



Maryland Health Quality and Cost Council

The Honorable Anthony G. Brown
Lieutenant Governor, State of Maryland
Council Chair

Health Disparities Workgroup Final Report and Recommendations

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Executive Summary

According to a number of measures, the State of Maryland is one of the highest performing states in the nation. We have the 3rd highest median household income, several of the nation's top medical schools, and 10th lowest rate of smoking. Despite these successes, Maryland continues to lag behind other states on a number of key health indicators. The State ranks 43rd in infant mortality, 35th in infectious diseases, 33rd in health outcomes, and 33rd regarding geographic health disparities. There are simply too many communities that are underserved by primary care clinicians.

Maryland also, despite its wealth, demonstrates significant disparities in health care and health outcomes. For example, black Marylanders have infant mortality rates that are almost three times the rate for white Marylanders; have an incidence of new HIV infections at almost 12 times the rate of the white population, and are almost twice as likely to lack health insurance as Whites.

Health and health care disparities are a serious challenge for our State and nation. A 2009 report estimated that between 2003 and 2006, the U.S. could have saved nearly \$230 billion in direct medical care costs if racial and ethnic health disparities did not exist.

The Maryland Health Quality and Cost Council was established by Governor Martin O'Malley to focus priorities for improving health care in Maryland. As Chair of the Council, Lt. Governor Anthony Brown established a health disparities workgroup led by Dean E. Albert Reece, M.D, Ph.D., M.B.A. of the University of Maryland School of Medicine to explore and develop health care strategies and initiatives, including financial, performance-based incentives, to reduce and eliminate health disparities, and to make recommendations regarding the development and implementation of those strategies.

The following report contains three recommendations that are intended to be bold and innovative. The workgroup believes that, through the use of incentives and improvements to data collection and analysis, we can improve health and health care disparities throughout Maryland and in our most underserved communities.

Maryland Health Enterprise Zones

Modeled after the Harlem Children's Zone and Promise Neighborhood programs, the workgroup has proposed creating Health Enterprise Zones (HEZ) in an effort to reduce health and health care disparities, improve health outcomes for Marylanders, and stem the rise in health care costs. Legislation would: (1) establish criteria for designation as a zone; and (2) enable a community based organization (CBO) or other qualifying community agency to apply for funds to improve health within a zone. Some of the criteria that may be used for designation as a zone include high rates of chronic disease (for example, diabetes, asthma, and hypertension), health disparities, and lack of access to primary care.

To incentivize primary care clinicians¹ to expand, move to or set-up their practice in a zone, the legislation would enable funding for the expanded Loan Assistance Repayment Program (established in 2009) *and* establish income, property, and/or hiring tax credits, assistance for health information technology and other practice expenses for clinicians in a zone. Among other requirements, the clinicians must participate in the Medicaid program to be eligible for zone benefits. Dependent on funding, we would expect that two to four pilot zones will be established in Fiscal Year 13.

Ultimately, the goal of a Health Enterprise Zone is to create an integrated health care system that expands health care access in a patient and family-centered manner. Working in tandem with new and existing providers, insurers, the public health system, non-health community agencies, and other stakeholders, the HEZ is designed to improve health and decrease costs, expand access, empower communities, and reduce health disparities. The HEZ initiative would comprise of three major components.

1. Community Based Organization (CBO). A CBO or other qualifying community agency, located within a zone, will apply for funding for public health and outreach projects linked to the health care system that address health disparities and reduce re-admissions.
 - Proposals that have a private/non-profit/foundation match and a plan for long-term funding and sustainability will receive priority. For example, a CBO may propose to match community health centers or a local hospital's investments in community health workers, evaluate their impact on re-admissions, and have the health centers and hospital continue to finance the health workers if the evaluation is positive.
 - Proposals that have the support of the local health improvement process will receive priority.
 - All CBOs must have a local steering committee including key partners.
2. Loan Assistance Repayment Program (LARP). The LARP will support existing and new primary care clinicians located within a Health Enterprise Zone that has been designated to receive community based funding (See component 1.). Priority will be given to clinicians who work in settings that meet DHMH voluntary standards for community service. The funding will be overseen by the DHMH Office of Primary Care.
3. Tax credits for hiring and other financial incentives. This funding will support existing and new primary care clinicians located within a HEZ that has been designated to receive community based funding (See component 1.). Priority will be given to clinicians who work in settings that meet DHMH voluntary standards for community service.

Maryland Health Innovation Prize

The Maryland Health Innovation Prize is a financial reward and public recognition for an individual, group, organization, or coalition thereof to acknowledge new and/or proven innovative interventions and programs that have achieved reductions in health or health care

¹ Primary care clinicians include: family physicians, internists, pediatricians, ob/gyns, psychiatrists, dentists, primary care nurse practitioners, primary care physician assistants.

disparities or aim to reduce and/or eliminate health and health care disparities in the State of Maryland.

Modeled after financial awards given by the X Prize Foundation, the Maryland Health Innovation Prize seeks to incentivize and reward unique ideas that have already or will seek to address health and health care disparities through health care, community, or individual interventions. The goal of the prize is to broaden the scope of participation and create interventions that positively affect the health and wellbeing of a particular community. In addition, these interventions will be evaluated for their capacity to influence and improve health and health care disparities in other parts of the State following the successful implementation in the initial project.

Health Innovation prizes will be awarded for new and existing interventions that address both wide-ranging health disparities as well as those which may be unique to a particular community and will bring to bear the expertise of all manner of health, business, non-profit, and community leaders.

Racial and Ethnic Tracking of Performance Incentive Data

In Maryland there are two areas, hospital care and primary care, where health care performance data currently or will soon be analyzed and incentive payments will be made (or potentially penalties assessed) to hospitals or providers based on the results. The first area, hospital care incentives, is currently administered by the Health Services Cost Review Commission (HSCRC). The second area is primary care incentives. The Maryland Health Care Commission (MHCC) administers a Patient Centered Medical Home Program that allows for the sharing of savings between participating payers and health care providers based on meeting certain measures.

These two health care quality incentive programs do not currently track incentives by race and ethnicity. Therefore, they do not base incentives or penalties on race-specific or ethnic-specific performance. They also do not reward reductions in racial or ethnic disparities in quality. This strategy, *Racial and Ethnic Tracking of Performance Incentive Data*, proposes enhancing these existing programs by requiring that the performance metrics be analyzed by race and ethnicity where the data are sufficiently robust to permit such analysis. Conducting this racial and ethnic analysis will:

- Identify areas of racial and ethnic disparities in health care quality metrics;
- Determine whether current race and ethnic-neutral incentive formats are in fact improving minority health care quality and reducing disparities; and
- Determine whether new race/ethnic-specific incentive formats are required.

The workgroup believes that requiring the performance metrics be analyzed by race and ethnicity, where the data are sufficiently robust, will allow the State to ensure that the improvements in health and health care that result from the incentive programs are shared equally among all Marylanders.

I. Background and Workgroup Process

Overview of Health Disparities in Maryland

According to the 2010 Census, Maryland's \$64,025 median household income ranks it as the nation's third most affluent state. Maryland is home to some of the finest hospital and medical institutions and ranks as one of the highest states in terms of the per capita number of primary care physicians. But despite these advantages, Maryland ranks 33rd overall in health outcome indicators and 33rd when it comes to geographic health disparities. There are simply too many communities that are underserved by primary care physicians.

As of the 2010 U.S. Census, 45.3% of Maryland's population reports some ancestry from racial and ethnic minority groups (Blacks or African Americans, Asians or Pacific Islanders, American Indians or Alaska Natives, and Hispanics or Latinos). All of these groups experience some disparities in health and/or health care when compared to Whites (see table below).

Selected Racial and Ethnic Health Disparities in Maryland

(Shows how many times higher the minority rate is compared to the White rate)

	Infant mortality	Late pre-natal care	End-stage kidney disease	No health Insurance	New HIV case rate
Black or African American	2.8	2.9	3.0	1.9	11.8
Asian or Pacific Islander	0.9	1.0	1.3	1.3	0.5
American Indian or Alaska Native	2.3	1.0	3.0	<i>Not Reported</i>	2.2
Hispanic or Latino	0.8	2.2	1.3	4.4	3.6

- Blacks or African Americans experience significant disparities in infant mortality, late prenatal care, end-stage kidney disease, and new cases of HIV, as well as in other areas.
- Hispanics or Latinos experience significant disparities related to lack of health insurance, and new cases of HIV, and disparities in late prenatal care, end stage kidney disease, as well as in other areas.
- American Indians or Alaska Natives experience disparities in infant mortality, end-stage kidney disease, and new cases of HIV, as well as in other areas.
- Asians or Pacific Islanders experience disparities in end-stage kidney disease and lack of health insurance, as well as in other areas.

Disparities are seen across many diseases and conditions: For nine of the fourteen leading causes of death in Maryland, Black age-adjusted death rates are higher than white age-adjusted death rates. In Maryland, nearly twice as many African Americans suffer from diabetes than Whites, and African American babies are three times more likely to die before the age of one (1) than White babies.

Disparities are seen throughout Maryland: Black age-adjusted all-cause death rates are higher than White age-adjusted all-cause death rates in 20 of Maryland's 24 jurisdictions. Differences in health and health care also exist between different parts of the State. For example, looking at age-adjusted all-cause death rates by race and jurisdiction from 2004 to 2006:

- The highest Black death rate was 1,211 deaths per 100,000 while the lowest Black death rate was 661 deaths per 100,000.
- The highest White death rate was 988 deaths per 100,000 while the lowest White death rate was 560 deaths per 100,000.

Workgroup Charge

In May, 2011, Governor O'Malley signed an executive order continuing the Maryland Health Quality and Cost Council. In this Executive Order, Governor O'Malley required the Council to establish a workgroup to explore and develop health care strategies and initiatives to reduce and eliminate health disparities, and make recommendations regarding the development and implementation of these strategies.

As a result of the Executive Order, the Maryland Health Quality and Cost Council established the health disparities workgroup. The workgroup was required by the Council to develop recommendations for best practices, monitoring, and financial incentives for the reduction of disparities in the health care system.

Disparities in the health care system may include:

- Lack of workforce diversity;
- Differences in quality of care within an office or hospital setting;
- Differences in access to care within a health plan or health care system; and
- Differences in patients' understanding of the care that they are receiving.

The Council envisioned that the workgroup would receive updates and provide input on other health disparities efforts through communication with the (1) the State Health Improvement Plan team on regional and state public health planning and (2) the Wellness and Prevention Workgroup on policy initiatives that will impact disparities. The Council requested that the workgroup provide a report with its findings and recommendations to the Council in December, 2011.

Workgroup Composition

The workgroup was developed to consider all factors contributing to the disparities in health and health care, bringing together experts from major academic health centers – University of Maryland School of Medicine and Johns Hopkins University School of Medicine – as well as leaders from community hospitals throughout the state, scholars studying health disparities, and community health officials. The goal was to develop a group that could delve into the fundamental underpinnings of health and health care disparities as well as more pragmatic issues related to the direct provision of care to minority populations.

The members of the workgroup were identified and selected by Lt. Governor Anthony G. Brown, Secretary of Health and Mental Hygiene Joshua Sharfstein, M.D., and workgroup chair E. Albert Reece, M.D., Ph.D., M.B.A.

The following individuals served on the Disparities workgroup:

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Workgroup Process

The workgroup met on seven occasions starting in July, 2011 and concluding in December, 2011. During the series of meetings, the group identified areas where health and health care disparities exist in Maryland through the use of health care data available through the federal Agency for Healthcare Research and Quality (AHRQ). Using the data as a guide, the workgroup then discussed a variety of recommendations that were ultimately pared down to three key recommendations that will address health and health care disparities.

Dr. Reece presented an interim progress report to the Health Quality and Cost Council on Monday, September 26, 2011. Feedback from the Health Quality and Cost Council was incorporated into the draft report and reviewed and revised by the workgroup.

During the development of the recommendations, the workgroup invited representatives from key stakeholder groups such as MedChi, the Maryland Nurse Practitioner Association, and CareFirst BlueCross BlueShield to review and offer feedback on the recommendations (See Appendix A for comments from these stakeholders.).

Dr. Reece presented the workgroup's final report to the Health Quality and Cost Council on Monday, December 19, 2011.

Targeted Outcomes and Supporting Data

The workgroup examined the Maryland disparity data by race available on the Agency for Healthcare Research and Quality's (AHRQ) State Snapshots website².

For the fourteen (14) ambulatory care measures (hospital admission rates for conditions where good outpatient care can prevent most hospital admissions) used by AHRQ, all but one showed meaningfully worse Black rates than White rates. These findings are shown in the table on the following page. Admission rates were as much as 4.5 times higher for Blacks for hypertension (high blood pressure) and diabetes. The percent of Black admissions that were in excess due to disparity for these two conditions was 78%. Limitations in the available data prevent drawing accurate conclusions about disparities in these hospital admission rates for Maryland's other racial and ethnic minority groups.

These admission rate disparities were found in three major conditions – lung diseases (especially asthma), cardiovascular diseases, and diabetes. As a result, the workgroup selected admission rates for these specific conditions as ideal targets for interventions with the goal of reducing health and health care disparities.

² <http://statesnapshots.ahrq.gov/snaps10/SnapsController?menuId=47&state=MD&action=disparities&level=80>

Maryland Prevention Quality Indicators by Race and Ethnicity with Black % excess
<http://statesnapshots.ahrq.gov/snaps10/SnapsController?menuId=47&state=MD&action=disparities&level=80>

Ambulatory Care Measures	Whites (Non-Hisp)	Blacks (Non-Hisp)	B/W Ratio	R a n k	B-W Differ	R a n k	Black % excess
Respiratory Disease							
Admissions for chronic obstructive pulmonary disease per 100,000 population, age 18 and over	190.8	179.19	0.94	14	-11.61	14	N/A
Bacterial pneumonia admissions per 100,000 population, age 18 and over	260.11	355.93	1.37	10	95.82	7	26.9%
Pediatric asthma admissions per 100,000 population, ages 2-17	95.98	294.09	3.06	3	198.11	3	67.4%
Asthma admissions per 100,000 population, age 18 and over	115.34	312.68	2.71	6	197.34	4	63.1%
Asthma admissions per 100,000 population, age 65 and over	262.86	519.71	1.98	9	256.85	2	49.4%
Immunization-preventable influenza admissions per 100,000 population, age 65 and over	23.51	24.33	1.03	13	0.82	13	3.4%
Heart Disease							
Admissions for hypertension per 100,000 population, age 18 and over	44.39	200.66	4.52	2	156.27	6	77.9%
Admissions for congestive heart failure per 100,000 population, age 18 and over	351.43	896.83	2.55	7	545.40	1	60.8%
Admissions for angina without procedure per 100,000 population, age 18 and over	47.82	65.07	1.36	11	17.25	11	26.5%
Diabetes							
Admissions for diabetes with short-term complications per 100,000 population, ages 6-17	20.56	22.25	1.08	12	1.69	12	7.6%
Admissions for diabetes with short-term complications per 100,000 population, age 18 and over	46.09	134.31	2.91	4	88.22	8	65.7%
Admissions for diabetes with long-term complications per 100,000 population, age 18 and over	101.61	291.09	2.86	5	189.48	5	65.1%
Admissions for uncontrolled diabetes without complications per 100,000 population, age 18 and over	10.09	46.72	4.63	1	36.63	10	78.4%
Lower extremity amputations among patients with diabetes per 100,000 population, age 18 and over	27.44	64.46	2.35	8	37.02	9	57.4%

II. Strategies for Success

Strategy 1: Health Enterprise Zones (HEZ)

Overview of Health Enterprise Zones

A Health Enterprise Zone (HEZ) is a geographic area in Maryland that is eligible for specific policy incentives and funding opportunities for both new and existing providers. A Health Enterprise Zone is a designated local community where special incentives and funding streams are available to address poor health outcomes by using healthcare-level, community-level, and individual-level interventions. An HEZ can be defined in contiguous geographic terms, has health outcomes and/or documented health disparities, and exhibits several characteristics that illustrate its need and potential for improvement.

A major characteristic is that health metrics for the entire population or for racial/ethnic minorities' health outcomes, and/or documented health disparities in the area exceed State wide levels. This includes increased minority hospital admissions and Emergency Department visits as compared to the non-Hispanic white population, especially for asthma, diabetes, hypertension and other Ambulatory Care Sensitive Conditions (also called Prevention Quality Indicators)³.

A Health Enterprise Zone has lower median family income than the State overall and higher unemployment, Medicaid enrollment or eligibility, and Free and Reduced Meals (FARMS) rates than the State overall.

A Health Enterprise Zone has a collective community identity through active collaboration among community groups that include local government, community organizations, providers, hospitals, and insurers. A geographic area is recognized as a Health Enterprise Zone when it has clearly demonstrated these characteristics and been certified as an HEZ by the State.

Justification and Rationale for the Health Enterprise Zone

Poor health outcomes in general and poor minority health outcomes in particular, result in part from the following **modifiable** factors (See table on page 12.). The identification and measurement of these factors may occur at the national, state, city/county, or community levels. By contrast, the remediation of these factors is almost always a local community exercise, and explains the local nature of this strategy.

³ For examples of these metrics in Maryland see http://statesnapshots.ahrq.gov/snaps10/disparities_data.jsp?menuId=48&state=MD&level=83

Modifiable Factors That Contribute to Poor Health Outcomes

Health Care Factors	Community Factors	Individual Factors
<ul style="list-style-type: none"> ○ Lack of health insurance ○ Inadequate health insurance ○ Local provider shortage ○ Providers not accepting all insurance (e.g. not accepting Medicaid) ○ Lack of extended provider hours (nights, weekends) for access by working poor ○ Lack of transportation for clients to providers ○ Poor patient-provider communication ○ Lack of adaptation to low health literacy ○ Lack of cultural competency ○ Lack of language interpretation services ○ Lack of provider workforce diversity ○ Lack of provider adherence to diagnostic and treatment guidelines ○ Inadequate patient education regarding the treatment plan 	<ul style="list-style-type: none"> ○ Non-availability of healthy foods (food deserts) ○ Non-availability of safe places for physical activity ○ Non-availability of jobs in the community ○ Community-level poverty ○ High crime rates ○ Inadequate schools ○ Substandard housing ○ Exposure to environmental toxins or disease triggers ○ Racism 	<ul style="list-style-type: none"> ○ Unhealthy diet ○ Inadequate physical activity ○ Tobacco use ○ Alcohol and/or substance abuse ○ Low educational attainment and/or lack of health knowledge ○ Low health literacy ○ Poverty and/or unemployment ○ Language and/or cultural barriers

Expected Benefits of the Health Enterprise Zone

The workgroup believes that there are a number of expected benefits that will result from the HEZ-based interventions that are both structural and outcomes based.

Structural Benefits of the Health Enterprise Zone

The structural benefits of the HEZ will positively alter the provision of care and broaden the scope of providers within a given community with the goal of reducing health and health care disparities. For example, benefits such as loan assistance repayment and tax credits for hiring or other financial incentives are intended to increase the local health care provider supply, especially in primary care. It could also increase the diversity of the local health care workforce.

In addition to boosting the local physician workforce, the HEZ would also encourage the expanded use of community health workers in an effort to provide earlier medical interventions

and chronic care management in the home health setting. Coupled with increased cultural, linguistics, and health literacy competency programs, health care would be delivered in a more culturally sensitive manner.

This new model would require and encourage increased multidisciplinary and/or inter-agency collaboration. This would result in increased referrals to social and health service agencies, which would broaden the level and quality of care provided to individuals in the HEZ.

Outcome Benefits of the Health Enterprise Zone

One of the main benefits of the HEZ will be a reduction in the number of preventable hospital admissions and/or emergency department visit rates for a number of chronic disease conditions, including asthma, diabetes, and hypertension. Another key benefit of this proposed intervention will be a reduction in the number of preventable hospital admissions and/or emergency visit rates for Ambulatory Care Sensitive Conditions (ACSCs). The HEZ will also result in reductions of racial and ethnic disparities in the aforementioned chronic disease conditions and ACSCs.

Since each individual HEZ will have the ability to address additional, community-specific health disparities through incentives and programmatic efforts, it is expected that there will be a reduction in other health disparities as determined by the community within a specified zone.

Ultimately, the goal of a Health Enterprise Zone is to create a community in which an integrated health care system leads health care and prevention efforts in a patient and family-centered manner. Working in tandem with new and existing providers, insurers, the public health system, non-health community agencies, and other stakeholders, the HEZ is designed to improve health and decrease costs, expand access, empower communities, and reduce health disparities.

Statute-based Incentives in the Health Enterprise Zone

One set of approaches to the attainment of the expected benefits of the HEZ can be described as **statutory incentives**. These approaches utilize policy-based financial incentives that are available to eligible parties within a designated HEZ upon application and approval. These incentives primarily target issues of workforce recruitment and retention within the HEZ, and could include:

- Tax incentives (property or income tax reductions or credits) for new and existing primary care clinicians⁴;
- Tax credits for hiring by new and existing primary care clinicians;
- Free or low rent use of city/county property for some initial term to set up or expand a primary care practice;
- Loan assistance repayment for qualifying new and existing primary care clinicians;
- Funding for practice start-up costs;
- Funding and other assistance to support conversion to a Patient Centered Medical Home (PCMH);

⁴ Primary care clinicians include: family physicians, internists, pediatricians, ob/gyns, psychiatrists, dentists, primary care nurse practitioners, primary care physician assistants.

- Higher reimbursement from Medicaid if the practice becomes a PCMH (as allowed by MHCC pilot and State budget); and
- Funding and other assistance to support health information technology implementation.

Provider eligibility to receive these incentives could be contingent upon compliance with certain desirable structural elements, which might include:

- Proper collection of patient data on race, Hispanic ethnicity, nationality, and language;
- Training in cultural, linguistic, and health literacy competency;
- Racial, ethnic, and linguistic diversity in that provider's workforce;
- Utilization of community health workers; and
- Acceptance and care of Medicaid patients.

Steps to Implement Statute-based Incentives in the Health Enterprise Zone

In order to implement the statutory incentives listed above in Health Enterprise Zones, the following prerequisites must be achieved:

- Passage of State legislation and/or regulation that defines Health Enterprise Zones and establishes the mechanism by which a community is certified as an HEZ.
- For tax-based incentives:
 - Identification of discounts or credits (such as credits for new hiring) to State or local income, sales, or property taxes that the State or the relevant localities will provide; and
 - Passage of State or local legislation and/or regulation that sets up the identified discounts or credits to income, sales, or property taxes and defines eligibility criteria.
- For property use incentives:
 - Identification of State or local properties that can be used at low or no rent;
 - Identification of potential discounts or waivers on occupancy permit fees; and
 - Passage of State or local legislation and/or regulation that sets up the procedures for such low or no rent use or fee discounts and defines eligibility criteria.
- For loan repayment incentives:
 - Identification of funding sources for loan repayment; and
 - Passage of State or local legislation and/or regulation that sets up the procedures for loan repayment and defines eligibility criteria, or that adapts the existing Maryland Loan Assistance Repayment Program⁵ (LARP) to this purpose.

⁵ http://fha.maryland.gov/ohpp/pco_larp.cfm

Contract-based Incentives in the Health Enterprise Zone

Another set of approaches to attain the expected benefits of an HEZ can be described as contract-based interventions. This approach utilizes a contract for services model to allocate funding on a competitive basis to an HEZ that submits an application and is approved. These contract-based interventions have more flexibility to target a wide variety of the adverse health care system and community factors listed above.

The workgroup envisions that a Community Based Organization (CBO) or other qualifying community agency will propose funding for public health and outreach projects linked to the health care system that address health disparities and reduce re-admissions.

Proposals that have a private/non-profit/foundation match and a plan for long-term funding and sustainability will receive priority. For example, a CBO may propose to match community health centers or a local hospital's investments in community health workers, evaluate their impact on readmissions, and have the health centers and hospital continue to finance the health workers if the evaluation is positive.

Other examples of contract-based incentives that a CBO might employ include:

- Training and deploying community health workers,
- Providing financial assistance to providers for language interpretation services,
- Providing cultural, interpretation, and health literacy training to health care providers,
- Developing and supporting a community coalition and providing leadership training,
- Implementing evidence-based community-level interventions on specific health issues, and
- Providing financial assistance to providers in need of electronic medical record deployment and infrastructure conversion to a PCMH.

Steps to Implement Contract-based Incentives in the Health Enterprise Zone

In order to implement contract-based incentives in Health Enterprise Zones, the following prerequisites must be achieved:

- Passage of State legislation and/or regulation that defines Health Enterprise Zones and establishes a mechanism by which a community is certified as an HEZ;
- Identification of a funding source that can be used to fund the contract-based projects proposed by the various HEZs;
- Development of operational policies for the contract awards process; and
- Establishment of data collection and reporting requirements to properly evaluate the HEZs.

In developing operational policies for the contract awards process, an application format and toolkit will need to be developed, the task of application review must be assigned to an existing State entity, and criteria for adequacy of an application must be developed. Successful applicants should be able to demonstrate a private sector match and a plan for long-term funding,

support of the local health improvement process, and a local steering committee including key partners.

Responsible Parties and Partners

The workgroup believes that an existing State agency, department, or commission will need to be identified to move this proposal forward after the enabling legislation is passed. The existing State entity should work with appropriate stakeholders to implement HEZs, in a formally designated advisory committee capacity. The stakeholders that the State entity should work with include:

- Representatives of the Maryland Association of County Health Officers;
- Representatives of various community-based organizations;
- Interested leadership from our various minority communities;
- Representatives from hospitals;
- Representatives from community-based providers and physicians, including Federally Qualified Health Centers;
- Representatives from practitioner societies (e.g. MedChi, MD Nurse Practitioner Association, etc.);
- Representatives from insurers;
- Representatives from medical education, including Schools of Medicine, Dentistry, Nursing, Pharmacy, and Public Health;
- Representatives from the business community – including pharmaceuticals, medical device companies, and biotechnology companies;
- Representatives from the philanthropic community; and
- Representatives of State Government (DHMH and other departments).

Assessment Benchmarks

Each approved HEZ will require an independent evaluator. The workgroup recommends that where available, all data should be analyzed by race and ethnicity where the data permit such analysis. The workgroup recommends that assessment benchmarks are needed on two levels: statewide program outputs and individual HEZ program performance. Metrics may vary by the strategies used.

Some examples of measurements of statewide program outputs that should be included are:

- Amount of funding available for HEZ program;
- Number of communities designated as HEZs;
- Percentage of communities applying for HEZ designation that receive designation (this indicates the need for community development and technical assistance);
- Number of HEZ funding requests submitted by HEZs;
- Percentage of HEZ funding requests that are of fundable quality (this indicates the need for community development and technical assistance); and
- Number of newly Maryland licensed primary care and interdisciplinary care providers practicing in HEZs (this indicates statewide provider expansion rather than just intrastate reallocation of existing providers).

Some measurements of individual HEZ program performance that should be included are:

- Number of person reached with educational materials or presentations;
- Number of persons newly enrolled in health insurance;
- Number of persons receiving particular health services⁶ (e.g. screening, treatment);
- Number new providers added to the HEZ (where incentive model is used);
- Provider workforce diversity in the HEZ;
- ACSC emergency department visit rates in the HEZ;
- ACSC hospitalization rates in the HEZ;
- Healthcare Effectiveness Data and Information Set (HEDIS) measures; and
- Maryland Health Care Commission's Patient-Centered Medical Home Quality Performance Measures

The expected benefits of the HEZ-based interventions include the following structural benefits:

- Increased local health care provider supply, especially in primary care;
- Diversity of the local health care workforce
- Cultural, linguistic, health literacy competency of health care workforce;
- Increased use of community health workers;
- Increased multidisciplinary and/or interagency collaborations;
- Increased referrals to social and health service agencies;
- Improved community leadership development; and
- Reduced racial and ethnic minority health disparities and improved minority health outcomes.

The expected benefits of the HEZ-based interventions also include reductions in preventable hospital admission and emergency department visit rates for asthma, diabetes, hypertension, and other ACSCs/PQIs.

Timetables and Milestones

The workgroup recommends that enabling legislation be passed in the 2012 Session of the General Assembly creating Health Enterprise Zones. The legislation should give an existing State agency, department or commission responsibility for enacting the HEZs.

⁶ Persons served to be collected using new HHS Data Collection standards, found at: (<http://minorityhealth.hhs.gov/templates/content.aspx?ID=9227&lvl=2&lvlID=208>)

Strategy 2: Maryland Health Innovation Prize

The Maryland Health Innovation Prize will be a financial reward and public recognition for an individual, group, organization, or coalition to acknowledge new and/or proven innovative interventions and programs that have achieved reductions in health or health care disparities or aim to reduce and/or eliminate health and health care disparities in the State of Maryland.

Justification and Rationale for the Maryland Health Innovation Prize

The Maryland Health Innovation Prize is another strategy for addressing, at the community level, the healthcare, community, and individual factors that were listed as justification as creation for the Health Enterprise Zones. Additional considerations that motivate the creation of the Maryland Health Innovation Prize include:

- Public health breakthroughs are needed to revitalize and move existing health systems to achieve measurable improvements in population health;
- Health care costs continue to escalate and need effective measures that curtail escalation while improving quality of care; and
- Model innovations can develop from outside the health care system that could have increased potential for resolving persistent health care delivery challenges.

Expected Benefits of the Maryland Health Innovation Prize

The workgroup believes that there are a number of expected benefits that will result from the implementation of the Maryland Health Innovation Prize (I-Prize). The I-Prize will result in the creation of new programs and propagation of successful programs that address and improve community health and public health. The I-Prize will spur and reward innovative interventions through research and development investments, and the prize will also inspire innovations from the non-health sector, including from youth and young adults.

The I-Prize will also improve health status and increase economic benefits to Maryland's local minority communities. This initiative will provide incentives and rewards for societal sectors outside of the health care delivery system that bring resources and value added, and participation of partners whose collaboration addresses causal factors outside the health system. The prize may also result in the formation of new health-related industries that vitalize and incentivize the nation's health system to operate with efficiency, leading to healthier population groups.

Naturally, the workgroup believes that this intervention will result in a reduction in the number of preventable hospital admissions and/or emergency department visit rates for a number of chronic disease conditions, including asthma, diabetes, and hypertension. Another key benefit of this proposed intervention will be a reduction in the number of preventable hospital admissions and/or emergency visit rates for Ambulatory Care Sensitive Conditions (ACSCs). The HEZ will also result in reductions of racial and ethnic disparities in the aforementioned chronic disease conditions and ACSCs.

Implementation of the Maryland Health Innovation Prize

Steps to implementation of the Maryland Health Innovation Prize include:

- Engage entities that will benefit from healthier populations such as industries, businesses, large employers, etc. to help in building “The Purse” as well as compete for the Prize;
- Engage all health delivery systems to participate in building “The Purse” that can be invested, utilizing the investment earnings to pay the Prize, maintaining the capital for growth. The Health delivery systems could also compete for the “Prize”;
- Designate or establish an entity responsible for administration of the Prize;
- Establish criteria for prize eligibility, and for ranking competing candidates for the Prize.

Responsible Parties and Partners

An organization needs to be identified or established to administer the Maryland Health Innovation Prize. This organization would be responsible for identifying funding sources and acquiring and disbursing funds for the Prize; defining the eligibility criteria for nominees for the Prize; defining the criteria for ranking and selection among nominees; reviewing material submitted in support of nominees; and determining the periodic winner of the Prize.

The organization should work with appropriate stakeholders to implement the Prize, including:

- Representatives of the Maryland Association of County Health Officers;
- Representatives of various community-based organizations;
- Interested leadership from our various minority communities;
- Representatives from hospitals;
- Representatives from community providers, such as Federally Qualified Health Centers;
- Representatives from practitioner societies (e.g. MedChi, MD Nurse Practitioner Association, etc.);
- Representatives from insurers;
- Representatives from medical education, including Schools of Medicine, Dentistry, Nursing, Pharmacy, and Public Health;
- Representatives from the business community;
- Representatives from the philanthropic community; and
- Representatives of State Government (DHMH and other departments).

Timetables / Milestones

If the Prize is to be sponsored by the State, legislation that establishes the Prize should be introduced and passed during the 2012 legislative session. However, it is not necessary that the State should establish the Prize. The Prize could be an entirely private operation, from funding to administration.

Whether the Prize is administered by the State or by a private entity, designation of the accountable organization to administer the Prize should take place in the first half of calendar 2012. The accountable organization should draft the operational criteria for the Prize before December 31, 2012.

Strategy 3: Racial and Ethnic Tracking of Performance Incentive Data

Justification and Rationale for Racial / Ethnic Performance Data Tracking

There are two areas in which health care performance data are or will be analyzed and incentive payments will be made (or potentially penalties assessed) to hospitals or providers based on the results. The first area is hospital care incentives administered by the Health Services Cost Review Commission (HSCRC). The HSCRC tracks and incentivizes hospitals based on process measures for quality, rates of complications from hospital-acquired conditions, and rates of hospital preventable readmissions. The second area is primary care incentives. The Maryland Health Care Commission administers a Patient Centered Medical Home Program, which allows for the sharing of savings between participating payors and health care providers based on meeting certain measures.

These two existing health care quality incentive programs do not currently track the incentives by race and ethnicity. Therefore, they do not base incentives or penalties on race-specific or ethnic-specific performance. They also do not reward reductions in racial or ethnic disparities in quality. Our Strategy 3: *Racial and Ethnic Tracking of Performance Incentive Data* proposes enhancing these existing programs by requiring that the performance metrics be analyzed by race and ethnicity where the data are sufficiently robust to permit such analysis. Conducting this racial and ethnic analysis will:

- Identify of racial and ethnic disparities in health care quality metrics;
- Determine whether current race and ethnic-neutral incentive formats are in fact improving minority health care quality and reducing disparities; and
- Determine whether new race/ethnic-specific incentive formats are required.

Background on the Existing Incentive Programs

Hospital incentive programs of the HSCRC are based on generally accepted hospital quality metrics. These existing programs hold hospital accountable for performance on quality of care processes, performance on rates of hospital acquired conditions (patient complications that develop in hospitals and are preventable), and performance on preventable hospital readmissions⁷.

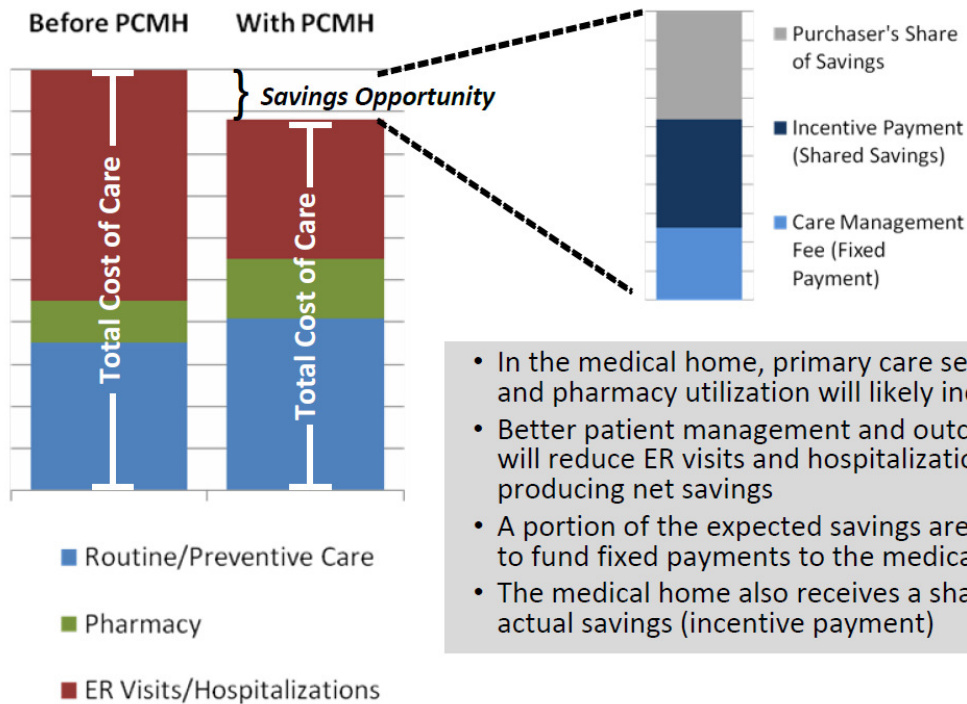
The shared savings incentive in the Maryland Patient Centered Medical Home Program⁸ takes advantage of the capability of improved preventive and primary care delivered in the medical home to reduce preventable and expensive emergency department visits and hospital admissions. The improved preventive and primary care can both improve the health status of patients and reduce the overall cost of their care.

⁷ Details on these hospital incentive programs are available at the HSCRC website at http://www.hscrc.state.md.us/init_qi.cfm

⁸ For more information about the Maryland Patient Centered Medical Home Program, see <http://mhcc.maryland.gov/pcmh.index.aspx>. A short bibliography regarding the success of medical homes in reducing costs can be found at <http://mhcc.maryland.gov/pcmh/studies.aspx>.

It is expected that outpatient visit costs and outpatient pharmacy costs may increase in the medical home, but that the savings from reduced hospital admission and emergency department visits will exceed those cost increases. The resulting net savings in care costs are then shared between the providers of and the payers for care (thus the term “shared savings” incentive). This gives providers both the incentive and the resources to implement practice improvements that can improve health and reduce costs. A diagram of the shared savings model is shown below and is taken from a presentation by the Maryland Health Care Commission that is available at <http://dhmh.maryland.gov/mhqcc/pdf/2010/Dec10/PCMH-Practice-payment-methods.pdf>.

PCMH Financial Model



Expected Benefits of Racial / Ethnic Performance Data Tracking

The expected benefits to the incentive programs of racial/ethnic data tracking include:

- Identification of racial and ethnic disparities in health care quality metrics;
- Determination of whether current race/ethnic-neutral incentive formats are in fact improving health care quality and reducing disparities; and
- Determination of whether new race and ethnic-specific incentive formats are required.

The expected benefits to Maryland overall of racial/ethnic performance data tracking include:

- Improvement in minority health care quality;
- Reduction and eventual elimination of health care quality disparities;
- Improvement in minority health; and
- Health care cost savings to private and public payers for health care

Implementation of Racial / Ethnic Performance Data Tracking

In order to implement racial/ethnic performance data tracking the work group recommends legislation that directs the HSCRC and the MHCC to include racial and ethnic data as part of their data collection. As an alternative, the MHCC and HSCRC could establish a process and timeline to:

- Study the feasibility of including racial/ethnic performance data tracking in quality incentive programs;
- Report data by race and ethnicity where feasible to the General Assembly by the 2013 session; and
- Explain the limitations where data cannot be reported by race and ethnicity and describe necessary changes to overcome those limitations.

A key feature of this strategy is that it builds upon existing data collection and analysis performed by HSCRC and MHCC. Thus, additional burden on providers should be minimal.

Responsible Parties and Partners

Responsible parties and partners for the implementation of this strategy include the Maryland General Assembly, the MHCC, the HSCRC, and stakeholder providers.

Assessment Benchmarks and Timetables / Milestones

If deemed necessary, relevant legislation should be introduced and passed in 2012. Where feasible, incentive data should be reported by race/ethnicity by 2013. Data limitations and strategies to address them should also be reported by MHCC and HSCRC by 2013. Once established, race/ethnic specific data should be monitored over 3-year intervals to assess trends. If minority quality improves and disparities decline, then current incentive can remain; if minority quality fails to improve and/or disparities do not decline, then race and ethnic specific incentives will need to be developed.

III. Implementation of Disparities Workgroup Strategies – Potential Challenges and Solutions

Health Enterprise Zones (HEZs) - Potential Challenges and Solutions

One potential unintended consequence of establishing HEZs is that the most poorly resourced zones and applicants may not be competitive for contract-based interventions, allowing more resourced areas to benefit disproportionately from these programs. This could be addressed by helping poorly resourced areas by identifying funding sources to support technical assistance. Smaller capacity-building grants, to be applied for by these communities, are another possible method to distribute resources to address this potential challenge.

Maryland Health Innovation Prize – Potential Challenges and Solutions

The major challenge related to implementing this strategy is likely to be fund-raising. However, creative strategies, such as those used by national advocacy groups, can be used to identify and engage potential donors. One strategy for fund-raising might be to find celebrity champions for the cause and to work with a broad base of stakeholder organizations and groups, including the top giving Maryland-based foundations focused on community empowerment, reduction of health disparities, advancement of health, and science education.

If the group determining the prize winner is dominated by representatives from any one of several groups – government, academia, industry, or community organizations – then there is the potential that unequal consideration will be given submitted projects and intervention strategies. Including representation from several (or all) stakeholder groups in the selection process will reduce the likelihood of domination by any one group and increase the likelihood that equal consideration will be given to all types of projects and intervention strategies.

Performance Based Incentive – Potential Challenges and Solutions

There is a risk that this strategy could result in a reduction of income and numbers of providers caring for poor and minority patient populations since these providers have fewer resources to devote to quality improvement and their patients may be less likely to adhere to treatment recommendations due to financial and social barriers. A possible solution is to reward both absolute quality scores and improvements in scores over time, otherwise known as pay for progress – and not just pay for performance; use risk adjustment and stratified analyses, either by geographic location of providers or by patient race/ethnicity; and include attention to the effects of incentive programs on disparities.

Some hospitals and practices may have small numbers of patients in certain ethnic groups, leading to unreliable estimates of quality metrics. *A potential solution to this challenge would be to use quality metric and incentives only when statistically reliable and valid measurements can be obtained.*

Some providers may perceive the strategy as increasing the burden of data collection and documentation of the problem without practical advice. In order to address this possible

concern, MHCC and HSCRC should avoid more regulatory approaches and incorporate more collaborative processes, such as those used by the Joint Commission to inspire excellence in providing safe and effective care of the highest quality and value.

IV. Summary and Conclusions

The workgroup determined that interventions which aim to reduce health and health care disparities through modification of individual and community health care factors would be the most prudent and promising. The three recommendations outlined in the report seek to address health and health care disparities by developing and enhancing the health care system's infrastructure in the State's most vulnerable locations. Through the use of incentives, education, outreach, technology, and innovation, the work group recommendations seek to empower and engage individuals and communities where the greatest health and health care disparities exist. The workgroup believes that these recommendations can and will have an immediate effect on health and health care disparities; but that these recommendations should be viewed as the initial steps in an ongoing effort to reduce disparities and improve health and health outcomes throughout Maryland.

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APPENDIX A



The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

To: Health Disparities Workgroup of the Governor's Health Quality and Cost Council

From: Gene Ransom
Chief Executive Officer, MedChi

Date: November 22, 2011

Re: Draft Recommendations Report

MedChi appreciates the opportunity to provide comment on the draft report of the workgroup as it works to finalize its recommendations to the full Council. Addressing Maryland's health disparities challenges is a priority for MedChi and we look forward to working with the Council as it considers the recommendations brought forth by this workgroup. MedChi has a health disparities committee and would welcome the opportunity to be included in future deliberations. We commend the workgroup on the comprehensiveness of its draft report and have only a few suggestions to offer as the report is finalized.

1. Inclusion of community based physicians in the HEZ Implementation Workgroup : The list of partners and responsible parties that recommended to comprise the HEZ Implementation Workgroup is comprehensive with the exception of the absence of community based physician representation. Academic health centers and hospitals have a different orientation than community based providers. The focus of this report is to bring care to the community to address health disparities. Any implementation workgroup should include representatives from the physicians in the community who will be providing that care.
2. Loan Assistance Repayment Program: Throughout the draft report there are references to loan assistance repayment programs. It is not clear whether these references refer to Maryland's loan assistance repayment program that was enacted into legislation in 2009 but has not yet been funded or whether the workgroup is contemplating the creation of other repayment programs. MedChi would urge clarification on this point. More importantly it would strongly urge the workgroup to include a recommendation that the State find a funding source for Maryland's program. The legislation that was enacted enables the State to determine the shortage areas and who is eligible to receive the assistance. That program, properly funded could provide the type of assistance contemplated in this report.
3. Recognition of Existing Providers: In the section of the report that discusses prerequisites for to implementation of incentive model tactics, it is not clear that these incentives could be utilized by existing providers for expansion of their current practices. There are currently physicians whose practices are located in areas likely to be considered HEZ's if adopted as recommended by the workgroup. These practices should be able to take advantage of any new incentives to expand their practices. In many cases, expansion may be more cost-effective than the location of new providers in an area. MedChi assumes that the workgroup intended to include existing providers but suggests that it clearly acknowledged in the report.

With these comments noted, MedChi applauds the workgroup for the comprehensiveness of the report and looks forward to working collaboratively with the workgroup and the Council as it continues its commitment to addressing health disparities.

NPAM: The Nurse Practitioner Association of Maryland

TO: Health Disparities Workgroup of the Governor's Health Quality & Cost Council

FROM: Kathy Becker, Nurse Practitioner Association of Maryland

DATE: December 8, 2011

RE: Draft Recommendations

NPAM appreciates the opportunity to provide comments on the draft report of the workgroup in advance of the final recommendations to the full Council. Addressing health disparities is a critical component of providing quality care to the diverse patient population in Maryland and we value the opportunity to be included in the workgroup discussions. We commend the workgroup on the thorough report and have only a couple comments to offer as the report is finalized.

1. Patient Centered Medical Home: The Maryland PCMH Pilot Program was implemented via legislation in 2010 and included Nurse Practitioners as Primary Care team leaders. As less and less medical school graduates specialize in primary care, the role of the nurse practitioner is leading the way in providing high quality primary care services. The report should focus on expanding the MD PCMH pilot model to incentivize more nurse practitioners to bring this innovative community care program to address health disparities in our communities across Maryland. The medical home concept is not new to nurse practitioners in primary care. Coordination of care, improved outcomes of chronic conditions, provision of wellness services, and prevention of complications of disease are integral to nurse practitioner practice.
2. Accountable Care Organization (ACO): NPAM supports the creation of an Accountable Care Organization to implement a Health Empowerment Zone (HEZ) to address the needs of local areas that consistently have poor health outcomes with regard to hospital readmission rates, chronic care and primary care needs. Inclusion of nurse practitioners as an interdisciplinary model with other practitioners with incentives such as loan repayment or higher reimbursement will benefit the patients in accessing quality care and retain the necessary workforce needed to sustain the health care delivery system.

Maryland's 3,400 nurse practitioners provide critical health care services in Maryland, including up to 40 % of primary care. Like physicians, nurse practitioners are certified, licensed health care practitioners who provide health care services in a variety of health care facilities (e.g. hospitals, outpatient clinics, freestanding medical facilities, nursing homes, etc) in both rural and urban underserved areas of the state.

Thank you for the opportunity to provide participation in the workgroup and we look forward to developing the relationship and dialogue with the workgroup and Council as we continue to work towards solutions to addressing health disparities.

The Nurse Practitioner Association of Maryland, Inc.
PO Box 540, Ellicott City, MD 21041
Toll Free: 888-405-6726 FX: 410-740-7217 www.NPAMonline.org

To: Health Disparities Workgroup of the Governor's Health Quality & Cost Council
From: Malcolm N. Joseph III, M.D., Medical Director, CareFirst BlueCross BlueShield
Subject: **Draft Workgroup Recommendations**
Date: December 13, 2011

CareFirst BlueCross BlueShield applauds the State of Maryland for recognizing that disparities in health care – both in the availability of services and in patient outcomes – should be of utmost priority. We also commend the Workgroup for outlining a strategy for addressing those disparities that is at once comprehensive and visionary. That the nation's most affluent state in terms of average household income ranks only 33rd by health quality indicators should be seen as a cause for alarm. That we permit access to quality health care services to vary so widely depending on one's race, income, geography and insurance coverage reflects how much work lies ahead of us in improving the health of *all* of our residents. Personally, I was proud to serve on the Workgroup alongside such a group of preeminent and caring individuals all dedicated to the proposition that real progress can be made in reducing the health disparities that currently exist among Marylanders.

Obviously, there can be no single, simple solution to a problem that is so pervasive and pernicious. For the State to make meaningful progress in addressing the challenge of health care disparity will require courage, creativity and commitment. Most of all, it requires a practical strategy, strong leadership and the resolve to carry it out. The proposed Health Empowerment Zones championed by Lt. Governor Brown meets all three of these imperatives. They offer a strategy and a potential structure for addressing a problem that heretofore has proven so resistant to change.

CareFirst shares the Workgroup's perspective that primary care clinicians are key to ensuring that everyone receives the coordinated, comprehensive care they need to achieve and maintain good health. Central to CareFirst's own Patient-Centered Medical Home initiative are financial incentives and support services that mirror in significant ways the incentives that are envisioned under the Workgroup's proposed Health Empowerment Zones. We especially applaud the proposed role to be played under the Community-Based Organization (CBO) concept in leveraging and coordinating the efforts of both the public and private sector in addressing the challenges before us. More meaningful and creative progress can be made by working collaboratively and cooperatively.

To that end, CareFirst offers to continue its role in the State's initiative by serving on the oversight group envisioned in the Workgroup's draft report. We believe the experience and expertise that we have developed in developing and supporting similar projects and programs through our CareFirst Commitment initiative would provide invaluable insight to the State's efforts. We have been committed to addressing health disparities with culturally competent, patient-centered, community-based solutions, such as: 1) our partnership with the University of Maryland to enhance community health awareness focused on cardiovascular disease in African Americans in Barber Shops and Beauty Salons in Baltimore City; and 2) our collaboration with Baltimore Medical Systems (BMS) to address well-documented health disparities in Latino and African-American populations at BMS centers in Highlandtown and Belair-Edison.

We look forward to working with the Workgroup and the Council in addressing these challenges.