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"Putting Heath Care Reform into Practice in Maryland - Opportunities and Challenges to Improve Health and Reduce Costs"
University of Maryland School of Pharmacy
National Leadership Roundtable
The Prescription for Health Care Reform: Where are the Pharmacists?
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Introduction

Thank you for the opportunity to speak today at such an interesting and well timed health policy roundtable. This really is an important conversation, and I'm honored to be a part of it.

Before I get too far along, I want to acknowledge and thank the University of Maryland School of Pharmacy, Dean Eddington, the Board of Visitors and all of the experts and practitioners gathered here.

I want to especially acknowledge all of the pharmacists in the room. Your work has changed significantly over the years. As the neighborhood "face" of health care, your knowledge and access to people, many of whom have never had insurance before, will be critical to the successful implementation of reform. Dispensing drugs will be the easy part…because we will rely on you to do more than ever; everything from educating customers about living healthier lives to conducting screenings for diabetes and high blood pressure; providing flu shots; and working in healthcare teams to provide coordinated care. That is why your work is critical to the delivery of health care, the implementation of health reform and the ability to improve the quality of care while bending the cost curve.

Four years ago, Martin O'Malley and I took office and we set ambitious goals to improve public education, lower violent crime, create new job opportunities and expand and improve health care for all Marylanders -- because we recognize that a healthy state is a productive state. Before taking office, Governor O'Malley asked me to lead our administration's health care portfolio, and I have had an exciting and challenging four years doing so. I've had the privilege of leading change in Maryland's health care system. I have learned quite a bit through this experience, but of course I don't bring the level of knowledge and expertise that you do. My role today, rather, is to provide you with a governor's perspective on health reform: What governors are focusing on; what Maryland is doing in response to the enactment of federal healthcare reform.

The Affordable Care Act (ACA) offers states an unprecedented opportunity to change the face of our health care system to better support the vitality and strength of our families, businesses and communities: opportunities to expand wellness and prevention; opportunities to reduce hospital readmissions and preventable complications; opportunities to expand health IT and the healthcare workforce; and opportunities to address health disparities and chronic disease management. And the ACA also provides an opportunity to save states money and reduce the number of uninsured.

Still, challenges remain. Challenges that indicate, if we do nothing, we do so at our own peril. The most significant challenge is the exponential increase in the overall cost of healthcare and what that means for state budgets and what that means for the quality and cost of living within our respective states.

Success will require sustained and collaborative efforts on the part of all public and private stakeholders to bend the cost curve. And if we can rise to this challenge, we can change the face of health care in America.

Outline of Discussion

My focus today will be a broad perspective on how one state – Maryland – has approached health care reform. We know that each state is unique in its approach to health care – just as each state will implement and benefit from federal reform in a unique way. The ACA recognizes that we are all different, whether it's our Medicaid eligibility system, our state population and its diversity, the current level of uninsured residents, the way our provider systems are organized, the number of carriers in our insurance markets or our budget challenges.

Now, my remarks are organized into three parts: First, I'll put the Affordable Care Act in the context of states' efforts to make care more accessible and affordable, and what Maryland has accomplished. Second, I'll discuss three of the many key challenges facing states in implementation, and how Maryland is addressing these challenges:

- How Maryland established the nation's 3rd health benefit exchange since the enactment of the ACA;
- How we strengthen our public assistance programs;
- How we develop our health care workforce.

And third, I'll talk about how Maryland is planning to seize this historic opportunity to address the long-term challenge of bending the cost curve by improving the quality of healthcare and health.

Reform in the States

The Affordable Care Act arrived in state capitols last spring, after years - if not decades of states taking individual approaches toward comprehensive health care reform; some successfully, others not as successful.

By mid 2009, three states – Maine, Massachusetts and Vermont – were implementing reforms that sought to achieve near universal coverage of state residents. For years, states have considered, and either adopted or rejected, proposals ranging from the creation of statewide purchasing pools, expansion of public programs, premium subsidies for individuals at certain income levels, and insurance regulations, to wellness and prevention programs.

Early in this decade, Maryland established a waiver program that provided primary care access and prescription drug benefits to low-income individuals. We were among more than 30 states to establish a high risk pool – the MD Health Insurance Plan, and we also created a subsidy – through tax credits – for small businesses to offer employees coverage at a reasonable cost. Since taking office in 2007 Governor O'Malley and I have expanded Medicaid coverage to parents, allowed young adults up to age 25 to stay on their parents' insurance, took steps to close the donut hole for seniors, banned indoor smoking in all public places and increased the tobacco tax to $2 per pack.

I mention these efforts to make the point that many states, including Maryland, were innovating in health care long before the federal government enacted the ACA. And also because many of the potential savings to be realized by states from the implementation of the ACA will be the result of shifting the costs associated with these earlier reforms to the federal government. For that reason, and others that I will touch upon in my remarks, Governor O'Malley and I believe that this law gives states the tools and a historic opportunity to take the next big step towards improved health for our citizens.

ACA in Maryland

The morning after President Obama signed the ACA into law, Governor O'Malley established the Health Care Reform Coordinating Council to develop recommendations for state implementation – a Council I was honored to co-chair.

Over the first year, we held more than 30 public meetings and received hundreds of comments from stakeholders, including physicians, hospitals, payers, unions, public and mental health advocates, brokers, patients, and lawmakers. We also partnered with a non-partisan healthcare think tank – to provide an independent analysis of reform's impact on Maryland's bottom line. This analysis found in part that because of the reforms already in place in Maryland, the implementation of the Affordable Care Act will save the state $850 million and cut the number of uninsured in half by 2020.

The major components of Maryland's savings include an increase in federal assistance for children's health insurance programs, revenue from phasing out Maryland's high risk pool, an increase in revenue from existing assessments on commercial insurance products, and partial reductions in direct state funding for state safety net programs. (And I emphasize partial because safety net programs will be needed for those that continue to go uninsured).

This past January, we presented Governor O'Malley with a final report covering the exchange, entry into coverage, safety net, workforce, and bending the cost curve. These 16 recommendations will help guide our state through the most critical aspects of implementation.

Three Challenges

The first implementation challenge that I want to discuss is setting up the health benefit exchanges and making them self-sustaining by 2016.

Last month, Maryland became the third state since enactment of the ACA to sign its Exchange into law and last week we announced our Exchange Board and convened our first meeting. The Exchange will be a challenge for government because we're used to regulating markets, not operating them. But as an independent government entity we believe that an open and transparent process will help us collaborate with stakeholders and produce effective policies and regulations for its operation.

A second challenge to implementation is how we address entry into coverage in time for the 2014 implementation of the major reform provisions: the individual mandate, the federal individual subsidy, and Medicaid expansion. During our work, stakeholders identified a number of encouraging options and strategies that could be part of an overall approach to entry into coverage: An approach that achieves the goals of simplifying the eligibility process; making eligibility integrated and seamless; embracing a culture of insurance; and advancing No Wrong Door Efforts.

A third important challenge facing states is how to develop our health care workforce for the increased number of insured and the need for enhanced primary care capacity. In other words, how do we solve for the workforce shortages? 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 and pharmacists able to meet their needs. For example, of the 52 health occupations tracked by Maryland's Department of Labor Licensing and Regulation, by 2018, Maryland will need another 2,000 new and replacement pharmacists, the 8th highest occupational growth rate.

We could simply let the law take effect and watch the health care system adapt – or struggle to adapt. Some states may choose this approach, but Maryland is going to be proactive. Shortages in Maryland's health care workforce already exist. These shortages will be exacerbated in the future by the increased demand for services resulting from reform and the increasing need for health services by an aging population. There are also trends in the health delivery system attempting to shift from acute to primary care, and from institutional to community-based settings, which will likely affect future workforce needs.

Some questions that arose during the Reform Council's workforce workgroup deliberations were: To what extent should Maryland use a broad range of tools to increase capacity and assure an adequate workforce, such as, fostering educational and training programs, loan assistance and repayment (of course a budget constrained strategy), changing and streamlining credentialing and licensing policies, supporting recruitment and retention strategies, and changing liability laws and regulations.

It would seem that there are more questions than answers at this time, so with assistance from a federal grant to Maryland's Workforce Investment Board, we have started to create a comprehensive workforce planning strategy.

Bending the Cost Curve

Lastly, I'd like to comment on bending the cost curve. The Affordable Care Act presents a tremendous opportunity for states. The opportunity may not be easily seen by those pressed so close to all the individual points and details, but when I take a step back and look at the whole painting, it is inspiring. The favorable savings forecast that Maryland and many other states anticipate should not weaken our commitment to reduce the overall cost of health care.

We know that net savings to states begin to decline toward the end of the decade as the ACA shifts a greater share of the financial responsibility for Medicaid expansion to the states. As such, our public assistance programs, as well as the entire health care system, will soon be unsustainable, regardless of these savings, unless we succeed in improving quality while reining in the runaway growth in costs.

So, in addition to realizing the projected savings, states must reaffirm and strengthen their commitment to begin serious and sustained efforts to bend the cost curve and align incentives toward quality, safety, and efficiency. We must establish State and Local Health Improvement Plans that identify our priorities and set measurable targets. In addition, we must improve chronic disease management and care coordination through patient-centered medical homes and health information technology and reduce hospital acquired infections, preventable complications, and readmissions. And we must address the financial and moral responsibility to reduce health disparities associated with poverty, race and ethnicity.

Everyone – consumers, employers, providers, businesses, insurers, and taxpayers – has a stake in promoting quality and access while improving efficiencies and incentives to reduce costs. In Maryland, we established a patient-centered medical home program to strengthen primary care. We made one of our 15 statewide strategic goals – and they range from creating more jobs to reducing violent crime –to establish the best-in-the nation statewide health information exchange and electronic health records adoption by the end of 2012. And we are being proactive in the areas of wellness and prevention by establishing the Healthiest Maryland Business campaign, a statewide movement to create a culture of wellness.

We are also improving quality and reducing costs by reducing preventable complications. Maryland is using the only all-payer hospital rate system in the country to collect reliable data on every hospital admission. In fiscal year 2010, there were nearly 50,000 potentially preventable complications that cost our system about $522 million. And we are now analyzing and using this data to drive financial incentives and improvements in quality.

Our hospitals were ranked by rates of complications, and through our rate-setting commission, we redistributed $4 million from the hospitals with more preventable complications to those that had fewer. And as we anticipated, since starting this process, rates of preventable complications have declined substantially across the board – about 12% for an annual cost savings of $62.5 million – benefiting our payers, our hospitals, and of course, our patients.

We are also using the state's all-payer rate setting system to rethink how health care is reimbursed. For example, we now have 10 community hospitals under global budgets – providing an incentive for hospitals to reduce unnecessary admissions, readmissions, and emergency department visits and to provide care efficiently. The hospitals with global budgets are enthusiastically looking for ways to improve care while lowering cost. For example, one is expanding its outpatient program for diabetes by hiring another endocrinologist. Another is planning to create multidisciplinary teams to plan for discharge and post-discharge care. As hospitals innovate, we will capture their best practices and share them throughout our system. All told, 10% of the system's $14 billion in revenue are under these global payment arrangements.

These initiatives, coupled with our pay-for-performance quality initiatives place Maryland at the cutting edge of bending the cost curve and improving quality in the United States. We will track the impact of these efforts publicly by developing a dashboard for health care quality to include as part of our state accountability program – StateStat – with new data coming each quarter. I invite each of you to follow these efforts online.

Finally, let me touch on one important issue that will help bend the cost curve and is a moral imperative – reducing health disparities: a national problem that strikes at the heart of America's promise. In Maryland in 2004, estimates of the hospital cost of excess African American hospital admissions for all diagnoses cost Medicaid $59 million and all other payers $481 million – excluding the physician component, emergency room and outpatient care costs. Reasons for healthcare disparities abound, but as we advance the reform agenda and expand access to insurance coverage, we should take extra steps to make sure we are not leaving people behind. We need to eliminate geographic barriers by providing incentives for primary care providers to deliver care in our poorer communities and our communities of color. We cannot forget that unacceptable disparities in health care delivery are the very definition of poor quality care. We should use health reform and financial incentives to improve access to care, including proximity to care, for underserved populations.

Conclusion

In the end, health care reform is not just about reform – which has been going on for many years. It is also not just about care, which is a means to an end. It is about health…Health is why we're all here. If we cannot change the paradigm of the health payment system, toward a value-driven health care system, we will fail to bend the cost curve and all of our best efforts to implement the Affordable Care Act will be jeopardized.

Health reform will not be sustainable if we continue to pay for volume rather than value; if we do not address the crushing burden of chronic disease; if we do not reduce preventable complications and re-admissions; if we do not make ending health disparities a priority; if we do not improve quality while reining in the runaway growth in costs.

Maryland intends to seize the moment and use the tools provided by the Affordable Care Act to build a better future for our state.

Thank you very much and please visit us at www.healthreform.maryland.gov to follow our progress.

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