

**Report to the New Secretary,
Maryland Department of Health
and Mental Hygiene**

**On Behalf of the
O'Malley/Brown Transition,
Department of Health and Mental Hygiene Work Group**

Submitted by:

Steven S. Sharfstein, M.D. and Ronald R. Peterson,

Work Group Co-Chairs

Patricia M.C. Brown and Bonnie Katz,

Assistants to the Co-Chairs

Nathan Brown, Melisa Lindamood, and Mark Luckner,

Work Group Staff

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Executive Summary

Health care, and health care reform, may be the most important issue facing the State of Maryland in the coming years. Maryland has an opportunity to be a national leader in improving health care. The new Secretary of the Department of Health and Mental Hygiene (DHMH) under the O'Malley/Brown Administration will quickly face many important issues relating to health care policy and the administration and organization of DHMH. These issues will shape the quality, availability, and affordability of health care for Marylanders for years to come.

The O'Malley/Brown Transition Team appointed a Work Group to identify and analyze the most important issues that will confront the new Secretary. As further reflected in this report, the Work Group developed the following recommendations.

- **Policy Priority Recommendations:** There are significant opportunities and challenges relating to the quality, availability, and affordability of health care.

- ***The Uninsured***

- *The new Secretary should immediately evaluate the full range of options and develop a comprehensive plan for covering the uninsured.*

- ***Medicaid Services***

- *The new Secretary should evaluate the adequacy of Medicaid provider rates and implement rate increases as necessary to maintain an adequate provider network.*

- *The new Secretary should begin to address the financing of long term care and assess the proper allocation of resources between HCBS and institutional care.*

- *The new Secretary should assess the legal risk of maintaining day limits and whether the limits provide beneficiaries reasonable access to needed services.*

- *The new Secretary should clarify coverage and verification rules applicable to immigrant groups for providers and local agencies, and assess whether immigrant groups are receiving access to services consistent with federal and state law.*

- *The new Secretary should coordinate with the Governor's office to evaluate pending demonstrations and coordinate with CMS to advance those that remain priorities.*

- *The new Secretary should immediately evaluate whether DHMH is in compliance with DRA requirements and identify needed resources and policy changes.*

- ***Health Disparities***

- *The new Secretary should encourage greater integration of health disparities priorities throughout DHMH, particularly in the public health Administrations.*

- ***Vulnerable Populations***

- *The new Secretary should reduce programmatic barriers to care and improve health outcomes for children.*

- *The new Secretary should conduct a broad system review of services for individuals with developmental disabilities and develop a strategy to address the needs of people waiting for community services.*

- *The new Secretary should proactively pursue policies to maintain the availability of high-quality services to the aging population and opportunities to deliver more effective home and community-based services.*
- *The new Secretary should support efforts to reinvigorate the State’s Interagency Council on Homelessness, promote access for homeless individuals to DHMH programs, and evaluate the adequacy of strategies within HealthChoice to serve this “special needs” population.*
 - ***Prince George’s Hospital and Dimensions Healthcare***
 - *The new Secretary should assist in the facilitation of a permanent solution to this issue that will stabilize the financing of Prince George’s Hospital.*
 - ***Emergency Department Overcrowding***
 - *The new Secretary should evaluate the policy options suggested by the MHCC and demonstrate strong leadership to facilitate their execution.*
 - ***HSCRC Rate Setting and Capital Expenditure Challenges***
 - *The new Secretary should encourage the HSCRC to be more flexible in its rate-setting process and allow for appropriate hospital rate increases to help fund these growing capital needs.*
 - ***Disaster Preparedness***
 - *The new Secretary should ensure the State meets critical benchmarks and achieves minimal levels of readiness throughout public and private health systems.*
 - ***Workforce Development***
 - *The new Secretary should assign high priority to the health care workforce crisis and allocate resources to recruit and maintain high-quality health care providers, including cost of living adjustments for community providers consistent with other state employees.*
 - ***Electronic Health Records***
 - *The new Secretary should exhibit strong leadership and employ a sense of urgency to encourage real public-private partnerships in the medical community, achieve interoperability among these systems, and improve patient safety and health care quality.*
 - ***Access to Affordable Prescription Drugs***
 - *The new Secretary should evaluate existing pharmaceutical assistance programs, assess the potential for leveraging additional federal resources, and work closely with the leadership of DBM to implement bulk purchasing programs.*
 - ***Key Public Health Issues***
 - *The new Secretary should work towards achieving “treatment on demand” by seeking additional funding and performing a comprehensive assessment of statewide need.*
 - *The new Secretary should ensure that the federal Mental Health Transformation grant is not jeopardized by the absence of leadership and insufficient momentum.*

- *The new Secretary should bring HIV surveillance into compliance with Ryan White reauthorization requirements.*
- *The new Secretary should support maintaining those provisions of state law that protect and promote reproductive health, and investigate opportunities to secure federal Medicaid funding to expand access to family planning services.*
- *The new Secretary should take advantage of growing local and national support to advocate for the improved health and fiscal outcomes that would result from increased statewide restrictions on smoking.*
- *The new Secretary should fund effective “primary” prevention strategies to reduce childhood lead poisoning and consider a coordinated strategy to lead poisoning prevention activities.*
- *The new Secretary should bolster the current oral health infrastructure by establishing a dental clinic in every local health department.*
- **Internal Departmental Recommendations:** DHMH faces organizational and administrative challenges that directly impact its ability to oversee the State’s health care system effectively. DHMH’s future success requires strong organization and leadership, a talented work force, and adequate technological systems.
 - ***Medicaid Program Administration***
 - *The new Secretary should act promptly to fill key positions with skilled personnel who can provide vision and initiate needed reforms for the Medicaid program.*
 - *The new Secretary should evaluate the shortcomings of the entire eligibility process; recommend needed changes in technology, training, policy, and oversight; and study the feasibility of a single, Department-wide eligibility system to encourage greater interoperability across programs and service-coordination.*
 - *The new Secretary should review the integrity of the claims payment system and address significant findings in order to guarantee the prompt and accurate payment of claims.*
 - ***Financial Accountability of DHMH Programs***
 - *The new Secretary should give priority to the prompt payment of claims, revenue maximization, cost recovery, and should initiate a comprehensive study to examine untapped federal revenue opportunities.*
 - *The new Secretary should consider the creation of a Deputy Secretary position to oversee internal operations at DHMH.*
 - ***Capital Assets and Infrastructure***
 - *The new Secretary should review the safety of the physical plants operated by DHMH and assess potential capital improvements that may be needed at state-run facilities. The Secretary should also study the value of re-deploying state resources to encourage greater participation among private hospitals.*
 - ***Inter-Agency Collaboration***

▪ *The new Secretary should give prompt and enduring attention to the working relationship between DHMH and a number of other distinct agencies and administrations within the state government.*

○ ***Health Care Quality Review and Oversight***

▪ *The new Secretary should evaluate whether OHCQ has sufficient resources and capacities to conduct and oversee required licensure and certification inspections and surveys of providers.*

● **Performance Measures:** DHMH currently employs performance measures largely based on public health outcomes. Additional performance measures could further gauge DHMH’s performance and provide an internal “audit” function.

▪ *The new Secretary should develop a core set of agency-wide performance measures that improve the financial accountability and service execution of key programs and facilitate day-to-day tracking and regular trouble-shooting at DHMH.*

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The report is divided into the following topics:

- I. DHMH Transition Work Group Process
- II. Overview of DHMH
- III. Priority Issues for the New Secretary
- IV. Internal Departmental Issues
- V. Departmental Performance Measures

In addition, the report contains six appendices:

- A. Work Group Participants
- B. Work Group Minutes
- C. Work Group Submissions—Recommended Characteristics for DHMH Secretary
- D. Work Group Submissions—Recommended DHMH Policy Priorities
- E. Work Group Submissions—Recommended DHMH Performance Measures

I. DHMH Transition Work Group Process

The DHMH Work Group sought input from a wide array of stakeholders and current DHMH officials. The Work Group included over 130 participants (*see Appendix A*) and held three general meetings (*see Appendix B*). Work Group participants were invited to submit written recommendations on three general topics: (1) Characteristics for the DHMH Secretary; (2) Priorities for DHMH; and (3) DHMH performance measures. In all, participants provided over 100 written submissions; these are included with this report as Appendices C, D, and E.

In addition, Work Group chairs and staff sought input from a wide range of stakeholders and state officials. The chairs conducted interviews with the current DHMH Secretary, several DHMH Assistant Secretaries, and other state officials, providers and their representatives, advocates, and others with knowledge of and experience with Maryland's health care system. The Work Group analyzed recent legislative audits of DHMH and various reports by state agencies addressing health care in Maryland. In addition, several state agencies and offices provided written materials either directly to the Work Group or to the O'Malley/Brown Transition team, including a DHMH Transition Book.

II. Overview of DHMH

DHMH is one of the largest segments of state government. The Department's annual budget for FY 2007 is over \$7 billion, with \$4.7 billion allocated to Medicaid. DHMH is divided into several sections:

- **Regulatory Programs**: Comprised of the Maryland Health Care Commission (MHCC), Health Services Cost Review Commission (HSCRC), Office of Health Care Quality (OHCQ), Commission on Kidney Disease, Community Health Resources Commission, and the Health Occupations Boards.
- **Health Care Financing**: Oversees Medicare Care programs, including the Medical Assistance program (Medicaid), the Maryland Children's Health Program (MCHP), Pharmacy Assistance, and Kidney Disease.
- **Public Health Services**: Encompasses the Community Health Administration, Family Health Administration, AIDS Administration, Developmental Disabilities Administration (DDA), Alcohol and Drug Abuse Administration (ADAA), Mental Hygiene Administration, Laboratories Administration, Office of the Chief Medical Examiner, and the Anatomy Board.
- **Operations Administrative Support**: Provides organizational infrastructure and financial management, including the Office of Public Relations and Government Affairs, Office of Human Resources, Vital Statistics Administration, Office of Capital Planning, Budgeting and Engineering Services, Office of Human Resources, Information Resources Management Administration, Office of Procurement and Support Services, and Office of Equal Opportunity Programs.

III. Priority Issues for the New Secretary

A. *The Uninsured*

There is growing momentum in Maryland to expand health care coverage for the nearly 800,000 Marylanders who are uninsured. This was the issue most frequently cited in submissions to the Work Group. Lack of insurance hurts not only the uninsured. It also is extremely expensive for the State and taxpayers, as per person expenditures for the uninsured are higher than expenditures for individuals with health insurance.

The Fair Share Health Care Act of 2005 (the “Wal-Mart Bill”) aimed to expand health coverage through a payroll assessment on certain large employers that did not provide health care coverage to their employees. A federal court struck down this legislation, however, and it is now on appeal.

There are a variety of other promising proposals to expand coverage, including:

- Medicaid Expansion: Medicaid currently covers children up to 300% of the federal poverty level (FPL). Adults are only eligible if their income is roughly 40% of the FPL. This threshold is lower than most states. Coverage could be expanded for adults by increasing the eligibility standard to 100% or more of the FPL for adults.
- MCHP Expansion: MCHP, Maryland’s State Children’s Health Insurance Program (SCHIP), provides coverage to low-income children and families who are not enrolled in Medicaid. Maryland is projected to exhaust its federal allotment in the coming year; therefore, any additional MCHP expansions beyond the federal threshold would not be matched with federal funds.ⁱ As a result, MCHP expansions would likely be funded solely with state dollars.ⁱⁱ
- Expanding Employer-Based Health Coverage: Helping small businesses provide health insurance to their employees has been a significant priority for the incoming Administration.ⁱⁱⁱ Proposals to increase employer health insurance include: (1) expanding the purchasing pool for small employers; (2) combining the small group and individual markets; (3) developing a reinsurance pool for high-cost beneficiaries; (4) providing premium subsidies or tax breaks for small businesses; and (5) establishing an insurance exchange to purchase health coverage.
- Healthy Maryland Initiative: This pending legislation and similar proposals would increase the tobacco tax by \$1 per pack. The added tax revenues and resulting federal matching funds would fund an expansion of the Medicaid program, provide support for small businesses, finance tobacco prevention and cessation programs and drug treatment services, and address health disparities. Supporters estimate the initiative would provide coverage to an additional 39,000 to 53,000 people.
- Other Proposals to Expand Access: There are other avenues to expand health care coverage, either incrementally or as part of a comprehensive “universal” coverage initiative. As part of its universal coverage program approved in 2006, Massachusetts imposed a coverage mandate on all residents, subject to the availability of affordable health plans; a similar concept has now been introduced in California. Maryland could consider an individual mandate, at least for higher-income individuals and

families. In addition, Massachusetts has allowed children to remain eligible for their parents' health insurance policies into early adulthood.

Recommendation: The new Secretary should immediately evaluate the full range of options and develop a comprehensive plan for covering the uninsured.

B. Medicaid Services

1. Adequacy of Provider Network

Rates for many Medicaid providers, including physicians, specialty care providers, providers of community-based services, and institutional providers, are below the market and Medicare levels. This potentially threatens the ongoing availability of services for Medicaid beneficiaries.^{iv}

Recommendation: The new Secretary should evaluate the adequacy of Medicaid provider rates and implement rate increases as necessary to maintain an adequate provider network.

2. Long Term Care

One of the most significant issues confronting Maryland (and the nation) is long term care. Long term care costs are rapidly consuming an ever-growing portion of Medicaid budgets. States also face challenges in ensuring the quality of long term care provided and in offering meaningful alternatives to institutional care. The “institutional bias” in Medicaid law leads to most long term care needs being met in nursing facilities or other institutional settings, despite the fact that many in need of such care would prefer to remain in community settings and community-based care is believed to be more cost-effective in many instances.

Existing home and community based services (HCBS) demonstration waivers provide community services or assisted living services to many Medicaid beneficiaries in need of long term care.^v However, these programs have significant waiting lists, due to budget limitations.^{vi}

Recommendation: The new Secretary should begin to address the financing of long term care and assess the proper allocation of resources between HCBS and institutional care.

3. Day Limits

Medicaid currently imposes day limits on inpatient hospital stays. These day limits were first imposed in 2002 during a budget shortfall. According to the HSCRC, the federal Centers for Medicare and Medicaid Services (CMS) expressed concern that the day limits amount to an impermissible shifting of costs from the Medicaid program to Medicare, potentially in violation of Maryland's all-payer waiver and threatening federal funding.

Recommendation: The new Secretary should assess the legal risk of maintaining day limits and whether the limits provide beneficiaries reasonable access to needed services.

4. Services for Legal and Undocumented Immigrants

Unique challenges exist in providing health care for legal and undocumented immigrants. Federal Medicaid funding is unavailable for five years for legal immigrants, but many state Medicaid programs cover this population with state funds. The General Assembly

passed legislation in 2006 that establishes an Immigrant Health Initiative to provide coverage to children and pregnant women who are legal immigrants. Other challenges include new federal citizenship verification requirements (see section III.B.6), language access services, and cultural competence issues for health care workers.

Recommendation: The new Secretary should clarify coverage and verification rules applicable to immigrant groups for providers and local agencies, and assess whether immigrant groups are receiving access to services consistent with federal and state law.

5. Pending Waiver Demonstration Requests

Maryland currently has several Section 1115 waiver demonstration requests pending before CMS, including the Community Choice proposal that would establish a managed care network for long term care services and provide a greater amount of services in community settings.^{vii} In some instances, CMS is waiting for additional information from the State, has requested revisions, or may be waiting for confirmation that the proposal remains a priority for the new Administration.

Recommendation: The new Secretary should coordinate with the Governor's office to evaluate pending demonstrations and coordinate with CMS to advance those that remain priorities.

6. Implementation of Deficit Reduction Act Requirements

The federal Deficit Reduction Act of 2006 (DRA) imposed numerous new requirements on State Medicaid agencies, such as citizenship verification requirements, new fraud and abuse provisions, and more restrictive asset transfer rules for applicants. There are indications that DHMH has not successfully implemented these new requirements, due at least in part to a lack of guidance by CMS. DHMH may need additional resources to satisfy these new federal requirements. Failure to comply with DRA provisions could risk federal funding.

Recommendation: The new Secretary should immediately evaluate whether DHMH is in compliance with DRA requirements and identify needed resources and policy changes.

C. Health Disparities

In 2004, DHMH established an Office of Minority Health and Health Disparities in accordance with a legislative directive.^{viii} Current statute mandates an organizational structure (*i.e.*, direct report to the Secretary),^{ix} which, while intended to ensure the authority and autonomy of the Office, encourages a "siloeed" approach to a complicated issue that is most effectively addressed through multi-faceted strategies and interventions.^x Separately, the public health Administrations play critical roles in reversing negative trends in infant mortality,^{xi} HIV/AIDS,^{xii} heart disease, and diabetes.^{xiii}

Recommendation: The new Secretary should encourage greater integration of health disparities priorities throughout DHMH, particularly in the public health Administrations.

D. Vulnerable Populations

1. Children

Children’s health and welfare could be improved by greater coordination between DHMH and other state agencies to ensure system accountability, reduce unnecessary or inappropriate juvenile detention, and increase access to health care through improved HealthChoice enrollment efforts (such as MCHP expansion) and enhanced school-based services. In addition, the State could realize improved health outcomes through greater emphasis on prevention and early intervention activities in the areas of childhood obesity, asthma, immunization, lead poisoning, and literacy.

Recommendation: The new Secretary should reduce programmatic barriers to care and improve health outcomes for children.

2. Individuals with Developmental Disabilities

Maryland ranks near the bottom of states in funding for community-based services for the developmentally disabled. Years of level funding threatens the care of 22,000 people currently maintained in the community and 16,000 additional children and adults on the DDA Community Services Waiting List—more than 40% of whom are determined to be in “crisis.”

Recommendation: The new Secretary should conduct a broad system review of services for individuals with developmental disabilities and develop a strategy to address the needs of people waiting for community services.

3. Elderly

The growing disease burden created by an aging population is likely to significantly increase demand for health care services in the coming years. Given the great expense of end-of-life care in hospitals and other institutions, the State will need cost-control strategies, including the expanded use of “advance directives” to limit undesired intensive care stay, and expand community-based services.

Recommendation: The new Secretary should proactively pursue policies to maintain the availability of high-quality services to the aging population and opportunities to deliver more effective home and community-based services.

4. Homeless

For at least 50,000 Marylanders annually, the experience of homelessness causes health problems, exacerbates existing illnesses, and complicates treatment. Lacking comprehensive health insurance, many homeless adults turn to hospitals and emergency rooms, at great cost to the State.

Recommendation: The new Secretary should support efforts to reinvigorate the State’s Interagency Council on Homelessness, promote access for homeless individuals to DHMH programs, and evaluate the adequacy of strategies within HealthChoice to serve this “special needs” population.

E. Prince George’s Hospital and Dimensions Healthcare

Prince George’s Hospital has been at the edge of collapse for years, and this financial insolvency and ongoing fragility threatens Maryland’s health care system. Dimensions Healthcare System has lost \$50 million over the last seven years and typically has about a week’s worth of cash on hand. The system serves 180,000 patients a year, and 60% of

these patients are uninsured, resulting in a high amount of uncompensated care. The hospital must absorb the cost of this care, which produces higher hospital rates to recoup their uncompensated care costs. A committee consisting of county, state, and Dimensions officials recommended in February 2005 that the County sever ties with Dimensions and called for a teaching hospital to take over Prince George's Hospital. The committee has been reviewing resulting bids since March 2006. There will likely be legislation this year to provide state funding to encourage the University of Maryland Medical System to take over the Prince George's Hospital System.

Recommendation: The new Secretary should assist in the facilitation of a permanent solution to this issue that will stabilize the financing of Prince George's Hospital.

F. Emergency Department Overcrowding

Numerous reports have documented the growing challenges placed on emergency departments (EDs), and there is consensus in Maryland that this issue must be addressed. The MHCC issued a report in January 2007, which found that there was a 23% increase in ED visits between 2000 and 2006 and that 35.4% of all ED visits in 2005 were classified as "non-emergent" or "primary care treatable." The report suggests that this use of the ED for non-emergent or primary care services is intensifying. The MHCC report calls for a multi-pronged approach and offered a number of policy options to help alleviate pressures being placed on Maryland's EDs. Highlights of these suggestions include:

1. the improvement of access to primary care and community-based mental health services
 - Private and public payors should examine ways to compensate providers to improve access to primary care services
2. the expansion of consumer education/outreach efforts to encourage the appropriate use of EDs
3. the establishment of urgent care and triage programs, navigator programs between EDs and primary care services, alternatives to access specialty care services and differential payment for evening and weekend visits^{xiv}

Recommendation: The new Secretary should evaluate the policy options suggested by the MHCC and demonstrate strong leadership to facilitate their execution.

F. HSCRC Rate Setting and Capital Expenditure Challenges

Many Maryland hospitals are facing significant capital expenditures to replace aging facilities and infrastructure. In its submission to the Work Group, the MHCC commented that hospitals are in the midst of a multi-billion dollar program of construction and innovation. Historically, the HSCRC, through its hospital rate-setting approval process, has managed the margins of hospitals at a level that has not allowed hospitals to build sufficient internal reserves to meet their future capital needs.

At its January 2007 meeting, the HSCRC staff recommended a 5.65% increase in hospital rates in each of the next two years, while the Maryland Hospital Association (MHA) called for a 6.41% increase. The HSCRC estimated that the rates it approved versus

those requested by the MHA represented an approximate difference of approximately \$150 million. The MHA pegged the difference at \$70 million.

Recommendation: *The new Secretary should encourage the HSCRC to be more flexible in its rate-setting process and allow for appropriate hospital rate increases to help fund these growing capital needs.*

H. Disaster Preparedness

Full participation and collaboration of hospitals and local public health departments is vitally important to statewide planning and response to a bioterrorism event, rare disease epidemic, radiological/chemical exposure, and mass casualty situation. Currently, the State is underperforming in the areas of surge capacity of emergency and trauma centers, electronic information, and first responder communication, as well as surveillance, epidemiology, and laboratory capacity.^{xv}

Recommendation: *The new Secretary should ensure the State meets critical benchmarks and achieves minimal levels of readiness throughout public and private health systems.*

I. Workforce Development

Rising vacancy and turnover rates, shortages in certain fields,^{xvi} geographic maldistribution, lack of qualified applicants, budget restrictions, and non-competitive pay scales have challenged Maryland's public health infrastructure and negatively impacted the delivery of health care services. Among other options to address the issue, DHMH should review methodologies for provider rate setting and adjustment, innovative certification and credentialing options, and loan forgiveness/tuition reimbursement initiatives.

Recommendation: *The new Secretary should assign high priority to the health care workforce crisis and allocate resources to recruit and maintain high-quality health care providers, including cost of living adjustments for community providers consistent with other state employees.*

J. Electronic Health Records

Although a number of Maryland providers and insurers currently utilize electronic health records (EHRs), there is growing consensus about the need to reach interoperability among these independent systems to improve patient quality and increase the availability of EHRs. Significant cost challenges prevent many providers from moving forward in implementing EHRs in their practices. The MHCC has established a Center for Health Information Technology, and is collaborating with the HSCRC to issue and fund several \$250,000 pilot projects this year, with the goal of a \$10 million project to implement the first phase of a statewide health information exchange.

Recommendation: *The new Secretary should exhibit strong leadership and employ a sense of urgency to encourage real public-private partnerships in the medical community, achieve interoperability among these systems, and improve patient safety and health care quality.*

K. Access to Affordable Prescription Drugs

Given the dramatic utilization of pharmaceuticals in our health care marketplace, efforts must be made to ensure access to affordable prescription drugs with an eye towards cost-containment. In addition to the Medicaid program, DHMH currently operates two programs. The Pharmacy Assistance Program, completely state-funded, is designed for low-income individuals and families who do not qualify for Medicaid.^{xvii} The Pharmacy Discount Program allows income-eligible Medicare recipients to purchase pharmaceuticals at 65% of the Medicaid rate.

The Maryland General Assembly has approved legislation to encourage the State to leverage greater purchasing power, in terms of state employees, and to employ an approach similar to Maine's Rx Plus Program for Maryland's Medicaid population.^{xviii}

Recommendation: The new Secretary should evaluate existing pharmaceutical assistance programs, assess the potential for leveraging additional federal resources, and work closely with the leadership of the Department of Budget and Management (DBM) to implement bulk purchasing programs.

L. Key Public Health Issues

The following are "highlights" distilled from the extensive input of community stakeholders and is offered as a basis for priority setting to guide investments in public and community health systems in key areas.

1. Substance Abuse

Declining federal funds and near-level state funding have made it difficult for local jurisdictions to maintain adequate levels of service in recent years.^{xix} All jurisdictions need more funding for treatment than is currently available.^{xx} Drug treatment has proven to be a fiscally prudent investment especially when available "on demand;" access to treatment reduces drug use, increases employment, and reduces crime.^{xxi} With the statutory establishment of local Drug and Alcohol Abuse Councils, regional planning and priority setting has been decentralized. In addition to increased funding statewide, DHMH has an opportunity to ensure the maintenance of an integrated statewide service delivery system that eliminates financial and geographic barriers to treatment.

Recommendation: The new Secretary should work towards achieving "treatment on demand" by seeking additional funding and performing a comprehensive assessment of statewide need.

2. Mental Health

Maryland is the recipient of a \$13.5 million federal Mental Health Transformation State Incentive Grant.^{xxii} Currently in its second year, the grant momentum has suffered due to insufficient stakeholder buy-in and goals that may not be fully consistent with predicted results. A time-limited opportunity exists to reinvigorate the grant with new leadership, a reconsideration of the most appropriate organizational placement for grant authority, and a re-articulation of grant deliverables.

Recommendation: The new Secretary should ensure that the federal Mental Health Transformation grant is not jeopardized by the absence of leadership and insufficient momentum.

3. HIV / AIDS

In accordance with the federal Ryan White Treatment Modernization Act, DHMH has prepared legislation to allow the transition from an HIV surveillance method of coded patient identifiers to a names-based reporting system. Maryland's prevalence data is a key factor in the formula used to determine its Ryan White funding allocation (currently \$36 million). The realization of a mature reporting system compliant with federal law by the April 1, 2008 deadline is critical to Maryland's ability to continue to provide high-level services to people with HIV.

Recommendation: The new Secretary should bring HIV surveillance into compliance with Ryan White reauthorization requirements.

4. Reproductive Health

Maryland was the first State to pass contraceptive equity legislation that requires health insurance plans that offer prescription drugs to provide the same coverage for contraception. State law also grants safe access to clinic entrances, affirmatively protects the right to choose to terminate a pregnancy prior to viability, and provides state funding of medically necessary abortion. Further progress could be made through the request of a Section 1115 demonstration to expand Medicaid family planning eligibility based on income to 100% of FPL and offer Medicaid coverage of family planning services to men.

Recommendation: The new Secretary should support maintaining those provisions of state law that protect and promote reproductive health, and investigate opportunities to secure federal Medicaid funding to expand access to family planning services.

5. Smoking Cessation

Four Maryland counties—Montgomery, Prince George's, Howard, and Talbot—have local prohibitions against smoking in bars and restaurants. To date, the State has left such decisions to local jurisdictions and municipalities. The experience of other states shows that statewide bans reduce smoking,^{xxiii} improve health,^{xxiv} and do not negatively impact businesses.^{xxv}

Recommendation: The new Secretary should take advantage of growing local and national support to advocate for the improved health and fiscal outcomes that would result from increased statewide restrictions on smoking.

6. Lead Poisoning

There has been a steep decline in blood lead levels in Maryland,^{xxvi} consistent with trends nationwide.^{xxvii} Maryland has adopted the federal goal of eliminating childhood lead poisoning by 2010, but state efforts remain somewhat fragmented among three key agencies (DHMH, Maryland Department of the Environment and Department of Housing and Community Development).^{xxviii} Consolidating resources, increasing interagency collaboration, and integrating financial assistance could enhance primary prevention efforts throughout the State.

Recommendation: The new Secretary should fund effective “primary” prevention strategies to reduce childhood lead poisoning and consider a coordinated strategy to lead poisoning prevention activities.

7. Oral Health

Inadequate availability of dental services in rural areas, lack of insurance coverage and services for the uninsured, and inadequate knowledge of the importance of dental hygiene continue to contribute to poor oral health in Maryland.^{xxix} Currently 11 of the 24 local health departments have no on-site dental services. Incentive programs, such as the Maryland Dent-Care Program (which provides educational loan repayment for dentists who maintain at least a 30% Medicaid patient mix), can help maximize limited resources to under-served areas and expand oral health capacity to high-need areas.^{xxx}

Recommendation: The new Secretary should bolster the current oral health infrastructure by establishing a dental clinic in every local health department.

IV. Internal Departmental Issues for the New Secretary

A. Medicaid Program Administration

1. Leadership and Morale

Over the last several years, the Medicaid program has lost a significant amount of expertise and experience through staff departures. Numerous senior vacancies now exist.^{xxxi} These vacancies and the underlying “brain drain” have resulted in a lack of leadership, reduced morale, and have hampered DHMH’s ability to undertake new initiatives or embark on innovative reforms or needed improvements.

Recommendation: The new Secretary should act promptly to fill key positions with skilled personnel who can provide vision and initiate needed reforms for the Medicaid program.

2. Eligibility Process

The State’s Medicaid eligibility process no longer operates efficiently or effectively, due to shortcomings in the CARES system and in training and administration. These issues are exacerbated because CARES is used for a variety of means-tested benefits programs.^{xxxii}

Recommendation: The new Secretary should evaluate the shortcomings of the entire eligibility process; recommend needed changes in technology, training, policy, and oversight; and study the feasibility of a single, Department-wide eligibility system to encourage greater interoperability across programs and service-coordination.

3. Claims Payment System

The State’s claims payment system, the Medicaid Management Information System (MMIS), is out-dated and slow, and may not be compliant with federal privacy requirements. The failures of the MMIS system have been addressed in several legislative audits, resulting in inappropriate payments and the loss of significant federal funding due to inaccurate, late, or unsubmitted claims.

Recommendation: The new Secretary should review the integrity of the claims payment system and address significant findings in order to guarantee the prompt and accurate payment of claims.

B. Financial Accountability of DHMH Programs

1. Claims Processing and Revenue Maximization

In recent years, Maryland has possibly lost significant federal funding opportunities due to inaccurate, late, or unsubmitted claims. In addition to shortcomings in the internal claims processing, recent legislative audits have found that DHMH did not claim certain federal reimbursements in a timely manner, and did not perform comprehensive financial investigations of legally liable third parties to maximize recoveries for the costs of care.

In addition to claims processing inadequacies, DHMH has not paid sufficient attention to maximizing opportunities for federal Medicaid matching funds. For instance, many public health activities such as lead screening are currently funded solely through state and local expenditures. There may be other areas in which the State does not maximize opportunities for federal financial participation, such as implementation of certain data systems and unused portions of the State's Medicaid Disproportionate Share Hospital (DSH) allotment.

Recommendation: The new Secretary should give priority to the prompt payment of claims, revenue maximization, cost recovery, and should initiate a comprehensive study to examine untapped federal revenue opportunities.

2. Internal Controls

Overall, DHMH has not exhibited strong leadership in managing its internal operations. As an example, several recent legislative audits of the department found that DMHM did not ensure financial accountability of state financial assistance awarded to local health departments.^{xxxiii}

Recommendation: The new Secretary should consider the creation of a Deputy Secretary position to oversee internal operations at DHMH.

C. Capital Assets and Infrastructure

DHMH operates a number of physical facilities and state hospitals across the State, many of which are old and not state-of-the-art.

Recommendation: The new Secretary should review the safety of the physical plants operated by DHMH and assess potential capital improvements that may be needed at state-run facilities. The Secretary should also study the value of re-deploying state resources to encourage greater participation among private hospitals.

D. Inter-Agency Collaboration

There exists a critical need to examine interagency collaboration, both on the intramural and external levels.

- Frequently, multiple agencies share accountability for programs or populations that are directly influenced by DHMH activities, and the unintended consequences of fragmented policy making and lack of coordination oftentimes negatively impacts

public welfare. Without creating new levels of multi-agency bureaucracy, careful attention should be paid to establishing meaningful coordination of effort between key agencies with synergistic influence.

A non-exhaustive list of prime examples includes:

- Coordination between DHR and the Mental Hygiene Administration (MHA) within DHMH around child and adolescent initiatives
- Coordination between the Maryland State Department of Education (MSDE) and MHA around education and mental health
- Coordination between the Department of Juvenile Services (DJS) and MHA around shared populations
- Coordination between DDA/MHA and the judiciary around the prudent use of state facilities with a goal of deterring the inappropriate placement of forensic detainees in state hospital beds
- Coordination between the Maryland Insurance Administration (MIA) and various DHMH agencies, including the Medicaid Administration, with respect to the impact of private sector insurance industry policies on public sector funding and access

Within DHMH, there is a crucial need to strengthen the communication and eliminate the policy collisions around a number of agencies with joint responsibility for vulnerable populations, which includes the interlocking practices of MHA, DDA, ADA, Medicaid, DHR, and OHCQ. The policies and priorities of these agencies need to be aligned, to assure that resources are maximized and consumers are not caught up in conflicting interagency initiatives.

Recommendation: The new Secretary should give prompt and enduring attention to the working relationship between DHMH and a number of other distinct agencies and administrations within the state government.

F. Health Care Quality Review and Oversight

OHCQ is responsible for carrying out surveys and inspections to guarantee that providers satisfy certification requirements, offer high quality services, and maintain a safe environment. Failure to conduct required surveys undermines the quality and safety of health care services and could jeopardize federal Medicaid and other funding.

Recommendation: The new Secretary should evaluate whether OHCQ has sufficient resources and capacities to conduct and oversee required licensure and certification inspections and surveys of providers.

V. Departmental Performance Measures

A. Existing Performance Measures

DHMH currently utilizes a number of performance measures. DHMH's "key goals, objectives, and performance measures," focus on thirteen public health objectives. The Department collects actual data over a multi-year period, sets target goals for future years, and is thus able to track agency performance in meeting these public health goals. Progress occurs in most of the outcomes measured in these goals.

Goal #1 states, “To improve the health status of Marylanders and their families by assuring the provisions of quality primary, preventive and specialty care services.” Performance measures for this goal include tracking infant mortality rates, number of pregnant women receiving prenatal care in the first trimester, and teen birth rates.

Goal #2 states, “To promote healthy behaviors, prevent infectious diseases, and ensure accurate public health surveillance.” Performance measures for this goal include the number of reported cases of vaccine-preventable communicable diseases, rates of syphilis, and percent of two-year olds with up-to-date immunizations.

Other goals include reducing tobacco use; preventing chronic diseases, reducing the incidence of HIV/AIDS; providing substance abuse treatment services; providing community-based services to the developmentally disabled; providing mental health services; improving the health of the Medicaid population; adopting cutting edge scientific technology to improve the quality of public health laboratories; and others.

B. Considerations for Additional Performance Measures

Previous administrations have attempted to instill performance measures across state agencies and departments. These efforts, while noble, have largely failed to produce substantive lasting results. These measures have had little impact on budget allocations nor have they seemed to influence the day-to-day operations of departments.^{xxxiv} Given this history, a renewed focus on performance measures will likely require significant personal leadership and sustained commitment from the incoming Secretary. The performance measures that DHMH currently utilizes focus on broad public health goals, not on financial accountability, program execution, or day-to-day operations of programs.

The Work Group received a number of suggested performance measures, and a compilation of these suggestions is included as Appendix E to this report. These suggestions range from measuring efforts to expand access for Maryland’s uninsured, to measuring the amount of primary and specialty care services provided to the uninsured by state-sponsored initiatives and community health centers; tracking the number of Maryland institutions employing electronic health records; determining the state-wide need for substance abuse treatment services; assessing the ability of adults with disabilities to receive supported employment; and other public-health related goals.

Recommendation: The new Secretary should develop a core set of agency-wide performance measures that improve the financial accountability and service execution of key programs and facilitate day-to-day tracking and regular trouble-shooting at DHMH.

ⁱ Congress recently provided increases for Maryland and other states. Even with this modest increase, however, the Congressional Research Service projects that Maryland would exhaust its SCHIP allotment in May 2007.

ⁱⁱ The availability of federal matching funds makes Medicaid and MCHP particularly attractive avenues for expanding access to health care coverage. Maryland receives a 50% match on its Medicaid expenditures. The State receives a 65% match on MCHP expenditures, but MCHP funds are subject to an overall state-specific cap.

ⁱⁱⁱ The MHCC and others have observed that prices for health insurance in the small group employer market continue to rise faster than inflation and somewhat faster than other markets. The number of insured employees has dropped in recent years. Moreover, it is estimated that 60 percent of Maryland’s uninsured are employed. For more information regarding recent developments relating to benefit plans provided by

the small group market, please see the Maryland Health Care Commission's *Report to the Governor, Fiscal Year 2005*.

^{iv} Commenters generally sought to increase Medicaid rates to the market level or Medicare level. Other proposed solutions included tax breaks for providers and a provider tax on nursing homes that would fund higher rates. Representatives of the nursing facility industry also sought greater input into budget development and rate setting.

^v These include the Older Adults Waiver, the Living at Home Waiver, and certain programs coordinated by the Developmental Disabilities Administration (DDA).

^{vi} Commenters made several recommendations to address long term care: (1) increasing slots in HCBS programs; (2) restoring Medicaid coverage for individuals needing 24-hour home supervision (e.g., individuals with cognitive impairments); (3) amending certain demonstration rules so that individuals currently residing in the community may qualify; (4) providing community services specifically for individuals who experience crisis situations; and (5) developing a comprehensive strategy to reduce the funding disparity between nursing home care and HCBS.

^{vii} Other pending demonstration requests include the Primary Adult Care demonstration expansion and a pharmacy demonstration proposal.

^{viii} Maryland General Assembly, Senate Bill 177/House Bill 86, 2004 Regular Session

^{ix} Health General, Section 20-1003.

^x Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002).

^{xi} Rates among African Americans are three times higher than those of whites. *See* Maryland Vital Statistics Administration, 2005 Preliminary Report.

^{xii} African American residents make up a greater and increasing proportion of the population living with HIV and AIDS. *See* Maryland AIDS Administration Report: Twenty-five years of AIDS in Maryland

^{xiii} Death from heart disease and diabetes disproportionately affects the Hispanic and African American communities. *See* Maryland Vital Statistics Administration, 2004 Annual Report.

^{xiv} In addition to the MHCC's recommendations included in the January 2007 report, other suggestions have been presented. The Maryland Hospital Association suggested the following steps: expanding the state's "Purchase of Care" Program to address needs of mental health patients; increasing access to additional crisis beds; establishing a case management system for the small cohort of patients that visit EDs frequently; expanding access to outpatient community services for the uninsured below 300% of the FPL; and sharing of the best inpatient client protocols with state-run mental health facilities.

A task force convened by Baltimore Fire Chief Goodwin and Health Commissioner Sharfstein issued recommendations that include enhancing the effectiveness of EDs and hospital care; improving access to primary health care; methods to attract and retain nurses; investing in housing individuals who are chronically homeless, and establishing a statewide "reverse alert" system to notify hospitals when EMS resources are being stretched too thin, an idea that has been accepted by the MIEMSS. The task force also recommended that Baltimore Substance Abuse Systems, Inc., and Baltimore Mental Health System, Inc., consider the creation of a "referral-diversion center" for patients who suffer the "co-occurring disorder" of substance abuse addictions and have mental health conditions.

^{xv} DHMH, Office of Public Health Preparedness and Response, Maryland bioterrorism hospital preparedness program (2005).

^{xvi} University of Maryland, Center for Health Workforce Development, "Maryland's nursing shortage: A workforce crisis" (2003).

^{xvii} The Program helps pay for certain kinds of maintenance drugs for chronic conditions, including anti-infective drugs, AZT, insulin, and syringes.

^{xviii} The Transition Work Group received a number of comments related to the utilization of brand name pharmaceuticals and potential cost savings achieved with greater use of generics; the potential implications of federal law for Medicaid reimbursement of dispensing fees; concerns associated with encouraging greater use of mail-order pharmacies; and the value of pharmacy-assisted disease management programs.

^{xix} DHMH, Alcohol and Drug Abuse Administration, *Outlook and Outcomes: 2005 Annual Report* (2005).

^{xx} Maryland Department of Legislative Services, Analysis of FY2007 Maryland Executive Budget: Alcohol and Drug Abuse Administration (2006).

^{xxi} Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration, *Outlook and Outcomes: 2005 Annual Report* (2005).

^{xxii} SAMHSA News Release, \$92.5 million awarded for mental health transformation state incentive grants, September 28, 2005.

^{xxiii} Gee G, et al., The impact of workplace smoking ordinances in California on smoking cessation, *American Journal of Public Health*, Vol. 90 (2000).

^{xxiv} Abrams S, et al, Early evidence on the effectiveness of Clean Indoor Air legislation in New York State, *American Journal of Public Health*, Vol. 96 (2006).

^{xxv} New York State Department of Health, The health and economic impact of New York's Clean Indoor Air Act (2006).

^{xxvi} Maryland Department of the Environment, Childhood Blood Lead Surveillance in Maryland, 2005 Annual Report (2006).

^{xxvii} Centers for Disease Control and Prevention, Surveillance for elevated blood lead levels among children- United States, 1997-2001. *Morbidity and Mortality Weekly Report*, Vol. 52 (2003).

^{xxviii} U.S. Department of Health and Human Services, Healthy People 2010 (conference ed., in 2 vols.), objectives 8-11 (2000).

^{xxix} DHMH Office of Oral Health, 5-year oral health plan for the Maryland Department of Health and Mental Hygiene (2004).

^{xxx} Ibid.

^{xxxi} The Medicaid program currently has no formal director; the DHMH Secretary serves as the acting Deputy Secretary for Health Care Financing (overseeing the Medical Assistance program). Two positions that report to the Deputy Secretary, the Director of Finance and Planning and the Director of Health Services, have both been vacant for significant periods of time.

^{xxxii} CARES, the Client Automated Resource and Eligibility System, is operated by the Department of Human Resources (DHR). It is an antiquated system, and its limitations impair cost containment efforts, program expansions, compliance, and reporting. The system's shortcomings are exacerbated because it is not used only for Medicaid. CARES, and DHR, also process applications for Temporary Assistance for Needy Families (TANF), food stamps, and other means-tested benefits programs, each of which tend to have distinct eligibility rules.

Such a system would help ensure that individuals enrolled in the programs receive services in a more timely manner without having to submit separate applications for each service that they may receive. Significant administrative costs could be achieved in out-years, and providers would likely be reimbursed in a more timely manner. The General Assembly passed legislation (HB 627) in 2005 that provided for \$15 million in funds available in the MHIP Program. CMS disapproved this request last year, and efforts have not progressed since then. It has been suggested that federal Medicaid funding could be leveraged to help facilitate the creation of a computerized eligibility system.

Commenters offered a range of recommendations to improve eligibility processing through improved policies, training, and technology, including: (1) the development of detailed guidance for eligibility workers that incorporates the new DRA verification requirements (see Section III.B.6 above); (2) improved and mandatory training of and coordination with eligibility workers at DHR and local offices; (3) greater oversight to ensure prompt and accurate eligibility determinations; (4) the purchase of a new eligibility system; (5) increased staffing; (6) creation of an electronic information repository for beneficiary information; (7) enhanced outreach efforts and streamlined application process to maximize enrollment of eligible individuals; (8) use of presumptive eligibility for children enrolled in other benefit programs; and (9) implementation of a 12-month eligibility period for children.

^{xxxiii} The following legislative audits of DHMH were reviewed by the Transition Work Group: Health Professional Boards and Commission, State Board of Physicians, State Board of Nursing, August 2006; Medical Care Programs Administration, July 2006; Health Regulatory Commissions, March 2006; Mental Hygiene Administration, September 2005; Family Health Administration, November 2005; Community Health Administration, September 2005; AIDS Administration, November 2004; Office of the Secretary and Other Units, August 2004; Developmental Disabilities Administration, October 2003; Alcohol and Drug Abuse Administration, July 2003.

^{xxxiv} For example, the Glendening administration announced a statewide “Managing for Results” (MFR) initiative in 1997 that sought to facilitate excellence in government. Under MFR, state agencies would develop vision statements, collect and record accountability measures, and track the outcomes of its “customers.” The hallmark of MFR was that agencies were to held accountable for their performance and outcomes, and that the Chief Executive would hold these agencies responsible for their performance at the time of their annual budget requests. Although departments still adhere to MFR reporting requirements, budget decisions made by the Governor and DBM are not influenced by MFR reporting data of the agencies. A 2004 OLA report suggested that DBM and the other state agencies are merely providing “lip service” to MFR principles.

Appendices

Appendix A: Work Group Participants

Appendix B: Work Group Meeting Minutes

Appendix C: Work Group Submissions—Recommended Characteristics for DHMH Secretary (compilation)

Appendix D: Work Group Submissions—Recommended DHMH Policy Priorities

Appendix E: Work Group Submissions—Recommended DHMH Performance Measures (compilation)