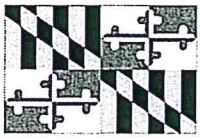
Dr.Ciotola_FAV_SB501

Uploaded by: Ciotola, Dr. Joseph
Position: FAV



Joseph A. Ciotola Jr., MD & Deborah Mizeur, MHA, MS
Co-Chairs, Maryland Workgroup on Rural Health Delivery

February 11, 2020

Senator Melony G. Griffith
James Senate Office Building, Room 220
11 Bladen St., Annapolis, MD 21401

Senator Stephen S. Hershey, Jr.
James Senate Office Building, Room 420
11 Bladen St., Annapolis MD 21401

Dear Senators Griffith and Hershey:

We are writing to express our enthusiastic support for your efforts to improve the physician and physician assistant workforce in rural and underserved areas of Maryland and urge swift passage of SB 501.

There is a vibrancy alive in our rural and underserved areas, contributing in meaningful ways to the overall success of the State. Even so, demographic challenges often make it difficult for our communities to attract health care workers. Loan repayment incentives, such as proposed in SB 501, are effective means to encourage providers to locate in rural and medically underserved areas.

As Co-chairs of the Maryland Workforce on Rural Health Delivery we applaud your efforts to improve access to health care services for vulnerable Marylanders and we remain at your service. Please contact us with any questions.

Sincerely,

/JAC

Joseph Ciotola, MD
joseph.ciotolamd@maryland.gov
410-382-1059

/DM

Deborah Mizeur, MS, MHA
deborahmizeur@gmail.com
301-742-0661

RuralMD_FAV_SB501
Uploaded by: Ciotola, Dr. Joseph
Position: FAV

Transforming Maryland's rural healthcare system: A regional approach to rural healthcare delivery

Report of the Workgroup on Rural Health Delivery

to the Maryland Health Care Commission

As Required by Senate Bill 707

Table of Contents

Introduction

During the 2016 legislative session, Senate Bill 707 Freestanding Medical Facilities-Certificate of Need, Rates and Definition (Appendix A) was enacted in response to the need for flexibility for general acute care hospitals to convert to ambulatory medical services campuses, while preserving access to needed emergency services.[1] These facilities are known as Freestanding Medical Facilities (FMFs).

SB 707 established a public notification process and defined specific information the hospital must make available to the public and other stakeholders. Specifically, the institution must describe the reason for the conversion and present plans for transitioning acute care services previously provided by the hospital, continuing to address the healthcare needs of the residents, and retraining displaced employees. The institution must also detail plans for the disposition of any part of the facility that would be closed. The legislation requires that this and other information be made available in a public information hearing and the results from that meeting must be shared with the Governor, Legislature, and other state policymakers.

Policy Background

The new law requires the Maryland Health Care Commission (MHCC) to complete a careful review of an exemption request. The MHCC organized a workgroup to assist in developing the regulations for FMFs. On May 18, 2017, the MHCC adopted COMAR 10.24.19 - State Health Plan for Facilities and Services: Freestanding Medical Facilities. These regulations became final in June of 2017. The regulations define the process for submitting the exemption request and the types of information the converting hospital and its parent hospital must provide to MHCC. To approve an exemption request, the MHCC must find that the conversion is not inconsistent with the State Health Plan; will result in the delivery of more efficient and effective healthcare services; will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as determined by the State Emergency Medical Services Board; and is in the public interest. MHCC will carefully review the evidence provided in the exemption request and consider the information gathered by the hospital in its public engagement processes.

Maryland's unique hospital payment model has been a key policy tool for softening the impact of declining hospital utilization on local hospitals. Over the past decade, the Health Services Cost Review Commission (HSCRC) has worked with rural hospitals to develop an alternative payment model, Total Patient Revenue (TPR) that was especially well-suited to the needs of rural hospitals. The success of that model was one factor that spurred Maryland to establish the All Payer Model Demonstration Agreement (All Payer Model, or

[1] Enacted as Chapter 420 of the 2016 Laws of Maryland.

Agreement) with the Center for Medicare and Medicaid Services (CMS) beginning in 2014. Under that agreement, Maryland committed to slow the growth in Medicare per capita hospital spending and to achieve ambitious quality and performance goals. All Maryland acute care hospitals committed to operate under a Global Budget Revenue arrangement, (which was similar to the TPR arrangement developed for rural hospitals) and to meet the challenging performance and quality improvement goals. Over the past three years, Maryland hospitals have met the key requirements of the Agreement. Negotiations are now underway with CMS for the next phase, called the Total Cost of Care (TCoC) Demonstration, which is set to begin in 2019.

Providing greater flexibility for Maryland hospitals to convert to ambulatory medical services campuses, while preserving access to emergency services, is a response to the declining use of inpatient services in Maryland and the incentives in new healthcare reform models. Declining hospital admissions and shorter lengths of stay are consistent trends across the United States. The appropriate use of an ambulatory setting lowers the cost of care and is often preferred, as it means patients can return home the same day that they have received services. Expanded use of ambulatory care reduces the per capita cost of care and is consistent with the aims of the All Payer Model and the new TCoC Demonstration now being finalized with CMS. As the models evolve, Maryland communities will need less inpatient hospital service capacity because hospitals will be increasingly focused on improving the health status of the population in their service areas rather than increasing hospital admissions.

Preserving access to emergency and ambulatory services is an important objective. The FMF and the ambulatory services situated on the FMF campus can provide a safe and effective site for treating a significant proportion of the patients that present at the hospital emergency department of a small acute care hospital. As important, the FMF, like the hospital, would be tightly linked to a large health care system through advanced EMS transportation and would be electronically linked via advanced telehealth capabilities.

During the debate on SB 707, state policymakers, legislators, and community representatives highlighted the challenges that residents of rural communities face in accessing the healthcare system. Many of the challenges for rural communities go beyond inpatient care and include access to care more broadly. These challenges are rooted in an inadequate supply of providers, a compromised transportation system, and limited health literacy. More narrowly, in some rural jurisdictions, the loss of its only hospital eliminates the hub for health care in that community. Representatives from these communities reminded state policymakers and legislators that in some rural communities the hospital was the principal source of care. A closure or conversion could trigger an unravelling of the fragile local healthcare system, including the exodus of primary care and other community providers, a significant direct and indirect economic blow triggered by job losses. Policymakers and legislators recognized that loss of local access to inpatient care and limited alternatives due to travel times and travel distances were important complicating factors.

One area of particular concern was the Mid-Eastern Shore region of Maryland (Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties). The healthcare delivery challenges in the Mid-Shore region include long travel distances to health care facilities, few public transportation options, a limited workforce, and a limited number of healthcare facilities. In fact, two of the five counties in the region (Caroline and Queen Anne's counties) have no acute care general hospital. In addition, there are shortages of primary care physicians and specialists in the Mid-Shore region as well as limited numbers of nurses and allied healthcare workers to care for rural residents. Although the five county Mid-Shore region of Maryland is not as vast and sparsely populated as the rural areas in some other states, it covers a large geographic area (almost 1,800 square miles). Similar to other rural areas throughout the United States, the population in the Mid-Shore region is older, has more chronic health conditions, and has fewer financial resources than residents in urban and suburban areas of Maryland.

Workgroup Selection

In response to these challenges, the legislation required the establishment of a workgroup on rural healthcare delivery and the provision of a study of the healthcare system in the Mid-Shore counties. The charge of the Rural Healthcare Delivery Workgroup (Workgroup) was to oversee a study of healthcare delivery, to make recommendations, and to develop a healthcare delivery model to meet the healthcare needs in the five county Mid-Shore region, which could also be applied to other rural areas in Maryland.

The MHCC was directed to establish a Workgroup on rural health delivery, including appointing members, selecting the chairs, and staffing the Workgroup in collaboration with the Maryland Department of Health (MDH). As required under the new law, MHCC sought recommendations for workgroup members from the legislative leadership in the Maryland Senate and House of Delegates, the Secretary of the Maryland Department of Health, chief executive officers of hospitals and regional medical centers, and individuals representing the interests of healthcare providers, businesses, labor, State and local government, consumers, and other stakeholder groups. The list of the Workgroup members can be found in Appendix B.

SB 707 stated that the Workgroup must oversee a study of rural healthcare needs in the Mid-Shore region. As part of its charge, the Workgroup was directed to hold public hearings to gather community input on healthcare needs in the five counties. The Workgroup was charged with reviewing, developing, and recommending policy options that would address the healthcare needs of Mid-Shore residents and improve rural healthcare delivery in the region as well as in other rural areas in Maryland.

The rural study, which was to be carried out by an entity with expertise in rural healthcare delivery and planning, was to examine challenges to the delivery of healthcare in the five study counties, including:

- the limited availability of healthcare providers and services;
- the special needs of vulnerable populations; transportation barriers; and
- the economic impact of the closure, partial closure, or conversion of a healthcare facility.

The University of Maryland School of Public Health in partnership with the Walsh Center for Rural Health Analysis at the University of Chicago, was selected by MHCC to conduct the study. Consistent with the instructions in the new law, the study team took into account the input gained through the public hearings, identified opportunities created by telehealth and the Maryland All Payer Model, and developed policy options for addressing the healthcare needs of residents and for improving the healthcare delivery system in the five county study region. The study team worked in close collaboration with the members of the Workgroup and MHCC staff. The study team attended all Workgroup meetings and public hearings and met weekly with MHCC staff during the study period. The final summary report can be found in Appendix C.

Workgroup Process

The Workgroup met seven times between August 2016 and September 2017. Five of the seven meetings were held in the five county region, including two in Kent County, two in Talbot County, and one in Dorchester County. During each meeting various stakeholders and experts in the health system in the Mid-Shore area and in rural health presented to the Workgroup. Presenters included staff from the University Of Maryland School Of Public Health, the Walsh Center for Rural Health Analysis at NORC, and the Maryland Department of Health.

The first meeting, The Rural Health Summit, took place August 30, 2016, at Chesapeake College in Wye Mills, Maryland. Workgroup members were able to take a tour of the Health Professions Center, which houses an ambulance simulator, digital radiology suite, surgery suite, hospital room and apartment. These facilities, along with human patient simulators, are used for training students interested in emergency medical services, nursing, phlebotomy, and other allied health professions. During the meeting, the Workgroup members reviewed the Workgroup's charge and discussed the plan for the study. Presentations were made on the current state of the health care systems in the five counties, including a presentation on the current health care workforce, and current health facility capacity. The Office of Rural Health staff and the Office of Minority Health and Health Disparities staff also presented on the delivery of healthcare in all Maryland rural communities and on health inequities on the Eastern Shore. Lastly, the Workgroup was given an overview of Maryland's All Payer Model by the Health Services Cost Review Commission staff in order to insure that all members had a basic understanding of Maryland's hospital payment model.

At the end of the first meeting the Workgroup Chairs announced the formation of four Advisory Groups (Transportation, Vulnerable Populations, Economic Development, and Workforce) made up of Workgroup members and other interested parties having subject

matter expertise. These advisory groups were charged with drilling down into issues by listening to experts and discussing areas of concern in order to help them understand the root causes of healthcare delivery problems, and to further inform the Workgroup's deliberations. The advisory groups' members formulated specific ideas which were later discussed by the Workgroup and served as the foundation for the Workgroup's recommendations. Each Advisory Group met multiple times between October 2016 and July 2017.

The second meeting of the full Workgroup was held in Cambridge, MD on November 1, 2016, and focused on understanding the role of the three major hospital health systems in the region: Shore Regional Health, Anne Arundel Medical Center, and Peninsula Regional Health System. Staff from each of the health systems presented on their role in the healthcare system and their plan for improving healthcare in the Mid-Shore region. At the conclusion of these presentations, the Workgroup Chairs, along with Senator Thomas Middleton, urged the three health systems' representatives to formulate plans for collaboration and strategies for improving the health system. Responses to that request were delivered to MHCC in the fall of 2017 and can be found on the Workgroup's website.[2] The research team from the School of Public Health and the Walsh Center for Rural Health Analysis presented the study plan and was given feedback from the Workgroup members.

As the process unfolded, the Workgroup members, the research team, and MHCC staff developed Guiding Principles to guide the Workgroup in making recommendations on the approaches for improving the delivery of healthcare in rural areas of Maryland (Appendix D). The Guiding Principles were discussed at the third meeting of the Workgroup, which was held at Washington College in Chestertown, MD on January 9, 2017. These Guiding Principles assisted the Workgroup members in maintaining focus on the legislative charge and the importance of taking a regional perspective. At this meeting, MDH staff briefed the Workgroup on plans for the Maryland Primary Care Model and HSCRC staff provided an update on the Maryland All Payer Model. Lastly, the advisory group leads reported on their working ideas for possible recommendations. Workgroup Chairs and members offered additional suggestions to the advisory group leads. At the conclusion of the meeting, Workgroup members had a better understanding of the State's major delivery system reforms being negotiated with CMS and how Workgroup recommendations would need to align with and take advantage of those reforms.

The fourth meeting of the Workgroup, held on March 27, 2017 in Annapolis, MD, focused on the research team's preliminary research findings gathered from empirical data analysis and a limited number of key informant interviews. The Workgroup members were able to provide feedback to the research team and discuss preliminary findings from the stakeholder interviews and focus groups. The experts from the Walsh Center on Rural Health Analysis presented promising approaches to improving rural health from other parts of the country. MHCC staff briefed the Workgroup on plans for the public hearings

[2] http://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_rural_health.aspx

scheduled for the late spring. Workgroup members offered suggestions on the scope and framework for the hearings.

On May 24, 2017 a Workgroup meeting was held at Washington College in Chestertown, MD. The Advisory groups began to report their preliminary findings. Workgroup members discussed the need to increase the coordination of care for patients and provide for a single point of entry to the healthcare system. This discussion later evolved into one of the key recommendations of the Workgroup, establishing a Rural Community Health Complex program.

The sixth meeting of the Workgroup was held on July 25, 2017 at Chesapeake College in Wye Mills, MD. MHCC staff presented the findings from the public hearings and final recommendations from the advisory groups were discussed. Preliminary workgroup recommendations were developed. These recommendations were finalized at the seventh, and last, meeting of the Workgroup which was held on September 28, 2017 in Annapolis, MD.

At each meeting a facilitator was presented to assist guiding any Workgroup discussion. All meetings were open to the public and at least fifteen minutes at the end of each meeting were allotted to public comment. Materials for each of these meetings, as well as meeting notes, can be found on the Maryland Health Care Commission's website Workgroup website.[3]

Public Hearings

The Workgroup was mandated to hold public hearings in all five study counties to gather information and to clarify needs. One public hearing was held in each of the five study counties between May 24th and June 13th in 2017. All of the public hearings were held in the evening hours at a location within the community that was selected by the county Health Departments' staff members. The hearings were publicized in local newspapers, on social media, in local libraries, and in retail stores. Residents were given the opportunity to comment on issues related to health and healthcare delivery in their communities. Individuals were also given the opportunity to write or email the MHCC with their comments for several weeks following each public hearing. At least one of the Workgroup's chairs and several Workgroup members and the research team attended each meeting. MHCC staff provided overviews of the Workgroup's charge, described the importance of the public meetings, and coordinated the discussions.

Discussions were lively at all of the public hearings. Attendance varied from over 100 residents in Kent County to roughly 20 residents in Dorchester County.[4] Residents shared their perceived ideas of the strengths and weaknesses of the current healthcare delivery system. Generally speaking, residents in the Mid-Shore region recognize that healthcare

---

[3] http://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_rural_health.aspx

[4] The public hearing in Dorchester County was held in Hurlock, MD because sites in Cambridge were not available and Shore Health was simultaneously providing overviews of their plans for Dorchester General.

systems need to accommodate culturally diverse populations and the growing number of vulnerable residents, including elders with chronic health conditions. The residents also feel that in order to improve the healthcare delivery system, recommendations must address social determinants of health. Residents support an integrated care delivery system across a continuum of care with services as close to home as possible.

Workgroup Recommendations

The Workgroup considered information gathered through the advisory group process, the public hearing process, the study, and at each Workgroup meeting when formulating final recommendations. The goals of each of the recommendations can be broadly placed into three categories. Each of these recommendations promote policies that:

- foster collaboration and build coalitions in rural areas to serve rural communities;
- bring care as close to the patient as possible to improves access; and
- foster participation in statewide models and programs in rural Maryland.

The Workgroup suggests that these recommendations be implemented in stages and that progress toward population health improvement be evaluated regularly. The Rural Healthcare Delivery Workgroup recommends that the State:

Establish and Support the Rural Community Health Complex Program

The Rural Community Health Complex Program serves as the focal point for redesigning healthcare delivery in a rural region. The overarching goals of the demonstration program are to:

- Better integrate existing government services and clinical services for improved outcomes, patient convenience and satisfaction, as well as to ensure less duplication, for overall lower costs.
- Better integrate primary care with behavioral health and dental services.
- Bring care as close to the patient as possible and decrease transportation needs as multiple appointments/services can be managed with the same trip. Specialists are brought onsite so that patients don't have to travel long distances.
- Decrease medically unnecessary emergency department use.
- Create a community of wellness.

The foundation of the Rural Community Health Complex is primary care. The most basic services offered at any complex site should be essential care. The Essential Care Complex (ECC) is a primary care office directed by a physician or other healthcare practitioner. The office is a stand-alone physical location and, in some instances, may be co-located in a nursing home, emergency medical services (EMS) facility, or even a school. A mobile unit, such as a health mobile, may also be appropriate for smaller communities. The ECC will provide routine primary care, including limited open access (walk-in) scheduling and some non-standard visits, such as group visits for managing some chronic conditions. The EEC could also act as the anchor for other initiatives planned by the Workgroup, including mobile integrated healthcare that pairs EMS and community health workers. The ECCs

will largely be new sites of care that will be established as part of the Demonstration. Sites should expand the scope of services offered to include;

1. Advanced primary care, or primary care based on the Patient Centered Medical Home model. This type of site could offer extended hours care, open access scheduling, and would support non face-to-face visits and group visits. Services in these advanced primary care sites should be tailored to the community served. Several existing Federally Quality Health Center (FQHC) sites are already delivering almost the entire range of services envisioned at these sites.

2. An advanced ambulatory care site consists of a freestanding emergency department and, potentially, observation units, with other outpatient services as appropriate. Behavioral health, substance abuse treatment centers, hospice and palliative care providers, medical, and ambulatory surgical services could be located on the campus. The site would have a formal relationship with a parent health system and any emergency facility would be designated by the Maryland Institute for Emergency Medical Services Systems (MIEMSS.) One advanced ambulatory care clinic (AACC) site in Queenstown now exists, although services may need to be expanded. Another AACC has been proposed in Cambridge, Maryland.

3. A Special Rural Community Hospital (SRCH) would be a small rural hospital consisting of an emergency department, an observation unit, which has the capacity to provide inpatient and outpatient surgeries, and would provide inpatient care. The SRCH would possess significant telehealth capability to support telehealth assessments and consults with patients outside of the hospital and with clinicians at regional and academic medical centers. Criteria for this category of facility will need to be developed that take into consideration the reality of hospital services in rural Maryland. While the Critical Access Hospital may be the closest federal analog, this designation is based on distance to another health facility, which is not ideal for rural parts of the State. In Maryland, particularly on the Eastern Shore, a better measure could be travel time. The program should be established under HSCRC's broad authority to establish reasonable reimbursement for Maryland hospitals, or through a legislative mandate to create such a program. To qualify, the hospital must specify concrete goals and its plans for implementing those goals. The plans could include initiatives for improving the quality of care and establishing expanded access to advanced primary care, thereby decreasing the number of avoidable admissions, readmissions, and transfers. Any special designation should include sustainable funding and should be linked to measureable outcomes and milestones.

Specialists, dentists, and behavioral health providers, along with hospice and palliative care providers, should be encouraged to partner or co-locate at the complex's site where feasible. The inputs to establish any site will be reflect the needs of the population, the scope of services that can be supported in the immediate community, and proximity to other health care resources in surrounding communities, the jurisdiction, and the region.

A Rural Community Health Complex Program would have a systems planning and management council, would be composed of representatives of hospitals, practices participating at the sites, local health departments, emergency medical services, and consumers. The State's higher education centers may be a useful model for the structure and functions of this council in the healthcare context.

The technology infrastructure will support coordination among healthcare providers and social services and provide a vehicle for educating patients on health literacy and self-management for chronic conditions. Services envisioned to be available through this "Patient Centered Support Hub" are already available through interoperable electronic health records (EHRs), EHR patient portals, services currently available through the Chesapeake Regional Information System for our Patients (CRISP), or planned to be available via the CRISP Integrated Care Network (ICN).

The Patient Centered Support Hub will enable better integration of multiple information sources allowing primary care physicians to track patient care and access and refer to specialists through their system. The Hub should also link providers and patients to other resources beyond medical care, including access to educational/self-management services, government agency and community-based social services and supports.

The Rural Community Health Complex Program should align with the goals of Maryland's Phase II Total Cost of Care (TCoC) Model (the State of Maryland's agreement with CMS for hospital rate setting in Maryland.) The State should consider providing sufficient funding to establish the Rural Community Health Program in the Mid-Shore area. All support should be linked to measureable establishment, process, and outcome milestones. The Workgroup emphasizes that the proposed Complex must make measureable improvements in the health status of the patients in the communities in which they operate. Simply establishing funding levels and program objectives will not be sufficient to drive improvements.

Establish and Support a Rural Health Collaborative

The Workgroup recommends that a Rural Health Collaborative (RHC) organization be designated as a first step in launching the complex. A convening organization is needed to mobilize and educate local groups, plan for the complex, and to establish and direct the complex. No existing organization is optimally organized, regionally positioned, or appropriately funded to establish the program. The existing Local Health Improvement Coalitions (LHICs) for rural counties may offer a suitable organizational foundation for the Rural Health Collaborative; however, there must be a critical mass of community voices heard, including patients and providers, in the planning and development of the organization. The Mid Shore LHIC is especially credible as it already includes the five Mid-Shore counties and many of its stakeholders are already active participants. To be successful, the Mid Shore LHIC would need a predictable funding stream from the State and local jurisdictions and additional authority to convene the complex.

The RHC could perform the following functions:

- Identify needs for the region, including the pockets of special needs within the counties.
- Develop strategic directions for improvement of health in the region.
- Work with health systems and independent providers to integrate clinical health needs with social, behavioral, and environmental needs that impact health and clinical outcomes.
- Manage data collection and analysis for Community Needs Assessments that roll into a Regional Health and Social Needs Assessment.
- Collaborate with other community organizations and health systems in seeking grant funds to improve health within the region.
- Work with healthcare organizations' collaborations in sharing services and staff across jurisdictional lines for economies of scale.
- Integrate the work of the local organizations into broader regional initiatives.

This Rural Health Collaborative will have a Director who will work with the key county representatives to facilitate planning, meetings, data collection, examples of proven strategies for rural health improvement, and distribution of information. Other staff or contractual services will be at the discretion of the RHC. Local jurisdictions would be expected to provide limited funds to establish and maintain the Collaborative with local funds matched by the State. The Rural Health Collaborative will need to work with healthcare providers to develop the full range of sites within the region. A Rural Health Collaborative will not compel a healthcare provider to establish a service, but it will be able to provide guidance on where services may be needed.

Community voices are essential to a well-functioning healthcare delivery system. The RHC would be an important convener of community voices and a forum for public input when planning for a regional health system. The RHC would also be an important resource for healthcare providers when planning population health improvement initiatives.

The Rural Community Health Complex Program begins as an experimental program in the Mid-Shore region. If the Program meets performance milestones, the Workgroup envisions that a Rural Community Health Complex Program could be established in each of the other rural regions: Lower Eastern Shore, Southern Maryland, and Western Maryland. The appropriate convening organization that serves as the foundation for the Rural Health Collaborative will need to be carefully considered in each region. Although the Mid Shore LHIC is stable and broadly supported, there may be different organizations in other regions that could serve as the RHC function. All existing organizational structures should be considered as each region considers establishing a new entity.

The Workgroup considers the recommendations that follow to be essential for the development of the program. Each recommendation represents an important building block for the operational structure and workforce needed for the complex to succeed. These recommendations can be understood and evaluated individually and some may need further definition. The Workgroup recognizes that State policymakers may establish an

implementation sequence that reflects funding and implementation priorities. However, the Workgroup members believe that implementing one or several recommendations alone will not produce the proportional benefits associated with a more limited investment.

Supportive recommendations

Expand the Healthcare Workforce

1. *Create and extend tax credits, loan, or grant opportunities for providers to practice in rural communities.* The Maryland General Assembly could establish tax incentives for medical, dental, and behavioral health care providers willing to practice in rural areas and for those who mentor students in these areas. Examples of these include the Health Enterprise Zone (HEZ) personal tax credit, HEZ hiring tax credits, tax credits for those providers who are near retirement and who move to rural communities, and State backed small business loans for practitioners to establish a practice in a rural community. The Maryland Department of Commerce could be encouraged to use its existing economic development funds to fund this program.

2. *Incentivize medical students and residents to practice in rural communities.*

    a. *Identify sustainable funding for a Primary Care Track program that enables medical students to work alongside family medicine, general internal medicine, or pediatric physicians that practice in underserved areas.* The focus of the University of Maryland School of Medicine (UMSOM) Primary Care Track is to introduce students to primary care role models early in medical school and to offer a longitudinal experience in primary care in rural and urban underserved communities to interested students. The goal is to increase the number of UMSOM students who choose careers in primary care by: 1) connecting first year students with primary care physicians in urban as well as rural underserved communities and to create the opportunity for longitudinal mentorship and clinical experiences with their mentors throughout their four years of graduate studies; 2) educating them early about important topics in primary care and community health; and 3) fostering a greater appreciation for the challenges and rewards of caring for the underserved in Maryland. This four year elective offering culminates in each student's participation in Primary Care Day, where the senior students serve as role models for their junior colleagues.

    b. *Establish a Rural Primary Care Residency Program.* Research suggests that residents who train in rural areas and whose training emphasizes services necessary for rural practice are more likely to choose to practice in rural areas. Residency programs in rural areas may expose residents to the benefits and challenges of practicing in these regions and prepare residents to practice rural primary care medicine. Residency programs may align with either a rural hospital or private practice. Federally Qualified Health

Centers (FQHCs) may be included in the residency experience, giving residents the opportunity to work with a higher volume of diverse and underserved patients. Residents may gain a deeper knowledge of the social determinants of health and explore potential remedies that address these issues on a local, regional, and national scale. Making any Graduate Medical Education (GME) funding available through enhanced hospitals rates could challenge the Global Budget Revenue limits agreed to under the State's current agreement with CMS for the All Payer Model and Total Cost of Care Model (TCoC) beginning in 2019.

Establish a rural specialty care residency rotation. The inability to recruit general surgeons, obstetricians, anesthesiologists and certain other specialists is an important contributor to the failure of many rural hospitals. Establishing specialty care residency rotations in rural hospitals could ease the challenge of attracting these specialists to rural communities.

All surgical and medical specialty residency programs in Maryland are located in Baltimore City and Baltimore County hospitals. The Baltimore hospitals provide valuable training in mostly academic teaching environments and the clinical staff are excellent. Often, these are the exact experiences that medical students seek in residency programs. However, limiting the training settings to these environments undervalues future practice in smaller hospitals and rural communities. Exclusive training in these settings tends to incentivize preferences for types of future employment in medical and surgical subspecialties. The concentration of training programs in Baltimore may also contribute to Maryland ranking 42nd (37.5%) of all states in retaining medical and surgical residents trained in the State.

Working as a general surgeon in an under-resourced setting might not generate as much attention as being a surgical subspecialist in a large urban or academic setting, but physicians working in under-served and rural areas often have high levels of job satisfaction and fulfillment that far exceed those of their colleagues in other settings. If residents are never offered the more diverse experiences, chances for selecting those clinical settings are low.

Establishing a rural medical or surgical residency program could be challenging. Rotating medical and surgical residents through rural hospitals offers the potential to expose residents to the challenges and benefits of delivering specialty and surgical care in rural communities. To establish these rotations, Maryland may need waivers from the Accreditation Council for Graduate Medical Education (ACGME) that requires residents to work at sites less than 50 miles from the sponsoring hospital. Most of the eligible rural hospitals are more than 50 miles from the Baltimore hospitals that have established residency programs. Rural hospitals would also need additional

funding to support surgical and medical specialty residents. As noted above, making any GME funding available through enhanced hospital rates could challenge the Global Budget Revenue limits agreed to under the current All Payer Model and future Total Cost of Care Model (TCoC) beginning in 2019. Testing the principle of allowing funding to follow the resident could be an additional benefit of this recommendation.

3. *Streamline and Expand the Maryland Loan Assistance Repayment Program (M-LARP).* The General Assembly should streamline the management of the State LARP by centralizing oversight of the program in either the Maryland Higher Education Commission or the Maryland Department of Health.

4. *Realign the Prioritization of the J-1 Visa Program.* The Maryland J-1 Visa Waiver Program offers a J-1 Visa waiver to foreign physicians who commit to serving for three years in an underserved area of Maryland, waiving the foreign medical residency requirement and allowing them to remain in the United States. The program is intended to provide physician services in areas that typically have difficulty attracting and retaining physicians. The Maryland program should:

    - Prioritize applicants who are willing to work in rural federally designated Health Professional Shortage Areas (HPSAs) and medically underserved areas for a limited number of State slots.
    - Encourage and assist communities where J-1 visa recipients are placed; including:
        - Creating a welcoming environment and developing programs to support visa recipients and their families.
        - Helping the spouse of a visa recipient find employment.
        - Improving the cultural competency of the members of the community.

5. *Establish a rural scholarship program for medical students and other healthcare professionals willing to practice in rural Maryland.* The Maryland General Assembly should establish a rural scholarship for medical, dental, behavioral, and other healthcare professional students willing to practice in rural areas of Maryland. Eligibility should be open to all students admitted to health services programs in the State who agree to serve in rural areas of Maryland upon graduation. The scholarship program could be open to all students admitted to recognized programs in public and private higher education institutions, but a preference would be given to students that originated from a specific rural region and committed to return to that region. The main goal of these workforce initiatives should be increasing the availability of primary care. Specialty care is also important and the loss of direct access to specialists is often the first stage in a broader decline in access to care for residents in rural areas. Scholarships for specialists should be targeted toward obstetricians and general surgeons. The Rural Scholarship Program should be developed so that any funds awarded do not constitute taxable income under Maryland law and, to the extent possible, under federal income tax law. The General Assembly should consider whether the program is open to all students;

whether preference should be given to Maryland high school students; and whether there is a source of matching funds, such as local funds, which should be required.

6. *Develop and fund additional nurse practitioner and physician assistant programs in rural colleges and universities.* The need for efficient primary care in rural Maryland areas is a growing concern due to changing demographic trends (such as an aging population) and the shortage of primary care physicians. One approach to meeting the increased demand for primary care services is through the use of non-physician practitioners such as nurse practitioners (NPs) and physician assistants (PAs). In addition, these health care professionals can help increase care coordination to reduce hospitalizations and re-hospitalizations for elderly patients and others with chronic health conditions, resulting in decreased healthcare costs and better health outcomes. Programs should actively recruit individuals from rural areas for entry into the program. The federal Health Resources and Services Administration's (HRSA's) Advanced Education Nursing Traineeship Program provides funding to schools of nursing for student support for tuition, books, fees and living expenses needed by RNs to become NPs.

7. *Increase coordination of care through the use of care managers and patient navigators.* Care managers help ensure that patients' needs and preferences for health services and information are met over time, especially at points of transition. Care managers may assess patient needs and goals, help create proactive care plans, link patients to community resources, and support patients' self-management goals. Patient navigators advocate for patients, coordinate their care, and help remove barriers to accessing timely services.

Expand Transportation/Access to Care

1. *Establish a Special Rural Community Hospital (SRCH). This would be a small rural hospital consisting of an emergency department, an observation unit, and the capacity to provide inpatient and outpatient surgeries as well as inpatient care.* The SRCH would possess significant telehealth capability to support telehealth consults and assessments with patients outside of the hospital and with clinicians at regional and academic medical centers. Criteria for this category of facility will need to be developed that take into consideration the reality in rural Maryland. Although the Critical Access Hospital may be the closest federal analog, this designation is based on distance to another health facility, which is not ideal for rural parts of this state. In Maryland, particularly on the Eastern Shore, a better measure could be travel time.- The program should be established under the Maryland Health Services Cost Review Commission's (HSCRC's) broad authority to establish reasonable reimbursement for Maryland hospitals, or through a legislative mandate to create such a program.[10] To qualify, the hospital must specify concrete goals and its plans for implementing those goals. The plans could include initiatives for improving the quality of care and establishing expanded access to advanced primary care, thereby decreasing the number of avoidable

admissions, readmissions, and transfers. Any special designation should include sustainable funding and should be linked to measureable outcomes and milestones.

2. *Enhance dental health services to rural residents*. Create opportunities for dental and dental hygiene students to participate in an elective during their clinical training for a rural health rotation. Access to dental care is limited due to the size of the available workforce and availability of dental insurance coverage for vulnerable populations. Where possible, dental care should be integrated with primary care and with services for populations with chronic conditions. The approach used by the Choptank Community Health System is an example of successful integration of dental services with primary care.

3. *Expand the availability of new telehealth and mobile capacity. Implement new programs for telehealth that will support the development of rural health community complexes. Take projects to scale that have shown promise in telehealth and the Mobile* Health Pilot Program.

    - Increase broadband and "last mile" connectivity to include all sites of service, FQHCs, and Health Departments.
    - Establish a stable funding level for telehealth that is consistent with the recommendations in the Maryland Telemedicine Task Force Report from 2014.
    - Direct the MHCC to develop methodologies for identifying provider practices and healthcare organizations that are suitable for using telehealth services and the types of patients that respond to treatment through telehealth.

4. *Expand or Enhance Community Paramedicine and/or Mobile Integrated Health Care.* Sending paid emergency medical technicians (EMTs), paramedics, mid-level healthcare professionals, or community health workers into the homes of patients can help with chronic disease management and education, as well as post-hospital discharge follow-up, to prevent hospital admissions or readmissions, and to improve patients' experience of care. These healthcare workers can help patients navigate to destinations such as primary care, urgent care, dental care, mental health care services, or substance abuse treatment centers, instead of emergency departments, thus avoiding costly, unnecessary hospital visits. While the Workgroup members are very supportive of these programs, sustainable funding is a concern. At its last meeting, the Workgroup briefly discussed the need for EMS providers to be recognized as healthcare providers. Currently, EMS providers are reimbursed for the transportation, but not the healthcare services provided. If EMS providers could bill for health care services the sustainability concerns for the MICH programs could be resolved. Payers may have other concerns and this stakeholder group was not represented on the Workgroup. MHCC's Provider Payer workgroup or another broadly representative workgroup that includes payers should be convened to discuss options for funding MICH including allowing EMS to bill for health care services, EMS's participation in payers' networks, and other operational questions.

5. *Expand non-Medicaid and Non-Emergency Transportation*
    a. The State should promote the use of innovative approaches to non-emergent transportation in rural areas where transportation deficits are the most acute. Explore the use of commercial transport, such as Uber and Lyft. These approaches could include seeking a health department interested in establishing a demonstration to test the feasibility of a transportation service, or promoting the use of ride sharing technology.

    b. The Maryland Department of Health, in consultation with the Maryland Department of Transportation, should develop standards for non-emergency programs based on best practices for these programs. The Rural Health Delivery Workgroup found that reimbursement for non-emergency medical transportation is extremely uneven. Greater effort needs to be placed on equitable funding for non-emergency medical transport. Residents and local governments would benefit from this standardization. Regulatory and or statutory changes may be necessary.

<u>Fund Economic Development</u>

1. *Charge the Maryland Community Health Resources Commission (CHRC) with incubating pilot projects in rural communities to support of the Rural Community Health Complex Program.* The Workgroup believes that the CHRC could be an important incubator for local initiatives in the Rural Health Complex Demonstration. CHRC's past experience in funding similar efforts makes that organization uniquely qualified to assess and fund proposals that would be valuable to establishing these proposed Complexes. The Workgroup encourages the CHRC to commit a significant share of its funds to the establishment of the Mid-Shore Rural Health Complex. To serve as this key incubator, CHRC will need adequate funds and staff to support initiatives, both across the State and the proposed efforts in the Mid-Shore region. CHRC's current and historic funding levels should be reviewed to ensure that the Commission is well positioned to meet the goals of the demonstration without crowding out other priorities.

2. *Consider the Recommendations of the Workgroup on Workforce Development for Community Health Workers and Foster the Development of the Community Health Worker Programs at Maryland community colleges and federal Area Health Education Centers (AHECs.)* Community health workers are frontline public health professionals who are also trusted members in their communities and have an unusually clear understanding of the communities they serve. During its 2014 legislative session the Maryland General Assembly established the Workgroup on Workforce Development for Community Health Workers. That workgroup delivered its recommendations in June of 2015. Stakeholders should be brought back together to revisit the recommendations of the Workgroup on Workforce Development for Community Health Workers.

Link the Model to Broader Population Health Initiatives

Vulnerable Populations

- *Enhance Behavioral Health and Substance Abuse Services in the Community.* Enhancement of behavioral health services in the community through mobile integrated healthcare, telehealth, and Assertive Community Treatment (ACT) Teams can reduce mental illness, improve the well-being of residents in rural communities, and lower the total costs of care by eliminating costly emergency and hospital care. Healthcare organizations should be encouraged to break down the invisible and very real stigma associated with behavioral health conditions by establishing education programs for their staffs. Existing infrastructure and programs that are working, but underfunded, should be favored before new programs are launched.

- *Address health needs of the immigrant and elderly populations.* The immigrant and elderly populations in the Mid-Eastern Shore and other rural areas of Maryland are growing. These populations may be at increased risk for poor physical and mental health because of inadequate healthcare services due to:

    - Lack of transportation;
    - Inability to pay for services;
    - Poor health literacy;
    - Lack of culturally competent healthcare professionals;
    - Complex paperwork to gain access to services;
    - Immigration status and the need for having documentation in order to get services; and
    - Limited English proficiency and the lack of translation services.

    In order to improve the health status of vulnerable populations in rural areas and to address the concerns of these populations:

    - Expand and strengthen the safety net infrastructure;
    - Provide access to preventive care and health education;
    - Increase the use of patient navigators and care managers; and
    - Encourage the development of programs to increase culturally and Linguistically Appropriate Services (CLAS).

Conclusion

The formation of the Rural Health Workgroup and the commissioning of the rural health study demonstrate both the Governor's and the General Assembly's commitment to the health of rural Maryland. The Workgroup's recommendations are but the first step in the effort to improving access to healthcare in rural areas.

Among the most important of the Workgroup's guiding principles are the commitments to empower Mid-Shore residents to be active participants in their health decisions and to join together to build a healthcare system in which all residents, regardless of their place residence, have access to appropriate and high quality care. These key principles are anchored in many of the Workgroup's recommendations. They are most visible in the two foundational recommendations: the creation of a rural health collaborative and the formation of health care complexes.

In Workgroup meetings, in focus groups, and at public hearings, the two most commonly voiced requests were to involve communities earlier and more directly in the design of their healthcare and to enable residents to have a point of contact with the healthcare system in their own community. For many communities, that will mean access to robust primary care services, in other larger communities, that will mean access to a broader array of services. In every instance, there is also recognition by the Workgroup members that some acute care services would be best accessed at a tertiary, or quaternary, medical center. The Workgroup members recognize the need for collaboration and coalition building in small communities. Solutions need to take into account the ability of the local community residents to recognize their own needs.

The Workgroup members discussed the possibility that all recommendations could not be achieved at once. Recommendations build on each other and may be implemented in several stages. Establishing a foundation for further collaboration and coalition formation is key to the success of these endeavors. Providing a framework for the establishment of the rural collaborative is an essential step for launching further reform. Maryland's five county Mid-Shore area is fortunate to have a well-established local health improvement coalition—or LHIC—which should provide the initial infrastructure for the rural collaborative. In 2018, the Maryland General Assembly could act by designating the Mid-Shore LHIC as the region's rural collaborative. A limited amount of funding will be needed and that funding could be obtained through the CHRC or another funding source.

A second broad need requiring immediate attention is expanding the health care workforce. The Workgroup members emphasize that the workforce deficits have developed over many years and that a single program alone is unlikely to have significant impact. Many of the recommendations of the Workgroup cannot be achieved without an expanded workforce.

Addressing these workforce deficits in order to improve access to care and enable rural communities to participate in the health delivery reforms envisioned under the TCoC Demonstration will require multiple programs. Some of the Workforce recommendations require immediate action but can be launched under current law. Others require the

collaboration of health systems. The Workgroup members hope that other workforce recommendations that require statutory changes will have broad support in the General Assembly.

In order to fully realize the goals of these recommendations, it is imperative that both the State and local communities commit to improving access and quality of care. Though rural communities across the State are similar in some of their deficiencies, such as lack of public transportation options, limited resources, and workforce shortages, each community is unique. Any solution needs to be flexible and take into account each unique community's attributes. Local government representatives and interested community members should have seats at the table when formulating the Rural Community Complex and the Rural Health Collaborative.

As State policymakers consider the next steps in moving forward, the importance of gathering information and documenting success will be important. The Workgroup members recognize the significant budget challenge associated with any initiative. Although the Workgroup members believe the investments in rural health will yield significant dividends, there are benefits to launching new programs on a pilot test basis, followed by conducting research to learn from the pilot test. When a test program yields no benefits, the State policymakers should not hesitate to modify or eliminate the program in the test phase. If the pilot yields meaningful results, successful interventions should also be tested in non-rural settings because many problems in rural communities have parallels in suburban and urban communities. If we adopt a framework for demanding evidence of success, Maryland will go a long way toward ensuring that new programs resulting from these recommendations have real impact on people's lives. As SB 707 intended, the Mid-Shore can serve as the important "test ground" for rural health improvement and, perhaps, for health improvements across Maryland.

AlzheimersAssoc_FAV_SB501
Uploaded by: Colchamiro, Eric
Position: FAV

Position of the Alzheimer's Association, Greater Maryland and National Capital Area chapters on

SB 501 – Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding

Position: SUPPORT

===

February 13, 2020

Dear Chairman Pinsky and Vice-Chair Kagan,

This letter is in support of SB 501: Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants, sponsored by Senators Griffith and Hershey. This legislation includes provisions which: transfers oversight of the Maryland Loan Assistance Repayment Program to the Department of Health; requires an annual report on the program; and restores funding to at least $750,000, to support additional medical specialists in high need areas.

There are currently over 110,000 Marylanders, and countless other caregivers, who face the cruel impacts of Alzheimer's Disease and related dementia. That number is expected to grow by over 18 percent in the next five years. As our state faces this dramatic increase, there is a significant shortage of medical specialists—including geriatricians—to care for them.

Geriatricians are primary care physicians who have additional training in geriatrics, and are typically prepared to manage multiple chronic conditions. Only a small percentage of healthcare professionals enter geriatrics because of the extra years of training required, and its comparatively low reimbursement rates to other medical specialties, as Medicare is typically its primary payer (as opposed to traditional private healthcare insurance). With the heavy burden of student loan debt medical students face upon graduation, there are disincentives to choose a career in geriatrics, and a workforce gap has emerged.

The Maryland Loan Assistance Repayment Program (MLARP) can make a difference and encourage more geriatricians to be educated in Maryland, and stay in Maryland to provide care. It will make a difference because MLARP awardees allows providers to practice in a rural or medically underserved area (MUA); there are 46 MUAs in Maryland, which are based on factors including a high number of senior citizens. As one out of three seniors dies of dementia, incentives for geriatric care in areas where they are concentrated matter.

I urge a favorable report on SB 501. If you have any questions, please contact our Director of Government Relations Eric Colchamiro at ercolchamiro@alz.org.

Sincerely,

Cass Naugle
Executive Director
Alzheimer's Association, Greater Maryland Chapter

KeithFanjoy_FAV_SB0501
Uploaded by: Fanjoy, Keith
Position: FAV

BESTER COMMUNITY OF HOPE Logic Model Diagram

Ultimate Goal: Kids are safe and nurtured, families are strong and resilient, and neighborhoods are connected and thriving through a collaborative primary prevention approach in the Bester community.

Target Population: Children and families in the Bester neighborhood.

Domain	Inputs	Strategies	Outputs	Outcomes	Assumptions
COLLECTIVE IMPACT	San Mar Family Bester Community of Hope (BCOH): * Executive Director * Care Coordinator * Executive Council * Sustainability Committee * External Evaluator * Interns/ Volunteers Funding Sources Community Partners	Parent, resident, student, and stakeholder voice via committees Personnel & financial management Data collection & reporting Capacity building Partnership agreements BCOH active role in partner initiatives (e.g. Homeless Coalition) Child Fatality Prevention Team	# of committee meetings # of new & existing partnerships Surveys by domain Development or expansion of funding mechanisms # of hours provided by interns/ volunteers # of active partnerships # of initiative meetings/ events attended/ participated in	Families and communities are meeting their own needs Decrease incidents of maltreatment Decrease child fatality Increase protective factors Increase use of data driven decision-making Increase overall well-being	All people have inherent worth & strengths therefore must have equitable access to opportunities. Families are the experts and forward motion is a choice. Relationships are the primary agent of change because we are hardwired to connect. Protective factors prevent and/or mitigate risk factors. People can work together which will maximize effectiveness and efficiency. Trauma significantly impacts individual, family, and community well-being. BCOH staff will adhere to their responsibilities as mandated reporters and public child welfare will assume the primary role in ensuring child safety (e.g. investigations) Primary prevention activities can mitigate stigma associated with accessing support
FAMILIES	Clinical Family Support Worker Lead Family Support Worker Family Support Worker Parent Advisory Committee Substance Exposed Newborn Care Team	Community Triage Services: * Check and Connect * S.T.E.P.S * S.A.F.E.-T. Primary Prevention Opportunities * Parent Cafes * H.O.P.E. * That Family Thing	# of families served Characteristics of families served # of service connections # of services provided PAPF scores (pre/ post) FAST scores (pre/ post) # of families transitioned/ reason # of CPS reports made # of group sessions provided # of incidents of maltreatment in neighborhood # of children removed & served in foster care	Increase family protective factors & parental capacities Decrease incidents of maltreatment Decrease utilization of foster care Decrease child fatality	
NEIGHBORHOOD	Neighborhood Partnership Coord. Community Advisory Board Neighborhood Ambassadors Volunteers South End Faith Network	Neighborhood Leadership Neighborhood Development Environmental Improvements Walking School Bus Community Data Portal	# of community events # of Neighborhood Ambassadors # of impact projects # of citizens leaders trained Data access	Decrease in violent crimes Increase in citizen leadership Increase in informal/ natural supports Increase in resident sense of well-being	
SCHOOLS	Director of Education Site Coordinators Program Support Staff Education Steering Committee Teachers/ Facilitators	South End 21- After-school Program Trauma Informed school culture School based health center Therapeutic Mentoring	# of children served # of partnerships Participation in family events # of trainings provided # of individual/ group sessions	Increase school attendance Increase child school attachment and performance Increase parental connections Increase positive school culture	

KeithFanjoy_FAV_SB0501
Uploaded by: Fanjoy, Keith
Position: FAV

bester community of HOPE

A SAN MAR INITIATIVE

A collective impact model focused on prevention with a place-based strategy for positive outcomes for the children and families located in the Bester Elementary School neighborhood in Hagerstown, Maryland.

Well-being of Children, Families, & Communities

Schools
Director of Education Services

Caring School Communities

School-Based Health Centers

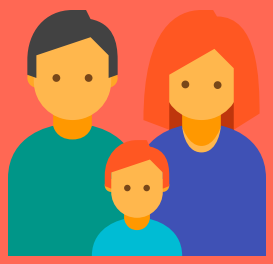
Therapeutic Mentoring

Small Therapeutic Groups

21st Century Community Learning Centers: South End 21

Walking School Bus

Families
Family Support Workers



H.O.P.E

Home Visiting Family Support

Substance Exposed Newborns Care Efforts

Family Day

Parent Advisory Comm.

Parenting Education & Support

Centralized Data Portal

Community Trainings

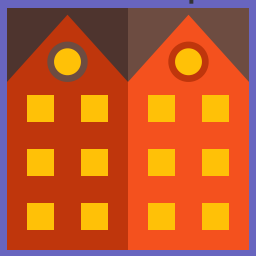
Community Coffee Hour

Community Adv. Bd.

Block Party

Babypalooza

Neighborhood
Neighborhood Partnership Coordinator



Cupcakes & Convo

Neighborhood Leadership

Neighborhoods First Groups

Environmental Projects

SAN MAR FAMILY AND COMMUNITY SERVICES

www.besterhope.org

www.sanmarhope.org

JohnsHopkins_Elizabeth_FAV_SB501
Uploaded by: Hafey, Elizabeth
Position: FAV

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

SB 501
Favorable

TO: The Honorable Paul Pinsky, Chair
Senate Education, Health, and Environmental Affairs

FROM: Elizabeth A. Hafey
Assistant Director, State Affairs
John Hopkins University and Johns Hopkins Medicine

DATE: February 13, 2020

Johns Hopkins supports **Senate Bill 501 Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding**. SB 501 will improve the efficiency of the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants (Program) and enhance Maryland's ability to respond to a growing demand for primary care physicians in underserved and rural areas. This bill seeks to restore the funding to, at least, the fiscal year 2016 level of $750,000.

Loan repayment is an immensely effective recruitment and retention tool for primary care physicians. Johns Hopkins University School of Medicine makes every attempt to minimize tuition costs for medical students. Nevertheless, most medical students graduate with substantial debt, and subsequently face additional years of training and mounting expenses. Loan forgiveness programs have proven to attract physicians to shortage areas and to specialties that are in short supply, such as primary care. Otherwise, many physicians will continue to choose higher paying specialties. Johns Hopkins strongly supports efforts to employ this strategy in order to meaningfully and quickly begin to have an impact on the physician workforce shortages affecting Maryland citizens.

Maintaining or bolstering the debt reduction options for physicians will encourage physicians to enter primary care. Over the years, primary care physician (family medicine, internal medicine, pediatrics, geriatrics, emergency medicine, and psychiatry) shortages have worsened, and will only continue to deteriorate. The national primary care physician shortage causes all health systems, including Johns Hopkins, to have continual vacancy rates that is usually five to ten percent. Consequently, these issues disproportionately affect medically underserved areas. For example, at least seven of Johns Hopkins Community Physician (JHCP)'s sites have the designation as a Primary Care Health Professional Shortage Area and/or is medically underserved area. Those sites include East Baltimore Medical Center, Canton, Johns Hopkins Bayview, Remington, Brandywine, Westminster, and Greater Dundalk. Recruitment can be very challenging at these sites. Sometimes, filling these vacancies may take up to two years.

Furthermore, this primary care shortage disrupts access to patient care, affects the quality of patient care, and can negatively impact the remaining health care providers. Having fewer physicians for more patients may result in safety concerns for the patient. This may lead to higher use of urgent care or emergency services. Ultimately, continuing to bolster this

Program will enable Johns Hopkins to attract and retain primary care physicians in shortage areas.

Johns Hopkins urges a **favorable report on Senate Bill 501 – Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding.**

cc: Members of the Senate Education, Health, and Environmental Affairs
Senator Paul G. Pinsky

UMMS_Ken Kozel_FAV_SB501
Uploaded by: Kozel, Ken
Position: FAV

Maryland
Hospital Association

Senate Bill 501 – Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants - Administration and Funding

Position: *Support*
February 13, 2020
Senate Education, Health & Environmental Affairs Committee

MHA Position

Maryland's 61 nonprofit hospitals and health systems care for millions of people each year, treating 2.3 million in emergency departments and delivering more than 67,000 babies. The 108,000 people they employ are caring for Maryland around-the-clock every day—delivering leading edge, high-quality medical service and investing a combined $1.75 billion in their communities, expanding access to housing, education, transportation, and food.

Recruiting and retaining a robust workforce is a major factor in the vitality of hospitals and health systems, the success of the Maryland Model and our ability to ensure all Marylanders have access to the care they need. That is why hospital leaders identified workforce as the No. 1 fieldwide priority to promote the health and well-being of our communities. By 2030, many of Maryland's 24 jurisdictions are projected to have shortages in primary care and mental health providers.[i] Despite having world-renowned medical schools here, we are a net exporter of physicians—losing 60% of our medical graduates every year.

Since 1992, Maryland has participated in the Health Resource and Service Administration's federal grant program which incentives physicians and physician assistants to practice in federally-designated health professional shortage areas (HPSAs). In exchange for a two-year service commitment, eligible providers can receive thousands of dollars to pay back their student loan debt.[ii] States can apply for up to $1 million to administer their own State Loan Repayment Program (SLRP) but must match every federal dollar received. Since the SLRP is a mix of federal and state funds, Maryland allocates funding for this program first. Any remaining funding is allocated to the Maryland Loan Assistance Repayment Program (MLARP). SLRP applicants must comply with federal eligibility criteria. In contrast, the state has the flexibility to broaden the applicant pool and address specific workforce shortages by allowing additional physician specialties, such as emergency physicians, and sites such as medically underserved areas.

Senate Bill 501 is an investment in keeping physicians trained in Maryland, working in Maryland—improving access to care, especially in rural and underserved areas. Maryland has seen promising results. A 2017 survey showed 83% of loan assistance recipients stayed in state or at their current site after completing their two-year service requirement.[iii] Unfortunately, contributions to MLARP have decreased from the original funding level to $400,000 despite growing demand and a high number of eligible applicants. This means the state is not capturing

the additional $600,000 federal dollars that could be used to attract and keep physicians. In fiscal years 2019 and 2020, more than 100 eligible applicants were denied loan assistance due to lack of funding.

Choosing to increase funding now allows the state to take full advantage of the federal matching dollars for the next four-year grant award in 2022. Currently, the state contributes funding annually, either through an appropriation by the Governor or through the Maryland Board of Physicians' licensure and renewal fees.[iv] Although at one time, utilization of the hospital rate setting system was considered a potential funding source, the Centers for Medicare & Medicaid Services rejected this request. The Total Cost of Care Model prohibits the rate setting system from being used for this purpose as referenced in Section 8.a.iii.2. However, hospitals are committed to working with the state to explore alternative, long-term funding sources. SB 501 would support this next step by establishing a stakeholder work group to explore ways to expand the program while ensuring funding sustainability.

This legislation would also centralize oversight of the loan repayment program which is currently shared between MDH and the Maryland Health Education Commission. Transitioning the program to be solely under MDH will improve the state's efficiency and make it easier to navigate for physicians. Since a majority of the administrative functions are already handled by MDH, this is expected to be a seamless transition.

Passage of SB 501 would allow the state to leverage a powerful, existing program to retain and recruit primary care, behavioral health and other specialty physicians—expanding access to care in underserved and rural areas. We are asking the state to invest in our health care workforce. By doing so, we are also investing in the health of all Marylanders.

For these reasons, we urge a ***favorable*** report.

For more information, please contact:
Nicole Stallings
Nstallings@mhaonline.org

[i] IHS Markit. (September 20, 2018). Maryland Primary Care and Selected Specialty Health Workforce Study: Study Methods and Findings
[ii] Health Resources & Services Administration. (February 28, 2018). State Loan Repayment Program (SLRP): Notice of Funding Opportunity
[iii] Maryland Department of Health, Office of Workforce Development. (n.d.). HRSA 18-011 State Loan Repayment Program, CFDA No. 93.165

LifeBridgeHealth_Martha_FAV_SB501
Uploaded by: Nathanson, Martha
Position: FAV

LIFEBRIDGE HEALTH®

CARE BRAVELY

SB501 - Maryland Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding
Senate Education, Health, and Environmental Affairs Committee – February 13, 2020
Testimony of Martha D. Nathanson, Vice President, Government Relations and Community Development, LifeBridge Health
Position: **SUPPORT**

I am writing in strong SUPPORT of SB501. LifeBridge Health is a regional health system comprising Sinai Hospital of Baltimore, Levindale Geriatric Center and Hospital in Baltimore; Northwest Hospital, a community hospital in Baltimore County; Carroll Hospital, a sole community hospital in Carroll County, and; Grace Medical Center in Baltimore (formerly Bon Secours Hospital). Sinai Hospital, our flagship center, is an "independent academic medical center (IAMC)." In addition to graduate medical education provided at teaching hospitals and integrated delivery systems that are either owned by or affiliated with medical schools, physician education is thriving at institutions affiliated with, but not governed by, medical schools. It is helpful to think of IAMCs as hybrid entities - community hospitals and systems sponsoring medical residency programs fully accredited by the Accreditation Council for Graduate Medical Education (ACGME).

This hybrid type of provider brings a level of care that otherwise may not be accessible – from primary care to specialty and subspecialty care, including research. The intense "real world" focus on translational diagnosis/prognosis/treatment rather than on pure science and lab work assures enhanced access. Sinai Hospital operates residency programs in the following practice areas:

- General Surgery
- Internal Medicine
- Obstetrics and Gynecology
- Ophthalmology
- Pediatrics
- Physical Medicine and Rehabilitation

While each area provides specialty and tertiary care, three of the areas – Internal Medicine, Obstetrics and Gynecology, and Pediatrics – focus on primary care. Residents are a key element of staffing at ALL of our facilities, either providing direct patient care or consults as needed, those being done either in person or through telehealth. They are joined in patient care by physician assistants, nurses and various types of technical personnel, as well as community physicians who practice at all our hospitals. The residents, physicians and physician assistants so noted will benefit from the opportunities presented in SB501, and given the nature of our work in medically underserved communities such as West and Northwest Baltimore City as well as parts of Western Baltimore County, will be incentivized to remain in Maryland to continue to serve these communities.

For all the above stated reasons, we request a **FAVORABLE** report for SB501.

MedStarHealth_VPurnell_FAV_SB501
Uploaded by: Purnell, Vanessa
Position: FAV

MedStar Health

10980 Grantchester Way
Columbia, MD 21044
410.772.6500 PHONE
410.715.3754 FAX
medstarhealth.org

SB 501 - Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants - Administration and Funding

Position: *Support*

Bill Summary

SB 501 would improve the efficiency of the state's loan repayment program and enhance Maryland's ability to respond to a growing demand for physicians and physician assistants in the underserved areas by:

- Centralizing oversight of the Loan Assistance Program to Maryland Department of Health
- Evaluating opportunities to expand loan repayment assistance to first- and second-year medical residents so physicians trained in Maryland stay in Maryland
- Restoring funding to at least the fiscal year 2016 level of $750,000

Position Rationale

Since 1992 Maryland has received federal funding to operate a State Loan Repayment Program (SLRP). The program helps primary care and behavioral health care providers pay off their student loans in exchange for a commitment to work in health workforce shortage areas for a minimum of two years. States participating in this program must contribute funds to match each federal dollar received. Failing to provide those matching dollars leaves federal dollars on the table, up to $1 million can be requested.

The Maryland LARP promotes the expansion of the workforce needed to ensure that all Marylanders have access to a primary care. Currently, debt incurred by pursuing medical training (including leading up to, during and following medical school) serves as a barrier to addressing access challenges. To address these workforce challenges, Medstar Health supports efforts that assist in reducing the debt burden caused by those practitioners choosing to work in workforce shortage areas.

Prior to 2016, significantly more funds were available for the program. State funding for the Maryland LARP program decreased from $750,000 to its current level of $400,000 today. This decline has meant that in FY 2019 and FY 2020 there were more applicants who met eligibility criteria but were denied due to lack of funding.

This bill would streamline the administrative process by having only one regulatory agency with oversight for this program, and this bill restores this program to previous funding levels of $750,000 which allows the state to draw down more federal money and thus provide more funding for physicians.

For the above stated reasons, MedStar Health requests a ***favorable*** report.

MarshallRock_FAV_SB501
Uploaded by: Rock, Marshall
Position: FAV

WASHINGTON COUNTY
MENTAL HEALTH AUTHORITY, INC.
339 East Antietam Street, Suite 5
Hagerstown, Maryland 21740
Telephone: (301) 739-2490
FAX: (301) 739-2250
E-mail: wcmha@aol.com

Marshall Rock, LCSW-C
Executive Director

February 12, 2020

Senator Andrew Serafini,
Washington County District 2
James Senate Office Office Building, Room 321
11 Bladen St.
Annapolis, MD 21401

Dear Senator Serafini,

Thank you for the opportunity to submit testimony for Senate Bill 501, Maryland Loan Assistance Repayment Program for Physicians and Physician 2 Assistants – Administration and Funding.

An examination of data provided by the Maryland Department of Health, Behavioral Health Administration, has shown a steady increase in the number of Washington County residents who are seeking behavioral health treatment. Washington County continues to have a high level of poverty and has not kept pace with the rest of the State in economic recovery since the most recent recession. According to Fiscal Year 2017 data, Washington County ranked 7th in the State of Maryland for all ages in total percent of population in poverty. In FY 19, 44,326 Washington County residents, or 29.4% of the total County population, were eligible for Medicaid benefits. Maryland Department of Health data shows that as of September 30, 2019, of the 44,326 Washington County residents, 8,772 individuals received some type of service through the Public Behavioral Health System for behavioral health treatment covered by Medicaid. The Medicaid Penetration Rate is the percent of people who have Medicaid insurance coverage and are accessing behavioral health treatment. The Medicaid Penetration Rate for FY 19 for Washington County residents was 19.8% compared to the State average of 15.3%.

An article in Health e Careers, June 27, 2019, "The Truth about the Psychiatrist Shortage" cited that a national physician recruiting firm reported that the most recent numbers from 2018 revealed that for the third consecutive year, "psychiatrists were second on the list of most requested recruiting assignments, reflecting a severe shortage of mental health professionals nationwide."

In addition, that same article reports that "the Association of American Medical Colleges (AAMC) documented in its comprehensive April 2019 report on physician supply and demand, the situation is

quite dire. In 2017, approximately 13.55 million adults reported an unmet need for mental health services and one in five people couldn't find treatment but instead found barriers to getting it."

AAMC also "determined that 5,906 psychiatrists were needed in 2017 to fill the gap, leaving demand at 13.5 percent more than supply. Using predictive modeling, the organization predicts a shortage of 3,400 psychiatrists by 2032."

Washington County residents experience challenges in accessing specialized behavioral health services due to the rural nature of the County. Behavioral health providers in Washington County have difficulty recruiting physicians and physician's assistants with specific training in that field of treatment. Washington County has difficulty recruiting against the metropolitan areas for physicians specializing in behavioral health due to a perceived lack of cultural advantages in rural areas.

Due to the demand of increasing behavioral health needs in Washington County, the predicted shortage of psychiatrists in the coming years, and the difficulty recruiting psychiatrists to Washington County, a "perfect storm" is occurring that will greatly impact the quality of life for Washington residents and the health of the County overall.

Senate Bill 501 is primarily focused on incentivizing physicians and physician's assistants engaged in primary care or medical residents specializing in primary care who agree to practice in a geographic area of the State that has been designated by the Secretary as being medically underserved. The result of this bill may assist with relieving some of the impact of the predicted psychiatry shortage by providing an alternative for primary behavioral health issues to be addressed at the primary care level which may head off more serious, chronic behavioral health needs.

Thank you for the opportunity to provide this testimony.

Sincerely,

Marshall Rock
Director

MHA_NicoleStallings_FAV_SB501
Uploaded by: Stallings, Nicole
Position: FAV

Maryland
Hospital Association

Senate Bill 501 – Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants - Administration and Funding

Position: *Support*
February 13, 2020
Senate Education, Health & Environmental Affairs Committee

MHA Position

Maryland's 61 nonprofit hospitals and health systems care for millions of people each year, treating 2.3 million in emergency departments and delivering more than 67,000 babies. The 108,000 people they employ are caring for Maryland around-the-clock every day—delivering leading edge, high-quality medical service and investing a combined $1.75 billion in their communities, expanding access to housing, education, transportation, and food.

Recruiting and retaining a robust workforce is a major factor in the vitality of hospitals and health systems, the success of the Maryland Model and our ability to ensure all Marylanders have access to the care they need. That is why hospital leaders identified workforce as the No. 1 fieldwide priority to promote the health and well-being of our communities. By 2030, many of Maryland's 24 jurisdictions are projected to have shortages in primary care and mental health providers.[i] Despite having world-renowned medical schools here, we are a net exporter of physicians—losing 60% of our medical graduates every year.

Since 1992, Maryland has participated in the Health Resource and Service Administration's federal grant program which incentives physicians and physician assistants to practice in federally-designated health professional shortage areas (HPSAs). In exchange for a two-year service commitment, eligible providers can receive thousands of dollars to pay back their student loan debt.[ii] States can apply for up to $1 million to administer their own State Loan Repayment Program (SLRP) but must match every federal dollar received. Since the SLRP is a mix of federal and state funds, Maryland allocates funding for this program first. Any remaining funding is allocated to the Maryland Loan Assistance Repayment Program (MLARP). SLRP applicants must comply with federal eligibility criteria. In contrast, the state has the flexibility to broaden the applicant pool and address specific workforce shortages by allowing additional physician specialties, such as emergency physicians, and sites such as medically underserved areas.

Senate Bill 501 is an investment in keeping physicians trained in Maryland, working in Maryland—improving access to care, especially in rural and underserved areas. Maryland has seen promising results. A 2017 survey showed 83% of loan assistance recipients stayed in state or at their current site after completing their two-year service requirement.[iii] Unfortunately, contributions to MLARP have decreased from the original funding level to $400,000 despite growing demand and a high number of eligible applicants. This means the state is not capturing

the additional $600,000 federal dollars that could be used to attract and keep physicians. In fiscal years 2019 and 2020, more than 100 eligible applicants were denied loan assistance due to lack of funding.

Choosing to increase funding now allows the state to take full advantage of the federal matching dollars for the next four-year grant award in 2022. Currently, the state contributes funding annually, either through an appropriation by the Governor or through the Maryland Board of Physicians' licensure and renewal fees.[iv] Although at one time, utilization of the hospital rate setting system was considered a potential funding source, the Centers for Medicare & Medicaid Services rejected this request. The Total Cost of Care Model prohibits the rate setting system from being used for this purpose as referenced in Section 8.a.iii.2. However, hospitals are committed to working with the state to explore alternative, long-term funding sources. SB 501 would support this next step by establishing a stakeholder work group to explore ways to expand the program while ensuring funding sustainability.

This legislation would also centralize oversight of the loan repayment program which is currently shared between MDH and the Maryland Health Education Commission. Transitioning the program to be solely under MDH will improve the state's efficiency and make it easier to navigate for physicians. Since a majority of the administrative functions are already handled by MDH, this is expected to be a seamless transition.

Passage of SB 501 would allow the state to leverage a powerful, existing program to retain and recruit primary care, behavioral health and other specialty physicians—expanding access to care in underserved and rural areas. We are asking the state to invest in our health care workforce. By doing so, we are also investing in the health of all Marylanders.

For these reasons, we urge a ***favorable*** report.

For more information, please contact:
Nicole Stallings
Nstallings@mhaonline.org

[i] IHS Markit. (September 20, 2018). Maryland Primary Care and Selected Specialty Health Workforce Study: Study Methods and Findings
[ii] Health Resources & Services Administration. (February 28, 2018). State Loan Repayment Program (SLRP): Notice of Funding Opportunity
[iii] Maryland Department of Health, Office of Workforce Development. (n.d.). HRSA 18-011 State Loan Repayment Program, CFDA No. 93.165

BenSteffen_MHCC_FAV_SB501
Uploaded by: Steffen, Ben
Position: FAV

Andrew N. Pollak, MD
CHAIRMAN

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

2020 SESSION
POSITION PAPER

BILL NO: **S.B. 501**
COMMITTEE: **Education, Health, and Environmental Affairs**
POSITION: **SUPPORT**

TITLE: Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants - Administration and Funding

BILL ANALYSIS: Transferring oversight of the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants from the Office of Student Financial Assistance within the Maryland Higher Education Commission to the Maryland Department of Health; requiring the Department, on or before a certain date each year, to submit a certain report to the General Assembly; altering certain provisions of law related to funding for the Program; requiring the Comptroller, in certain fiscal years, to distribute certain fees in a certain manner for a certain purpose if the Governor does not include a certain amount of funding for the Program in the State budget; requiring the Comptroller to distribute certain fees to the Board of Physicians Fund if the Governor includes in the State budget a certain amount of funding for the Program; requiring the Department to convene a certain workgroup; providing for the duties of the workgroup; requiring the workgroup to submit a certain report to the General Assembly on or before a certain date; and other changes generally relating to the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants.

POSITION AND RATIONALE:
The Maryland Health Care Commission (the "Commission") supports Senate Bill 501 for two reasons: 1) this bill aligns with recommendations that the Workgroup on Rural Health Delivery made to the Commission in 2017 and 2) this bill helps address geographic disparities in health care access identified in a 2018 study of projected workforce supply.

In the 2017 report "Transforming Maryland's rural healthcare system: A regional approach to rural healthcare delivery", the Workgroup on Rural Health Delivery recommended to the

Note: The Maryland Health Care Commission is an independent State agency, and the position of the Commission may differ from the position of the Maryland Department of Health.

Maryland Health Care Commission that the General Assembly should streamline the management if the State Loan Repayment Assistance Program (LARP) by centralizing oversight of the program in either the Maryland Higher Education Commission or the Maryland Department of Health. S. B. 501 centralizes this program in the Maryland Department of Health. The 2017 report also recommends creating or extending tax credits, loans, or grant opportunities for providers to practice in rural communities. S. B. 501 expands the funding available under LARP.

In 2018, the Commission conducted a workforce study focused on primary care providers, behavioral health care providers, and selected specialty types (including obstetrics/gynecology). This study modeled demand and supply for these provider types through 2030. Maryland's population is projected to grow 9 percent between 2016 and 2030 and the population age 65 and older will grow 52 percent.

This study showed that Maryland has a sufficient supply of primary care physicians as of 2017, but that the demand for primary care physicians may outpace supply (depending on assumptions in the model) in the near future.[1] However, the supply of nurse practitioners and physician assistants working in primary care is expected to expand in the near term, so that the overall primary care provider workforce is expected to be adequate (under all assumptions tested in the model in this study) within the next five years.

In addition to modeling state-wide supply of health practitioners in primary care, this study looked at the geographic distribution of supply. There are substantial differences in the projected adequacy of primary care physician supply by county.

The study also looked at women's health providers (obstetrics and gynecologists and women's health nurse practitioners) and found inadequate supply beginning in the next few years, as well as geographic disparities in supply.

Looking at behavioral health, the State currently has enough psychiatrists and psychologists to meet current demand. However, behavioral health care is underutilized. If demand increased to meet even 20 percent of currently unmet need, than the supply of these behavioral health providers would be insufficient in the next few years.

SB 501, by providing loan repayment for providers who practice primary and behavioral health care in underserved areas in the State, can help limit disparities in health care access between geographic areas in the State and improve healthcare access.

The Commission recommends a favorable report on SB 501.

[1] The demand for family practice physicians is much larger than supply for the whole 2016-2030 time period covered by the study.

Note: The Maryland Health Care Commission is an independent State agency, and the position of the Commission may differ from the position of the Maryland Department of Health.

UMMS_Tiffany Sullivan_FAV_SB501

Uploaded by: Sullivan, Tiffany
Position: FAV

Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding
Senate Bill 501

Before the Education, Health, and Environmental Affairs Committee

February 13, 2020
Position: Support

Good afternoon and thank you for the opportunity to share my support for Senate Bill 501. I am Tiffany Sullivan and I serve as Senior Vice President for Clinical Integration and Ambulatory Services for the University of Maryland Capital Region Health. I relocated to Maryland in 2016 and have experience recruiting primary and specialty care providers in South Carolina and Maryland.

Residents living in rural communities face disparities that result worse health care than that of urban and suburban residents. Residents face challenges including few local providers and remote locations that contribute to lack of access to care. Traveling long distances to reach a health care provider could mean our residents have to take hours off from work for an initial appointment or follow-up, which may cause many to delay or avoid care.

The passage of SB 501 would significantly help to address concerns related to healthcare provider shortages in rural areas but could also pave the way for solutions to extend difficult to recruit specialists to rural areas. This bill would increase the funding for the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants (LARP) and transfer oversight of the program from the Maryland Higher Education Commission to the Maryland Department of Health. It would require the Governor to include at least $400,000 in the State Budget for the program for each of fiscal years 2019 through 2021, and increasing the amount to $1,000,000 in fiscal year 2022 and each year after. This Bill would also require the Department of Health to submit a report to the General Assembly detailing the number of physicians and physician assistants who applied to the program.

LARP provides financial assistance to physicians, physicians completing residencies, and physician assistants practicing in designated geographic areas. The goal of the program is to mitigate the healthcare provider shortages in rural and underserved regions of the state by alleviating some of the financial burdens new doctors and providers face in repaying their student loan debt. According to a 2016 National Health Service Corps participant survey (most recent available data), 88% of participating clinicians remained at their practice obligation site for up to one year after their obligation, and 43% intend to remain for 5 or more years. Scholarships and loan repayment programs are effective in achieving long-term retention of physicians in the communities they serve. For these reasons, we urge a favorable report on Senate Bill 501.

Respectfully submitted,

Tiffany Sullivan, MPH
Senior Vice President, Clinical Integration and Ambulatory Services
University of Maryland Capital Region Health

AllenTwigg_LoS_SB0501
Uploaded by: Twigg, Allen
Position: FAV

Office of the Sheriff:
Washington County Sheriff's Office
500 Western Maryland Parkway
Hagerstown, MD. 21740-5199
Phone: 240-313-2100

Sheriff Douglas W. Mullendore

Major Craig Rowe, CJM
Warden
Office: 240-313-2121
Fax: 240-313-2152
Email: crowe@washco-md.net

TO: Judicial Proceedings Committee
FROM: Major Craig Rowe, CJM
Warden, Washington County Detention Center
DATE: February 13, 2020
RE: Senate Bill 356 - Possession of Medical Cannabis - Local Correctional Facilities and Home Detention Program - Prohibition

Position: SUPPORT

The Washington County Detention Center supports Senate Bill 356 which is designed to prohibit the possession of medical cannabis on the grounds of a local correctional facility or while an offender is in a home detention program.

Currently, there are provisions in the law that address the use or smoking Medical marijuana or cannabis. The prohibition includes public places, motor vehicles, private property rented from a landlord that decides to have a policy against the use, condominiums where the council of unit owners or a homeowners association may prohibit the use as well as in the State Prison Systems. We are supporting Senate Bill 356 so that the grounds of local correctional facilities and inmates under the supervision of Home Detention are included in the law so that possession or use is prohibited.

The majority of local correctional facilities within the State have their inmate medical services contracted with an outside vendor that cannot store or distribute the drug without violating Federal Law. The medical vendors cannot have marijuana or cannabis on their formulary as that is a violation of the Law. The practice of any type of prescription not on the formulary being accepted from an inmate's property, an inmate's family or caregiver ended long ago for security and safety reasons. There are numerous accounts of contra-band and medications being laced with CDS. The medical services professionals have many alternative treatments available and are relied upon to make professional medical decisions within a correctional facility.

In today's correctional environment it is not safe to allow medication to come into a facility other than from a pharmacy so there is no possible way for a correctional facility to provide marijuana or cannabis in any form. §13-3304 of the Health General Article provides that "a qualifying patient or caregiver may obtain medical cannabis only from a medical cannabis grower licensed by the Commission or a dispensary licensed by the Commission." There is no provision that anyone else may obtain the drugs.

The prohibition of any controlled substance including medical cannabis on the grounds of a correctional facility or for a participant in a home detention program is common sense legislation that Washington County supports. I respectfully ask that the Judicial Proceedings Committee Support Senate Bill 356 with a favorable report also.

MattDudzic_FWA_Board of Physicians_SB501

Uploaded by: Dudzic, Matt

Position: FWA

Maryland
DEPARTMENT OF HEALTH

Board of Physicians

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

2020 SESSION
POSITION PAPER

BILL NO:	**SB 501 – Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding**
COMMITTEE:	**Senate Education, Health and Environmental Affairs**
POSITION:	**Support With Amendments**

TITLE: **Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding**

BILL ANALYSIS:

SB 501 moves the administration of the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants ("MLARP") to the Maryland Department of Health ("the Department"), and creates annual reporting requirements for the program. SB 501 also increases the total fees contributed to the program by the Maryland Board of Physicians ("the Board") to $1 million annually beginning in Fiscal Year 2022. Finally, SB 501 establishes a stakeholder workgroup to further incentivize medical students to practice in medically underserved areas in Maryland.

POSITION AND RATIONALE:

The Board supports the expansion of MLARP and consolidating the administration of the program under one agency. The Board further supports the addition of new annual reporting requirements, which should allow the General Assembly to track the program's efficacy.

However, the Board has noted numerous issues with the program's administration since its inception in 1993 and would like to see a full audit of the program prior to any long-term increases in Board-contributed funds. Additionally, the Board has served as the sole source of funding for the program for almost three decades. The Board urges that the stakeholder workgroup explore new broader funding models to expand the scope of the program without requiring additional taxes on Board physicians and allied health professionals. Finally, the Budget Reconciliation and Financing Act of 2020 (SB 192 / HB 152) increases the Board's contributions to $1 million for Fiscal Year 2021. The Board recommends the completion of an audit and the workgroup prior to any permanent increase in Board contributions.

State and Federal Funding Sources

MLARP is funded by a combination of state funds and a federal matching grant from the National Health Service Corps. This federal grant, known as the State Loan Repayment Program ("SLRP"), will match up to $1 million in funds for loan repayment for physicians and other health professionals working in federally-designated health professional shortage areas ("HPSAs").

The current statute requires that the Board contribute funds to MLARP whenever the Governor does not allocate funds in the state budget. The Board is special-funded, and its budget comes entirely from licensing fees paid by Maryland physicians and allied health professionals. Only physicians and physician assistants are eligible for MLARP, but licensure fees from all of the practitioners licensed by the Board support the program (athletic trainers, radiographers, respiratory care practitioners, perfusionists, naturopathic doctors and polysomnographers)[1]. Since the program's inception in 1993, physicians and allied health professionals have contributed more than $20 million to support loan repayment[2].

It should be noted that the statute under the Education article states that the fund consists of *"[r]evenue generated through an increase, as approved by the Health Services Cost Review Commission, to the rate structure of all hospitals in accordance with § 19–211 of the Health – General Article."* It is the Board's understanding that hospitals contribute and fund the nursing support program in this way. However, despite the language already in statute, no similar assessment on hospitals is currently used to fund MLARP.

At this time, the Board's annual contribution to MLARP is set at $400,000 per Health Occupations (H.O.) §14-207. In addition, the Budget Reconciliation and Financing Act of 2020 establishes an additional transfer of $400,000 to the program for Fiscal Year 2021, as well as a $199,517 transfer to the Office of the Secretary in the Health Department to cover the cost of previous overpayments. Collectively, this will increase the Board's contribution to loan repayment in FY 2021 to roughly $1 million.

The proponents of SB 501 have argued that providing less than $1 million in available state funds is "leaving money on the table," as the National Health Service Corps may match up to that amount via the SLRP grant. However, MLARP is one of 43 states and U.S. territories currently utilizing this grant, and SLRP awards are based on total fund availability. To determine how these funds are distributed, the National Health Service Corps ranks each state's application. A review of the funds contributed by the Board compared to funds matched by SLRP has shown that the program has consistently failed to meet the full federal match even for the $400,000 that the Board is currently contributing, and all previous larger amounts dating back to 2013.

While the Board questions whether there is an immediate need for increased funding to MLARP given the 8-year reporting, the Budget Reconciliation and Financing Act should satisfy that request. However, before any increase is permanent, the program should be audited and any legislative workgroup should include exploring alternative funding models to ensure that the program is able to meet the full federal match.

---

[1] All licensees also pay a fee to the Maryland Healthcare Cost Commission (MHCC) for each renewal. In FY 18 and FY 19, Board licensees paid more than $1 million to MHCC.

[2] $10.6 million for MLARP from 1997 to 2018 and $9.5 million to HPSIG for the same period.

Alternative Models

There are currently more than 80 state support-for-service programs for health professionals across the United States. The SLRP grant alone provides federal monies to 43 state and U.S. territories. Many of these programs have unique funding and implementation models that MLARP could potentially utilize.

The SLRP grant will match any non-federal dollars for state-run loan repayment programs that benefit healthcare practitioners in HPSAs. These funds do not have to be limited to taxes and fees on healthcare practitioners. Their program will match dollars contributed from state appropriations, other state or local grants, hospital or school contributions, employer matching, private foundations and more. The largest and most successful programs in the country often have multiple sources of state funding. In fact, none of the six states that received the full $1 million SLRP match in 2019 utilize fees on practitioners at all.

Many state loan repayment programs differ in other ways beyond their funding models. For example, many states have strict eligibility requirements for participating sites, which allows those states to ensure all applicants will be working in areas with a high HPSA score. This in turn improves the state's application score when applying for the grant, and can help the state receive the full match from SLRP.

Another common feature of loan repayment programs includes detailed reporting requirements. While SB 501 requires the Department to submit an annual report to the General Assembly detailing participants, awards and other information, most states shift the burden of collecting that data to the participants by requiring quarterly or annual reports from grantees or participating sites. Some states even include elements such as exit surveys, site visits and more.

Finally, many state models include elements designed to increase the program's reach. For example, some states develop employer recruitment prerogatives and networks to help employers in rural or underserved communities connect with practitioners. Other states have programs geared toward reaching out to practitioners while they are still in medical school, allowing them to retain talented practitioners who are already working within the state.

In summary, there are a myriad of ways that MLARP can be made more robust and reach more people. Any legislative workgroup should focus on these elements, with any funding increases contingent upon their implementation.

Conclusion

Loan repayment is a valuable resource for physicians and physician assistants and can help bring health professionals to medically underserved communities. However, any expansion of the program should be accompanied by an audit and review of other models. Therefore, the Board urges a favorable report on SB 501 with the Board amendments.

Amendments Offered by the Maryland Board of Physicians

Amendment 1: Audit

The Board would support the addition of language requiring that the Office of Legislative Audits conduct a full audit of the Maryland Loan Assistance Repayment Program to evaluate the effectiveness and efficiency of the program and its management.

Rationale: *Due in part to its joint administration between two agencies, MLARP has never received a full legislative audit. In previous instances when the Board has requested information, the figures provided by the Department, the Maryland Higher Education Commission and the Health Resources and Service Administration have been inconsistent with each other. A legislative audit is necessary to resolve these issues before the program is expanded.*

Amendment 2: Remove Language Increasing Board Contributions

The Board recommends removing the language found on page 7, lines 29 through 38 and page 8, lines 1 through 7. This language currently increases the annual Board contributions to $1 million beginning in Fiscal Year 2022.

Rationale: *The Board believes that any permanent funding increases should not occur prior to the completion of an audit and investigation of ways to expand the program and incorporate other funding models. The Budget Reconciliation and Financing Act of 2020 increases the Board's contributions to MLARP for FY2021, raising the total fees assessed on the Board to $999,517. This temporary budgetary increase should serve to keep the program well-funded while the program is audited and alternate funding models are explored. However, permanently increasing contributions to this level would be unsustainable over the long-term and would eventually require an increase in health practitioner licensing fees.*

Amendment 3: Expand the Legislative Workgroup and Identify its Participants

The Board recommends adding additional language to Section 3, which creates a legislative workgroup to examine how Maryland can implement a program within or in addition to MLARP to further incentivize medical students to practice in HPSAs and medically underserved areas. In addition to the current requirements, the Board believes that the workgroup should also:

- examine and recommend alternative funding models utilized by other states and jurisdictions for state loan repayment, loan forgiveness, scholarships, tuition-reduction, state or local grants, hospital or school contributions, employer matching, private foundations, and
- examine and recommend increased application and reporting requirements for participating sites and grantees, and
- investigate other federal grants to further expand loan repayment and loan forgiveness for health professionals in Maryland, and
- include the Department, Board of Physicians, MedChi, Maryland Hospital Association and representatives from Johns Hopkins and University of Maryland medical schools as participants.

Rationale: *A review of other states currently participating in the National Health Services Corps SLRP grant shows that the most successful loan repayment programs in the country incorporate multiple funding sources and have built-in reporting requirements that increase transparency and efficiency for the program. A previous legislative task force recommended exploring these models in 2009*[3] *and a subsequent report from 2016*[4] *recommended creating a rural scholarship*

[3] "Task Force to Review Physician Shortages in Rural Areas Established Under Senate Bill 459 - Final Report and Recommendations," December 2008.

[4] "Transforming Maryland's rural healthcare system: A regional approach to rural healthcare delivery as required by Senate Bill 707 - Report of the Workgroup on Rural Health Delivery to the Maryland Health Care Commission," 2016.

program for medical students and other healthcare professionals and again recommended that MLARP be streamlined and expanded, but these recommendations were not implemented.

For more information, please contact Wynee Hawk, Manager, Policy and Legislation, Maryland Board of Physicians, 410-764-3786.

The opinion of the Board expressed in this document does not necessarily reflect that of the Maryland Department of Health or the Administration.

PHYSICIAN LOAN REPAYMENT: EXPLORING OTHER MODELS

A brief review of state and federal funding models for loan repayment programs for physicians and other health professionals.

MLARP FUNDING

*The Maryland Board of Physicians has been funding MLARP since 1993. A recent review of the program found that since 1997, MBP has contributed **$20,916,091.10**. MBP is currently required by statute to contribute $400,000 annually. All of these funds come **directly from licensing fees on physicians and allied health practitioners**.*

FEDERAL MATCHING

*Most state-operated loan repayment programs are structured around qualifying for federal grants. The most common grant source is the **NHSC Student Loan Repayment Program (SLRP)**, which provides cost-sharing grants for states to operate loan repayment programs for healthcare practitioners working in federally-designated health professional shortage areas (HPSAs). SLRP will provide dollar-for-dollar matching of all non-federal funds for state-administered loan repayment programs.*

LOAN REPAYMENT ACROSS THE COUNTRY

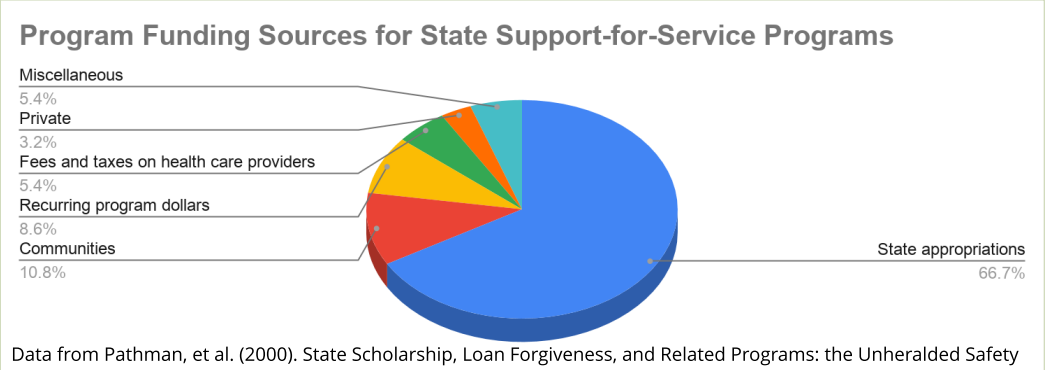
State-administered support for service programs are common across the country. SLRP currently lists 43 states and US territories with active programs, and some states carry multiple programs or qualify for different federal grants.

SLRP will match any non-federal dollars for programs that benefit healthcare practitioners in HPSAs, including state appropriations, other state education loan repayment programs, employer matching and/or donations from eligible service sites, private foundations or community organizations. The most successful programs often have multiple sources of state funding.

Beyond SLRP, there are many other federal grant programs for loan repayment. While these funds cannot be used for SLRP matching, they still represent an under-explored opportunity for expanding physician loan repayment.

Maryland has one of the few loan repayment programs nationwide to be solely funded by taxes or fees on health care providers. In fact, a study published in the Journal of the American Medical Association reviewed 82 state-funded support-for-service programs. **Of those 82 programs, only 5 programs received any funds from fees on practitioners**.

And while many states primarily focus on loan repayment, several states have established relationships with schools or developed state loan programs and set up loan forgiveness programs for health professionals who remain in under-served areas within their state.



Data from Pathman, et al. (2000). State Scholarship, Loan Forgiveness, and Related Programs: the Unheralded Safety Net. Journal of the American Medical Association, 284(16), 2084-2092. doi:10.1001/jama.284.16.2084

*According to the annual figures published by the National Health Service Corps SLRP, the six states who qualified for the greatest amount of federal matching dollars are Alaska, Arizona, California, Colorado, Michigan and Washington, all of whom receive **a million dollars in federal funds annually**. Of note, **none of these six states are funded by taxes or fees on physicians**.*

OTHER STATE MODELS

ALASKA

With many difficult-to-staff facilities in remote locations, Alaska has developed a unique loan repayment program known as SHARP that is particularly notable for using **no state appropriates, general funds or taxes/fees on practitioners**. Despite these setbacks, SHARP has generated over $16.8 million in loan repayment over the course of four years, providing more than 250 service contracts.

After finding that facilities in the Alaska Tribal Health System **typically spent more than 14 months and $31,000 to recruit a primary care provider**, Alaska developed SHARP, which instead shifts those recruitment costs toward loan repayment. Employers with positions to fill offer two-year contracts where they agree to pay between 50% and 100% of the loan repayment based on how difficult the position is to fill. Participating employers receive various recruitment prerogatives, and only pay into the fund when contracts are granted.

In this way, the bulk of the financial burden rests on the employers who are most benefiting from the program, while employers save on recruiting costs and only pay for filled positions.

CALIFORNIA

California has the nation's largest state loan repayment program, providing more than **$4.6 million annually** in loan repayment.

Program funding in California comes primarily from three sources: state appropriations into a fund managed by the Office of Statewide Health Planning and Development, federal grants and employer matching. **Employers must agree to match SLRP awards on a dollar-for-dollar basis in order to be listed as an eligible site**. In this way, hospitals and other facilities provide up to $2,333,000 in funds each year.

MAINE

While Maine only receives a relatively modest amount of matching funds from SLRP ($170,000), they stand out from other states in that they have a wide variety of loan repayment, loan forgiveness, recruitment and scholarship programs to attract and retain professionals into medically under-served areas.

The programs include:

- Other federal grants focused on loan repayment for health practitioners,
- A state-administered rural health network that connects employers with health professionals,
- Loan forgiveness arrangements with schools for graduates who remain in the state to work in HPSAs, and
- The Maine Health Professionals Loan Program, which offers zero interest loans to medical students if they work in HPSAs in Maine after graduation, or 3% interest loans for those who work in non-HPSA under-served areas in Maine.

SAMPLE STATES:

ALASKA

CALIFORNIA

MAINE

OTHER MODELS...

With more than 80 state support-for-service programs across the country covering loan forgiveness and repayment for a broad variety of health professionals, there are many additional models to explore. Many of these programs have elements that could be incorporated into MLARP, allowing it to increase its scope without relying on additional taxes or fees on health providers.

SLRP GRANTS AND BOARD CONTRIBUTIONS

Fiscal Year	MBP Contribution	SLRP Grant Award	Difference	Percentage
2019	$400,000	$360,000	$40,000	90.00%
2018	$550,000	$360,000	$190,000	65.45%
2017	$550,000	$400,000	$150,000	72.73%
2016	$582,986	$400,000	$182,986	68.61%
2015	$678,529	$400,000	$278,529	58.95%
2014	$546,645	$400,000	$146,645	73.17%
2013	$631,372	$379,600	$251,772	60.12%

Total unclaimed federal dollars since 2013: **$1,239,931**

SLRP grant award figures provided by the Health Resources and Services Administration.

MARYLAND BOARD OF PHYSICIANS

For more information, please contact Matthew Dudzic, Maryland Board of Physicians, 410-764-5042, matthew.dudzic1@maryland.gov.

MACHC_Pam Kasemeyer_FWA_SB0501
Uploaded by: Kasemeyer, Pam
Position: FWA

MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS

Serving Maryland and Delaware

4319 Forbes Boulevard
Lanham, Maryland **20706**

(301) 577-0097
Fax (301) 577-4789
www.machc.com

TO: The Honorable Paul G. Pinsky, Chair
The Honorable Guy Guzzone, Chair
Members, Senate Education, Health, and Environmental Affairs Committee
Members, Senate Budget and Taxation Committee
The Honorable Melony Griffith
The Honorable Steve Hershey

FROM: Pamela Metz Kasemeyer
Danna L. Kauffman
Richard A. Tabuteau

DATE: February 13, 2020

RE: **SUPPORT WITH AMENDMENT REGARDING FUNDING** – Senate Bill 501 – *Maryland Loan Assistance Program for Physicians and Physician Assistants – Administration and Funding*

The Mid-Atlantic Association of Community Health Centers (MACHC) is the federally designated Primary Care Association for Delaware and Maryland Health Centers. Its members consist of community, migrant and homeless health centers, local non-profit and community-owned healthcare programs, including all of Maryland's federally qualified health centers (FQHCs). MACHC's members provide health care services to the medically underserved and uninsured. MACHC is built on helping our members in the delivery of accessible, affordable, cost effective, and quality primary health care to those in need. MACHC supports Senate Bill 501 which enhances the funding for the Loan Assistance Repayment Program (LARP) and moves administration of the program from the Higher Education Commission (MHEC) to the Department of Health (MDH). MACHC acknowledges that there must be a resolution of the funding sources for increasing the LARP program but is not weighing in on how best that should be accomplished.

MACHC has historically been a strong supporter of the LARP, which provides loan repayment assistance to physicians and PAs who agree to work in underserved areas of the State for a period of 2 years or more. FQHCs are by definition located in federally designated health professional shortage areas (HPSAs) and are acutely aware of the challenges medically underserved areas have in recruiting health care providers. Typically, Maryland's FQHCs, because of their location in HPSAs, are able to access the National Health Service Corps Loan Repayment Program to assist in recruiting health care providers. The National Health Service Corps program also requires a recipient to serve of a period of at least 2 years in a HPSA designated area. However, if HPSAs are realigned federally or an FQHC or other community-based health care program expands their services into State designated shortage areas, the State's LARP could be a critical resource in recruiting health care professionals.

MACHC strongly supports enhanced funding for LARP. They also strongly support the transfer of the LARP program from MHEC to MDH as MDH is historically the agency that selects the recipients and is better suited to ensure the program is both accountable and maximizes the objectives of addressing health professional shortages. MACHC understands that there is dialogue amongst relevant stakeholders on the funding source for enhancing the LARP program. MACHC hopes the General Assembly is able to identify an equitable funding framework that provides the necessary revenues to expand the program.

For more information call:
Pamela Metz Kasemeyer
Danna L. Kauffman
Richard A. Tabuteau
410-244-7000

HSCRC_FWA_SB501
Uploaded by: Terry, Tequila
Position: FWA

State of Maryland
Department of Health

Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

Stacia Cohen

John M. Colmers

James N. Elliott, M.D.

Adam Kane

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Katie Wunderlich
Executive Director

Allan Pack, Director
Population Based Methodologies

Chris Peterson, Director
Payment Reform & Provider Alignment

Gerard J. Schmith, Director
Revenue & Regulation Compliance

William Henderson, Director
Medical Economics & Data Analytics

February 13, 2020

The Honorable Paul G. Pinsky, Chair
Senate Education, Health, and Environmental Affairs Committee
2 West, Miller Senate Office Building
Annapolis, MD 21401

Dear Chairman Pinsky and Committee Members:

The Health Services Cost Review Commission ("HSCRC") submits this letter of support with amendment for Senate Bill 501 (SB 501) titled, "Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding". SB 501 transfers oversight of the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants from the Office of Student Financial Assistance within the Maryland Higher Education Commission to the Maryland Department of Health.

The HSCRC acknowledges the importance of having high quality physicians and physician assistants practice medicine in the State, particularly in rural and medically underserved areas. The Total Cost of Care (TCOC) Agreement requires the State to save $300 million per year in total cost of care spending by 2024. The State will only be able to reach this target if Marylanders have access to high quality providers. The HSCRC also understands that loan repayment assistance is a strong incentive for physicians and physician assistants to practice in communities that otherwise lack resources. The HSCRC believes the following factors should be considered when deciding the source of funding for the Maryland Loan Assistance Repayment Program.

Under the State's former Medicare waiver agreement with the federal government, the Centers for Medicare and Medicaid Services (CMS) rejected a plan to increase hospital all-payer rates to fund the Loan Assistance Repayment Program. Because of this, the HSCRC was unable to implement the funding mechanism referred to in the current statute. The HSCRC believes that CMS' position on this issue would not change under the current TCOC Agreement, which explicitly gives the federal government final authority to make decisions on rate setting approaches. The TCOC Agreement requires the HSCRC to provide written notice to CMS regarding any new payment methodology, which CMS can then accept or reject (Section 8. A.

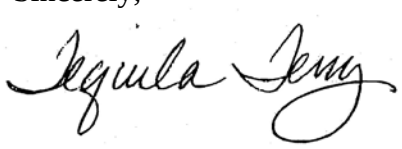
iii., p 17-18). This includes new payments that are included in legislation passed through the Maryland General Assembly.

In addition, HSCRC has received several requests this Legislative Session to build additional funding into hospital rate structures. These requests add up over time and, if implemented, would result in an increase in the total cost of care in the State. Increasing total cost of care could threaten the State's ability to achieve its savings goals under the TCOC Agreement. Doing so would jeopardize all the benefits that the State's Medicare waiver brings to Marylanders. These benefits include equitable funding of Uncompensated Care, which improves access to care in the same areas that are disproportionately affected by physician shortages, as well as a payment mechanism for the state-designated health information exchange (CRISP), which physicians often cite as a valuable component of the State's healthcare system.

The HSCRC remains committed to ensuring Marylanders have access to high quality healthcare, which requires attracting high quality physicians. For the aforementioned reasons, however, the HSCRC encourages the Committee to consider alternative sources of funding for the Loan Assistance Repayment Program. The HSCRC therefore proposes the below amendment, which removes language that requires the rate setting system to fund the Program.

If you have questions, please feel free to contact me at tequila.terry1@maryland.gov.

Sincerely,



Tequila Terry
Deputy Director

AMENDMENT:

On page 4, strike beginning with "Revenue" in line 8 down through "and" in line 10.

MedChi_Steve Wise_FWA_SB0501
Uploaded by: Wise, Steve
Position: FWA

MedChi

The Maryland State Medical Society

1211 Cathedral Street
Baltimore, MD 21201-5516
410.539.0872
Fax: 410.547.0915

1.800.492.1056

www.medchi.org

TO: The Honorable Paul G. Pinsky, Chair
The Honorable Guy Guzzone, Chair
Members, Senate Education, Health, and Environmental Affairs Committee
Members, Senate Budget and Taxation Committee
The Honorable Melony Griffith
The Honorable Steve Hershey

FROM: J. Steven Wise
Pamela Metz Kasemeyer
Danna L. Kauffman
Richard A. Tabuteau

DATE: February 13, 2020

RE: **SUPPORT WITH AMENDMENT** – Senate Bill 501 – *Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports with amendment** Senate Bill 501.

MedChi strongly supports the Loan Assistance Repayment Program for Physicians and Physician Assistants ("LARP"), which provides loan repayment assistance to physicians and PAs who agree to work in underserved areas of the State for a period of 2 years or more. MedChi's members have put their money where their mouth is with LARP: Each year, $400,000 of license fees are transferred from the Board of Physicians Fund to LARP, and there are federal matching dollars available. Over $11 million dollars in license fees have gone to LARP since 1997.

MedChi agrees that more funds are needed and wants to work to identify funding sources. We also agree that the Department of Health should administer the program rather than the Higher Education Commission, where oversight and administration have been lacking. **However, MedChi does not support increasing the annual amount of license fees going to the program from the current $400,000 to $1,000,000 as the bill directs at page 7, line 29.** If this were to occur, 10% of the Board's entire budget would be going to fund LARP. Physician license fees are already the 12th highest in the country on an annualized basis.

Furthermore, license fees should not be the sole source of funding for LARP. Since 2015, there have been 57 awardees of LARP funds, and 44 of them have been employed by hospitals, yet the hospitals

supply absolutely no funding to the LARP program. As the chief beneficiary of LARP as employers, the hospitals should be contributing. Likewise, the public interest in an adequate supply of physicians and PAs supports the use of General Fund dollars, which were supposed to be the primary source of LARP funding since its inception, but this has never occurred.

MedChi believes that a one-year fix should be adopted by the General Assembly using a limited amount of the Board of Physicians' Fund Balance, but not the amounts proposed in the Budget Reconciliation and Financing Act (See Senate Bill 192 at p. 35). During the 2020 interim, the stakeholders should be brought together in a workgroup to look for long-term, equitable funding sources and to recommend other improvements in the LARP program.

Amendments to address our concerns are set forth on the attachment. MedChi supports the bill, but only with their adoption.

For more information call:
J. Steven Wise
Pamela Metz Kasemeyer
Danna L. Kauffman
Richard A. Tabuteau
410-244-7000

MedChi's Proposed Amendments to SB 501

AMENDMENT NO. 1

On Page 7, delete line 29 through line 7 on Page 8.

AMENDMENT NO. 2

On Page 10, at line 5, strike starting with "how" through "the" in the same line.

AMENDMENT NO. 3

On Page 10, at line 13, strike "and".

AMENDMENT NO. 4

On Page 10, at line 16, after "school" insert "; AND (4) EXAMINE AND RECOMMEND FUNDING SOURCES OTHER THAN LICENSE FEES FOR THE LOAN ASSISTANCE REPAYMENT PROGRAM FOR PHYSICIANS AND PHYSICIAN ASSISTANTS."