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Honorable Anthony Brown
Honorable John Colmers
Maryland Health Care Reform Coordinating Council
State House
Annapolis, MD 21401

Dear Lt. Governor Brown and Secretary Colmers,

The Maryland Health Care Reform Coordinating Council's work will be vitally important to assuring that the state implementation of new federal health reform legislation advances your state's goal of Maryland's goal of making high quality, health care affordable for all Marylanders, while reducing waste and controlling costs. I'd like to commend Governor O'Malley and you for your leadership in this important mission.

I am writing to highlight some important opportunities for Maryland included in the recently-enacted Patient Protection and Affordability Act (PPACA), H.R. 3590. I am aware of your state's policy interest in expanding the use of the patient-centered medical home in both preventing and managing chronic illness. I believe this is an important direction, since 75% of health care spending is associated with chronically ill patients and up to a third of the rise in spending is traced to obesity-related chronic disease. One of the key policy goals in the PPACA is to work with states to accelerate the use of team-based care in Medicare and Medicaid and to incent private insurers to adopt a parallel approach to delivery system innovation for private health plan beneficiaries.

I would like to highlight three aspects of the PPACA offer particular opportunity for accelerating health reform in the direction Maryland has charted.

1) The first opportunity is outlined in Title 1, section 1311, addressing creation of state health insurance exchanges. The provisions of this section allow states considerable flexibility in design and implementation of insurance exchanges that advance PPACA goals. A well-designed state health insurance exchange can promote competition

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between high performance, team-based providers of care in the same direction Maryland is already charting toward effective prevention and management of chronic illness, improvement of medical outcomes, and containment of the growth in premiums Maryland families and business pay.

In fact, the PPACA provides a range of incentives for states to undertake this kind of redesign of their private sector health insurance markets. An illustration can be found in section 1311, subsection (g), entitled "Rewarding Quality through Market-based Incentives." The provisions, here, create incentives for qualified health plans (e.g.. health plans eligible to participate in state insurance exchanges) to undertake "activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, ***including through the use of the medical home model***, for treatment or services under the plan or coverage." [italics added]

Of special note is another provision in subection. 1311(h) that requires, starting in 2015, providers contracting with qualified health plans to provide coordinated health care services, including post-hospital discharge care support. This provision provides the opportunity for the states to require that qualified health plans, along with their contracted providers, assure that team based, coordinated care is available to plan members.

PPPACA provisions like these clarify the intent of H.R. 3590. They provide a consistent set of incentives and an unprecedented opportunity for Maryland to transform the state's private insurance market, in short order, into a marketplace that moderates inflation of health costs by promoting competition among high performance health plans on the basis of value, quality, and price. Maryland can seize this opportunity by integrating two essential features into the design of the state's health insurance exchange: a) a requirement that participating health plans offer all enrollees in the exchange an option of team-based, care coordination that meets at least level 2 NCQA standards for medical home certification, and b) a requirement that all participating health plans comply with uniform quality reporting requirements that will enable Maryland health care consumers to select health plans on the basis of both price and medical outcomes comparisons.

I would recommend that the Health Care Reform Coordinating Council assign high priority to design of a Maryland health insurance exchange that incorporates these features. Planning grants are available from HHS next year to work out how the details of this team-based care requirement facing providers would work. I would be interested in discussing these opportunities with you further.

2) A second important opportunity is included in H.R. 3590 (as amended), Title II, section 2703, which is a new state option to provide health care homes to Medicaid patients with chronic disease. Health care homes in the section are defined generally in Title 3,

section 3502, which defines the concept of a community-based health team. What is important is the enhanced federal match associated with paying the health care team. As the legislation specifies, "Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent." This section provides an obvious immediate financial opportunity for the state. It could also serve as the platform for expanding the use of team-based care to other payers—a point I will highlight in the conclusion of this letter.

3) A third and related opportunity is included in the Medicaid Global Payment Demonstration (Title 2, section 2705) and the Demonstration to Evaluate Integrated Care Around a Hospitalization (section 2704). Both of these payment reforms would serve to complement the incentives embedded in the medical home. The Global Payment Demonstration requires the Secretary of Health and Human Services, in coordination with the CMS Innovation Center, to establish a demonstration project in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service structure to a capitated, global payment structure. The Integrated Care Demonstration would require the Secretary to establish a demonstration project in up to eight states under which bundled payments would be made for provision of integrated care to Medicaid beneficiaries that includes hospitalization.

There are several reasons to recommend that the above opportunities be assigned priority consideration by the Health Care Reform Coordinating Council. First, they align closely with the direction Maryland has already charted to expanding the use of team-based care coordination for delivering cost-effective, high quality care to Marylanders. Second, PPACA offers several sources of financial support for advancing smart priorities the state has already set for meeting its health care goals. Third, a significant portion of working Marylanders are likely to fluctuate between coverage through private plans in the state health insurance exchange and coverage by Medicaid. By seizing as fully as possible the opportunities outlined, above, Maryland will create a health delivery system that allows Marylanders to enjoy continuity of care coordinated and supported by health teams they prefer, even as their insurers may change between public to private health plans over the course of their working lives.

In closing, I'd like to highlight a fourth and final opportunity that was recently announced by the Secretary of HHS. Although this new Multi-Payer Advanced Primary Care Demonstration was launched prior to enactment of the PPACA, its objectives are aligned closely with those of the PPACA provisions discussed above. This new multi-payer demonstration project would provide funds to include Medicare patients in medical homes (like the ones outlined in H.R. 3590, section 3502). This would, of course, compliment Maryland's existing efforts and, in combination with the PPACA opportunities presented above, would provide an important

opportunity to drive transformation of Maryland health care to a high-performance, cost-effective care delivery system. I have included the link outlining this new multi-payer demonstration program (http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1230016)

Thank you for this opportunity to provide input to the Council regarding opportunities the new federal health reform legislation offers for meeting Maryland's health care goals. I believe a decision to pursue of the above-listed opportunities provided in the PPACA, as well as the new HHS demonstration program, will provide additional federal funding to the state, accelerate progress in the direction Maryland is moving, already, with respect to the patient-centered medical home, and help assure implementation of PPACA that achieves both Congress' and Maryland's health reform goals.

The Health Care Reform Coordinating Council might support these objectives by including among its working groups, two groups charged specifically with: a) Design of a Smart Health Insurance Exchange and b) System-wide Expansion of Team-based Care (including the multi-payer, patient-centered medical home).

Please don't hesitate to call me to discuss any of these recommendations further (cell: 404-277-2637). I would be happy, at your request, to work with you, the Council, and its workgroups on any, or all, of these initiatives.

Sincerely

Kenneth E. Thorpe
Professor and Chair