Maryland
Hospital Association

December 14, 2016

Dr. Howard Haft
Deputy Secretary of Public Health
Department of Health & Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201

Dear Dr. Haft:

On behalf of the Maryland Hospital Association's (MHA) 64 member hospitals and health systems, we appreciate the opportunity to provide feedback on the Department of Health & Mental Hygiene's (DHMH) *Maryland Comprehensive Primary Care Redesign Proposal*.

Maryland's hospitals support the submission of the *Maryland Comprehensive Primary Care Redesign Proposal* to the Centers for Medicare & Medicaid Services (CMS), as it aligns with the goals of the state's All-Payer Model agreement with CMS, as well as the Institute for Healthcare Improvement's Triple Aim: better care for individuals, better health for populations, and lower per capita costs.

Hospitals recognize that the development and implementation of this model carry both risks and opportunities for the state's success under the All-Payer Model. A successful model is one that supports the next phase of the Maryland model by:

- building on the significant investments made by Accountable Care Organizations (ACOs) and other models to encourage physician integration
- expanding access to physicians, which fosters better outcomes through more coordinated care for patients
- reducing unnecessary hospital utilization
- reducing the rate of growth in Medicare total cost of care
- using strategies and incentives that create measurable physician accountability
- expanding opportunities for Maryland physicians to meet new federal regulations around alternative payment models

While this proposal seeks to achieve those aims, hospitals offer the following for consideration.

Total Cost of Care

Since the All-Payer Model began in January 2014, hospitals have undergone tremendous transformation – an evolution that has made significant headway toward improving the health of populations, the care of individuals, and lowering per capita costs. This work has been difficult, but its arc has bent toward better health for all Marylanders. To ensure that this progress is not stymied, hospitals are seeking assurances that the primary care model will, in no way, place the All-Payer Model at risk, as experience has demonstrated that physician care integration models

will increase Medicare total cost of care, at least in the near term. While CMS and the HSCRC have stated, and hospitals agree, that the core hospital model needs to be protected, the proposal contains no reference to risk to the total cost of care guardrail.

We recommend that the proposal commit to an approach that accounts for the influx of additional federal dollars resulting from upfront care management fees and performance-based incentive payments and as increased primary care utilization due to enhanced access. It should be made explicit that these additional dollars will in no way impinge on the total cost of care calculation, thereby affirming there would be no additional risk to the core hospital model.

Governance and Oversight

The role of governance and oversight is central to any care delivery experiment. The document lacks detail on how the Coordinating Entity, a new "state-sponsored, public private partnership" will coordinate and align with existing entities charged with overseeing the multiple transformation models being considered by CMS for approval. Also, the proposal is unclear about how the Coordinating Entity will be funded and what resources will be necessary to properly administer and oversee the program. For example, will any portion of the model funding targeted for providers or the Care Transformation Organizations (CTO) be used to fund the state-sponsored entity?

To ensure that the model operates as intended and achieves the desired results, we recommend a majority of the governing board be made up of providers. Also, we recommend that the document be revised to address expected resources needed to administer and oversee the program.

Overlap with Other Initiatives

We appreciate that the model is being designed to integrate with models currently under development in the All-Payer Model Progression Plan. The state's recently approved Complex and Chronic Care Improvement Program, for example, will enable hospitals to partner with community providers and practitioners to provide vital resources and support to primary care so that potentially avoidable hospital utilization is reduced. As this program shares many facets with DHMH's primary care model, it is unclear how these initiatives and their respective funding streams will interact. Given the similar goals of the initiatives there seems to be a significant risk for duplication of effort with limited resources. In addition, there is limited discussion of the alignment with the Medicare Shared Savings Program ACOs, the most prevalent integration model across the state.

It will be critically important in the next stage of this initiative to clearly articulate how the primary care model will interact with the Chronic Care Improvement Program and other relevant programs.

Care Transformation Organizations
The introduction of the Care Transformation Organization (CTO), whose role is to provide care management resources and infrastructure, is a departure from the federal Comprehensive Primary Care Plus (CPC+) program. We appreciate an environment that fosters a variety of existing health care entities, including ACOs and clinically integrated organizations, as well as an environment that allows hospitals to serve these roles within their communities. In addition, we support the participation of any qualifying organization to be able to act as a CTO for the purposes of this model

We recommend that any payer that wants to participate as a CTO for Medicare patients under the Maryland approach must also provide revenue to physicians to support the goals of the CTO for their non-Medicare enrollees. Such a requirement would facilitate the multi-payer goals of the model and align it with the federal CPC+ program. Further, while we agree that every provider must affirmatively designate a CTO, we recommend that CTOs be able to apply on behalf of a group of physicians with which they have a participation agreement. This would be consistent with the Medicare Shared Savings Program ACO arrangements.

Maryland's hospitals appreciate the work that has gone into drafting the *Maryland Comprehensive Primary Care Redesign Proposal*, and look forward to continuing to collaborate with DHMH and primary care physicians on a program that aligns Maryland's health care providers in service of the Triple Aim.

Sincerely,

Nicole Stallings
Vice President