HFAM
Health Facilities Association of Maryland
Partners in Quality Care

October 7, 2013

The Honorable Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, MD 21201 – 2399

Dear Secretary Sharfstein,

It has been productive and a pleasure to work with you on the Maryland Hospital Waiver over this last year on behalf of the majority of Maryland's skilled nursing, rehabilitative and post-acute care providers.

We have had the opportunity to review the most recent and updated waiver application and are encouraged by the continued focus and advancement on issues related to the 3-day hospital stay and observation days.

We look forward to continuing to work with you on the details and are hopeful for the success of this important work.

Be well,

Joseph DeMattos, Jr.
President

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Maryland
Hospital Association

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October 4, 2013

Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health & Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201

John M. Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Secretary Sharfstein and Chairman Colmers:

On behalf of our 66 member hospitals and health systems, the Maryland Hospital Association (MHA) is pleased to submit this letter in support of the updated draft application to the Centers for Medicare & Medicaid Services (CMS) and Center for Medicare and Medicaid Innovation State Innovation Models Group, for modernization of Maryland's All-Payer Model. The revised and improved application seeks to advance our shared goals of a better patient experience of care, improved population health outcomes and care at lower per capita cost, and builds upon the decades of innovation in health care payment and delivery demonstrated in our current all-payer system.

It is important to note that the proposal includes a number of goals that have never been tried nor tested on a scale of the magnitude contemplated. Toward that end, we are committed to working with state officials, the Health Services Cost Review Commission (HSCRC), payers, and other stakeholders, on the collaboration necessary to ensure successful implementation of the proposal, if approved by CMS.

It is in that spirit of cooperation that MHA offers the following corrections and clarifications:

- Throughout the application where Medicare savings targets are identified, the application should reference spending per *beneficiary* rather than per *capita*;
- In addressing the Medicare per beneficiary *total* cost of care growth, Maryland spending is proposed to grow no more than *one percentage point* (as opposed to one percent) above the national rate of growth without triggering the corrective action plan process specified in the application;
- In describing the model's purposes and objectives (page 10), the first objective is stated as "reducing expenditures for all payers, including CMS." It would be more appropriate to describe the objective of this model as reducing the *rate of growth* in expenditures for all payers;
- The application should clarify that the waiver that the state is seeking from CMS from provisions of section 1814(b)(3) of the Social Security Act would include the waiver of any penalties to be imposed during the two-year transition period specified in the event of a termination of the proposed model;

-more-

- In setting the target for moving Maryland hospital revenue to population-based models, further clarification is needed on how this target will be calculated. Specifically, it is unclear whether the exceptions identified in footnote seven on page 19 of the application would be excluded from the denominator of the fraction identified on page 20 of the application (we believe it should).

We appreciate the time and dedicated efforts that the two of you, as well as the entire staff of the HSCRC, led by Acting Executive Director Donna Kinzer, have devoted to the revision of this demonstration model, and the opportunity you have provided to us to share our comments. We look forward to our continued dialogue as this process moves forward.

As always, if you have any questions regarding the comments we have shared, please contact me at the Association at 410-379-6200.

Sincerely,

Michael B. Robbins,
Senior Vice President, Financial Policy & Advocacy

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

October 7, 2013

The Honorable Joshua Sharfstein, MD
Secretary, Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Sent via email to joshua.sharfstein@maryland.gov

RE: Medicare Waiver Application

Dear Dr. Sharfstein:

As you are aware, MedChi has been actively involved in discussions relevant to the design of the waiver. MedChi is committed to assuring that the adoption of new payment models and system designs create the intended incentives for increased efficiency and quality but do not negatively affect payments for professional services or create tension between hospitals and physicians. MedChi along with several physician organizations identified its top priorities and concerns with the waiver in a letter submitted to you in July 2012 (See attached).

MedChi appreciates this opportunity to provide comment on the revised waiver application prior to its submission to CMS. As stated in our previous letter and throughout our involvement in the process, MedChi has been opposed to any bundling of physician professional fees in this waiver application. MedChi applauds the HSCRC for clearly limiting this waiver's applicability to facility fees for the first five years. MedChi believes this will ensure that the State can address issues relative to gain-sharing and other mechanisms for system reform in a manner that balances the risks and benefits of various approaches in an environment that does not create tension between facilities and physicians or otherwise causes unfair and an unjustified leverage by hospitals over the practice of medicine.

MedChi, would like to raise two specific issues/recommendations relative to this application.

- The waiver document fails to provide a funding mechanism for the loan assistance repayment program. Maryland enacted a state specific loan repayment program in 2009 to address the well-documented physician shortage. Despite clear evidence that the shortage continues to escalate, Maryland has failed to date to identify a source of funding for the program. Maryland's physician shortage threatens to undermine every incentive for system efficiency and quality enhancement that is reflected in this waiver document. Without sufficient access to care – access which is severely constrained due to the physician shortage – there will be no "bending of the cost-curve", enhanced efficiencies or improved outcomes. Maryland must identify funding for this critical component of physician recruitment and retention. MedChi is extremely disappointed that the State did not utilize the waiver to advance a funding mechanism.

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- Gain-sharing mechanisms and other payment mechanisms for incentivizing broad system reform should be developed through a stakeholder process that includes broad physician participation. While physician professional services are not included in the institutional reforms presented in this waiver, the waiver clearly reflects the State's interest in ultimately moving toward more comprehensive system reform that includes payment models and system designs involving services that are both institutional and community based. To that end, MedChi urges the HSCRC to immediately begin stakeholder consideration of gain-sharing mechanisms that create positive incentives for physician alignment with the institutional reforms reflected in the waiver. Absent a focused effort that commences concurrent with the new waiver implementation, hospitals may be incented to adopt policies that create unnecessary and counterproductive tension between physicians and institutions that could lead to increased costs, decreased quality and put at risk the success of the waiver's reforms. Therefore, the State should quickly move resources and incentives toward physicians for the development of innovative care models that extend across the continuum of care, and to the extent allowable under law, to truly integrate all specialties and care providers.

MedChi believes the proposed waiver application holds great possibility for positive reform that improves both cost trends and quality outcomes. However its ultimate success relies on a critical balance of often competing interests. Physician involvement, alignment and support are essential if success is to be realized. MedChi looks forward to working on the issues of gain-sharing and incentives that must follow the submission of this application.

Sincerely,

Gene M Ransom III

Gene M. Ransom, III
Chief Executive Officer

cc: John M. Colmers, Chairman HSCRC

Attachment

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July 30, 2012

The Honorable Joshua Sharfstein, MD
Secretary, Department of Health and Mental Hygiene
201 West Preston
Baltimore, MD 21201

Re: New payment models and the waiver

Dear Dr. Sharfstein:

The various physician groups and MedChi understand the need for better management of healthcare costs, improved quality of care, and the need for payment reform.

There is no better evidence to demonstrate the Physician/MedChi commitment to this cause than the recent announcement of three Maryland ACOs co-sponsored by MedChi that were approved last week. However, as Maryland moves forward with new payment models and modernizes the waiver we want to stress to policymakers the need to be careful with any bundled payment programs that affect payments for professional services.

Organized medicine recommends the following principles with regard to bundled payment programs in Maryland:

- Continue the current Total Patient Revenue and Preventable Readmission facility fee bundling programs.

- Inclusion of gain sharing with physicians as a new tool for facility fee bundled payment programs.

- Use measures in the waiver that ease and increase participation in the Medicare ACO program.

- Support of new programs and innovations to create incentives to improve Medicaid in the unregulated outpatient system.

- That special tort protection be granted to physicians in bundled payment models. The cost and risk of defensive medicine must be addressed.

- Bundled payment programs for professional services would create tension between hospitals and physicians, and negative incentives for the system, increase costs, and generally increase the risk to the waiver, and should not be implemented.

We hope to be involved in the waiver process with regard to this issue and the Governor's physician loan program. As you are know, we started that process with the meeting we had at MedChi with HSCRC staff a couple of weeks ago. Please keep us informed and let us know how we can help in your attempts to protect and improve Maryland health care.

Sincerely,

Harry Ajrawat, M.D.
President
MedChi, The Maryland State Medical Society

Scott Krugman, M.D., FAAP
President
Maryland Chapter, American Academy of Pediatrics

Paul Staats, M.D.
President
Maryland Society of Pathologists

Laura Pimentel, M.D.
President
Maryland Academy of Emergency Physicians

Basil Morgan, M.D.
President
Maryland Society of Eye Physicians and Surgeons

Albert L. Blumberg, M.D.
President
Maryland Radiological Society

J. Margaret Moresi, M.D.
President
Maryland Dermatologic Society

Jessica Schmidt, RPSGT, MA
President
Maryland Sleep Society

Paul Celano, M.D., FACP
President
Maryland/DC Society of Clinical Oncology

James E. Chappell, M.D., FACS
President
Maryland Society of Plastic Surgeons

Rick Howard, M.D.
President
Maryland Society of Anesthesiologists

CC: Maryland Congressional Delegation
Health Services Cost Review Commission

Chet Burrell
President and Chief Executive Officer

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October 7, 2013

Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

John M. Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Sharfstein and Chairman Colmers:

I am providing, on behalf of CareFirst BCBS, a number of detailed comments and suggestions regarding the recently released "Maryland's All Payer Model: Proposal to the Center for Medicare and Medicaid Services." These comments supplement the general comments that I provided to you in a separate letter regarding the Proposal.

As noted in our general comment letter, CareFirst strongly supports the basic design, objectives and methods that have been included in the Proposal. We believe that the changes that would be wrought in the health care system by the proposed Demonstration would be highly beneficial to individuals, businesses and governments in Maryland. The comments that are presented below are meant to strengthen and clarify some of the technical aspects of the Proposal.

With this said, our team offers the following more detailed comments:

1. The right that Maryland will have, with CMS approval, to update the GSP per capita data after the third year of the Demonstration (which is described on p. 9 of the Proposal) is unlikely to be beneficial because the GSP per capita trends in 2003 and 2004 (and 2005) (see the Table on p. 15 of the Proposal) were relatively high. Therefore, dropping those years and adding more recent years is not likely to provide a higher overall cap test. The likely stringency of the Medicare updates in the next two or three years, and the improbability of obtaining a helpful adjustment to the GSP per capita, make it imperative

for the HSCRC to set rates and approve policies for 2014 that put Maryland on a cost trend trajectory that does not imperil our ability to meet the cap tests that are prescribed in the Demonstration.

2. The Proposal states (on page 16) that the denominator of the Medicare total hospital cost per capita will be based on Medicare FFS beneficiaries who are enrolled in Medicare Part A and/or Part B. There should be a provision to adjust the test if the current fraction of Medicare beneficiaries who reside in Maryland that do not have both Part A and Part B coverage changes relative to the national average.

3. The Proposal (on page 16) refers to an opportunity for Maryland to appeal to CMS for an adjustment if we are differentially harmed by "exogenous" factors such as localized disease outbreaks that affect Maryland to a greater extent than they affect other states. We believe it is reasonable to include a provision that would be a basis of an appeal tied to major exogenous factors that clearly impose a differentially disadvantageous effect on our ability to meet the all payer and/or Medicare cap tests. However, it would be beneficial to work with CMS to further clarify that this provision is not meant to open up appeals on other bases that could distract from a concerted effort to control hospital expenditures in Maryland.

4. We note that the Proposal indicates that efforts will be made to strongly discourage and monitor cost shifting activities affecting the private sector since this will impact our ability to achieve targets under phase 2 when the targets include all beneficiary costs (institutional and professional). We stand ready to assist the HSCRC by providing relevant data regarding our experience regarding cost shifts under the Demonstration.

5. Page 17 of the Proposal contains a very brief discussion of how the demonstration will positively impact Medicaid and CHIP: "Medicaid will benefit from the model through the reduction in utilization of inpatient services as well as the reduction in costs associated with hospital admissions." The demonstration now creates a circumstance where there could be duplicative underwriting risk assumed by hospitals who are paid under capitated global payment models and MCOs, who receive a capitated payment from the State. The duplication of underwriting risk means that the State Medicaid program may effectively pay twice for any cost and utilizations reductions realized under this system (i.e., Medicaid pays its share of the hospital capitation for hospitals under Global Models and it also pays the MCOs on a capitated basis). In light of this, the State may wish to undertake an overall evaluation of Medicaid MCO programs to ascertain the impacts if the demonstration is successful.

6. The Proposal states, on p. 19, that Maryland will shift virtually 100% of its hospital revenue to "population-based models" over the five year period of the Demonstration. The Proposal states that, in addition to the TPR and PBR systems, the definition of population-based models would include the "Admission/Readmission Revenue" (ARR) program. Currently, approximately 31 Maryland hospitals have accepted the ARR program. It is our understanding that Maryland (and CMS) would treat only the readmissions component of the revenue covered by the ARR as revenue covered by the

population-based framework, but this is not clear. This ambiguity should be clarified when the Proposal is submitted to CMS because it would not be appropriate to consider all of the revenue covered by the ARR as revenue covered by a population-based model.

7. We believe the efforts described in the Proposal to reduce readmissions and Potentially Preventable Conditions (PPCs), and to drive quality improvements through the MHAC and QBR systems, are appropriate. We also believe that the various patient experience surveys will be helpful if they are independently performed and if the results are made available to the public in a readily accessible and well-publicized way.

8. The Proposal discusses "Volume Controls" on p. 36 and provides an example of the use of a 50% "Variable Cost Factor" (VCF) rather than the 85% VCF that currently applies to volume changes. As you know, we have strenuously argued for years that the HSCRC's use of a VCF of 85% has provided a strong financial stimulus for volume increases in the hospital system. We support a reduction in the VCF to 50%, or less, as long as the VCF is applied on a consistent basis relative to a particular historic base year so that upward and downward swings in volume do not produce incongruous approved revenue levels. It will be necessary, we believe, to differentiate between market share shifts resulting from redirected volume under a Shared Savings Program (SSP) to efficient and effective hospitals and market share shifts resulting from other causes. This is challenging to do but, we believe, it should be intensely focused on early in the life of the new demonstration and an appropriate approach determined.

9. We also believe that the VCF should be different for volume changes that are driven by population dynamics (i.e., changes in the number of persons and the age distribution) rather than by other factors. The HSCRC should attempt to distinguish the impact of population dynamics across geographic areas rather than treat all hospitals and markets as though they are facing the same population-based volume pressures. For example, the population in Montgomery County is growing rapidly and the age dynamic is changing, while the population in Baltimore City has generally been declining or holding flat. The HSCRC should use the various tools available that have been mentioned in the Proposal (e.g., readmission rates, levels of ambulatory-sensitive conditions that are treated on an inpatient basis, etc.) in an effort to make equitable distinctions among hospitals in regard to the appropriateness of their existing volume levels and their ability to absorb additional volume.

10. We strongly endorse the use of an overall "Volume Governor," and adjustments in the annual update factors, as tools to ensure that Maryland meets the overall payment cap test that is included in the Proposal. But, we would suggest that the technical aspects of such control be fully explained early in the process to avoid misunderstandings during the next Update Factor negotiations.

11. We appreciate the statement on p. 51 of the Proposal that "Maryland believes that the targets established in this model are achievable without any change in the payment differential between public and commercial payers" and the prescription that CMS must

review and approve any change in the differential prior to its implementation. The all payer nature of the Maryland system is a key feature of the Demonstration that would be undermined if savings for Medicare (and Medicaid) were achieved by raising private sector payment rates. We support the efforts that the HSCRC has indicated it will initiate to encourage hospitals to make special efforts to address the Medicare cost problem, and to meet both the Medicare test and the all payer test, and we believe that the Medicare population offers many opportunities to hospitals to reduce costs and improve quality.

12. On p. 52 of the Proposal, it is stated that: "The Maryland All-Payer Model will be successful if the model reduces program expenditures and improves the quality of care for Maryland residents, including Medicare, Medicaid and CHIP beneficiaries, more than other states." We believe this statement should be modified to read "The Maryland All-Payer Model will be successful if the model reduces *expenditures and improves the quality of care for all Maryland residents, including Medicare, Medicaid, CHIP beneficiaries, persons covered by private health insurance, and other persons, at a faster rate than such improvements are achieved on a national basis*." (Note: Modified language is in italics.)

We appreciate the opportunity to submit these comments on behalf of CareFirst and its 2 million subscribers in Maryland and would be pleased to discuss any of them with you. We stand ready to work with you, the hospitals in the State and the HSCRC to implement the Proposal which, we believe, is a most forward looking demonstration and one of a kind in the nation. We believe that it could form – with aligned physician incentives – a truly effective model for not only Maryland, but for the nation.

Sincerely,

Chet Burrell
President and Chief Executive Officer

Cc: Commissioners, HSCRC
Donna Kinser, Acting Executive Director, HSCRC Commission
Carmela Coyle, CEO, Maryland Hospital Association
Gene Ransom, CEO, MedChi
Gary Simmons, Regional Vice President, United Health Care

BARBARA MARX BROCATO & ASSOCIATES

October 7, 2013

Joshua M. Sharfstein, M.D.
Secretary of Health & Mental Hygiene
Office of Secretary
Department of Health & Mental Hygiene
201 West Preston St.
Baltimore, MD 21201 - 2399

John M. Colmers, Chair
Health Services Cost Review Commission
4201 Patterson Ave.
Baltimore, MD 21215

Dear Secretary Sharfstein and Chairman Colmers,

Thank you for the opportunity to comment on the CMS waiver application that was publicly released on Friday, September 27th. We are writing on behalf of our clients: the Maryland Society of Anesthesiologists (MSA), Medical Emergency Professionals (MEP), the Maryland Society of Otolaryngology (MSO), First Colonies Anesthesia Associates (FCAA) and Advanced Radiology. Both of you have long known and understood our interest and efforts in this matter and we appreciate your attention to our concerns.

From reading the document we understand that physician fees are not immediately brought under the auspices of the waiver. It is very important that physicians have a decision making role in key aspects of the new waiver system. A decision making role is of particular importance with regard to the allocation of funds in global payment models, governance structure of ACOs, establishing parameters of gainsharing, exposure to liability and assumption of risk, and very many other issues.

We respectfully request that you consider additional language indicating that resources and incentives should be available to physicians for the development of innovative care models that extend across the continuum of care, and to the extent allowable under law, integrates other specialties and care providers.

We are sure you are aware that physicians wish to share in shaping any policies under which ultimately they must operate. We realize that in the future dramatic changes will occur among relationships between physicians, hospitals, insurers, and patients. It is important that we work with all parties to secure the success of the waiver system in the future.

Thank you for your consideration of our comments and concerns.

Sincerely,

Barbara Marx Brocato

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Maryland Community Health System

October 7, 2013

Joshua M. Sharfstein, M.D., Secretary
Department of Health and Mental Hygiene
201 West Preston Street, Fifth Floor
Baltimore, MD 21401

John M. Colmers, Chairman
Health Services and Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Secretary Sharfstein and Chairman Colmers:

Thank you for the opportunity to submit public comments on the draft application for "Maryland's All Payer Model" from the Department of Health and Mental Hygiene (DHMH) to Centers for Medicare and Medicaid Services. The application reflects a bold, innovative approach to reshape Maryland's health care system through its hospital financing system. We strongly agree that Maryland must move steadily towards reforming its health care delivery system, as we can achieve better patient outcomes by redesigning the relationship between hospital and community-based care. The five-year timeframe seems ambitious, given the complexity of the health care system and the historic lack of resources allocated to the community-based health care system however, we are fully supportive of the systemic changes outlined in the waiver proposal.

The application proposes a broad outline of a new five-year model for the all-payer system. The success of the new model will depend on separate but related initiatives including the establishment of the State Innovations Model, effective accountable care organizations, and a robust outcomes evaluation system. We suggest a simple, yet important, addition to the application that will support DHMH in meeting its goals. All of the initiatives under the model require input of community providers and consumers to develop. However, there is not yet a structured mechanism to gather that input. Therefore, we suggest that the State establish a Community Provider and Consumer Advisory Committee for the all-payer model. The Advisory Committee would provide the focal point for the presentation of design and implementation issues to the public. State agencies could gather input from Advisory Committee members and collect other public feedback through this process. This Advisory Committee could function in a manner similar to the Medicaid Advisory Committee and the to-be-established Standing Advisory Committee to the Maryland Health Connection.

Although the draft proposal notes that the Health Services Cost Review Commission has an open meeting process, the Commission, because of its history, is a largely hospital-focused regulatory agency. Since the new model is expanding its reach into shaping the consumer experience in community-based settings, we strongly suggest that there needs to be structured community provider and consumer input into this program. In addition, the new waiver will involve multiple programs outside of the Commission, including DHMH, and the State Innovation Model, Maryland Health Care Commission and the Multistate Patient Centered Medical Home Pilot, and consumer protection programs under the Office of the Attorney General and the Maryland Insurance Administration. Therefore, it makes sense to have an Advisory Committee which can support the work of multiple agencies and programs within State government.

We are eager to continue contributing to the development of pilots and models that support the transition of appropriate care from institutional providers to community-based providers. We have been actively involved in the stakeholder workgroup for the State Innovation Model and would like to offer the same type of assistance with other initiatives. Working together, we can support hospitals and community-based providers in the development of innovative models that reward providers for hitting triple aim targets of care, health, and cost.

Thank you for the opportunity to provide these comments on the draft waiver proposal. If I can be helpful in any way, please contact me at (443) 557-0258 or salborn@chipmd.org. You may also contact Ms. Robyn Elliott at (443) 926-3443 or relliott@policypartners.net.

Sincerely,

S. Alborn

Salliann Alborn
Chief Executive Officer

C: Maryland Community Health System Board of Directors

802 Cromwell Park Drive, Suite V, Glen Burnie, Maryland 21061
410-761-8100 Phone 410-761-5835 Fax

October 7, 2013

Joshua M. Sharfstein, M.D.
Secretary
Department of Health and Mental Hygiene
201 W. Preston St.
Baltimore, MD 21401

John M. Colmers
Chairman
Health Services and Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Secretary Sharfstein and Chairman Colmers:

Thank you for the opportunity to submit public comments on the draft application for "Maryland's All Payer Model" from the Department of Health and Mental Hygiene (DHMH) to Centers for Medicare and Medicaid Services. The Maryland Women's Coalition for Health Care Reform (Coalition) is a health policy advocacy organization that includes thousands of individuals and 95 member organizations. The Coalition strongly agrees that Maryland must move steadily towards reforming its delivery system to align with the goals of delivering better health, better care and lower costs. We have several specific suggestions on how to enhance the success of the new waiver, and have identified several areas in which we would like to be helpful in developing a more robust implementation plan.

Process Recommendations

The Coalition is dedicated to working with the Department and other stakeholders to ensure transparency and meaningful public input in the waiver design and implementation. To support these two aims we recommend that a permanent consumer and community provider standing committee at the Governor's Office level. As the draft wavier is currently constructed, the Health Services Cost Review will continue to be the lead organization that has oversight on the implementation of the waiver. The Commission primarily has expertise in Maryland's hospital industry, yet the new model will expand the scope of the waiver to include a broader portion of the health care system. To be successful, the Commission will need the input of consumers and community providers at every stage of implementation. This will not only ensure that these important perspectives are incorporated into the program design, but it will also

increase a commitment to its success. Consumers will be better partners if they have a full understanding of the implications of any changes in the delivery system and the impact on them. We note that the most appropriate place for the Advisory Committee may be at the Governor's Office level, perhaps in conjunction with the Governor's Office on Health Care Reform, as the new model involves multiple state agencies.

Such an Advisory Committee will help address some gaps in the opportunity for consumer input into the current waiver redesign process. For example, the current public comment period is only 10 days long, with a posting only on the DHMH website. This is not a sufficient length of time for review, analysis, and discussion amongst consumer advocates, provider organizations, carriers, and State agencies.

There are precedents and models for this type of committee, including the Medicaid Advisory Committee and the Standing Committee to be established under the Maryland Health Progress Act of 2013. That law and those passed in 2011 and 2012 are examples of the success of a meaningful stakeholder process. Integral to its success would be a requirement that State agencies seek input from this committee and the general public throughout implementation and at any time that changes are proposed to the waiver application.

Policy and Implementation Concerns:

The Coalition has identified a number of policy and implementation questions that should be addressed including:

- **Focus on the improvement of population health:** There is a direct corollary between strategic investments in public and population health and a reduction in expenditures. Two strategies that could be considered to address this goal are: (1) a multi-stakeholder learning collaborative to identify evidence based strategies; and (2) ensure that "no wrong door" is a reality and that consumers have full access to the full range of services for which they are eligible.
- **The waiver proposal must be patient centered:** Bending the cost curve requires patient-centered activities that promote the Triple Aim. This includes programs that improve patient compliance, encourage healthier life styles and embrace shared decision-making. Incorporating the consumer perspective will promote the identification of effective strategies and incentives. Consideration might be given to

having projected savings invested in required services such as expanding needed primary care and care coordination services.

- **Allow consumers to opt out of new models of care:** Consumers would be best served if the waiver includes a process for them to opt out.
- **Focus on Interdisciplinary Teams:** Improving health outcomes requires coordination with the consumer, family, and an interdisciplinary team of health care practitioners. The waiver application is largely focused on building the relationship between hospitals and physician offices. We would like to be helpful in discussions of how to use the waiver to create more interdisciplinary teams – nurses, rehabilitation health care professionals, and behavioral health professionals that will benefit the consumer. Some of this work is already underway in the SIM discussion.
- **Implement safeguards for vulnerable populations:** We are concerned that the waiver may impose financial risk on providers to reduce the total cost of care for patients. By shifting risk to providers consumers may be left without a champion as they attempt to get payers to cover necessary treatments. Currently, patients generally have the support of doctors in this process. With this proposal, however, patients may face disagreements with their doctors over their required treatment. One scenario is that providers may not tell them about more expensive options, even when those are favorable to the patient, because of the provider's full or partial financial responsibility for those options.

  Low-income Medicaid enrollees, compared with the general population, are more likely to suffer from multiple chronic conditions and serious mental illness. Further, due to higher incidence of low education levels and English proficiency issues, they are often less able to advocate for themselves. For Medicare beneficiaries, the prevention of admission to inpatient care or discharge from inpatient care is often complicated by inadequate access to the most effective and person-centered types of care such as home care. The proposal does not adequately describe how these problems will be addressed, raising concerns that this issue will be addressed by shifting cost and care to patients and family members.
- **Preserve Culturally-Competent Providers:** This proposal will encourage hospitals to partner with community-based providers – a very positive goal also being championed by the SIM work. Some hospitals may seek to vertically integrate services in communities – a trend which predates this waiver proposal. There are many

positives to vertically integrated care – including better opportunities for care coordination. However, we would like to caution that small, safety-net providers often have unique expertise and existing relationships with hard-to-reach populations. Larger health care systems may have more difficulty in adapting to the needs of smaller, more specific populations. The SIM project and Local Health Improvement Coalitions have recognized the role of key safety-net providers. We would like to work with the Department to see how that recognition could be incorporated into the Medicare waiver.

- **The creation of a robust complaint, grievance and appeal process:** The proposal may result in restricting access without an appeal process. Therefore there needs to be a clear articulation of patient rights and a process for submitting complaints, grievances and appeals. These safeguards must be in place before changes are made to the waiver. Consumers must have clear avenues for the handling of grievances, complaints and appeals for matters concerning access and quality of care. The current avenues for consumer complaints are largely focused on complaints about a carrier's coverage of services or network adequacy or an individual practitioner's adherence to standards of care. However, under this model, it is not clear if the complaint would be about insurance coverage, inadequate provision of care by a hospital or community provider because of some kind of financial arrangement through an ACO or other model, or inadequate care coordination. There is no single State or federal agency that handles these types of complaints. Even with the existing avenues for consumers to make complaints, we have concerns that these are relatively inaccessible to consumers – especially those who have complex medical and social needs.
- **Robust evaluation process is required:** To ensure stakeholder confidence and regulatory compliance, a robust evaluation process should be developed at the outset. Integral to this are meaningful quality measures that reflect issues of concern to consumers, including denials of care. The draft waiver application gives a general outline of some of the resources that may be available to conduct an evaluation. However, we think that consumer input during the development of the evaluation system will be valuable. An example of the importance of this is the recommendations on metrics and data related to health equity that have been provided to the Maryland Health Benefit Exchange.

- **A reasonable timeline and adequate resources are required to assure success:** Given the fact that this proposal will be integrated into the current complex task of ACA implementation and the proposed SIM, we believe that a timeline that reinforces the opportunities for success must be considered. To support this and the proposals' long-term success funding must be sufficient for the transition. This includes investments in information technology, patient education and training at multiple levels.

Again, we very much appreciate the opportunity to provide these comments on the draft waiver proposal. We would be happy to respond to any questions or provide further information.

Leni Preston, Chair

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HEALTH CARE for All
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October 7, 2013

Secretary Dr. Joshua Sharfstein
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Secretary Sharfstein,

The Maryland Citizens' Health Initiative commends the O'Malley-Brown Administration for this proposed amendment of Maryland's landmark Medicare waiver making possible our unique all-payor hospital payment system. Although this system, which is the only one of its kind in the nation, has been working well to help contain rising health care costs, it is in critical need of being updated to address modern health care needs. Most importantly, we agree wholeheartedly with the Administration that the present system which incentivizes hospitals to keep patients in their care needs to be changed in order to put the incentives on keeping people healthy and out of the hospitals. The global payment structure envisioned by this proposal goes a long way to achieving this goal. We also commend the Maryland Hospital Association for understanding the need to make these changes and for their commitment to making the tough decisions that will be necessary to implement them.

We believe that the details of how the incentives, needed under the new plan, will work will be critical to the success of the program. We encourage robust public comment and input on the incentives early in the process. We also urge you to build in a formal structure for meaningful consumer engagement in the implementation and monitoring of the waiver to help ensure that it serves consumer interests.

On behalf of the hundreds of faith, community, labor, business and health care organizations in our Health Care For All! Coalition, we commit to working closely with the Administration and the Maryland Hospital Association to make sure that the final version of this new waiver application addresses the needs of Maryland's health care consumers. We will also work closely with the Administration and the Maryland Hospital Association to devise and implement smart strategies to keep health care costs down, including reducing hospital readmissions and value based insurance design, which can help to encourage use of quality but also more affordable health care services.

Sincerely,

Vincent DeMarco
President