Maryland
Hospital Association

December 28, 2016

Deputy Secretary Shannon McMahon
Department of Health & Mental Hygiene
201 West Preston Street, 5th Floor
Baltimore, Maryland, 21201

Dear Deputy Secretary McMahon:

On behalf of the Maryland Hospital Association's (MHA) 64 hospital and health system members, we appreciate the opportunity to comment on the *Integrating Care to Meet the Needs of Medicare-Medicaid Dual Eligible Beneficiaries in Maryland Concept Paper*. We also appreciate that the state's process in developing the duals integrated care concept included significant stakeholder input, and we recognize that the concept paper is a reflection of this process.

We understand that while the concept paper will be submitted as part of the All-Payer Model Progression Plan, it is not a formal proposal to the Centers for Medicare & Medicaid Services (CMS). Rather, it allows the state to continue engaging stakeholders in the construction of the duals accountable care organization (D-ACO) model throughout 2017. We look forward to our continued engagement on this effort.

As we have shared in the duals care delivery work group, for hospitals – indeed, for the state's entire health care delivery system in light of our All-Payer Model – the ideal D-ACO model will:

- Integrate with the state's All-Payer Model, accountable care organizations, and other hospital partnerships
- Reduce potentially avoidable hospital utilization
- Promote better care coordination and chronic care management while incentivizing innovation
- Provide patients the right care, at the right time, in the right setting

As we all recognize, creating this type of integrated, accountable care system will not be simple. While the concept paper contains significant detail on how to design the D-ACO model to achieve these goals, many specifics that will lead to successful implementation remain to be determined. We offer the following for consideration as the design of the D-ACO model progresses.

1. Take a measured approach that allows the flexibility to leverage existing resources as well as to innovate. The dual eligibles population includes some of the most complex patients, with varying somatic and behavioral health needs. The notion that a D-ACO will need to present itself from the beginning as having relationships with all Medicare and Medicaid providers will

require a significant up-front investment. Therefore, at the outset of the design efforts next year, all stakeholders should prioritize the resources needed to serve this population, identify where adequate resources may already exist and, conversely, where they will need to be created. More importantly, it must be determined how D-ACOs will be able to develop these resources (*e.g.*, via upfront funding, a phased-in approach, or a combination of these and other methods).

As we continue to identify the needs of this population, it will be important to maintain a balance between understanding which existing structures and networks can be leveraged, and where new investments and innovations are needed. We appreciate the recognition of the significant investments made by hospitals via their informal and regional partnerships, and the Medicare Shared Savings Program ACOs. However, these investments are not limited to the structuring of provider networks. Rather, they extend to the development of care coordination and care management protocols. These investments should be preserved to the extent possible, and considered in the continued design work to ensure that any new infrastructure is not duplicative.

Along the same lines, we suggest that design efforts take into account the Medicare-Medicaid ACO model recently announced by the Center for Medicare and Medicaid Innovation. These efforts should draw out distinctions between it and Maryland's efforts, and identify whether those distinctions will benefit Maryland's implementation of the D-ACO model.

2. Data to drive integrated care delivery. As discussed in the work group meetings, any integrated care delivery system for this population will rely heavily on access to timely data along all points in the timeline for development and implementation. Initially, as noted above, timely program-level data will allow for hot-spotting and inform where investments must be made. As the D-ACO is implemented, this data will prove necessary for upfront care management funds and total cost of care benchmarks. To this point, we suggest that data that can provide a more stratified view of the dual eligible population beyond the cohorts discussed in the concept paper be made available during the design efforts next year. We appreciate the possibility of implementing an additional risk adjuster beyond the five cohorts, and encourage an analysis of the data to ensure that funds are adequately targeted to meet the needs of this complex population.

3. Clarity on interplay with all payer model. Perhaps the most important detail of the D-ACO model's development is its interplay with Maryland's core hospital All-Payer model. While there have been efforts to examine this interaction, specifics remain limited. As we design the D-ACO, many important questions must be answered and implications must be modeled. For example, how, if at all, are the five key metrics of the All-Payer model impacted, and how may we separate the impact of the D-ACO model from the impact of hospitals' efforts under global budgets? The data we note above will e critical to addressing these issues.

Finally, as noted in our comments on the Health Services Cost Review Commission's (HSCRC) *Maryland All-Payer Model Progression Plan* and the Department of Health and Mental Hygiene's *Maryland Comprehensive Primary Care Redesign Proposal*, the financial changes for

care delivery envisioned by the D-ACO model will certainly raise the total cost of care. Any agreement with CMS on a D-ACO model should therefore explicitly note that any upfront funds, such as care management funds, provided under the D-ACO model, as well as the expected increase in the use of services that will result initially as individuals are connected with care resources and currently unmet needs are addressed, are not part of the total cost of care calculation under the core hospital model. In addition, as we have noted to HSCRC, the implementation of the D-ACO model will require successful negotiation of an adjustment to the total cost of care calculation that takes into account this higher cost and use of care.

Thank you once again for the opportunity to comment on the concept paper. Please do not hesitate to contact us if you have any questions.

Sincerely,

Maansi K. Raswant

Maansi K. Raswant
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