Presentation to the Health Occupation Boards
by
The Maryland Health Care Commission
in response to comments on Proposed Regulations
COMAR 10.25.02 – User Fee Assessment on Health Care Practitioners

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SUMMARY OF COMMENTS

Board of Pharmacy – Oppose Increase; All other Boards assessed EXCEPT the Nursing Board – Oppose Increase (same letters)

- **The MHCC fee cap was increased two years ago resulting in a surplus.**
- **The MHCC surplus may eventually be taken by the State (BRFA) to support the State deficit, therefore, the Pharmacy practitioners and all other practitioners may again be placed in a position of paying a greater share of State general taxes.**
- **Boards do not feel that the report provided by MHCC conclusively justifies the proposed permanent 4% increase in the user fee apportionment.**
- **Boards do not feel they should continue to be responsible for collecting fees that are not intended for or related to administrative costs in regulating its practitioners. They are concerned that they are tasked with collecting and defending MHCC's fees and that the assessment has no obvious benefit. They would like the Commission to directly assess the user fees.**

Board of Physicians – Oppose Increase

- **Report under Senate Bill 786 – "MHCC User Fee Assessment" is not clear how expenditures allocated are related to the practitioners assessed, specifically physicians who receive little benefit from it.**
- **Many licensees cannot afford the increase (sub categories under the Board).**
- **Wages (state employees) have decreased in efforts to balance the budget.**
- **Budget Surplus**
- **Health General Article 19-111 limits the total fee assessed by the Commission at $12 million.**
- **The Board will also have to increase their fee in 2015 – competing fee increases.**
- **Does not feel they should continue to be responsible for collecting fees.**

STATUTE

Health General Article 19-111 – Assessment of fees

- **(a) *Definitions* – (1) In this section the following words have the meanings indicated**
- **(4)"Health Care Practitioner" means any individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.**
- **(b) Authorized – Subject to the provisions of subsection (d) of this section, the Commission shall assess a fee on: (1) All hospitals, (2) All nursing homes; (3) All payors; and (4) All health care practitioners**
- **(c) *Maximum amount of f*ees (1) The total fees assessed by the Commission may not exceed 12 million**
- **(d) *Amount* (1)(2) The Commission is to Use a methodology that accounts for the portion of the Commission's workload attributable to each industry assessed; and Recalculate workload distribution every four years**
- **(e)Fees on health care practitioners – (1) The fees assessed in accordance with this section on health care practitioners shall be:**
  - **(i) Included in the licensing fee paid to the health care practitioner's**
  - **(ii) Transferred by the health care practitioner's licensing board to the Commission on a quarterly basis**
- **(2) The Commission may adopt regulations that waive the fee assessed under this section for a specific class of health care practitioners.**
- **(3) (i) Subject to subparagraph ii of this paragraph, the Commission shall adopt regulations to permit a waiver of the fee assessment requirements for certain health care practitioners.**
- **(3) (ii) In adopting regulations to permit a waiver of the fee assessment requirements for certain health care practitioners, the Commission shall:**
  - **1. Consider the hourly wages of the health care practitioners; and**
  - **2. Give preference to exempting health care practitioners with an average hourly wage substantially below that of other health care practitioners.**

METHODOLOGY

- The Commission tracks all renewals by fiscal year
- The Commission tracks all renewal cycles for the boards
- Projection for the number of licensees is done as a "look back" of actual renewals in the last even year and odd year. Boards that renew annually are only counted once.

- Methodology is simple:

  Allocation percentage (22%) times the Commission's budget (12,000,000) divided by the number of licensees – 146,000. The results are a fee for an annual licensee, renewals that are bi-annual cycle are doubled.

TRANSFER OF FUNDS

- The Commission devised a Memorandum of Understanding to ensure audit protocols are followed.
- The Commission requests authorization to transfer.
- The Commission handles all journal entries.
- The Commission sends a "thank you" to let fiscal officers know entry is complete.
- The Commission tracks revenue during the fiscal year from board revenue reports.

HISTORY OF BOARD ASSESSMENT

FISCAL YEAR	Bi-annual Fee	Annual Fee	Comments
FY 99 and prior	$58.00	$26.00	
FY 00	$58.00	$26.00	
FY 01	$34.00	$17.00	(Reduction $2,000,000 –first year)
FY 02*	$34.00	$17.00	(Reduction –second year-Boards only)
FY 03	$34.00	$17.00	(Registered Nurses added)
FY 04	$34.00	$17.00	
FY 05	$27.00	$11.75	(Reduction $1,000,000 – first year)
FY 06*	$27.00	$15.25	(Reduction – second year - Boards only)
FY 07	$29.50	$14.00	(Reduction $1,000,000 – first year)
FY 08	$29.50	$15.50	(Reduction – second year – Boards only)
FY 09	$32.00	$16.00	
FY 10*	$26.00	$13.00	
FY 11	$26.00	$13.00	
FY 12	$28.00	$14.00	
FY 13	$28.00	$14.00	
FY 14*	$36.00	$18.00	(Proposed)

* Workload Distribution Study – Change to Budget Apportionment between industries assessed

HISTORY OF BOARD ALLOCATION

% Allocation

FY 99 and Prior – 50%
FY 00 - 50% (merger OF HCACC AND MHRPC)
FY 01 - 19%
FY 02 - 21%
FY 03 - 21%
FY 04 - 21%
FY 05 - 21%
FY 06 - 20.5%
FY 07 - 20.5%
FY 08 - 20.5%
FY 09 - 20.5%
FY 10 - 18%
FY 11 – 18%
FY 12 – 18%
FY 13 – 18%
FY 14 – 22% - Proposed (4 year change)

HISTORY OF BILLED VERSUS WHAT HAS BEEN COLLECTED

FY	Budget	Board Fee	Amount Billed	Amount Collected	+/-	Explanation
FY 01	7,148,820	1,354,388	835,709	799,000	-36,709	2 million reduction – 1st year
FY 02	8,151,670	1,548,817	963,731	901,170	-62,561	2 million reduction – 2nd year only to boards
FY 03	8,570,594	1,799,824	1,799,824	1,804,963	+5,139	
FY 04	8,217,649	1,725,706	1,725,706	1,812,458	+86,752	
FY 05	8,570,924	1,799,824	1,589,824	1,560,267	-29,557	1 million reduction – 1st year
FY 06	8,925,507	1,829,728	1,703,942	1,521,225	-182,717	1 million reduction – 2nd year only to boards
FY 07	9,611,789	1,970,417	1,765,416	1,799,547	+34,131	1 million reduction – 1st year
FY 08	10,476,446	2,147,671	1,942,671	1,669,609	-273,062	1 million reduction – 2nd year only to boards
FY 09	10,820,777	2,218,259	2,046,786	2,068,441	+21,655	No billing of indirect costs paid to DHMH $836,455
FY 10	11,056,391	1,990,150	1,838,612	1,711,305	-127,307	No billing of indirect costs paid to DHMH $841,878
FY 11	11,132,363	2,003,825	1,854,487	1,817,620	-36,867	No billing of indirect costs paid to DHMH $829,575
FY 12	11,356,791	2,044,222	1,899,989	1,821,075	-78,914	No billing of indirect costs paid to DHMH $801,295
FY 13	11,685,921	2,103,465	1,959,711			No billing of indirect costs paid to DHMH $798,637

*FY 13 Budget Amendment $900,000 for Patient Centered Medical Home Program - $240k from Vacancy Savings (FY 13) $ 640K taken from existing surplus - Not billed to industries - Primary benefit to practitioners

FY 14	12,509,727	2,752,140	2,640,000		*Only assessed $12 million per cap ceiling - balance to come from surplus

CAP INCREASES REQUESTED BY COMMISSION : FY 02 – $8.25 million to $10 million; FY 08 – $10 million to $12 million

THE MARYLAND HEALTH CARE COMMISSION

Mission: To plan for health system needs, promote informed decision-making, increase accountability, and Improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost and quality of services to policy makers, purchasers, providers, and the public.

Vision: To ensure that informed consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation

The Commission contends that with the broad array of statutory mandates before it, that benefits are received by the entire health care community, either directly or indirectly, but most importantly to the residents of Maryland.

RESPONSIBILITIES OF THE MARYLAND HEALTH CARE COMMISSION

- The Certificate of Need program;
- Oversight of specialized inpatient services such as cardiac surgery, obstetrics, neonatal intensive care, organ transplant, and psychiatry, including developing the state health plan chapters, managing certificates of need for these services, and granting appropriate waivers to allow hospitals meeting rigorous criteria to perform emergency angioplasty;
- Publishing the Hospital Guide, containing both general information and specific quality and outcome measures; Reporting on the quality of hospital efforts in surgical infection prevention and is developed key strategies to gather and report the rates of hey hospital acquired infections;
- Serves as the lead for studying emergency department crowding;
- Health planning regarding long-term and community-based care, including the policies guiding the determination of need in the Certificate of Need process for nursing homes, ambulatory surgical centers, home health agencies, and hospices;
- Responsible for the study of long-term care vision and needs over the coming 25 years;
- Publishes the Nursing Home Guide for Marylanders;
- Pioneering the public reporting of resident and family satisfaction measures for long-term care;
- Responsible for the small group health insurance market, including regulation of the Comprehensive Standard Health Benefit Plan;
- The Maryland Partnership Program – implements small business subsidies for affordable health insurance
- Reporting publicly on the performance of and satisfaction with health plans in the HMO/EPO/PPP Consumer Guide;
- Responsible for the development and analysis of state health policy options affecting the organization and financing of health care
- Reporting disparities in health care and is responsible for the Commission's Racial and Ethnic Disparities initative;
- Physician services, including physician reimbursement and reporting on the cost and quality of physician services
- The Patient-Centered Medical Home Program
- The Maryland Trauma Physician Services Fund and Grant Program;
- Working closely with the Health Services Cost Review Commission, publishing each hospital's charges for the most common Diagnosis Related Groups (DRGs) as part of the Commission's Price Transparency Initiative;
- Plan and implement a statewide health information exchange;

MHCC PROVIDED WEB DEVELOPMENT AND SUPPORT FOR BOARDS AND COMMISSIONS ON-LINE LICENSE RENEWAL SITES

The following license renewal sites were developed and are maintained by the Maryland Health Care Commission and allow practitioners to renew their licenses, provide data to DHMH about the health provider, and allow the Board to collect their assessment along with the MHCC assessment:

- Acupuncture
- Audiologist, Hearing Aid Dispensers and Speech Language Pathologists
- Chiropractic and Massage Therapy Examiners
- Dietetic Practice
- Morticians and Funeral Directors (not assessed an MHCC fee)
- Optometry
- Physical Therapy Examiners
- Physicians (and Allied Health Professional sub categories)
- Psychology
- Podiatric Medical Examiners
- Professional Counselors and Therapists
- Social Work Examiners

- Each site is different and custom developed for the board and type of license.

DIRECT Benefits to Providers

•Patient Centered Medical Home Program

•Directly benefits participating primary care physicians and the staff who are employed by the primary care physicians by providing them with additional funds to provide more accessible, better coordinated care for their patients. All participating practices get periodic transformation payments from payers (based on the number of active patients and continuing education from the Maryland Learning Collaborative funded by the MHCC. If the practice meets agreed upon care quality metrics and is able to keep its patients health care expenditure growth below the statewide growth rate, the practice is eligible for additional payments from the savings.

•Health Information Technology

•The Maryland Health Care Commission is the State agency responsible for advancing health information technology in Maryland. Effective implementation of health IT will assure that providers of health care services have accurate information at the time and place of patient care to improve treatment, prevent errors, and reduce health care costs. Health IT diffusion will also facilitate the collection and utilization of information, which can improve disease surveillance, increase health care knowledge, and shape best practice guidelines. The crucial components of health IT include the implementation of health information exchange, the widespread adoption of electronic health records (EHRs), and the diffusion of telemedicine to increase access to health care, reduce health disparities, and create efficiencies in health care delivery. The activities underway in Maryland to advance health IT directly impacts all health providers. These activities are as follows:

•Implement a statewide HIE;

•Increase the availability and use of standards-based health IT through consultative, educational, and outreach activities;

•Certify electronic health networks that accept electronic health care transactions originating in Maryland;

•Develop programs to promote electronic data interchange between payers and providers;

•Designate management service organizations to promote the adoption and advanced use of EHRs;

•Develop the Electronic Health Record Product Portfolio as a free resource for providers to compare information about EHR systems, which includes details regarding their EHR system pricing and functionality, along with negotiated vendor discounts;

•Establish standards for payers and pharmacy benefit mangers round the electronic preauthorization of medical services;

•Participate in provider association trade shows;

•Present at provider meetings on topic specific health IT issues;

•Work with providers to identify issues related to privacy and security of electronic health information that lead to development of regulations; and

•Facilitate the development of regulations for State-regulated payers to provide EHR adoption incentives to certain providers.

DIRECT Benefits to Providers - continued

•The Maryland Trauma Physician Services Fund

•The Maryland Health Care Commission is responsible for administering the "Trauma Fund" which cover the costs of medical care provided by trauma physicians at Maryland's designated trauma centers for uncompensated care, Medicaid-enrolled patients, trauma related on call and standby expenses and trauma equipment grants.

•Health Practitioner Performance Measurement Project – (on the horizon)

•The purposes of the performance measurement project are to:

•Produce consistent information – unlike the varied information provided by payers – on practitioner performance in quality, cost (resource use), and efficiency that will be available to health care providers, payers and patients;

•Promote performance improvement in the provision of health care services, by enabling practitioners to track their performance over time and compare their performance to their peers, and;

•Promote transparency in practitioner performance measurement so that referring practitioners, employers, and patients can make better informed practitioner selection.

The measures will be produced using health insurance claims data from both public and private insurers. The measures will be specialty-specific and risk-adjusted for patient mix. Practitioners will be able too review and correct their reports before they are made available to the public. The project will start with a limited set of performance measures that will be expanded over time. Measurement selection will be made by a workgroup of stakeholders from a variety of health care organizations, as well as independent practitioners.

•Expansion of the Medical Care Data Base to an All Payer Claims Data Base – (on the horizon)

•In order for the Practitioner Performance Measures to be accurate, the claims data needs to be complete, necessitating the expansion of the Medical Care Data Base to an All Payer Claims Data Base to include information on Medicaid patients and carved out services for patients covered through self-insured employers.