountable care organizations (ACOs)—was a common topic in many comments.

Bundled Payments

Contributors were worried that a bundled payment system would place a high financial risk on providers. They also requested a clear definition of how a bundled payment would be divided fairly between a hospital and the hospital-based providers so that the quantity of hospital-based providers in the state would not decrease. One contributor suggested including a hospital-based physician as a Commissioner on the Health Services Cost Review Commission (HSCRC) to offer a provider perspective on bundled payments. In addition, community-based physicians and other providers also shared concerns about bundled payments and how they would be divided.

Regarding the use of bundled payments for readmissions, some contributors stated that it was important to remember that hospitals and providers cannot prevent all readmissions. Patients sometimes do not comply with post-discharge instructions, causing a readmission. Also, hospitals and providers should not be held responsible for operating in an area that lacks outpatient resources. A few contributors argued that, for a bundled payment method to be practical, it is essential for hospitals to be electronically connected to multiple providers, such as physicians, pharmacists, nurses, and other health workers in the community.

ACOs

Contributors said that reimbursement for ACOs should include funds for upfront costs to implement electronic health records, expand hours, teach patient education, and perform other activities. Also, it is important to determine and resolve any federal legal barriers that might impede the development of ACOs, such as federal anti-trust and anti-kickback laws. At the state level, it is necessary to determine what, if any, changes are needed to the HSCRC Medicare Waiver in order for the HSCRC to promote the creation of ACOs in Maryland.

Another contributor stressed that quality and outcomes measurement and data that are used to determine payments should be developed with the assistance of specialty-specific national and local medical societies and other professional societies. An additional comment suggested that Maryland create a plan in which hospitals receive a fixed (block) payment to cover their patients' chronic disease needs.

Appendix H. Workgroup White Papers

Electronic Health Records/Health Information Technology

Electronic health records (EHRs) and health information technology (health IT) are being pursued as ways to improve health care quality, streamline administrative processes, and reduce medical errors and expenditures.

Many contributors agreed that EHRs and health IT are important for helping the health care delivery system operate more efficiently while lowering costs. One contributor was afraid that, like PCMHs, EHRs and health IT might be considered unrealistically quick fixes to the rising cost of care, even though a more realistic assessment might be that these benefits will not be seen for several years. Also, this technology is extremely expensive, especially for small group practices. One contributor pointed out that a large health care system spent $100 million on this technology, while a small community hospital spent $40 million. The cost of launching this technology on a widespread basis would require public financing and public investments.

Other comments regarding EHRs and health IT included the following:

- Primary care providers should be eligible for incentive payments given through the Maryland Health Care Commission (MHCC) that promote the use of EHRs

- Health care professionals, such as nurse informaticists, should help implement EHRs and health IT into practices

- Hospitals should receive incentives for adopting technology that allows for patient monitoring to reduce readmissions and patient noncompliance

- Meaningful use compliance of EHRs is needed

- Data reporting requirements are very expensive

- Health care providers will need to be educated to use EHRs and health IT properly

- Health IT, such as telehealth devices, can be used to address the health care workforce shortages in rural and underserved areas

- MHCC should permit hospital-owned practices to receive incentive payments to adopt EHRs. These practices, when not "based" at hospitals, could receive funds within the intent of ARRA, which bars federal incentives only to hospital-based practices. Moreover, hospitals cannot easily finance the adoption of EHRs by hospital-owned practices without potential legal issues under Stark and related laws. Thus, one contributor urged MHCC to reconsider its policy regarding incentive payments to hospital-owned practices.

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Evidence-Based Practices

The National Guideline Clearinghouse is a database of clinical practice guidelines for health providers. These guidelines have been created based on evidence-based practices. However, studies have demonstrated that some providers do not follow established clinical guidelines or use evidence-based practices.

There are several barriers to the adoption of evidence-based practices, including lack of knowledge, familiarity, or agreement with the guidelines; limited ability to apply guidelines; lack of description of the type of patients to which the guidelines apply; and ambiguity about the effects of guidelines on health outcomes. Also, a survey demonstrated that providers believe the value of a treatment option ultimately relies on the opinions of the patient and provider. In addition, limited funding to support evidence-based research prevents evidence from being discovered. Further, some providers believe evidence-based research is subjective because it can rely on qualitative evidence, such as experts' recommendations. Another barrier to the adoption of evidence-based practices is convenience. In a busy practice, it is difficult for providers to find time to search for a clinical guideline.[32]

The workgroup received comments regarding the promotion of evidence-based practices in order to avoid payments for procedures and treatments that are either not efficacious or not the most cost-effective option from among the treatment modalities that are equally safe and effective. One contributor said that evidence-based practices would be more readily accepted by providers if these practices were emphasized in the curriculum of providers' training programs.

Others said that health IT is essential to encouraging the use of evidence-based practices. Health IT can offer clinical guidance to all practitioners, including those who practice in rural areas where practitioners feel isolated from other providers and do not have the resources to discuss practice issues. Health IT would give providers the most current clinical treatment guidelines.

A few comments affirmed that Maryland should not duplicate the work that is being completed at the national level, but instead should set up a mechanism to disseminate evidence-based practices research. Also, the work of the Governor's Quality Council should be continued, safe harbor protections should be implemented for the use of evidence-based practices, and hospital-owned practices should be allowed to participate in EHR funding through HB 706.

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[32] Mendelson, D., & Carino, T. V. (2005). Evidence-based medicine in the United States – de rigueur or dream deferred? *Health Affairs, 24*(1), 133-136.

Appendix H. Workgroup White Papers

Behavioral Health

Behavioral health is a critical part of health care and a person's overall wellbeing. Maryland's public mental health system serves about 117,000 adults and children, while the public substance abuse system assists nearly 35,000 individuals.

As the following comments indicate, the public mental health and behavioral health systems are in need of change:

- Better integration of somatic and behavioral health services would help bend the cost curve, as well as the "incidence" curve, through cost-effective early prevention and treatment.

- Support and funding for behavioral health PCMHs should be incorporated in the state's plans regarding PCMHs.

- Substance abuse services and the mental health system should be combined into a single system. If this were to occur, a contributor said that it would require a significant change in either the substance abuse or the mental health system.

- The standards of parity should be maintained in Maryland's new health care delivery system. This can impact whether the mental health and substance abuse treatment systems can be integrated.

- It is unclear if parity laws apply to a carved-out system. This should be determined before changes in the system are made.

- The state should include behavioral health providers in incentive payments for electronic health records.

- The state should include behavioral health in the health information exchange.

- The state should support the use of integrated dual-disorder treatment systems and integrated care best practices.

- The state should support efforts to reverse the workforce crisis in behavioral health and reduce turnover rates.

- The state should implement compliance monitoring for private behavioral health carriers to ensure the new parity requirements are honored.

- The state should provide funding for a more extensive array of services, such as home visits to recovering addicts.

Appendix H. Workgroup White Papers

Controlling Health Care Costs

Health care spending in the United States is of grave concern among policymakers around the country. In 2009, the United States spent approximately $2.5 trillion—or 17.3 percent of gross domestic product (GDP)—on health care. This figure is expected to increase to 19.6 percent of GDP by 2019.[33]

Contributors suggested the following ideas to address the cost drivers of the health care system.

Public Health

Evidence-based prevention activities can help circumvent premature mortality and be cost-saving and cost-effective. Bending the incidence curve (reducing the incidence of certain diseases, such as tobacco-related illnesses, through cost-effective public health interventions) can help bend the cost curve. Testimony presented literature showing that if a prevention program in Maryland focused on physical activity, diet, and smoking, then the return on investment for every dollar spent on the prevention program would equal $6.67 after 10 to 20 years. Contributors said that county health departments should be expanded to address population-based health issues, and the Healthiest Maryland Initiative should be strengthened. Also, Maryland should increase the focus on disease prevention in the transformation of the existing health system.

Childhood Obesity

One contributor indicated that Maryland should consider legislation that requires body mass index (BMI) screenings in schools. School-based clinics can enforce the screenings and follow up with parents to offer education and support about proper nutrition, exercise, and other factors that influence obesity. Another contributor voiced concern that schools without school-based clinics would not have the expertise to counsel students with high or low BMI screenings. This contributor said that BMI is a medical matter and school professionals may not communicate properly with students, which can be harmful if students have body image issues.

Community Health Workers

Community health workers can improve the health of patients at a low cost. These workers address the cultural, lifestyle, and environmental factors that influence health while allowing providers to concentrate on treating disease. Maryland should consider adopting payment mechanisms and policies that reward providers who use community health workers in their practice.

Tort Reform

Maryland should enact tort reform measures to reduce the costs of defensive medicine.

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[33] Centers for Medicare and Medicaid Services. (2010). *National health expenditure projections 2009-2019, forecast summary*. Baltimore, MD. Retrieved September 14, 2010, from https://www.cms.gov/NationalHealthExpendData/Downloads/NHEProjections2009to2019.pdf

Appendix H. Workgroup White Papers

Pharmaceuticals

Buying power should be pooled in order for patients and payers to be able to afford expensive medications. Also, one contributor suggested a tax on pharmaceutical companies to encourage companies to lower costs.

Medicaid Coverage Rules

Review Medicaid coverage rules that prevent the delivery of cost-effective care.

Case Management

Similar to Maryland's Rare and Expensive Case Management program, case management should be expanded to additional medically complex and chronic conditions, which can help lower costs.

Reducing Unnecessary Care

Patient education that teaches patients how to weigh the benefits and burdens of certain treatments may help reduce unnecessary care. Also, a public education campaign about the nature and availability of hospice and palliative care and the difference between the two was suggested. One contributor was concerned that if added quality-adjusted life years (QALYs) were used to determine the value of a medical treatment, then it may cause unintentional discrimination against vulnerable populations who perceive their quality of life to be higher than QALYs estimate. Thus, this contributor suggested that the HCRCC consider rejecting the use of QALYs.

Home-Based Primary Care

Maryland should test a home-based primary care program, in which health care teams, directed by physicians or nurse practitioners, provide care in the patient's home and coordinate the patient's care across treatment levels. A contributor said that this type of program could improve outcomes and satisfaction for these patients, who typically have multiple chronic conditions. Another contributor said that home-based provider care, when coupled with technology, could help patients avoid unnecessary institutional placement in settings such as nursing facilities; this would be a cost-effective alternative.

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Regulated Insurance Products

Employer-sponsored insurance is the primary source of health insurance in the United States, providing coverage to nearly 157 million nonelderly individuals. However, in recent years, companies have been struggling to offer health insurance coverage as insurance costs continue to escalate. From 2009 to 2010,[34] average annual premiums for single coverage employer-based health insurance increased 5 percent (from $4,824 to $5,049). Average annual premiums for family coverage increased 3 percent (from $13,375 in 2009 to $13,770 in 2010). Since 2000, average family coverage premiums have risen 114 percent. To cope with high insurance costs, employers have used strategies such as increasing cost sharing, eliminating benefits and the scope of coverage, and raising the amount employees pay for insurance.[35]

Public comments insisted that Maryland continue to ensure that insurance rate and premium increases are justified. Also, in order to reduce administrative costs, insurers should be encouraged to be more efficient when handling claims from hospitals, providers, and practices.

Other comments requested that Maryland provide more information to the public regarding premium rate reviews and insurance regulation.

One contributor suggested that Maryland encourage insurance companies to remove barriers that exclude nurse practitioners from insurance provider panels because nurse practitioners are often a more cost-effective alternative for delivering primary care. This contributor also stated that payment parity between physicians and nurse practitioners should be promoted.

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[34] The 2009 survey was conducted January 2009 through May 2009. The 2010 survey was conducted January 2010 through May 2010.

[35] Kaiser Family Foundation/Health Research and Educational Trust. (2010). *Employer health benefits: 2010 summary of findings.* Washington, DC: The Henry J. Kaiser Family Foundation. Retrieved September 13, 2010, from http://ehbs.kff.org/

Appendix H. Workgroup White Papers

Health Care Professional Schools

Health care professional schools provide and train the future generation of health care workers. The following issues regarding health care professional schools were raised in the public comments.

Student Debt

Many health workers have high debt due to the costs of professional health schools. Unfortunately, state funding for scholarships and loan repayment programs is limited. More funding options for students will be necessary to have a diverse workforce and to encourage students to work in primary care and underserved areas after graduation.

Faculty Compensation

Salaries for faculty members who work in health care professional schools are often below salaries in the clinical field. In order to encourage faculty members to train and educate health workers, compensation must improve.

Interprofessional Education

To encourage clinicians from various health professions to work together, it is important to emphasize interprofessional teams during the education process. In these teams, each member uses his or her expertise and works with other members to achieve patient-centered goals.

Appendix H. Workgroup White Papers

Grants, Demonstration Projects, and Pilots for Maryland

The ACA and HCERA provide Maryland the option to apply for grants, demonstration projects, and pilots that are related to payment and delivery system reform.

Through public comments, Maryland was encouraged to pursue the following grants, demonstration projects, and pilots that were suggested by the Health Care Delivery System Workgroup:

- *Section 2706 – Pediatric Accountable Care Organization demonstration project:* Establishes a demonstration project that would allow qualified pediatric providers to be recognized and receive payments as ACOs under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings.

- *Section 3022 – Medicare shared savings program:* Would reward ACOs that take responsibility for the costs and quality of care received by their patient panel over time. ACOs could include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality of care targets and reduce the costs of their patients relative to a spending benchmark would be rewarded with a share of the savings they achieve for the Medicare program. Section 10307 provides additional flexibility to the Secretary of the U.S. Department of Health and Human Services (HHS) to implement innovative payment models for participating ACOs, including models currently used in the private sector.

- *Section 2403 – Money Follows the Person Rebalancing Demonstration:* Extends the Money Follows the Person Rebalancing Demonstration through September 30, 2016, and changes the eligibility rules for individuals to participate in the demonstration project by requiring that they reside in an inpatient facility for no less than 90 consecutive days.

- *Section 2703 – State option to provide health homes for enrollees with chronic conditions:* Would provide states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination.

- *Section 3502 – Grants or contracts to establish community health teams to support the patient-centered medical home:* Would create a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community-based, coordinated care. Section 10321 clarifies that nurse practitioners and other primary care providers could participate in community care teams.

- *Section 3504 – Design and implementation of regionalized systems for emergency care:* Would provide funding to the Assistant Secretary for Preparedness and Response to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

Would require the Secretary of HHS to support emergency medical research, including pediatric emergency medical research.

- *Section 5405 – Primary Care Extension Program:* Would create a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The Agency for Healthcare Research and Quality (AHRQ) would award planning and program grants to state hubs, including, at a minimum, the state health department, state-level entities administering Medicare and Medicaid, and at least one health professions school. These state hubs may also include Quality Improvement Organizations, Area Health Education Centers, and other quality and training organizations.

- *Section 10202 – Incentives for states to offer home and community-based services as a long-term care alternative to nursing homes:* Would add a new policy that creates financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into home and community-based services (HCBS). Would provide Federal Medical Assistance Percentage (FMAP) increases to states to rebalance their spending between nursing homes and HCBS.

In addition to the above, contributors also suggested the following grants, demonstration projects, and pilots for Maryland:

- *Section 2401 – Community First-Choice Option:* Establishes an optional Medicaid benefit through which states could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for individuals with mental retardation.

- *Section 2402b – Removal of barriers to providing home and community-based services:* Removes barriers to providing HCBS by giving states the option to provide more types of HCBS to individuals with higher levels of need through a state plan amendment (rather than through a waiver) and to extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment.

- *Section 4306 – Funding for childhood obesity demonstration project:* The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 included several provisions designed to improve the quality of care under Medicaid and CHIP. This law directed the Secretary of HHS to initiate a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity. This section appropriates $25 million for the childhood obesity demonstration project and adjusts the demonstration time period to fiscal years 2010 through 2014.

One contributor suggested that Maryland fully fund the Older Adults Waiver and Living at Home Waiver. Other general ideas for pilots were suggested, such as a pilot examining:

- The re-direction of stable, older adult patients to sub-acute or nursing facilities instead of admission into acute care facilities

- Technologies that offer preventive care for chronic illnesses

- The effect of medical malpractice reform on total cost savings

- Wellness-, prevention-, and lifestyle-related programs for the state employee/retiree population

Conclusion

The Co-Chairs of the Health Care Delivery System Workgroup wish to thank everyone who tendered comments for their invaluable contributions to this process. They hope the HCRCC can utilize the perspectives presented in this document to begin to construct a health care delivery system that best serves the needs of Marylanders.

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Contributors

American Academy of Home Care Physicians
American Academy of Pediatrics, Maryland Chapter
American College of Physicians, Maryland Chapter
Baltimore Medical System, Inc.
Barbara Marx Brocato & Associates
Behavioral Health Leadership Institute
CareFirst
Community Behavioral Health Association of Maryland
Community Health Integrated Partnership
First Colonies Anesthesia Associates
Healthcare-Now of Maryland
The Independence at Home Coalition
Johns Hopkins Bloomberg School of Public Health
Legal Aid Bureau, Inc.
Maryland Academy of Family Physicians
Maryland Addictions Directors Council
Maryland Catholic Conference
Maryland Citizens' Health Initiative Education Fund, Inc.
Maryland Community Health System
Maryland Department of Health and Mental Hygiene
Maryland Hospital Association
Maryland Insurance Administration
MedChi, the Maryland State Medical Society
Medical Management and Rehabilitation Services
MedStar Health
Mid-Atlantic Association of Community Health Centers
Mid-Atlantic Kaiser Permanente Medical Group
National Council on Alcoholism and Drug Dependence, Maryland Chapter
Patient First
University of Maryland, Baltimore
University of Maryland School of Nursing
University Physicians, Inc.