Maryland General Assembly
Joint Committee on Health Care Delivery and Financing
2011 Interim
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December 22, 2011

The Honorable Thomas V. Mike Miller, Jr., Co-Chairman
The Honorable Michael E. Busch, Co-Chairman
Members of the Legislative Policy Committee

Ladies and Gentlemen:

The Joint Committee on Health Care Delivery and Financing respectfully submits a summary of its 2011 interim activities. The committee held four meetings on the topics of bundled hospital payments, prior authorization of health care services and prescription drugs, Medicaid cost and coverage trends and cost containment, the Vermont single payer law, long-term care, end-of-life issues, health care reform implementation, and innovative approaches in hospital emergency departments.

The Joint Committee on Health Care Delivery and Financing appreciates the advice and assistance of the numerous private citizens and public officials who participated in the committee’s activities during the 2011 interim. As chairs, we would also like to thank the committee members and staff for their time and effort.

Respectfully submitted,

Senator Robert J. Garagiola
Senate Chair

Delegate Dan K. Morhaim
House Chair

RJG:DKM/LLS/vin

cc: Ms. Lynne B. Porter
Mr. Karl S. Aro
Mr. Warren G. Deschenaux
The committee met four times during the 2011 interim: July 20, September 6, October 4, and December 13. At those meetings, the committee received briefings on bundled hospital payments, prior authorization of health care services and prescription drugs, Medicaid cost and coverage trends and cost containment, the Vermont single payer law, long-term care, end-of-life issues, health care reform implementation, and innovative approaches in hospital emergency departments. Summaries of the issues discussed follow.

Bundled Hospital Payments

Dr. Stephen Jencks, Senior Fellow, Institute for Healthcare Improvement, and consultant to Health Services Cost Review Commission (HSCRC) discussed bundled payments as a mechanism for improving hospital quality of care. He stated that the purpose of bundling is to promote, coordination, and improve results, thereby lowering costs, that measuring outcomes is essential, that bundling that builds communities is powerful, and that Maryland’s rate-setting system gives the State a big advantage.

Mr. Stephen Ports, Acting Executive Director, HSCRC and Dr. Graham Atkinson, consultant to HSCRC discussed HSCRC’s bundled payment strategies. They stated that the existing charge per case rate-setting system gets in the way of patient-centered care. They also noted that newer strategies, including global budgets, admission/readmission payments, and population-based rate setting, provide incentives for better care and reduced costs.

Ms. Valerie Overton, Senior Vice President, Legislative Policy, Maryland Hospital Association (MHA); Mr. Thomas Mullen, President and CEO, Mercy Health Services and Mercy Medical Center; and Mr. James Xinis, President and CEO, Calvert Memorial Hospital discussed the MHA task force on payment, the need to alter the State’s Medicare waiver, and the experience of individual hospitals with bundled payment. All providers across the continuum of care need to be brought into play for bundled payments to be successful.

Dr. Laura Pimentel, Maryland Chapter, American College of Emergency Physicians (ACEP); Dr. Ramani Peruvemba, First Colonies Anesthesia Associates, Maryland Society of Anesthesiologists; Dr. Mollyann March, First Colonies Anesthesia Associates; Ms. Barbara Brocato, ACEP, First Colonies, and MD Society of Anesthesiologists; and Ms. Pamela Kasemeyer, State Medical Society (MedChi) discussed the need to involve physicians in the development of bundled payment incentives. They noted that any increase in financial risk to physicians needs to be accompanied by a reduction in liability and that the health information exchange should help providers share information about patients as they move through the health care delivery system.
Ms. Deborah Rivkin, Vice President Government Affairs, CareFirst BlueCross BlueShield discussed CareFirst support for HSCRC’s initiatives and how CareFirst’s patient-centered medical home program is changing incentives.

Issues that arose from Ms. Rivkin’s discussion included:

- how to promote/incentivize coordination of care across the health care provider continuum;
- roles of hospitals, physicians, patients, and insurance carriers;
- how to measure results; and
- specific changes needed in the Medicare waiver.

Prior Authorization of Health Care Services and Prescription Drug Benefits

Mr. Joseph Schwartz, Esq.; Dr. Anuradha Reddy, Past President, Baltimore City Medical Society; and Dr. Gary Pushkin, Past President, Baltimore County Medical Society discussed the onerous process required to obtain preauthorization for brand name drugs and diagnostic procedures through health insurance carriers. It was stated that the KePro process used by medical assistance is more efficient.

Ms. Kimberly Robinson, Esq., League of Life and Health Insurers; Ms. Debbie Rivkin, Esq., Vice President Government Affairs, CareFirst; Mr. Winston Wong, Associate Vice President Pharmacy, CareFirst; Mr. Robert Enten, CVS/Caremark; Mr. Russell Ring, CVS/Caremark; and Mr. Andrew Friedel, Medco discussed statutory requirements for preauthorization; in particular, once a carrier preauthorizes, the carrier must then pay for the service. Carriers are looking for ways to improve and automate the process.

Mr. Benjamin Steffen, Acting Executive Director, Maryland Health Care Commission (MHCC); and Mr. David Sharp, Director, Center for Health Information Technology, MHCC discussed the possibility of standardizing prior authorization requirements, using information technology to assist in the implementation of standardizing prior authorization requirements. It was stated that MHCC will look into this and get back to the committee by December.

Mr. Benjamin Mann, Senior Director for State Policy, Arthritis Foundation; and Mr. Paul Gileno, President, U.S. Pain Foundation expressed support for standardizing prior authorization requirements to speed up treatment.

The committee requested MHCC convene a workgroup to develop recommendations on automation of prior authorization.
At the committee’s December 13 meeting, Mr. Benjamin Steffen, Acting Executive Director, and Mr. David Sharp, Director, Center for Health Information Technology, MHCC, presented the recommendations of a multi-stakeholder workgroup convened after the committee’s July meeting to look into automating prior authorization. It was reported that the workgroup has recommended:

- requiring payers and third-party administrators to accept a single sign-on authority, designated by MHCC, for providers to access their prior authorization websites or portals;

- following a phased approach from July 1, 2012 to July 1, 2013, for payers and third-party administrators to implement electronic prior authorization requests;

- requiring payers and third-party administrators to report to MHCC on their implementation of electronic prior authorization; and

- requiring providers to utilize an electronic prior authorization process by January 1, 2015.

It was stated that most stakeholders prefer voluntary adoption of the recommendations, rather than legislation.

The committee makes no recommendation on the issue at this time.

Medicaid Budget Cuts: Process for Obtaining Stakeholder Input

Ms. Tricia Roddy, Director of Planning, Medical Care Programs, Department of Health and Mental Hygiene (DHMH) and Mr. Kevin Lindamood, Chair, Maryland Medicaid Advisory Committee discussed the need to realize $40 million in budget savings, as well as upcoming public hearings scheduled for the purpose of obtaining ideas for cost saving measures.

This was an informational item for the committee; however, the Department of Legislative Services reviewed the budget cuts eventually adopted by DHMH and suggested that DHMH should have adopted reductions yielding ongoing, rather than one-time, savings.

Medicaid Spending, Coverage, and Policy Trends – Comparative Data from Other States

Ms. Robin Rudowitz, Associate Director, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation discussed state and federal Medicaid spending; growth in
spending driven by growth in enrollment, and spending on high-need populations such as the elderly and/or disabled; expansion of Medicaid under federal health care reform; and continued state budget shortfalls and focus on cost containment.

**Medicaid Cost Containment and Efficiencies – Multi-State Overview**

*Ms. Melissa Hansen, Senior Policy Specialist, National Conference of State Legislatures,* discussed state Medicaid reform and focus on cost containment measures (including increased use of managed care, attention to fraud/abuse, changes in long-term care, and changes in pharmacy utilization); Medicaid block grants (including traditional block grants vs. global commitment); state trends for improving care and containing costs (including elimination of inefficiencies, tying pay to performance, and creating greater unity in Medicaid budgeting and management); “best buys” for Medicaid reform and cost containment (including quality improvement strategies, systems of care for aged/blind/disabled beneficiaries, care management for high-risk/high-cost members with multiple chronic conditions, and integrated care for dual eligibles).

The committee has concerns about the impact of cuts to providers on access to care as Medicaid costs continue to rise.

**Medicaid Cost and Coverage Trends and the Role of Managed Care Organizations (MCO)**

*Ms. Tricia Roddy, Director of Planning, Medical Care Programs, DHMH* discussed Maryland’s enrollment and spending growth due to recession and parent expansion; Maryland spending compared with other states; inappropriate emergency room usage; increases to provider assessments and reductions to provider rates; managed care organizations (MCOs) financial statements; and the move toward selective contracting (i.e., competitive purchasing) with MCOs.

*Kathleen Loughran, Vice President of Government Operations, Amerigroup Community Care; Deborah Kuchka-Craig, Vice President, Managed Care, MedStar Health, Inc.; Ms. Cynthia Demarest, Chief Executive Officer, Maryland Physicians Care; and Mr. Richard Reeves, President and Chief Executive Officer of Maryland State Sponsored Programs, United HealthCare* discussed the role of MCOs in improving care and controlling costs; and quality improvement and state budget savings through coordinated care of aged and/or disabled individuals.

Consumers *Mr. Wendell Muldrow, Mr. Mark Schumann and Mr. Joseph Loyal* discussed gaps in coverage; the need for greater outreach; and the necessity of providing integrated services for co-occurring disorders.
The committee notes as potential ideas for achieving long-term savings in Medicaid:

- rebalancing Medicaid’s long-term care system;
- expanding patient-centered medical homes;
- introducing payment reforms that change incentives;
- promoting care coordination in Medicaid fee-for-service population and in HealthChoice; and
- expanding use of advance directives.

**Services Carved In vs. Services Carved Out of Medicaid HealthChoice**

*Mr. Thomas P. Cargiulo, Director, Alcohol and Drug Abuse Administration* discussed behavioral health integration in Maryland, and the regulatory, administrative, and financial processes the department is using with respect to changes to the carve-out.

The committee looks forward to the DHMH report on behavioral health integration at the end of the year.

**Vermont Single Payer Law**

*Ms. Robin J. Lunge, Director of Health Care Reform, Vermont Agency of Administration* discussed the history of coverage, quality, and cost-containment initiatives in Vermont, and implementation of Vermont’s single-payer law (including state legislative challenges, design options, and financing).

**Long-term Care Issues**

*Mr. Mark Leeds, Director, Long-term Care and Community Support Services Administration, DHMH* discussed State and national rebalancing efforts; key provisions of federal health care reform (including Health Homes, the 1915(i) Option, the Balancing Incentive Payment Program, and Community First Choice); quality assessment of nursing facilities; and the Pay for Performance (P4P) model.
Ms. Susan O'Brien, Vice President for Public Affairs, Health Facilities Association of Maryland; Mr. Robert Lanza, Regional Director of Operations, Mid-Atlantic Health Care; Ms. Danna Kauffman, Senior Vice President of LifeSpan Network; and Mr. Aric Spitulnik, President and Chief Operating Officer, Levindale Hebrew Geriatric Center and Hospital discussed the impact of recent federal cuts to Medicare on Maryland’s long-term care providers; Maryland’s efforts to rebalance long-term care services and reform the long-term care Medicaid reimbursement system; concerns that rates be sufficient to ensure that quality standards are maintained; and culture change in long-term care facilities.

End-of-life Care Issues and Advanced Directives

Mr. Paul J. Ballard, Assistant Attorney General, Counsel for Health Decisions Policy and the Office of Health Care Quality, DHMH discussed the creation of the Medical Orders for Life-Sustaining Treatment form; the State Advisory Council on Quality on Care at the End of Life’s educational campaign to increase awareness regarding palliative care, hospice care, and life-sustaining treatments; and the support of the advisory council and the Office of the Attorney General’s for funding the advance directive registry.

Ms. Marie Grant, Director of Governmental Affairs, DHMH discussed the State’s implementation of an advance directive registry; key issues being explored by the department, including the need for a real-time, web-based system; and the department’s expectation that focus group findings and recommendations be made in the next year.

Issues that arose from the discussion included the feasibility of:

• developing and promoting a real-time, web-based advance directive registry;
• integrating the registry with the health information exchange; and
• funding the registry.

Update on Health Care Reform

Ms. Joy Johnson Wilson, Health Policy Director and Senior Federal Affairs Counsel, NCS provided an overview of where states are with regard to the establishment of state health insurance exchanges. Issues that all states share include:

• essential benefits, particularly as they relate to state mandated insurance benefits;
• eligibility and enrollment, and how simplified eligibility can be accomplished through use of other data systems;
health benefit plans inside and outside the exchange, and how they will be treated to avoid adverse selection;

- how active states will be in regulating the health benefit plans inside the exchange, particularly in use of selective contracting;

- role of and credentials to be a navigator;

- basic health plan, and whether a basic health plan threatens the viability of the exchange; and

- risk adjustment, as adverse selection issues must be addressed for the exchanges to be functional.

Ms. Carolyn Quattrocki, Executive Director, Governor's Office of Health Care Reform, provided an update on health care reform implementation in the State with the following information. The Maryland Health Care Reform Coordinating Council is overseeing the implementation. Good progress is being made in developing the Maryland Health Benefit Exchange, putting into place necessary information technology, improving health insurance benefits, moving forward with enhanced rate review, and developing plans to address health disparities and health care workforce needs. Legislation is anticipated in several of these areas at the 2012 session.

Better, Faster, Cheaper: Managing Hot Spots of Care Using Innovative Approaches

Dr. Angelo Falcone, CEO, Medical Emergency Professionals, described three types of high volume emergency department users who present particular problems and account for high costs. He stated that his emergency physician group has developed innovative ways of handling these patients to keep them out of the hospital. He further noted that a transitional care program with 48-hour follow-up has been developed for patients with chronic disease who are at particular risk of readmission and that physicians are looking to establish gainsharing arrangements with hospitals to continue such programs.

The committee requested the Governor’s Office and the Maryland Health Care Commission to look into such gainsharing arrangements. Also, the committee understands that patients may be inconvenienced by being unable to obtain a sufficient quantity of a prescription drug from an emergency physician to bridge the gap in time between their emergency
department visit and trip to their community pharmacy. The committee also requested the Board of Pharmacy to look into the reason for this situation and advise of ways to address it.