**Maria Harris Tildon**
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November 19, 2020

Adam Kane, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane:

CareFirst appreciates the opportunity to support the direction and progress of the Statewide Integrated Health Improvement Strategy (SIHIS) as presented at the November public meeting of the HSCRC. We have been involved with the State process to date and look forward to working with the State and the rest of the health care industry toward the stated SIHIS goals.

The guiding principles for the SIHIS as provided in the MOU between the State and CMMI include the following priorities:

- Goals, measures and targets should reflect an all-payer perspective;
- Measures should be focused on outcomes whenever possible; milestones, including process measures, may be used to signal progress toward the targets; and
- Maryland's strategy must promote public and private partnerships with shared resources and infrastructure.

We are pleased that the current direction of the SIHIS is consistent with these key goals. In addition, the focus on maternal and child health, diabetes, and behavioral health is consistent with CareFirst's health priorities for our members.

In particular, we strongly support the inclusion of the proposed maternal and child health measures in SIHIS and believe that it shows the State's commitment to improve population health on an all-payer basis, and not just for Medicare beneficiaries, as well as addressing longer term total cost of care and improved health outcomes. Moreover, now more than ever, it is important for the entire health care industry to be focus on driving health equity – both through the Model, and outside the Model. As the Maryland Department of Health (MDH) has highlighted on many occasions, there are stark racial and ethnic disparities in both maternal morbidity, and asthma-related ED and hospital visit rates. Greater accountability in both areas will help to put greater focus on health equity statewide and improve health care and outcomes for those who are most in need.

While we fully support the asthma-related ED and maternal morbidity rate measures, we also recommend consideration of non-emergency scheduled Cesarean section rates as an additional population health measure. Maryland has the 12th highest rate of Cesarean delivery, tied with New York.

In addition to the maternal and child health priority, we are very supportive of SIHIS's focus on diabetes, and we also applaud MDH's efforts to create a data-driven Diabetes Action Plan. According to MDH, more than 10 percent of Maryland's adult population currently has diabetes, and an additional 34 percent are estimated to have prediabetes. Diabetes is the sixth leading cause of death in Maryland and was the fifth leading cause of death for Black Marylanders in 2018. Currently, more than 200,000 CareFirst members, representing 8.3% of our 2.4 million commercial and federal employee populations have been diagnosed with diabetes, and this population accounts for approximately $2.3 billion in annual health spending.

Finally, the recent pandemic has highlighted the dire need for a redoubled focus on solutions to the opioid crisis, and the need for accessible behavioral health services across the State. After some improvement in the number of opioid-related fatalities in 2019, deaths have surged during the first quarter of 2020. Even worse, opioid-related emergency department visits and EMS naloxone administrations were down substantially during that time, an indication that individuals in need of help are not getting it. We support the State's efforts to reduce opioid deaths and including this issue in the SIHIS plan.

We believe that the SIHIS can help to incent health care industry coordination and aligned resources around preventing and managing diabetes, reducing opioid-related deaths, as well as advancing the goals of the Diabetes Action Plan.

We are excited about how the SIHIS provides a wonderful opportunity for collaboration among health care providers, payers, consumers, and the State that is centered around the greatest health care needs of Marylanders. We look forward to enhancing our efforts and partnering with all stakeholders toward these critical goals.

Sincerely,

Maria Harris Tildon

Cc: Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
Stacia Cohen, R.N.
John Colmers
James N. Elliott, M.D.
Sam Malhotra
Katie Wunderlich, Executive Director

**Nicki Sandusky McCann**
**VP Provider/Payer Transformation**
**Johns Hopkins Health System**
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211


November 19, 2020

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Wunderlich,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the Statewide Integrated Health Improvement Strategy (SIHIS) goals. Johns Hopkins is supportive of the Total Cost of Care Model (Model) and welcomes the opportunity to help ensure the Model's future success. We acknowledge that advancing the health of all Marylanders requires improvement across the three domains – hospital quality, care transformation, and population health.

JHHS is encouraged that the SIHIS "is designed to engage State agencies and private sector partners to collaborate and invest in improving health, addressing disparities, and reducing costs for Marylanders." Success under the Model requires participation and investment from all stakeholders who benefit from the Model, not only hospitals. Despite the goal to engage both the public and private sectors, there are stakeholders noticeably absent from SIHIS goals such as commercial payers, the Medicaid program, the Maryland Insurance Administration and elected officials. The goal of the Model to improve population health and care outcomes for individuals is achievable only when every stakeholder is collectively and collaboratively investing to achieve the SIHIS goals. The state must maintain and even increase its investment in population health initiatives in order for success to be attainable. If the SIHIS goals and the Model simply shift from state public health investments to hospital investments, achieving the goals will be impossible, threatening the entire Maryland Model.

The Domains, including the Total Population Health Goals, appropriately identify health disparities as a focus for improvement. Transformation in health disparities also requires action and investment from all stakeholders. Hospitalizations related to diabetes, opioids and asthma are often the result of failed or inadequate investments in social determinants of health, primary care, and public health for those who are most in need. Hospitals can and should play a role in addressing health disparities, but other public and private stakeholders must also contribute. JHHS is

encouraged that the General Assembly leadership has pledged to make health disparities a priority issue and we hope that this effort has a broad impact beyond hospitals.

Many of the Domains focus on Medicare beneficiaries or Medicare data only, with the caveat that Maryland will pursue adding and setting goals for additional payers as data becomes available. Maryland is six years into the Model, which remains an All-Payer Model. Not having actionable data from other payers is no longer acceptable. The HSCRC, working with colleagues across state government, including the General Assembly, should propose concrete actions that could be taken to align non-Medicare beneficiaries with the SIHIS goals. These could include legislative or regulatory requirements that Commercial and Medicaid payers align value-based programs with the SIHIS goals and provide appropriate data for the state to be able to track progress towards meeting them.

In addition to these broad concerns, JHHS also has comments and concerns related to specific domains.

**Domain 1- Hospital Quality**

- The Readmission Disparity Gap (15% improvement by 2023; 25% improvement by 2026) may be too aggressive unless there is strong public investment in social determinants of health. Additionally, any payment incentive should appropriately recognize hospitals that have already reduced the disparity gap for readmissions.

**Domain 2- Care Transformation Across the System**

*Improve care coordination for patients with chronic conditions*

- Adding the measure for timely follow up after acute exacerbations of chronic conditions is dependent on the ability to identify the patients and tracking of those patients. A significant percentage of patients may not be able to be identified or tracked if they are outside the respective facility or outside of the health care network. The HSCRC should work with CRISP to develop and leverage Health Information Exchange tools that provide real-time encounter-level patient information to assist hospital in tracking follow up for patients outside their facility or network. Otherwise, hospitals will be accountable for efforts without the appropriate tools.

*Increase the amount of Medicare TCOC or number of Medicare beneficiaries under CTIs/CRPs*

- Expecting that Maryland will have either 50% of TCOC under CTIs or 30% of beneficiaries under CTI or a CRP program does not seem reasonable especially considering that the CTI program is launched during a public health pandemic when time and resources are focused elsewhere.
- In light of the HSCRC's likely adoption of increased financial risk for hospital operated Care Transformation Organizations (CTO), the HSCRC should also consider counting the Maryland Primary Care Program's (MDPCP) beneficiaries and attributed total cost of care towards meeting the threshold goals. A specific domain of MDPCP is care transformation,

requiring that the practices transform the way primary care is delivered with support from CTOs.

**Domain 3- Total Population Health**

*Diabetes*

- Using BMI would require significant policy changes in order to create the environment that would make it easier for adults to achieve and maintain a healthy weight. This goal is not achievable by hospitals alone. Focusing solely on clinical interventions alone is also not sufficient. Hospitals do not have the expertise, outside of clinical interventions, to make changes necessary to ensure success within the goal. Public health professionals, payers, the business community and state and local governments would have to be engaged and accountable for the changes to be successful.
- Considering the limitations hospitals will have in addressing BMI, the state should considering creating greater alignment between the Diabetes Regional Partnership scale targets and the SIHIS diabetes goal.
- Sufficient consideration and vetting of the comparison and control states is necessary. The development of standards to evaluate the policy environment and select similar states is critical.

*Opioids*

- Sufficient consideration and vetting of the comparison and control states is necessary. The development of standards to evaluate the policy environment and select similar states is critical. For example, several states (NY, OH, MA and KY) received large, targeted federal grants to move the needle on opioid use and opioid overdoses. Comparing Maryland to states that have received significant public investments in opioid use disorder or that have fully integrated Medicaid (unlike Maryland's current bifurcated system) programs would not be appropriate.
- Increasing SBIRT in MDPCP practices is an important goal. The state should consider incentives or enhanced fee structure for buprenorphine induction in primary care practices. This action creates treatment on demand and will significantly reduce opioid use disorder.

*Maternal and Child Health*

- JHHS is pleased to see measures identified that address maternal and child health. Many HSCRC programs and targets are Medicare only. Focusing on maternal and child health demonstrates a strong commitment from the state to address population health as a long-term priority.

*Asthma*

- Addressing childhood asthma requires more engagement and accountability at a community level; hospitals cannot achieve the goal on their own. Reducing the ED rate for asthma for

children 2-17 requires significant health care transformation, health education and changes in housing and education policies.

- A health equity lens reporting of data by race would be appropriate for the asthma goal considering the high prevalence of health disparities with childhood asthma.

*Maternal Morbidity*

- The language identifying this goal should be changed to "Address severe maternal morbidity rate stratified by race and ethnicity." Using the language "decrease" could be interpreted to imply that an ongoing disparity is acceptable.
- Addressing disparities in maternal morbidity is an appropriate population health goal, however significant work must be done to optimize the outcome targets, identify appropriate interventions, and convene the appropriate complement of subject matter experts on maternal morbidity, health disparities/health equity, and structural determinants of health to get the interventions right.

Thank you for the opportunity to provide feedback on SIHIS. Success under SIHIS is critical to the future of the Maryland Model. All stakeholders must contribute to ensuring these goals are met. As noted with several other HSCRC policies, there is a need for consideration of the potential impact that COVID may have on implementation of these goals. There are strong indications that COVID will continue to disrupt our health care system through 2021.

Sincerely,

Nicki McCann
Vice President Provider/Payer Transformation
Johns Hopkins Health System

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James Elliott, MD
Sam Maholtra

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November 19, 2020

Mr. Adam Kane
Chairman
Health Services Cost Review Commission

Dear Chairman Kane,

On behalf of Luminis Health, we strongly support the Statewide Integrated Health Improvement Strategy (SIHIS). The metrics and targets outlined in the proposal are impactful and appropriately ambitious. They reflect a necessary redesign of the healthcare system in Maryland to improve access, quality, equity, and costs of health. To meet these goals and ensure the continuation of the Total Cost of Care Model, hospitals, providers, payers, and state agencies must all contribute and work collaboratively.

**Hospital Quality**

Maryland hospitals have focused on readmissions for several years and have made substantial improvements. Data shows that there is still opportunity to reduce readmissions further, especially by engaging community-based providers and facilities. Provider engagement programs, such as the Maryland Primary Care Program (MDPCP), incentivize collaborative efforts between hospitals and community providers to ensure patients have the appropriate supports and avoid unnecessary readmissions. Furthermore, focusing on reducing the readmissions disparity gap is an important step in improving health equity in Maryland. Lessons learned through this effort can inspire additional health equity improvements throughout the healthcare system.

**Care Transformation**

Successful care transformation requires sophisticated data analysis, engaged care partners, and continuous improvement. The Care Transformation Initiatives (CTIs) and Care Redesign Programs (CRPs) provide hospitals and care partners the resources necessary to develop, adjust, and grow care transformation throughout the system. Sharing best practices across hospitals and provider practices is key to adopting and expanding successful strategies to improve quality and reduce costs. Although CTIs and CRPs focus specifically on Medicare FFS populations, the care processes developed to meet program goals often spread to all patients.

**Population Health**

All Marylanders deserve to reach their full health potential. The true measure of success for healthcare systems is performance in population health. SIHIS' goals for improving diabetes, opioids, and maternal and child health will be challenging. However, they are necessary to move our system towards healthier living. Population health success requires investment in infrastructure, resources, and collaborative

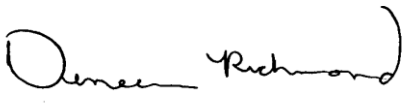
partnerships. We are committed to doing the challenging work to meet these goals, and we trust that our provider, agency, and payer partners are as well.

We urge the Commission to be resolute in pursuing the hospital quality, care transformation, and population health objectives of this proposal. Policies and grants should reflect SIHIS goals so that we avoid creating competing priorities and pulling away resources. We also ask that the Commission support hospitals in engaging physicians, post-acute facilities, payers, and other healthcare partners. Hospitals alone cannot control the total cost of care or redesign the healthcare system. Changes of this magnitude require intentional partnership, resource planning, and aligned incentives.

Thank you for the opportunity to provide comments. We look forward to future collaboration.

Sincerely,

Sherry B. Perkins, PhD, RN, FAAN
President, Luminis Health, Anne Arundel Medical Center



Deneen Richmond, MHA, RN
Acting President, Luminis Health, Doctors Community Medical Center

Maryland
Hospital Association

November 19, 2020

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Wunderlich:

As the advocate for Maryland's hospital field, MHA appreciates the opportunity to comment on the proposed Statewide Integrated Health Improvement Strategy (SIHIS).

The SIHIS offers a platform for public and private entities across the state to align around the chosen priorities to make a difference in the longer-term health of Marylanders. We applaud the enthusiasm, dialogue, and effort state partners have contributed to choose priorities and targets.

As you know, the SIHIS carries outsized significance by virtue of its role in the long-range prospects of the Maryland Total Cost of Care Model. Late in 2024, the Centers for Medicare & Medicaid Services (CMS) will decide whether our Model is worthy of "expansion," that is, being made permanent. That event is of great moment not only to the hospital field but also to the State and all other stakeholders. Continuation of the Model will bring economic gain, stability to major parts of the health sector, and the best chance to advance the health of all Marylanders.

It is vital that CMS's evaluation of Maryland's Model is favorable in 2021 and 2023—SIHIS measures included. The State must, therefore, choose areas of engagement on which Maryland can demonstrate progress within one to three years. And we are asked to do this while a pandemic ravages our entire nation, diverting precious resources from addressing the priorities everyone agrees upon.

We are especially concerned by the spike of COVID-19 in Maryland during the past two weeks, and the implications for the whole health care industry for the coming year. Since November 1, the number of new cases daily has more than doubled, from 900 per day to more than 2,000. Even more alarming, the number of hospital beds occupied by COVID patients has also more than doubled, from 520 to almost 1,200 beds yesterday. This constitutes an all-hands-on-deck situation for hospitals, health care practitioners, and the public health staffs of the State and localities. Even if the pandemic abates, the after-effects will be long-lasting.

Given these facts, we are deeply concerned about Maryland's ability to hit the targets set in the proposed SIHIS. We therefore encourage the State to submit these goals and targets as preliminary pending review once the pandemic is under control, the health care system is no longer operating in crisis, and social distancing is no longer a part of everyday life. This is

especially important for the maternal and child health goals as planning and implementation of activities are just getting started.

The memorandum of understanding that called for Maryland to create the SIHIS identified three domains, each of which must contain at least one goal: hospital quality, care transformation, and population health.

**Hospital Quality and Care Transformation Goals**

The goals in the domains of hospital quality and care transformation will require hospitals to go beyond current efforts, try new things and expand their reach further into communities. We agree with all four goals in the two domains and all but one of the targets.

In the Care Transformation domain, we recommend setting the 2026 target for participation in downside risk arrangements at 40% of beneficiaries or 25% of total spend. Aligning ambulatory practices with the aims of the Total Cost of Care model is crucial. Investment in data systems, point-of-care tools, and resources to identify and meet patients' social, self-management and behavioral health needs is critical. As are policies and incentives to advance ambulatory capabilities.

Meeting the 2026 targets will require a large increase in the number of practices participating in an advanced track of the Maryland Primary Care Program. We hope that will happen, but the advanced track is still under development and no one can predict the rate of uptake.

**Population Health Goals**

The proposed priority areas are rife with disparities and the legacy of systemic racism across much of society and its institutions. Changing the trajectory on the root causes and their impact on health will have lasting benefits, though to show tangible progress within just a few years is very, very difficult. Maryland hospitals will do the hard work of changing internal cultures and connecting with every patient in the way that works best for the patient. They are *all in*.

But hospitals cannot do this work alone. Success demands the full partnership of state and local government agencies, community organizations, health insurers, employers, and many others. Real resources—people and funding, plus leadership commitment—must be brought to bear.

MHA appreciates that HSCRC is committing $165 million over five years to expand access to behavioral health crisis and diabetes prevention and management services through its Regional Partnership grants. Partnerships' requests for funding exceeded earmarked limits by $100 million. For sure, $165 million is a substantial investment. But $100 million in shovel-ready initiatives on these two priorities alone will go unfunded. Regardless of the decisions made on the SIIHS, the $50 million remaining in Regional Partnership funding should be awarded.

Thank you again for the opportunity to share our views. We welcome further discussion.

And to you, the HSCRC staff, and commissioners, please stay safe.

Sincerely,

Bob Atlas
President & CEO

cc: Robert Neall, Secretary, Maryland Department of Health

UNIVERSITY of MARYLAND
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Finance Shared Services

November 19, 2020

Katie Wunderlich
Executive Director, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comments on SIHIS Measures

Dear Katie:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Statewide Integrated Health Improvement Strategy (SIHIS).

We would like to acknowledge the collaborative effort placed on developing the measurements for each domain of the Statewide Integrated Health Improvement Strategy (SIHIS). The industry greatly appreciates the opportunity to contribute to the development of these targets to ensure they are reasonable and achievable.

Our efforts remain strong and steady through an ever-changing healthcare environment related to the pandemic. While we make every effort to consistently drive practices we know improve care and patient safety, our ability to focus and sustain previous improvements is difficult while we are currently fighting, with all available resources, to manage the SARS-CoV-2 virus.

This challenge is now compounded by the recent increase in employee SARS-CoV-2 positivity rates. Across our health system we have seen our November employee positivity rates more than double those of September, growing from as low as 6% to a 7 day average of 13% to 15%. These percentages equate to a loss, on average, of 125 employees per week. As resources are limited and diverted to sustaining the safest environment for both patients and staff, we do have concerns that the expected pace of improvement in these quality metrics will not be consistent with those previously demonstrated.

**Domain 1 – Hospital Quality Measures**

We agree with HSCRC staff's proposed targets for AHRQ Risk-Adjusted PQIs. We feel that these targets are consistent with previous performance and are reasonable. We do have concerns that the impact of the ongoing COVID pandemic may be greater than anticipated for CY 2020. We would recommend that this be monitored closely on a statewide basis, and if performance is found to be significantly different than anticipated for this metric, that a modification to the target should be considered.

We also in agreement with the overall goal of reducing disparity in hospital readmission rates and are supportive of studying this metric further and developing a reasonable target in the future.

**Domain 2 – Care Transformation Targets**

We agree with the staff's recommendation to include NQF measure 3455 – Timely follow up after acute exacerbations of chronic condition. We feel timely follow up is a necessary part of successful care plans for patients with these chronic conditions. The ability to influence this metric is dependent on the ability to identify and track of those patients timely. We are worried that a significant percentage of patients (> 50%) may not be able to be identified or tracked if they're outside the respective facility or outside of the health care network. We would like the commission to consider a slight delay in including this metric until hospitals have the ability to consistently and accurately track these patients.

We support the staff's concept of including more patients and cost under the HSCRC defined Care Redesign Programs (CRP) and Clinical Transformation Initiatives (CTI) as a measure of care transformation. We are concerned, however, about the significant increase targeted for this metric over the next five years. As noted in MHA's comments, this increase would require a significant increase in the number of practices participating in track 3 of the MDPCP program, which is still being developed. UMMS supports MHA's suggestion to reduce the 2026 target for participation to 40% of beneficiaries or 25% of total spend.

**Domain 3 – Population Health Measures**

We support the inclusion of broader population based measures. Both the diabetes and the opioid metrics align with the new catalyst regional partnership grants that were recently approved for Diabetes Prevention Programs and Behavioral Health Crisis Programs. This alignment will support and focus the efforts of hospitals and their care partners in these areas. We agree with MHA's comments that the remaining funding earmarked for Regional Partnerships that has not already been distributed should be awarded to support these population health efforts once the third metric in this domain has been solidified.

Thank you for the opportunity to provide feedback. If you have any questions, please do not hesitate to contact me.

Sincerely,

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

Cc: Adam Kane, Chairman
HSCRC Commissioners
Mohan Suntha, MD, MBA, UMMS CEO
Michelle Lee, UMMS CFO