

Summary of Public Comment

The Maryland Department of Health and Mental Hygiene (DHMH) had an open public comment period from December 1 – December 14th, 2016 for the Maryland Comprehensive Primary Care Model (Model) Concept Paper. DHMH received 27 comments from primary care physicians, representatives of provider organizations, behavioral health organizations, hospital groups, consumer groups, and academia. DHMH carefully reviewed each comment and thoughtfully reconciled many of the comments within the Concept Paper and Model.

Glossary

A number of comments asked for the Concept Paper to include a glossary of terms. DHMH created a glossary of terms and a list of acronyms to support the programs reflected in the Model. The glossary exists as Appendix A in the revised Concept Paper.

Primary Care Model Design

Patient Designated Providers (PDP)/ Person Centered Homes (PCH)

DHMH incorporated concerns voiced by practicing physicians to emphasize the importance of their role in the Model. Care management and prevention activities of non –hospital providers and practices are required to ensure alignment with the Maryland All-Payer Model. Non-hospital based care contributes to meeting the All-Payer Model’s targets by slowing the growth of total health spending and generating measurable savings for Medicare.

Care Transformation Organizations (CTO)

DHMH received a number of comments asking for clarification about the roles and functions of the Care Transformation Organizations (CTOs). In response, DHMH added detail to support the roles and responsibilities of the CTO. Clarification was provided on criteria to participate in the Model as a CTO. A Comparison Chart of the Maryland Model with respect to CMS CPC+ Model was added as Appendix Item C. The Concept Paper provided clarification with regard to the desirability of competition between CTOs in addition to their role in building linkages to local departments of health and social services. Furthermore, DHMH clarified that CTOs must be risk-bearing entities. Quality metrics for accountability have not been directly addressed in the Model to date. The goal is to limit the quality metrics in scope and incrementally increase them over time. Routine reporting of quality metrics will be required upon implementation of the proposed Model.

Coordinating Entity (CE)

DHMH received comments asking for clarification about the roles and responsibilities of the Coordinating Entity (CE) Advisory Board. These comments were addressed through further clarification of the Board’s composition. The Advisory Board will determine the rule sets by which CTOs and PCHs can participate in the Model. The Advisory Board will have broad representation of individuals who interface with the healthcare system; who will bring their skills, knowledge of primary care, and innovation experience. Providers will be represented on the Advisory Board in a capacity equivalent to other stakeholder groups, including consumers, payers, health systems, and community-based organizations.

Complex and Chronic Care Improvement Program (CCIP)

DHMH received questions about the interaction between the Complex and Chronic Care Improvement Program (CCIP) and PCHs. The Concept Paper was modified to include more clarity about the transition and integration of care between CCIP to CTO/PCH through Example Scenario C, under Model Design.

Primary Care Model Interactions under MACRA

Regarding Medicare Shared Savings program ACOs, DHMH has modified the Concept Paper to clarify MSSP programs may participate in the Model. However, programs participating in the Next Generation ACO program may not participate in our proposed model.

Work Force Challenges

Other comments highlighted work force concerns that were subsequently addressed throughout the Concept Paper. More information was added to address the shortages of primary care physicians, including issues with maldistribution of providers in rural and lower-income urban areas, through the Concept Paper's companion document, "Outreach and Dissemination Plan to Primary Care Providers and Patients in Maryland". Comments also highlighted the need for an appropriate composition of providers whose services would be made available by CTOs to primary care practices, including nutritionists, pharmacists, behavioral health providers, social workers, and health IT specialists who can help connect primary care providers to CRISP and additional existing health infrastructure. Other inclusions were meant to broaden the scope of the Model by recognizing the important contributions Community Health Workers can add to the overall success of the Model along with important support from faith-based partners.

Sustainable Funding Mechanism

DHMH recognized the concerns of providing a sustainable funding mechanism to support the community-based organizations that will provide social services ultimately supporting the transformed primary care system. DHMH supported the commenting organizations' assertion that increasing the services available to ultimately reduce unnecessary hospital utilization will necessitate increased availability of community-based services through returns on investment. These additions have been further substantiated by Hilltop research on behavioral health problems that has been added and cited within the Concept Paper.

Behavioral Health

The most frequent comments asked for more inclusion of behavioral health and substance abuse resources into the model. DHMH included additional design regarding behavioral health as well as clarifying how behavioral health providers can serve as PDPs. DHMH included suggestions that highlighted the need for strong linkages between primary care practices and behavioral health providers and the importance of addressing the full range of behavioral health needs, ranging from community-based and residential services through crisis intervention and hospitalization. These modifications were made within the Model Design section of the Concept Paper.

Conclusion

DHMH is grateful for the thoughtful and articulate comments on the Maryland Comprehensive Primary Care Model Concept Paper. DHMH has systematically reconciled all comments received. While DHMH was unable to modify the Concept Paper based on every suggestion, DHMH was able to use the majority of comments and suggestions to improve the Concept Paper. DHMH is confident that this input will ultimately build a stronger Model and lead to ensured success. DHMH will continue to engage stakeholders on the process of creating a transformed and improved healthcare system in Maryland.