



**Maryland's State Innovation Plan –
A Community-Integrated Learning health System for Maryland
Advocates Comments**

Submitted 15 April 2014 & Re-Submitted 28 April 2014 With Additional Signatories

Advocates for Children and Youth (ACY), the Maryland Women's Coalition for Health Care Reform (Coalition), and the Mental Health Association of Maryland (MHAMD) appreciate the opportunity to jointly comment on "Maryland's State Innovation Plan – A Community-Integrated Learning Health System for Maryland (CIMH)." Maryland's proposal was submitted to the Centers for Medicare and Medicaid Services (CMS) on March 31, 2014, and was subsequently released to the public for comment April 1, 2014.

Contacts:

ACY –Leigh Cobb, Health Policy Director lcobb@acy.org

Coalition –Leni Preston, Chair leni@mdchcr.org

MHAMD –Adrienne Ellis, Director, Maryland Parity Project, aellis@mhamd.org

The following **individuals and 32 organizations have also signed on** to these comments:

Community Behavioral Health Association

Madeleine Shea

Maryland Addictions Directors Council

Maryland Coalition of Families for Children's Mental Health

Maryland Citizens' Health Initiative

Maryland Disability Law Center

National Alliance on Mental Illness (Maryland and 12 County Chapters)

National Council on Alcoholism and Drug Dependence

Primary Care Coalition of Montgomery County

Progressive Cheverly

Public Justice Center

Additional signatories (post 15 April 2014)

Baltimore Healthy Start

Institutes for Behavior Resources

League of Women Voters of Maryland

Maryland Association of Core Service Agencies

Maryland Association of Resources for Families and Youth

Maryland Chapter of the American Academy of Pediatrics

Maryland Clinical Social Work Coalition of the Greater Washington Society for Clinical Social
Work

Maryland Environmental Health Network

Unitarian Universalist Legislative Ministry of Maryland

University of Maryland Carey School of Law, Drug Policy and Public
Health Strategies Clinic

Introduction

We applaud the State's commitment to integrating primary care with broader community health initiatives and are excited about the potential this holds for addressing the social determinants of health. We also believe that the State's progress with respect to CRISP will leverage opportunities for effective integration. However, it is **not possible to consider the CIMH proposal apart from the other transformative initiatives** the State is currently undertaking. These include the Maryland Health Benefit Exchange (MHBE), the All-Payer Hospital System Modernization (Medicare Waiver), and the integration of mental health and substance use disorder financing for publicly provided behavioral health services (BHI) through the recently released Administrative Service Organization Request for Proposals. None of these stands on its own. Rather they can and should work as integrated tools to create a true *culture of health* in Maryland. Together these efforts can ensure that individuals have not only access to an insurance card (Exchange and Medicaid expansion) but also access to high-quality and patient-centric care (Waiver, CIMH, and BHI). To ensure the success of all of these, **we**

recommend the establishment of a central oversight group for all state-based health care reform initiatives, as discussed below.

In addition, **to leverage rather than duplicate or hinder the work of other initiatives, it is critical that the work on all of these be predicated on a comprehensive catalog of current efforts** at all levels prior to further design development. Examples of efforts that should be catalogued include, but are not limited to, those delineated above as well as among others, the second iteration of the Medicare Waiver, Community First Choice program, the CHIPRA demonstration grant and the health home initiative. We see no or little mention of these programs in the current proposal. It is likely the target populations will be inclusive of individuals eligible for multiple programs. Therefore, some of the funding mechanisms as well as assessments and service planning could be leveraged across programs. This could encourage participation by assuring consumers that they will not be subject to multiple assessments or that multiple entities will not be determining their eligibility for services or coordinating their care.

Each of these initiatives presents distinct challenges, some known and some unknown, as we have so recently learned from the first ACA-mandated Open Enrollment period. Our comments are informed by that experience and by our own work across the full and complex landscape of health care reform. We also build upon the comments that the Coalition originally submitted October 28, 2013. In those we recommended that the expertise and experiences of consumer advocates be incorporated throughout the planning and implementation process. We also proposed six core principles and proposed strategies to implement them¹.

The comments that follow are grouped in two specific buckets:

- I. Areas that appear not to have been adequately addressed in the proposed plan, including:**
 - A. Consumer Perspective
 - B. Consumer Protections

¹ Core Principles included: 1) Ensure Transparency and Meaningful Public Input; 2) SIM Initiatives, including the CIMH, must be patient centered; 3) Focus on Coordination of Care; 4) Support Culturally-competent providers; 5) Infrastructure and Technology must underpin all aspects of care delivery; 6) Data-Driven design, implementation and evaluation. 7) Transparent and Efficient Governance

- C. Governance and oversight, including full integration with the All Payer Hospital System Modernization (Waiver) and Legal Issues

II. Issues relating to plan design and implementation, including:

- A. Consumers:
 - 1. Education and engagement
 - 2. Choice and access to services and supports
- B. Interrelationship with other reform and public health initiatives and the leveraging of assets and/or strategies
- C. Definition of Target Populations
- D. Quality and Cultural Competence
- E. Adequate Safeguards for Vulnerable Populations
- F. Program Evaluation

I. Comments and Recommendations: Areas Not Adequately Addressed

A. Consumer Perspective:

It is our strong belief that **robust public engagement is essential** for the development of a program that has the potential to profoundly impact Maryland’s consumers both directly and indirectly. Therefore, the expertise of consumers and consumer advocates, including children and families among others, is critical at every stage from preliminary planning through implementation and evaluation. Such interactions can fundamentally strengthen the model and ensure its success. We believe that the process to date should have been open to a broader community of consumer voices. There were two “stakeholder” groups. However, their membership was limited, with consumers and consumer advocates’ participation restricted to those individuals who received a recommendation from their own Local Health Improvement Coalition and were able to commit to attending multiple all-day stakeholder sessions. These two limitations made it difficult for many well-informed advocates to participate. In addition, public dialogue was restricted both due to the lack of comment time at any of the meetings and the submission of the CIMH proposal to CMS prior to opening it up to public comment.

We are certainly pleased to be able to provide that comment now, and we believe that the Advisory Board, newly created under Maryland statute, will provide greater opportunities

going forward to ensure that the CIMH meets the full needs of Maryland consumers and patients. We suggest that Health Systems Infrastructure Administration (HSIA) look to the process that the Health Services Cost Review Commission (HSCRC) has created for the Medicare Waiver. The HSCRC workgroup process provides transparency on the Commission and workgroup deliberations, which supports an informed and openly deliberative process. It also ensures that all those with a stake in the process have access, in a timely manner, to all meeting information as well as all presentations, background materials, white papers, etc.

B. Consumer Protections:

In this area we have two specific concerns:

1. **Data Sharing and Consumer Consent** - We appreciate the proposed use of the HHS Integrated Consent Form, but the choice of the form is merely one step in the process. There is little discussion of the education and informed consent process that is necessary to ensure that consumers understand the implications of allowing their data to be shared. **Consumers must be allowed to decide what data is shared, and with whom, with no repercussions or reductions in service eligibility.** Further, the recipients of consumer data must be made aware of the legal limitations on data sharing imposed not only by the Health Insurance Portability and Accountability Act, but by other laws, including 42 C.F.R. §2 ("Part 2"), governing confidentiality standards related to substance use disorder treatment. More thought must be given to restricting data sharing to only those individuals who need access and also limiting the data shared to the minimum necessary for the requesting individual to do his/her job.
2. **Complaints, grievances and appeals** – Given the potential impact on patients, especially given the lack of consumer engagement as described elsewhere, it is particularly concerning that the proposal lacks identification of the agency responsible for issuing legal notices related to patient eligibility and care or accepting and addressing consumer complaints and appeals. Nor does the proposal include a substantive process for how consumer complaints or appeals may be filed or addressed. An effective process will not only improve access for individual consumers, but add an important feedback mechanism for the program overall.

C. Governance and Oversight, and Legal Issues:

Given the complexity of the CIMH and the need to ensure that it is fully integrated with other reform initiatives, and in particular the Medicare Waiver, it is critical that the governance structure comport with all legal and regulatory requirements. At the same time, it must be designed in a way in which existing regulatory entities support an efficient model that guarantees consistency and transparency. As currently described, and as illustrated in the diagram on page 110, we have identified a number of areas of concern:

- The CIMH model reflects a “siloes approach” that we believe led to many of the failures with the MHBE’s development of Maryland Health Connection where the lack of effective integration of operations became so apparent. In that regard, **we recommend the establishment of a central oversight group for all state-based health care reform initiatives.** This would support the goal of effective and efficient integration of the multiple initiatives. Central to this would be a **role for those who represent the needs and interests of consumers.** An example for such a model comes from Connecticut where the Governor has established a Health Care Cabinet². This is somewhat analogous to Maryland’s Health Care Reform Coordinating Council, but it provides for a strong and on-going consumer voice. In this regard, the Connecticut construct includes a Healthcare Innovation Steering Committee and a Consumer Advisory Board. These oversee the work of the Program Management Office.³ We strongly recommend that Maryland consider such an approach.
- There is also a **lack of clarity around the use of the HSCRC Medicare Waiver workgroups.** The workgroups are included on the diagram of CIMH implementation and oversight, but there is very little discussion in the proposal of how the workgroups would be used in the CIMH implementation process. In addition, the HSCRC currently has authority over the Medicare Waiver alone. Therefore, it is unclear what the jurisdictional authority would be in regard to the use of these workgroups for the CIMH.
- The proposal, as written, also does not appear to take into account the fact that the **current Medicare Waiver ends in five years.** It is our understanding that the HSCRC will then transition to a broader waiver that puts all providers, not just hospitals, into a global budget. The development of that proposal will begin in the

² <http://www.healthreform.ct.gov/ohri/lib/ohri/HealthCareCabinetMemberChart.pdf>

³ http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/ct_ship_2013_12262013_v82.pdf

2017-19 timeframe and will be predicated on the success of the current Medicare Waiver. A clear delineation of the necessary synergy between that next step and the CIMH is missing from this proposal and underscores the need for coordinated oversight of all reform efforts.

- In addition, the proposal does not appear to anticipate the **role of the Advisory Body as set out in [HB1235](#), recently passed by the Maryland General Assembly**. The Advisory Body that is referenced in the proposal seems to focus on determining how established standards, metrics and methods should change post implementation. In contrast, the statutory language for the legislatively required Advisory Body, including representatives from consumer advocacy organizations, requires the Advisory Body to make recommendations on “the model, standard, and scope of services for the Community Integrated Medical Home Program,” as well as on the nature of the relationship between CIMH and patient centered medical homes, carriers, managed care organizations and other payers. These differences will need to be addressed in subsequent planning documents that ensure that the mandate of the legislated Advisory Committee is incorporated into the final model.

II. Comments and Recommendations: Issues Relating to Plan Design and Implementation

A. Consumer Issues:

1. **Education and engagement**: The SIM, like other reform initiatives, will only succeed if those who are directly impacted by it are both educated and engaged. In order for there to be effective participation, consumers must have a full understanding of the implications, as well as the potential benefits to them, of the proposed changes to their health care delivery system, and there must be levers to actively engage them. The current proposal does not address this need. We recommend that the Advisory Body prioritize the discussion of consumer engagement. They may also wish to consider how trusted community organizations and leaders can be engaged to encourage and educate consumers in their communities. Examples to consider are Connector Entity navigators and the faith-based community. **We recommend that a strategy for consumer and community education and engagement be integral to the final design and that these efforts be effectively coordinated with those for the Medicare Waiver.**

- 2. Choice and Self-Directed Care:** While the Community Integrated Medical Home holds promise for many patients, it is important that consumers have the choice to participate or not, based upon their own needs. In the current PCMH models and other reform initiatives, consumers have the right to decide whether to participate and which services to accept as a part of their care plan. In the models of care for older adults, individuals with disabilities, and other vulnerable populations the trend is toward self-directed care. The **principle of shared decision making should be incorporated** to ensure that medical care better aligns with patients’ preferences and values as new models of care are developed that will fundamentally change how patients access care. **In order to understand the needs and potential barriers to participation, HSIA should convene a focus group of identified super-utilizers.** This group could provide feedback on consumer education and engagement strategies, concerns about data sharing, and assist in identifying the particular social service needs that could be addressed by the CIMH, as well as helping to shape an effective appeal and complaint process.
- 3. Provider Choice:** Critical to empowering consumer choice is an effort to ensure that primary care and behavioral health providers are supported in their ability to participate. Consumers with established provider relationships should not be compelled to change providers in order to participate in the CIMH. HSIA must work to remove barriers for providers to participate including how to ensure that interested providers who do not currently have electronic medical record capabilities can participate.

B. Definition of Target Populations

We believe that the **narrowness of the eligibility criteria** risks losing the full benefit of a truly integrated community approach. For example, the merits of using the Community-Integrated Medical Home to address asthma in children are clearly set forth in the plan. However, as currently designed, children who go to the ER to address life threatening breathing issues, but are not subsequently admitted, do not meet the criteria for super-utilizers. As part of the cataloguing of current initiatives, we **recommend that HSIA compare eligibility criteria for other effective programs** and determine the feasibility for the expansion of the “super-utilizer” definition.

In addition, it is our understanding that the current data available through CRISP that will be used to identify super-utilizers, may not provide a complete picture of an individual's health care utilization. For example, there is very limited behavioral health data available through CRISP for various reasons, including the limits on sharing of substance use disorder data and the lack of behavioral health providers currently participating with CRISP.

Finally, there is **no reference to oral health or dental care** in the proposal. In 2012, 2,899 Medicaid or MCHP enrolled children were seen in the Emergency Room 5,699 times for dental, non-injury, issues. Furthermore a recent school screening pilot in Prince George's County found that 6.3% of the 3,091 children seen had severe dental issues requiring immediate attention and affecting basic functions such as speech and eating -- not to mention pain and the ability to focus in school. **Oral health cannot be ignored in any comprehensive integration of health services.**

C. Interrelationship with other reform and public health initiatives and the leveraging of assets and/or strategies:

Three areas should be addressed in a more comprehensive manner:

- 1. The relationship between the Medicare Waiver and the CIMH**, which should include the areas of consumer education and engagement as cited above. Other areas that should be addressed and are also cited above relate to governance and oversight, as well as the areas of incentives for both hospitals and providers, and the concept of shared savings that could have a positive impact on the long-term reduction of health care costs for consumers.
- 2. The opportunity to leverage the anticipated IT capabilities of the MHBE** to interact with enrollees with respect to their care. For example, care coordination opportunities could be leveraged through the enrollee data in the MHBE and Medicaid systems. Another opportunity could be grounded in the Connector Entities and their Navigators and Assisters, who will be trusted communicators for those who have enrolled through that process.
- 3. The opportunity to leverage additional collaborative care and community health initiatives**, such as the current and future Health Enterprise Zones and supporting program elements, Community First Choice Waiver, behavioral health recovery programs including the meaningful employment of peer support specialists, care management entities (CMEs) that provide wrap-around services for children with

serious mental illness. It is likely that many of the identified “super-utilizers” may already receive services in one or more of these programs. It only makes sense that the CIMH would collaborate with the oversight entities of each to determine how to best utilize these successful programs, as well as consider how funding mechanisms can be leveraged. Some of the aforementioned programs are supported by Medicaid while others are supported by grant funding which may or may not be sustainable.

D. Quality and Cultural Competence:

Cultural Competence is a core tenet of the Affordable Care Act. Maryland, through strong leadership in the Governor’s office and the Maryland General Assembly, is moving in the right direction in establishing and supporting the delivery of culturally competent, quality health care. In fact, Maryland leaders have recognized that the quality of health care delivery and outcomes is dependent on a culturally competent delivery model. We have great concern that there is very **little discussion of cultural competency in the CIMH proposal or that**, as written, **it will support such care**. It is critical that the new Community Health Worker Advisory Body develop recommendations on required cultural competency training and standards for these new workers.

We are also concerned that the CIMH proposal, in an effort to encourage more primary care providers to participate in the PCMH program, may not require that they undertake the same certification process required of current PCMHs. The certification standards were established to ensure that consumer safety and receipt of quality care.

E. Adequate Safeguards For Vulnerable Populations:

While the CIMH proposal attempts to address the needs of the behavioral health population through expansion of the Behavioral Health in Pediatric Primary Care (BHIPP) program and utilization of the Four Quadrant Clinical Integration Model used to determine whether an individual’s primary health home should be the primary care provider or the behavioral health provider, there are other things the CIMH does not adequately address. And, while the CIMH proposes to expand the BHIPP program beyond the current pediatric practice to include adult primary care, our understanding is that the federal funding that sustains BHIPP may be ending in the fall of 2014. There may be discussions underway at the Behavioral Health Administration to determine how to continue BHIPP in its current

iteration, but we would recommend that HSIA coordinate with BHA to determine what funding mechanisms can be used to reach the goals of the proposal.

We also **recommend that in implementing a coordinated care model for behavioral health consumers, the CIMH reflect the recovery model**, which employs community supports and peer support specialists trained in working with individuals in recovery from a mental illness or a substance use disorder. Maryland is currently establishing a certification requirement for this workforce, and we highly recommend that they be employed in the CIMH program.

Finally, because of the sensitive nature of behavioral health information and the persistent stigma surrounding these disorders, extra care must be taken to protect this data. While we appreciate all of the coordination of data efforts proposed, we believe **more focus must be placed on how consumer data, especially sensitive data will be protected**. This includes consumer education and informed consent requirements, as well as allowing behavioral health consumers to determine which segments of their data are shared with which providers.

F. Program Evaluation:

We appreciate the recognition that the CIMH, as well as other reform initiatives, will “require iterative cycles of refinement and improvement and even the most successful will face the challenge of implementing on a larger scale with sustained effectiveness.” However in laying out the initial evaluative proposal, we believe that a number of key factors have been overlooked. We believe that **a greater emphasis on patient satisfaction is required** - both in determining their understanding of their options to participate in the program and their ultimate experience with it. While the final measure (page 93) is “the patient experience with care,” we do not believe this addresses the consumer perspective in a comprehensive manner. The second area relates to the lack of outcome measures for mental illness and substance use disorders. We encourage **HSIA to work with the behavioral health community to determine what evidence-based behavioral health outcomes** can be assessed.

We also have concerns that the program evaluation will be housed in the Public Utility rather than as part of a regulated body, which would have oversight responsibility and

enforcement authority. In addition, because the effectiveness of the CIMH is so integral to the Medicare Waiver, we believe there must be a **more integrated model for evaluating performance and effectiveness**. This again emphasizes the value of an Advisory Board that has oversight over all health reform initiatives.

Conclusion

Given that no financial model for the CIMH was included in the proposal, it is somewhat difficult to comment on the adequacy of allocated resources. However, given our experience with other reform initiatives, we would like to emphasize that there must be appropriate investments in IT, consumer education and engagement, as described above, and training at all levels.

Not only has Maryland created innovative models that will be examined by other states, but the reverse is also true for the community health team concept. Specifically, eight states have implemented programs that support multidisciplinary community health teams that are shared among multiple practices. All eight emphasize in-person contact with patients and integration with primary care providers and community resources. All of these state-supported programs feature a stakeholder engagement strategy, explicit expectations for community health teams, a defined payment and financing model, and an evaluation strategy. North Carolina's program has been in existence the longest. The program, Community Care of North Carolina Networks, was launched in 1998, and has demonstrated success in both bending the cost curve and improving quality. For example, it ranks in the top 10% of programs nationally for HEDIS measures related to diabetes, asthma and heart disease, and saved Medicaid alone close to \$2 billion between 2007 and 2010.

In addition, Connecticut's SIM project has created both a governance and oversight platform that ensures strong consumer participation as discussed above. We believe that the current SIM proposal would benefit from a closer examination of these and other relevant models, as well as the creation of detailed catalogue of current Maryland initiatives. Without this investment in understanding how the CIMH can coordinate with current programs, such as the Community First Choice Program, the Health Enterprise Zones, the new Administrative Services Organization for Medicaid-funded behavioral health services, the CIMH risks not only duplicating efforts but could risk a decrease in consumer and provider participation. With this

investment and the inclusion of a broader stakeholder community in future plans, Maryland can create an innovative program that best meets the needs of Maryland health care consumers.

With these comments, we reiterate our own commitment to continue to be actively and productively engaged in developing a successful model that will benefit Marylanders, and to working with all stakeholders to make that a reality.

CC: Dr. Laura Herrera, Deputy Secretary of Public Health Services
Chuck Lehman, Acting Deputy Secretary of Health Care Financing
Dr. Gayle Jordan-Randolph, Deputy Secretary of Behavioral Health
Ben Steffen, Executive Director of the Maryland Health Care Commission
Donna Kinzer, Executive Director of the Health Services Cost Review Commission
Dr. Tricia Nay, Executive Director of the Office of Health Care Quality



Comments from Alzheimer's Association re State Innovation Model

Cass Naugle <mnaugle@alz.org>
To: marylandSIM@gmail.com

Tue, Apr 29, 2014 at 11:52 AM

The Alzheimer's Association is in support of many of the concepts in Maryland's State Healthcare Innovation Plan submission to the Center for Medicare and Medicaid Innovation. However, it is concerning that there does not appear to be coordination with or understanding of Medicaid long-term care program and the effect this plan would have specifically on people receiving services through the Community First Choice program or the Combined Options waiver (formerly the Older Adults Waiver and the Living and Home waiver).

The Plan discusses people who are dually eligible as being one of the top target populations for this effort. Unfortunately, it is silent or unaware of the many new changes that have been made in Medicaid long-term care program with CFC and the Combined Options waiver. In particular, the Plan states that

- Care coordination does not exist for people who are dually eligible and therefore must be enrolled into this plan. Care coordination, while never perfect, has an improved emphasis in CFC, was designed in collaboration with the CFC Implementation council and now in regulation, and also exists within the waiver. Also, under CFC, there must be a choice of care coordination providers for the program recipient. It seem to make sense that care coordination be provided to individuals who don't already receive that service and not overlap where services are provided already creating confusion.

- A new category of worker called a Community Health Worker (CHW) will be created that will be providing assessments to each individual, and provide some delegated lower-level health care, among other tasks. This raises two concerns:

- 1) First, people in the Medicaid Long-Term Care program, including those who are dually-eligible, are now already receiving a lengthy assessment that may be duplicative. Without knowing how this interfaces with the Medicaid LTC program, it may create unnecessary confusion and extra assessments of individuals.

- 2) The second large issue this raises has to do with the absence of CNAs, GNAs, and CMTs as part of this team. It seems to deem CHWs as new health workers without the current licensure or certification required by OHCQ. This also raises concerns with regulation and oversight of this new class of workers, which of course leads to concerns about quality of care and patient protections. It also isn't clear how these are distinguished from our current home health agencies and RSAs. It's unclear how current laws and Board requirements about nurse delegation will interface with this new Plan.

It seems that there needs to be a clear understanding of how this Plan would interface with other programs, regulations, and practice requirements. Lastly, it seems there is a definite need to bring into this effort, all

affected stakeholders to ensure this Plan works for the various populations and individuals it seeks to serve.

Sincerely,

Cass Naugle

Cass Naugle | Executive Director | Alzheimer's Association, Greater Maryland Chapter | office:410.561.9099 |
24/7 Helpline: 1.800.272.3900 | mnaugle@alz.org | www.alz.org/maryland

Join the National Alzheimer's Advocate Network



ENEWS
SIGN-UP



TONI HOLNESS
PUBLIC POLICY
ASSOCIATE

Maryland Department of Health and Mental Hygiene
Public Health Services
201 West Preston Street
Baltimore, MD 21201

April 25, 2014

RE: Maryland's State Healthcare Innovation Plan

Dear Secretary Sharfstein:

AMERICAN CIVIL
LIBERTIES UNION
OF MARYLAND

MAIN OFFICE
& MAILING ADDRESS
3600 CLIPPER MILL ROAD
SUITE 350
BALTIMORE, MD 21211
T/410-889-8555
or 240-274-5295
F/410-366-7838

FIELD OFFICE
6930 CARROLL AVENUE
TAKOMA PARK, MD 20912
T/240-274-5295

WWW.ACLU-MD.ORG

COLEMAN BAZELON
PRESIDENT

SUSAN GOERING
EXECUTIVE DIRECTOR

C. CHRISTOPHER BROWN
GENERAL COUNSEL

We write to express concern regarding the recently released grant proposal, “A Community-Integrated Learning Health System for Maryland—Maryland’s State Healthcare Innovation Plan.”

We understand that the proposal seeks to improve healthcare access through greater integration of service delivery. However, we have two main concerns regarding the privacy of patients’ health records under the proposal.

Our first concern pertains to the privacy of patient data and the potential for patients to lose control over which health providers have access to their health records. Patients may wish for some health providers to access all their records, while wanting other providers to access a limited subset of the patient’s records. From the grant proposal, there does not appear to be any safeguards for limiting access to patients’ health records, which may expose patients’ records to a broader audience than necessary and violate patients’ right to consent to the disclosure of this information.

Second, it is unclear whether patients must share their data in order to have access to services under the proposed model.

Thank you for your time,

Toni Holness, Esq.
Public Policy Associate



Maryland's State Healthcare Innovation Plan: Public Comments

Ancona, Vincent <Vincent.Ancona@amerigroup.com>

Tue, Apr 15, 2014 at 12:50 PM

To: "marylandSIM@gmail.com" <marylandSIM@gmail.com>

As always, we appreciate the opportunity to provide additional input into the proposed State Healthcare Innovation Plan for integrating the concepts of the Community-Integrated Medical Home. As you may recall in an email dated September 12, during the initial development of the design, we shared several thoughts, suggestions and questions. While many of the questions have been answered, important details remain outstanding, including those stated below:

1. Proposal does not define the importance, value or role of HealthChoice program or MCO's current or future role. There is a need to consider the work, knowledge, contribution and risk being undertaken by MCOs.
2. A pay and/or play reimbursement model has been proposed, however questions remain as to the impact and how MCOs will fund cost? Will they be built into rates/budget? How/who pays for non-MCO benefit costs?
 - o While the proposal recognizes the complexity of attribution of savings, proposal needs to include solution to enable full understanding, evaluation, value and ROI of program.
3. MCOs are at risk regardless of program's success. MCOs will continue to manage their members even if comfort is gained in delegating some responsibilities. Concern remains; we could be duplicating outreach and engagement with members, increasing costs and confusion to the patient.
4. Measure of success reflects quality metric that do not fully align to the HealthChoice program measures, such as NCQA, HealthChoice Report Card, HEDIS or Value Based Purchasing for which MCO's are already at financial risk. If the proposed Program is to successfully achieve improved quality and efficiency, a greater understanding of the Medicaid Quality Program and alignment of the measures would be preferred.

Thank you for all the hard work you and your team has put into such a thoughtful program and your willingness to allow us a voice in the process.

Vince

Vincent M. Ancona

Amerigroup Community Care

7550 Teague Road, Suite 500

Hanover, MD 21076

P. 410-981-4001

F. 410-981-4010

vincent.ancona@amerigroup.com

www.amerigroup.com



Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may include AMERIGROUP member(s) information that is legally privileged. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy copies of the original message.



SIM Feedback <marylandsim@gmail.com>

SIM Feedback

Laurie Fetterman <hdfett00@aacounty.org>

Mon, Apr 28, 2014 at 4:58 PM

To: marylandsim@gmail.com

Cc: Jinlene Chan <hdchan22@aacounty.org>, David Rose <hdrose11@aacounty.org>, Antigone Vickery <hdvick00@aacounty.org>

Hello:

Please see below for feedback and questions regarding the SIM proposal from the Anne Arundel County Department of Health.

- 1) The model is very complex, and could be very confusing for consumers/clients.
- 2) The model potentially requires a large number of contracts and agreements. For example, CHH may directly provide services or subcontract them out; PCMHs would need to have agreement with CHH/CHTs, etc.. Will there be sufficient funding for staff positions to provide the necessary oversight functions?
- 3). Community Health Hubs:
 - These have the potential to foster competition, rather than collaboration among LHIC partners, especially in jurisdictions with competing hospitals.
 - What if no one applies to be a CHH in a given area?
 - Why are LHICs charged with maintaining a "comprehensive and up-to-date inventory of resources, services and current contacts for the CHH to access in coordinating care for their patients"? Wouldn't this task be better undertaken by the "boots on the ground" organization?
- 4) CHW Certification:
 - How does this compare to the existing public and community health programs offered?
 - What level is the proposed certification, as this is not clear from the proposal?
 - The timing of the development and roll-out of these certification programs is not clear in relation to having the CHH's become operational—would CHW's need to be certified before working in a CHH?
- 5) How would the work of the CHH's intersect with the Community First Choice program in which seniors (Medicare and dual-eligible) also get home visits, home-based personal care and nurse monitoring home visits? There is likely a fair amount of overlap in the target population for the CHH and the CFC program, and while the focus is slightly different for the different programs, it may be even more confusing for the consumer about who manages what part of their care.
- 6) Is there a timeframe that lays out how all of the different components/proposed activities would be developed and implemented in relationship to each other?

Thank you for the opportunity to review and comment on the proposal and we look forward to working with you to implement this in Maryland.

—
Laurie B. Fetterman, M.S.W.
Health Planner
Office of Assessment, Planning and Response
Anne Arundel County Department of Health

3 Harry S. Truman Parkway, Annapolis, MD 24101
Phone: 410-222-7203; Fax: 410-222-7348

Maria Harris Tildon
Senior Vice President
Public Policy and Community Affairs

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-605-2591
Fax 410-781-7642



VIA EMAIL (marylandSIM@gmail.com)

April 15, 2014

Karen Matsuoka, PhD
Director, Health Systems and Infrastructure Administration
Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21202

Dear Dr. Matsuoka:

I write on behalf of CareFirst BlueCross BlueShield (CareFirst) and in response to the Maryland Department of Health and Mental Hygiene's (DHMH) State Healthcare Innovation Plan (Plan) that was submitted on March 31, 2014 to the Center for Medicare and Medicaid Innovation (CMMI). We write from the perspective of being the largest insurance carrier in the region, as well as having the experience of operating the largest Patient Centered Medical Home Program (PCMH) of its kind nationwide. CareFirst has demonstrated great success in reducing costs and improving outcomes in the populations that we serve through our PCMH.

We recognize that aspects of the Plan are intended to improve population health and the State's public health foundation; however, we are concerned that the Plan does not take into account the value of health care delivery innovations already underway in Maryland and also has the potential to stifle further innovation in health care delivery in the State.

Some of our key concerns about the Plan are listed below:

- 1) If approved, the Plan would create a burdensome and complicated public utility to implement the Community Integrated Medical Home (CIMH) model that would regulate all commercial, single payer patient centered model home programs in the State. This is overbroad and unwarranted, as innovations already operating in the State have produced meaningful impacts on costs and quality in the commercial market.
- 2) Instead of supporting current PCMH models, the Plan proposes to create a single set of PCMH standards that would cover all programs. While the Plan indicates that the new program would be inclusive of the standards used in current programs, the criteria listed do not make this clear.
- 3) The 15 Medicare Accountable Care Organizations currently approved to operate in the State – all under different models – would be deemed to be certified. However, no such assurance is given to existing successful single carrier PCMH programs.

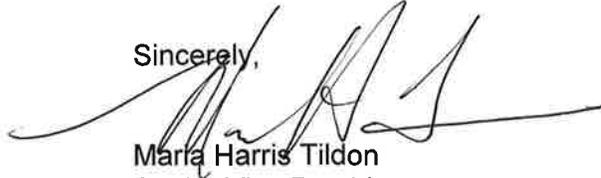
- 4) The Plan goes into great detail to outline the standardization of PCMH elements ranging from accreditation requirements to quality standards and all other underlying methods to implement these programs, with no recognition of how this effort would be informed by the operation of current, successful single carrier PCMH programs. This is particularly troubling given CareFirst's demonstrated success in reducing costs and improving outcomes in the populations that we serve through our PCMH program. Approximately 85% of eligible primary care providers (PCPs) participate. Our program is comprehensive, providing the necessary resources to PCPs to differentially focus on patients most in need of care planning and coordination. We are steadily enhancing and improving the program through experience and rigorous internal and external evaluation. In recognition of the promise of our model, CareFirst received a grant from CMMI to apply our innovative program to serve approximately 35,000 Medicare beneficiaries in Maryland.
- 5) Carriers are excluded from the State's depiction of the drivers that meet CMS's triple aim, revealing a lack of understanding of the importance of the role that carriers can play in improving health care delivery.
- 6) The Plan seems to treat current well established efforts as if they did not exist and proposes to start from scratch with standardized requirements that are very generally stated, making it impossible to know what the practical implementation may mean or yield.
- 7) The Plan notes that there are core PCMH principles necessary for success and treats these as a given, even while there is little in the existing literature to prove that these principles or standards result in better outcomes. A more logical State approach would be to allow different models to operate and test criteria, with flexibility for the model to change course as experience dictates, rather than to stifle innovation.

In addition to these concerns, the document suggests that the Plan is the result of work sessions representing stakeholder consensus. While CareFirst was invited by DHMH to participate in stakeholder work sessions on the design of SIM during the summer of 2013, no draft of the Plan was presented to stakeholders for review prior to submission, and there were no discussions of the Plan after CMS' approval of the modernized all-payer hospital payment model. At stakeholder meetings in 2013, much concern was expressed by many stakeholders about the potential of a model such as that proposed in the Plan to stifle innovation. The Plan does not address these concerns.

We also note that many aspects of the Plan are presented as a certainty, yet they are not currently within DHMH's authority and would require legislation in order to be implemented. We would expect that in advance of any legislation that all stakeholders would be invited to participate in its development in a meaningful way.

In short, the Plan ignores to its detriment health care delivery reform efforts that already exist, and does not appear to have used insights that could have been gleaned from these efforts. We are concerned that the Plan as submitted could stifle innovation and undermine the success that has so far been achieved. The Plan needs much more careful development and consideration of the successful delivery models that already exist in Maryland, and certainly far more discussion with us and others before we could support it.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Harris Tildon', with a long horizontal flourish extending to the right.

Maria Harris Tildon
Senior Vice President
Public Policy and Community Affairs

Carroll County SIM/CIMH Comments:

Participant 1:

- Payer Participation & Payment Model (pp. 59-60)

“CHHs will be financed on a capitated severity-adjusted “case rate” basis, based on what it costs to deploy the set of interventions appropriate for their specific target populations.”

-It’s unclear where the reimbursement process begins i.e. claims submission and how funds are disbursed (i.e. claims adjudication and claim payment)? Are there “new” billing codes associated with the CIMH?

-Beside Medicare/Medicaid is the CIMH model open to commercial HMOs, PPOs, and other managed care organizations?

-How is “capitated severity-adjusted case rate” basis calculated?

-What are the tangible selling points to providers who may want to participate in the CIMH?
- CHH Core Performance Measures

-In addition to first visit following enrollment, time to first visit after hospital discharge, time to completion of initial assessment, when can CHHs anticipate a more complete or finalized list of measures and will this list be provided prior to the approval of the CIMH testing phase?
- General

-The state has hosted several stakeholder meetings beginning May 9, 2013 thru September 10, 2013, and crafted legislation specific to CIMH, has the state designed a plan to reach-out and educate a “target community” on the specifics of the model or will that responsibility rest on the LHICs/CHHs?

-Under the CIMH model, a population is segmented into 4 categories: healthy, chronically ill but under control, chronically ill and at risk of becoming super utilizers, and super utilizers. The model appears, initially to target the super-utilizers within a given community for a time period. What if, concurrently, the focus is maintaining the healthy segment, healthy?

-Much attention has been given to The Partnership for a Healthier Carroll County as a national exemplar in terms of its strong and long standing partnership with Carroll Hospital Center and the Carroll County Health Department. As a result, several key healthcare initiatives and improved community health status have been realized. The Partnership and its team members have already invested significant time and efforts in preparation for the SIM/CIMH initiative from attendance in the stakeholder meetings, presentations to several groups, design and creation of its Population Health Governance Group and scheduled

meetings, and planning and preparation for the Chinese Delegation visit in May, would the State be willing to allocate start-up funding to The Partnership as a future LHIC/CHH prior to the approval of the CIMH Testing Phase by CMMI?

Participant 2:

I'm curious about the school based health centers. Where, when, how and why, are there any teeth in this? Will SBHC be established at all schools prior to CIMH model? If not, it can't be built as part of the partners? All schools? All schools in every county?

Participant 3:

- 1) Technology can be a huge barrier - practices and facilities already have their own electronic records so how will data be collected without duplication of effort?
- 2) How and who will set education standards for workforce and will this fit with current DBM specs? Hospital or primary care specs?
- 3) It's an election year - enough said.

Participant 4:

Pg 8 - Under Importance of Pillar and Goal top chart – first sentence stops with “through” and think there is something missing there. The rest reads fine but I have also been very close to the process. It makes sense to me but maybe not to someone less familiar. Could use an acronym index.

Participant 5:

Workforce development – competency building could use Career Pathway and works with funding potential from the Department of Labor.

Make sure to emphasize information in appendix 8.4

For more information or contact information:

Barb Rodgers – barbara.rodgers@maryland.gov

Julia M. Huggins
President, Mid-Atlantic Region



10490 Little Patuxent Pkwy
Suite 400
Columbia, MD 21044
Telephone 410.884.2510
Facsimile 800.657.3073
julia.huggins@cigna.com

April 28, 2014

Dr. Laura Herrera, M.D.
Deputy Secretary,
Public Health Services
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Dr. Herrera:

Thank you for the opportunity to participate as a member of the workgroup developing the Community Integrated Medical Home Program, while I have followed this process closely, scheduling conflicts often precluded my personal attendance. I am writing to provide comments on Maryland's State Healthcare Innovation Plan (Plan) which is to be submitted to the Center for Medicare and Medicaid Innovation in partial fulfillment of the State Innovation Model Design award.

Cigna is dedicated to helping the people we serve improve their health, well-being and financial security. Cigna offers products and services under the Connecticut General Life Insurance Company (CGLIC) or the Cigna Health and Life Insurance Company (CHLIC). Cigna HealthSpring, formerly Bravo Health, also offers a variety of Medicare Advantage related products. All of these Cigna companies proudly serve our Maryland customers by providing health care solutions to meet their unique needs.

Cigna shares the goals and objectives of the proposed Plan and commends the Department for undertaking such an ambitious endeavor. While the plan contains significant detail on a number of items, there is one glaring omission. Medical home programs and payment reform models are achievable only when providers and carriers are in network relationships. Cigna believes that in order to accomplish payment reform and have effective population health management, the State should adopt policies that promote the participation of primary care doctors and specialists in carrier network contracts.

State laws and policies that encourage providers to remain outside insurance carriers networks undermine the broader goal of health system reform in Maryland. The Plan should be amended to call for substantial revisions to the Assignment of Benefits statute (Chapter 537, 2010 Laws of Maryland) to eliminate the financial incentives for providers to remain out of network with insurance plans. The Plan should recognize that in network relationships among providers and insurance carriers are essential to achieving the quality, care coordination and financial goals set forth by state policymakers.

When reading the Plan, I was struck by the following statement on page 27, "...the CIMH model will initially focus on Medicare FFS and dual eligible patients, given that there is no systematic care management offered to these individuals despite the need..." We recognize that in traditional Medicare

Proud National Sponsor of the March of Dimes WalkAmerica@... the Walk that Saves Babies

"CIGNA" and "CIGNA HealthCare" refer to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these operating subsidiaries and not by CIGNA Corporation. These operating subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Connecticut, HMO plans are offered by CIGNA HealthCare of Connecticut, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.

Fee for Service this statement holds true. At Cigna HealthSpring, however, the cornerstone of our physician partnership model is the coordination of care. The Cigna HealthSpring model offers comprehensive benefit design and care coordination required to ensure that duals have access to high quality care. This model also provides an efficient management of Medicare and Medicaid resources. The result of these aligned incentives is better outcomes for instance, Cigna HealthSpring patients have 51% fewer Emergency Room visits and the average length of a hospital stay is 19% shorter for Cigna HealthSpring patients when compared to traditional Medicare.

Medicare Advantage plans like Cigna HealthSpring already have the infrastructure in place to serve many of the policy goals outlined in the Plan. One significant impediment to better care, however, is the low enrollment numbers for dual eligibles in Medicare Advantage plans-about 17% of those eligible are enrolled whereas 25% of all Medicare beneficiaries are enrolled in Medicare Advantage. Cigna believes the Plan should be revised to recognize the positive impact that Medicare Advantage plans can have on improving care for dual eligibles and include efforts to enroll more dual eligibles in Medicare Advantage plans. If you have an interest in pursuing this approach, the Cigna HealthSpring leadership is available to meet with you and serve as a resource.

You may recall that Cigna operates its own Collaborative Accountable Care (CAC) program. This program provides a market based solution to many of the coordination of care and other population health management issues properly identified in the Plan. Cigna believes that our proprietary model achieves the "triple aim" of improved quality, affordability and patient satisfaction. While we believe our program is the best nationwide, we recognize that other carriers employ their own models. Cigna urges you to clarify within the Plan document that programs like the Cigna CAC will be allowed to continue without the imposition of mandated performance standards or mandated payment models.

Without this flexibility, the Plan could stifle innovation within the marketplace as carriers and providers would be unable to determine the nature of their own contractual relationships. Similarly, Cigna does not support a single State mandated model of a Patient Centered Medical Home (PCMH). Cigna strongly believes that carriers should have the ability to fashion individual agreements with hospitals and doctors. Effective competition among insurance carriers hinges on the ability to employ innovative contracting methods. A one size fits all approach coupled with mandated participation for insured plans undermines that feature of the marketplace.

Cigna has previously gone on record with the Maryland Health Care Commission (MHCC) expressing our concerns about the All Payer Claims Database systems which are prominently referred to in the Plan. These systems impose a significant administrative burden on carriers when there is increased pressure to reduce costs. Unique state programs, with vastly different reporting requirements, create added challenges for national carriers who operate claim platforms across multiple states. Claim systems are designed to process claims and are ill-equipped to meet the cross functional reporting requirements contemplated in the Plan and by MHCC. In short, we believe the Plan overstates the potential utility of this data and should include a return on investment calculation to justify the cost and burden on carriers.

Cigna has significant concerns with the proposed creation of a "public utility" as described in the Plan. While the services to be provided by this new entity are valuable they are largely duplicative of health plan features already provided to Cigna customers. The Plan also suggests that Cigna's employer customers could be targeted as the source of funding of this utility. Cigna does not support the imposition of new taxes or assessments on our employer customers to fund the operation of this public utility. The Plan should be amended to clarify that any interaction with this "public utility" should be on a purely voluntary basis by payers and that the State will not seek to impose additional taxes or fees to support the operations of the utility.

Julia M. Huggins
President, Mid-Atlantic Region

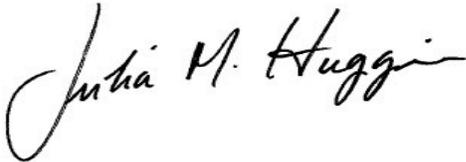
Moreover, Cigna would not support the economic regulation of payers or provider relationships that the term “public utility” suggests. There is robust competition among carriers in Maryland whereas public utilities are created in the absence of true market competition for services. Cigna believes the use of the term “public utility” is entirely inappropriate unless it is the State’s intention to economically regulate doctors or carriers under a rate base/rate of return methodology. If so, the Plan should clearly articulate that intention.

Cigna finds the governance structure for the public utility described in Chapter 5 of the Plan to be wholly inadequate to protect the public interest and lacking in appropriate checks on executive authority. The proposed public utility board does not include any representation from members of the public who actually purchase insurance or health care services as either employers or individuals. Unless the public utility is to be entirely funded from federal grant funds, the proposed composition of the utility board would deny the payers; employers, individuals and carriers from having any representation.

Chapter 5 of the Plan should be amended to include payer members on the public utility board and require these individuals be appointed by the Governor with the advice and consent of the State Senate. Also, the creation of this public utility and the specific delineation of its powers and duties should be accomplished only by a statutory enactment of the Maryland General Assembly with a five year sunset provision. The Plan should also require that the budget for the public utility be included as part of the proposed executive budget in the state budget process. In order to provide full transparency and allow for public participation, any proposed rules, regulations, operating procedures or technical requirements of the public utility should be adopted under the public rulemaking process governed by Maryland’s Administrative Procedure Laws.

Thank you for the opportunity to express these concerns and comment on this proposal. With every best regard, I am

Sincerely,

A handwritten signature in black ink that reads "Julia M. Huggins". The signature is written in a cursive, flowing style.

Julia M. Huggins
President, Cigna Mid-Atlantic



STATE OF MARYLAND

Community Health Resources Commission

45 Calvert Street, Annapolis, MD 21401, Room 336

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor

John A. Hurson, Chairman – Mark Luckner, Executive Director

April 15, 2014

Laura Herrera, M.D.
Deputy Secretary, Public Health Services
Maryland Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, MD 21201-2301

Dear Deputy Secretary Herrera:

Thank you for the opportunity to provide comments on the Maryland State Healthcare Innovation Plan, which was submitted by the Maryland Department of Health & Mental Hygiene (DHMH) to the Centers for Medicare and Medicaid Services on March 31, 2014. This letter serves as formal comments from the Maryland Community Health Resources Commission (CHRC) and our request to serve on the CIMH Advisory Board established under HB 1235. We plan to apply at the appropriate time.

The CHRC has been following the State Innovation Model (SIM) stakeholder process convened by the Department earlier this year. At the stakeholder summit on September 10, 2013, the Department presented the concept of establishing “Community Health Hubs” to deploy community wrap-around interventions for defined populations. The Department’s presentation stated that the DHMH Community-Based Public Utility, *in collaboration with the CHRC*, would conduct an RFP process to select the Community Health Hubs. Eligible entities could include local health departments, hospitals, Local Health Improvement Coalitions, 501c3 organizations, or a collaborative process. The CHRC has long history working with these types of organizations and a demonstrated track record in issuing Calls for Proposals, distributing resources in a strategic, nimble and efficient manner, serving as the fiscal agent of public funds, and conducting performance monitoring activities to ensure that programmatic goals and objectives are met. For this reason, the CHRC was delighted and honored to be mentioned in the Department’s presentation this past September and assist in conducting the RFP under the guidance of DHMH to select Community Health Hubs.

The CHRC was created by the Maryland General Assembly in 2005 to expand access to affordable, high-quality health services in underserved areas in the state. The CHRC has an established track record in distributing resources in a strategic, nimble, and efficient manner. Over the last few years, the CHRC has awarded 142 grants, totaling \$42 million, supporting programs in all 24 jurisdictions of the state. In recognition of the important role of the CHRC in

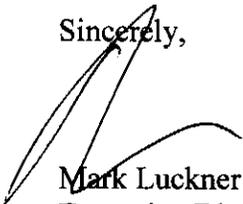
expanding access, the Maryland General Assembly approved legislation this past legislative session (HB 1431/SB 1040) to extend the re-authorization period of the CHRC until June 2025.

The CHRC has worked to align its grant-making activities to support multiple priorities of the Administration and DHMH, including efforts to reduce infant mortality rates; increase access to integrated behavioral health services; promote the adoption of health information technology; and help reduce preventable hospital admissions and re-admissions. In addition to these activities, the CHRC has facilitated multiple delivery and payment reform models referenced on page 8 of the State Healthcare Innovation Plan: (1) The CHRC has supported the state's Multi-Payer Patient Centered Medical Home Program by providing the initial funding to establish the Maryland Learning Collaborative, which provides transformational assistance to primary care practices; (2) The CHRC issued the Call for Proposal process to establish Health Enterprise Zones and jointly implements the HEZ Initiative with DHMH; and (3) The CHRC supports the State Health Improvement Process and has awarded 24 grants totaling \$1.9 million to support the activities of Local Health Improvement Coalitions (LHICs). Given its experience with these programs, its expertise in issuing RFPs, distributing public resources and serving as the fiscal agent, and its relationships with community-based providers and health resources, the CHRC is well positioned to execute the competitive Community Health Hub Call for Proposal process and support the work of the CIMH Public Utility.

In Maryland's State Healthcare Innovation Plan, the selection, function, and other aspects of Community Health Hubs are described, but the CHRC's role in assisting with the issuance of the CHH RFP is omitted from the document. The Plan states on page 57, "CHHs will be selected through a competitive RFP process to allow local assets to apply for this role." The Plan states on page 81, "The CIMH Public Utility will select Community Health Hubs through an RFP process and oversee their implementation and administration." The CHRC is well-equipped to execute the CHH RFP process, and would request that this role be included in future materials relating to the establishment of the CIMH Program.

The CHRC congratulates DHMH on the submission of the Maryland State Healthcare Innovation Plan and looks forward to working with the Department, Maryland Health Care Commission and other interested stakeholders in the coming weeks and months as the work of the Community Integrated Medical Home Advisory Board begins and Maryland continues to develop the framework for a future State Innovation Model Testing grant.

Sincerely,



Mark Luckner
Executive Director
Maryland Community Health Resources Commission

cc: The Hon. John A. Hurson, Chairman, Maryland Community Health Resources Commission
Joshua M. Sharfstein, M.D., Secretary, Maryland Department of Health & Mental Hygiene



**A Community-Integrated Learning Health System for Maryland
Maryland's State Healthcare Innovation Plan**

Comments Submitted by: Delmarva Foundation for Medical Care

Delmarva Foundation for Medical Care, Inc. (Delmarva) supports the Maryland State Healthcare Innovation Plan and offers these comments with the hope that the Department of Health and Mental Hygiene (DHMH) might find them helpful as it plans for implementation.

Physician Engagement Success

Delmarva works extensively with physician practices on quality improvement and the reporting of measures, including National Quality Forum (NQF) and Physician Quality Reporting System (PQRS) measures. Delmarva applauds the State Innovation Model (SIM) plan for its attention to balancing performance measurement with the provider burden for reporting as described on page 40, and the staging of measure reporting as presented on page 42 so physician practices can participate even if they are not initially able to report all measures.

In our experience of recruiting practices to work on quality improvement initiatives, a primary reason practices decline technical assistance is the fear of committing to data reporting that may require staff resources or paying their Electronic Medical Record (EMR) vendor to produce. Based on our experiences and approaches we have taken with success, we encourage DHMH to consider the following in relation to physician engagement:

- a) Craft messaging to physician practices that clearly lays out data reporting or EMR requirements over time; physician offices will lose trust in the program if the data burden is more than originally explained.
- b) Work initially with practices representing a very small number of EMRS; offer technical assistance for pulling data.
- c) Under-promise on the CRISP implementation of the PopHealth open source software service as described on page 68 until it is proven across a number of EMRs. An early successful roll-out will help to gain the engagement of many physician practices but overpromising, whether on capabilities or timeframe for delivery, will decrease physician trust. Expect push-back on a system that automatically standardizes, aggregates and reports on clinical outcome measures. There remains high sensitivity to quality measures being shared. Define how, when and by whom the measures will be used, and for what purpose. Perhaps implement a 30 day preview cycle such as exists for the Hospital Compare reports from CMS.
- d) Clearly demonstrate how physician practice efforts in this program tie back to practice revenue.

Patient-Centered Medical Home (PCMH)

Recent studies have questioned the impact of full PCMH accreditation on outcomes. Reducing the hassle for physician practices while retaining successful elements of the PCMH model as described in the SIM flexible PCMH model will likely be embraced by physician practices. In our work with small primary care practices which may have just a few staff supporting the physician, full PCMH accreditation is seen as onerous by these practices. Delmarva will consider ways in which flexible PCMH content could be a value added service to the quality improvement technical assistance we already provide to practices in Maryland. Our Learning Action Networks (LAN) collaboratives may be a means to offer training in short, ready to implement fashion. Our experience shows primary care practices rarely shut down their schedules for offsite training, but webinars, remote coaching or on-site technical assistance that can be integrated during the work day is accepted.

The Community Integrated Medical Home (CIMH)

For this model DHMH might consider the following.

- a) The staff in the HUBs will make the difference between success and failure, and passion and a true commitment to the community being served can be more valuable than credentials. For this reason, DHMH might consider including additional points in the HUB the RFP for those proposals that commit to employing staff from the population to be served.
- b) Community Colleges are a good choice for training Community Health Workers (CHWs). There must be a reimbursement source to grow jobs for these CHWs upon certification. Further, the need for bilingual, bi-cultural or representation of racial and ethnic populations among CHW graduates should be considered from the start in building these programs, not as an afterthought. Delmarva, through its Population Health Center, works with national leaders on CHW training and is hosting the annual national conference for CHWs in Baltimore May 21-23, 2014. One area Delmarva sees a gap that it can fill related to CHW education is courses on the supervision of CHWs. To build a workforce, which is somewhat unique in its characteristics, but not to build the skills for supervising and leading such a workforce, would be counterproductive.
- c) Evaluating the impact of these HUBs will be complicated by the need to track what community services are used by enrolled clients. This will also be helpful in evaluating the impact of individual community services on outcomes of individuals and the population. Through a CMS funded special project, Delmarva implemented a Baltimore Healthy Eating Leading Partnerships with Seniors (HELPS) project, aimed to increase access to health education and wellness resources in order to improve health outcomes among Baltimore seniors with high prevalence of chronic diseases. The Delmarva team created a coalition of engaged stakeholders to coordinate an expansion of services, education and resources to reduce chronic disease disparities. The HELPS project and its HEZ partner, a key member of the coalition, have used a swipe card methodology provided by Delmarva to collect this data. The cards are issued with an identifying number to allow the data to be stored in the cloud without Personal Health Information (PHI) or Personal Identifying Information (PII). The HUB can retrieve the data and the data is theirs, but they do not have to have servers.



Local Health Improvement Coalitions (LHICs)

A big variable in the model may be the strength of the individual LHICs. The strong ones will need little help and yet some will need guidance and intense support to get them engaged, truly operational, and productive.

- a) Leadership may have to come from outside the health department.
- b) More active physician engagement in the Local Health Improvement Council's may be useful along with other key healthcare stakeholders.
- c) Training may be needed as well as early facilitation of meetings. Delmarva introduced the ReThink model (<http://rethinkhealth.org/>) with the Baltimore HELPS project and found it useful.
- d) Recruiting consumers that can represent their peers and assisting them reach a comfort level for active coalition participation will greatly benefit the many components of the state model. The Satcher Institute has a program that might be modified for this purpose and provided locally.
- e) Tools exist to assess the resiliency of coalitions and suggest how they can be strengthened. Delmarva used one such tool with the Baltimore HELPS project to evaluate and understand member perceptions regarding leadership, formal structures and communications

In summary, Delmarva supports the DHMH and MHCC on this State Innovation Model. We look forward to the implementation phase, and are available for further discussions if our experiences can add value.

Contact:

Mary Kay Kohut

President

Delmarva Foundation for Medical Care, Inc.

410-290-2109

kohutm@dfmc.org



SIM Feedback <marylandsim@gmail.com>

Fwd: Maryland's State Healthcare Innovation Plan: Comment Period Extended until April 28

Karen Matsuoka -DHMH- <karen.matsuoka@maryland.gov>
To: SIM Feedback <marylandsim@gmail.com>

Sun, Apr 27, 2014 at 6:23 PM

----- Forwarded message -----

From: **Joseph Weidner Jr., MD** <drweidner@jkwmd.com>

Date: Sunday, April 27, 2014

Subject: Maryland's State Healthcare Innovation Plan: Comment Period Extended until April 28

To: Karen Matsuoka -DHMH- <karen.matsuoka@maryland.gov>

Hi Karen: The plan looks good. I have no comments. Thanks for all your hard work on this.

Joe Weidner, Jr. MD FAAFP

From: Karen Matsuoka -DHMH- [mailto:karen.matsuoka@maryland.gov]

Sent: Tuesday, April 15, 2014 4:44 PM

Subject: Maryland's State Healthcare Innovation Plan: Comment Period Extended until April 28

In order to provide all interested parties sufficient time to review the State Healthcare Innovation Plan and provide comments, the Department has extended the deadline for comments until **Monday April 28**.

Please send all comments to MarylandSIM@gmail.com by **April 28** in order to receive full consideration. In the absence of comments or questions, the Department will assume that you or your organization have no concerns with the Innovation Plan.

We thank everyone who has already submitted comments and questions. We have included a couple of the most frequently asked questions in the FAQs below.

In light of the deadline extension, anyone who has already submitted comments should feel free to submit additional comments, as necessary.

Frequently Asked Questions & Comments

What is SIM?

SIM stands for the "State Innovation Model" initiative sponsored by the Center for Medicare and Medicaid Innovation. More information can be found here: <http://innovation.cms.gov/initiatives/state-innovations>

What is the difference between the SIM Model Testing award, the SIM Model Design award, and the State Healthcare Innovation Plan?

The SIM Model Design award is a planning grant. Maryland was one of 16 states that received this award. The State Healthcare Innovation Plan is the main deliverable for this planning grant. The SIM Model Testing award is an implementation grant which, if awarded to Maryland, would fund the implementation of parts of the State Healthcare Innovation Plan.

How will public comments be used? Is it worth commenting if the Plan has already been submitted to CMS?

Public comments will be used to inform DHMH's proposal to CMS for the SIM Model Testing award.

When will DHMH submit its proposal to CMS for the SIM Model Testing award?

CMS has not yet announced when it will release the Funding Opportunity Announcement (FOA) for the Model Testing award.

The Innovation Plan seems very ambitious. How will one Federal award fund it all?

According to the terms of the SIM Model Design award, the Innovation Plan is meant to articulate a broad vision of where the State would like to go in order to advance population health. It is meant to be ambitious and, per CMS, not constrained by the parameters of any particular funding source or grant.

No one Federal award is likely to be able to fund it all. However, in articulating the vision, the Innovation Plan helps to sharpen the focus on what the possible funding sources might be, including – but not limited to – SIM Model Testing, and to align those future funding proposals with the Innovation Plan.

The Innovation Plan is interesting from a conceptual perspective, but how will DHMH actually implement it?

The Innovation Plan is meant to be a high-level conceptual document. As the Department pursues a variety of funding streams to implement different parts of the Innovation Plan, operational details will be developed as part of those funding proposals.

CONFIDENTIALITY NOTICE: This message and the accompanying documents are intended only for the use of the individual or entity to which they are addressed and may contain information that is privileged, confidential, or exempt from disclosure under applicable law. If the reader of this email is not the intended recipient, you are hereby notified that you are strictly prohibited from reading, disseminating, distributing, or copying this communication. If you have received this email in error, please notify the sender immediately and destroy the original transmission.

--

Sent from Gmail Mobile on my iPhone

CONFIDENTIALITY NOTICE: This message and the accompanying documents are intended only for the use of the individual or entity to which they are addressed and may contain information that is privileged, confidential, or exempt from disclosure under applicable law. If the reader of this email is not the intended recipient, you are hereby notified that you are strictly prohibited from reading, disseminating, distributing, or copying this communication. If you have received this email in error, please notify the sender immediately and destroy the original transmission.



1201 S. Sharp St. Suite 109
Baltimore, MD 21230
410-685-6567
www.equalitymaryland.org

April 15, 2014

Karen Matsuoka, PhD
Director
Health Services Infrastructure Administration
Department of Health and Mental Hygiene

BY EMAIL: marylandSIM@gmail.com

Dear Dr. Matsuoka:

Equality Maryland is pleased to offer comments on the State Innovation Model (SIM) report that was submitted to the Center for Medicare and Medicaid Innovation (CMMI) in partial fulfillment of Maryland's State Innovation Model (SIM) Design award. It is our understanding that the State will be applying for a SIM Testing grant based on the design developed and described in this document.

Equality Maryland has reviewed the SIM report because of our commitment to promoting health equity for the LGBT communities of Maryland. We recommend incorporating a stronger emphasis on patient choice and privacy because of the challenges faced by some LGBT individuals in finding a trusted health care provider. It is critical for consumers, particularly people, who face discrimination, to be able to select their providers and be assured that all of their personal information remains private. Otherwise, they will be less likely to access health care services.

LGBT communities are recognized by the Centers for Disease Control and Prevention as medically underserved, and the Institutes of Medicine has documented health disparities in this population compared to heterosexuals. This is due in large part to the lack of providers with sufficient expertise in LGBT health issues, discrimination, and the effects of stigma. Moreover, transgender individuals are less likely to have health insurance than non-transgender people because few plans cover gender-specific and trans-gender specific care. LGBT individuals are more likely to avoid medical care and to delay filling prescriptions because of discrimination or

harassment. In order to improve outcomes for this community, the service delivery model needs to address the systemic barriers that LGBT individuals face in accessing health care. In our comments, we have focused on the need to incorporate choice of provider and the stronger confidentiality protections of personal information.

1. Consumer Choice: Consumers should be able to choose to participate in a community-integrated medical home

The community-integrated medical home (CIMH) model described in the SIM report offers no opportunity for a patient to choose whether to participate in the model, nor can a patient select the professionals who will be coordinating their care at the community health hubs. Individuals in LGBT communities need to be able to choose their providers, including care coordinators, to ensure they are receiving appropriate, compassionate, and culturally competent care. The concerns of LGBT communities extend beyond the provision of health care services per se because the risk of being subjected to harassment and stigma is, unfortunately, very real and persistent. In the last 30 days, members of the General Assembly have ridiculed transgender people, including insinuating they were sexual predators and calling transgender people “confused” on the floor of the House of Delegates. Young LGBT people suffer discrimination and harassment at school and some adult LGBT people still fear “coming out” in Maryland.

As currently conceived, the CIMH model would require all patients of providers enrolled in the program to participate. Thus without a choice, consumers would be assigned care coordinators who will be involved in care across all aspects of life that impact health outcomes. For those patients with unique circumstances, this could pose a greater risk of harm than can be justified by the potential benefits. LGBT people who are already discouraged from enrolling with a primary care practice or seeking treatment will behave similarly under the CIMH model. Depriving them of choice under such circumstances would be tantamount to depriving them of access to meaningful care.

2. Privacy: patients need enhanced protection of sensitive information in a CIMH model and to retain the ability to control sharing of identifiable information.

The SIM report foresees a “robust data infrastructure” to ensure the effectiveness of service coordination, monitor performance, and provide feedback to providers to improve outcomes. It also mentions the development of a uniform patient consent form that must be signed before sensitive personal data may be shared. While informed consent is a good start, it is insufficient to protect against unauthorized disclosures in a CIMH model that reaches beyond the clinical care infrastructure. Confidentiality is especially important for members of LGBT communities and those with health conditions that may subject them to discrimination or

stigma. Consumers need to retain control over the exchange and disclosure of data sharing on a particularized and ongoing basis, and to have an opportunity to renew or reconsider consent to information disclosure as circumstances or potential recipients change.

Before the SIM project moves forward, we recommend that the Department work with stakeholders to develop more robust protections of confidential information. These protections should take into account: 1) the breadth of information exchanged across multiple sectors, entities, and individuals; 2) questions of confidentiality protections for non-health information; and 3) the changing preferences of patients over time. The SAMHSA template cited by the SIM report and the consent forms being used by existing PCMH programs do not allow for a dynamic consent process and are inadequate to prevent unauthorized re-disclosures. We would recommend, at a minimum, the following, which would maximize autonomy and minimize unwanted disclosures or breaches of confidentiality that could result in adverse consequences for patients:

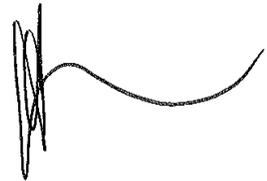
- Develop a detailed evaluation of the security infrastructure, policies, and protocols needed to ensure that the data used in care coordination and hot-spotting is confidential. Access should be granted only to the people and for the purposes to which the consumer has consented. The SIM Report does not discuss how this will be accomplished. We anticipate that creating this framework will require a significant investment of time and resources by many stakeholders;
- Avoid blanket consent for disclosure of a class of information (e.g., diagnosis, treatment, etc.). The SAMHSA template, for example, merely describes the information that will be shared as including, but not limited to “laboratory, medications, medical care & HIV/AIDS, alcohol & substance abuse and mental or behavioral health information,” and provides a space to enter the names of recipient organizations. This is clearly insufficient to ensure meaningful control over disclosures, especially when the information is shared outside the health sector. Consent in the CIMH model should be authorized only on a particularized basis—that is, specific to the precise data being shared, for a certain purpose, and with a given provider either internal or external to the CIMH, including care coordinators, nonclinical staff, and personnel of social service entities;
- Develop a system by which consumers routinely review their authorizations to consent to data sharing. The SAMHSA template advises patients that they may revoke permission for data sharing at any time by giving written notice, but patients need a more systemic mechanism to review authorizations of data sharing, as personal information could damage their reputation, employment, relationships, or other aspects of their lives;

- Develop protocols to ensure that patients are not penalized or perceive being penalized for withholding consent to the release of the personal information. The protocols must prioritize autonomy and ensure that the quality of care and scope of services they receive are not contingent on the consent to share personal data; and
- Ensure that there are sufficient privacy protections for personal data that is not protected by HIPAA. According to the SIM report, there will be a significant amount of non-clinical data collected, shared, and analyzed; yet there is no discussion of how that information will be protected. It will be important to ascertain the extent of protections (including enforcement and penalties) that exist in current federal and state law for such data and to consider new legislation that will fill the gap.

Conclusion

We appreciate the opportunity to comment on the SM report and urge you to take patient interest in choice and privacy into consideration as threshold concerns prior to implementation of the CIMH or other model. We would be happy to collaborate with the Department and other stakeholders.

Respectfully,

A handwritten signature in black ink, consisting of a series of vertical lines on the left that curve into a long, sweeping horizontal line extending to the right.

Carrie Evans
Executive Director



SIM Feedback <marylandsim@gmail.com>

Comments on MD SIM Plan

Michael McKnight <mmcknight@ghhi.org>

Mon, Apr 28, 2014 at 10:50 AM

To: "MarylandSIM@gmail.com" <MarylandSIM@gmail.com>

The model listed in the plan, on p.84, "Putting it All Together: A Community-Integrated Approach to Asthma" lists "24 evidenced based services" including environmental assessment and self management education. In the Green & Healthy Homes Initiative asthma program, called "Safe At Home", which has been funded through grants from HUD's Office of Healthy Homes and Lead Hazard Control, our team not only provides inspections and self-management education, but also conducts environmental improvements in the home such as remediation mold and removing asthma triggers such as pests. Are environmental interventions included as part of the "24 evidenced based services"? If not we think that would be a missed opportunity to implement cost-effective and needed improvements to help asthma patients manage their condition. We have data from hundreds of patients we've served over the last decade on the improvements that have come about through a fully integrated model the includes inspection, education, and environmental improvements. Through a technical study from HUD, we are also now tracking direct Medicaid claims for the patients we work with and will be able to see the specific impact of our GHHI intervention on medical services.

Also, with this model of community based asthma care (and community based services in general), being connected to the medical services, Maryland needs to ensure that localities have the capacity to conduct those community based services. GHHI would be willing to conduct training for inspectors, assessors, and asthma educators/community health workers across the state to ensure that those community integrated medical homes are able to conduct a thorough environmental assessment for asthma triggers and other home based services. We have conducted hundreds of training both in the state and across the nation, and are working with DHMH on conducting training and building capacity for asthma efforts through the asthma control program.

Other environmental and home hazard conditions that we think SIM should look at, in addition to asthma, as part of the community based services, is lead poisoning prevention, trip and fall injuries for seniors, COPD, and radon. GHHI's comprehensive home based services looks at all of these issues based on the clients we serve, and we'd be happy to work with DHMH on a suite of services that the Community Integrated Medical Homes as part of the Health Hubs would provide.

Thanks,

Mike

Michael McKnight | Senior Program Officer

Green & Healthy Homes Initiative

1612 K Street NW, Suite 902, Washington, DC 20006

(P) 202.769.5763 | mmcknight@ghhi.org

[website](#) | [e-newsletter](#) | [facebook](#) | [twitter](#) | [linkedin](#) | [donate](#)

This e-mail and any attachments within are intended solely for the use of the addressee and may contain privileged, confidential, copyrighted, trademarked, or other legally protected information. If you are not the intended recipient (even if the e-mail address above is yours), **you may not use, copy or retransmit it.** If you have received this by mistake **please notify me** by return e-mail, then delete. Thank you.



STATE OF MARYLAND

DHMH Board of Professional Counselors and Therapists

Maryland Department of Health and Mental Hygiene
4201 Patterson Avenue • Baltimore, Maryland 21215-2299

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

April 25, 2014

Karen Matsuoka, Ph.D
Director
Health Services Infrastructure Administration
Department of Health and Mental Hygiene
300 W. Preston St.
Baltimore, MD 21201

Re: Comment on Maryland's State Healthcare Innovation Report submission to the Center for Medicare and Medicaid Innovation (CMMI), March 31, 2014

Dear Dr. Matsuoka:

The Health Occupation Boards' appreciate the opportunity to provide comments on the State Innovation Model Report (SIM Report) referenced above. The Health Occupation Boards were not informed of this report until very recently. We understand that the Department of Health and Mental Hygiene (the Department) has submitted this report to the Center for Medicare and Medicaid Innovation (CMMI) as a final report for the planning grant and is submitting an application for implementation funds. While we think such an effort is laudable, we have concerns about the delineation of the roles of the members of the health care delivery team, in particular community health workers.

The SIM Report, contemplates the development of community healthcare workers (CHWs) whose role would be to act as "critical connectors" to the hospital system, the public health infrastructure and primary care teams and to perform certain tasks such as conducting ongoing assessments and screening, stress management education and counseling, and

410-764-4732 Fax 410-358-1610 TTY 800-542-4964
Toll Free 1-877-4MD-DHMH • TTY for Disabled - Maryland Relay Service 1-800-735-2258

Web Site: www.dhmh.state.md.us/bopc

Comment on SIM Report

April 28, 2014

Page 2 of 2

assessment and counseling for behavior change. (SIM Report, p. 65.) Additionally, the SIM Report references CHWs doing some direct care services under the supervision of a licensed clinician, nurse, or social worker. (SIM Report p. 61.) This raises concerns because the report ignores or fails to contemplate that each health occupation has a scope of practice strictly defined and set out in statute and regulation as well as laws on unlicensed practice. Delegation authority is not something that can be done without express authority being granted in statute. The majority of the health occupations do not have delegation authority; physicians and nurses have some authority to delegate limited and proscribed duties defined in statute and regulations. This delegation authority is to licensed allied health professionals not to lay workers such as CHWs. Furthermore, individuals licensed under the health occupation boards cannot simply supervise unlicensed people because it runs afoul of unlicensed practice statutes. Historically, scope of practice matters are set forth in statutes and regulations not through policy.

While the objectives set out in the SIM Report are commendable, in its current iteration a number of questions and concerns are raised. We would strongly recommend the participation of a broader range of participants, including representatives from the health occupations boards to explore solutions to the issues noted in this letter.

Thank you for considering our comments. Should you have any questions or need additional clarification feel free to contact Ms. Kristen Neville, Legislation and Regulation Specialist for the Health Occupations Boards at 410-764-5978 or kristen.neville@maryland.gov.

Sincerely,

Health Occupation Boards

cc: Kristen Neville
Health Occupations Executive Directors

From: Deborah Agus, BHLI

Comments SIM Paper

Overall: Excellent Job

Integrations: Integration is a population-based approach to support prevention and reach those who need treatment but are not walking in the door.

Page 26: Continuing Paragraph – What about youth outside of schools? (e.g. drop-outs or those expelled or suspended for long period)

Page 29: Goal should not be limited to just reducing hospitalization in the short-term but to instead build system for population-based health, reduce disparities and improve health and wellness outcomes. This population-based model will lead to improvement in both public-health goals and economic/fiscal goals.

Page 35 First Paragraph – last sentence

Highlight as well key role of CIMH in engaging in prevention, wellness and health promotion.

Page 37: Last paragraph – GREAT

Interesting to note that “assignment “ PCPs is largely unrelated to “ linked and treated” by PCPs including even places like FQHCs. In our programs we have seen many people “assigned” who had no idea and had never seen or heard of their PCP. On the flip side are the PCPs/practices/clinics who bemoan the failure of their assigned patients to show up for appointments and engage. These no show patients are labeled as difficult, resistant and other pejorative terms.

Page 38: Great – govern by performance not standardization/rule-making

Page 39: Last sentence of first paragraph – these statistics are similar to those achieved by Baltimore Capitation Project for the SMI serving 300 highest utilizers and yielding high savings and high performance

Second Paragraph: Great – Yippee

Page 40: Paragraph #2 YES!!

Page 41: In continuation of paragraph last sentences – What happens with jail?

Second paragraph under Exclusivity – Good

Page 43: Very limited measures for mental health and no measures for substance use disorders. Needs to re-vamped/enhanced

Page 46: Quadrant 1: last sentence. Who is actually in charge? Can it be either?

Page 47: First full paragraph - - - is it enough to have “encouraged to participate in”, this doesn’t seem to work to well, need mechanism for active engagement/transition. Also, there are difference between diagnoses – even a lower need person with schizophrenia has very different needs for treatment and support than a patient with a similar level of need but a diagnosis of depression.

Second full paragraph – SBIRT In general evaluation and referral without strong treatment component attached is not very successful for mental health treatment. SBIRT is important but not sufficient.

Payment Models: SIM approach lends itself very well to risk-based case rate/bundling mechanism. Share risk/share profits and regulate by outcomes rather than rules.

Page 51: It is problematic to adapt the relatively rigid/detailed outcomes from the HQP model. Especially for relatively known populations like SMI, can have much more qualitative and individualized outcomes. For non-smi with mental health, SUD and chronic health can use broad health indicators as well as engagement. Needs more thought.

Page 57:

Last paragraph. Sometimes having too many partners and too much collaboration results in very little action and status quo rather than changes. Additionally, with many many partners, lots of administrative costs and everyone wants piece of the pie. So – need to be careful.

Page 58 under list of CHH responsibilities: Question – What authority/leverage will CHH have over others such as over hospitals for example or vis a vis LHIC. Who can make ultimate decisions? And, do they report directly to the state?

Conclusion : Excellent job overall. Thoughtful and comprehensive synthesis of systems components, inter-relationships and clinical expertis.



SIM Feedback <marylandsim@gmail.com>

LifeBridge Health Comments on Maryland SIM

Darleen Won <dwon@lifebridgehealth.org>
To: marylandSIM@gmail.com

Tue, Apr 15, 2014 at 9:34 PM

LifeBridge Health is concerned that the Maryland State Healthcare Innovation Plan focuses on the social determinants of health (SDH) to test initiatives that can be “brought to statewide scale under the total cost of the modernized hospital waiver.” (p. 30). While we recognize initiatives that address SDH are a critical component to providing better health care for a lower cost of care, we are concerned that the State plan may be under-estimating the tenacity of SDH, and therefore the necessary time and money needed to address them.

As noted on p. 48, recent research suggests that, “. . . the effectiveness of the Primary Care Medical Home (PCMH) is limited by the fact that resources are not sufficiently targeted with a generic care coordination regimen AND a payment model that is inadequate to address the full range of services and supports that super-utilizers need.”

The proposed model of testing interventions for a 2-year period then expecting sustainability for year 3 and beyond, “. . . which reallocates some portion of the cost-savings that accrue to the hospitals, gets reinvested back into the community to maintain the strength of the Hub,” (p. 124) seems overly-ambitious to expect meaningful outcomes in a short time frame (2-3 years) for remediation of the effects of the major and intractable social determinants of health, and perhaps underestimates the cost of such remediation.

An example of this over-ambition, and potential under-estimation of cost is on p. 53: “By ensuring that a person’s basic needs—food, housing, income, etc.—are better met through the improved uptake of available social services the CIMH model improves health and reduces total cost of care by minimizing avoidable hospitalizations and ER visits.” While this goal is laudable, the presumption that there are sufficient services and resources to provide adequate food, affordable housing and non-poverty income to those whose health is already impaired by these social determinants, and others that accompany them, is unfounded.

The model that is highlighted from Hennepin County, MN is creative, in that the funds are redirected to needed services such as a homeless shelter or “sobriety center,” but the payment model for continued and expanded services is unclear, whether indeed, cost savings from high cost hospital services are directly responsible for, and adequate to cover, these services.

The DHMH intends (p. 54) for the social service branch of the State, DHR, to assume the responsibility for providing the social services component of the model either through direct services or referral to the already over-extended, existing community social service providers who are suffering from limited funding themselves. In addition, it is not clear that these agencies would even have the capacity to increase their services.

Similarly the suggestion (p. 50) that hospitals may want to further develop systems they have

already established or use “a more efficient and cost-effective approach...(that) leverages already available resources in the community and partner with organizations such as schools, social service providers, health departments and other community-based organizations, who have deep relationships and developed expertise in delivering home and community care” does not take into account that LifeBridge Health hospitals have been providing these types of services for many years and have already developed significant expertise in this area. Additionally, many of those community organizations that do this work are often underfunded; and the funding mechanisms limit them to certain criteria and restrictions in their work, which precludes them from efficiently providing the full spectrum of services needed to combat SDH. For example, what funds or services can be leveraged to improve education in a distressed public school system, to make housing available and affordable in Baltimore or to make more treatment slots available to reduce waiting lists in addictions recovery facilities?

LifeBridge Health urges the State to recognize the deep-seeded nature of the social determinants of health, and as such, to not limit hospitals to community partnerships to address these issues. Allow us the latitude to design a portfolio of the most efficient and targeted hospital-based programs **and** community collaborations to provide better health at a lower cost.

Darleen Won
Director, Population Health
LifeBridge Health
2401 West Belvedere Avenue
Baltimore, MD 21215
ph: 410-601-8121
fax: 410-601-6489
dwon@lifebridgehealth.org



THE INFORMATION CONTAINED IN THIS MESSAGE IS LEGALLY PRIVILEGED
AND CONFIDENTIAL INFORMATION INTENDED FOR THE USE OF THE ADDRESSEE LISTED ABOVE.
This record has been disclosed in accordance with Subtitle 3 of
Title 4 of the Health-General Article of the Annotated Code of
Maryland. Further disclosure of medical information contained
herein is prohibited.

If you are neither the intended recipient nor the individual
responsible for delivering this message to the intended
recipient, you are hereby notified that any disclosure of
patient information is strictly prohibited. If you have received this
email in error, immediately notify us by telephone or return email.



The Maryland Addictions Directors Council

Board of Directors

President: John Winslow

Vice President: Mark Santangelo

Treasurer: Kenneth Collins

Secretary: George Plesniak

Members-at-Large

Heather Brown

Marian Currens

Kathleen O'Brien

Yngvild Olsen

Craig Stofko

Director Emeritus

Gale Saler

Executive Director

Tracey Myers-Preston

Director of Public Affairs

Lynn H. Albizo

Member Services Coordinator &

Administrator

Maureen Zingo

April 28, 2014

Comments on Maryland's State Innovation Plan – A Community-Integrated Learning Health System for Maryland

The Maryland Addictions Directors Council (MADC) submits the following comments addressing issues that impact substance use disorders and other behavioral health concerns. MADC has also reviewed and supports the advocates comments submitted by Advocates for Children and Youth (ACY) and its partners and signatories on April 15, 2014. In the interest of efficiency, MADC will not further address issues highlighted in those comments.

MADC whole-heartedly supports Maryland's whole person, evidence-based and population integrated approach. As we have noted in numerous documents related to the behavioral health integration process, MADC supports a system that is person-centered, outcome-based and integrates general medical healthcare and behavioral healthcare to provide fully integrated comprehensive and clinically appropriate care at the point of service. The overall plan presented is compressive and generally supports this goal. Please note the following comments offered to strengthen the plan presented.

1. The term behavioral health is used throughout the plan without a clear definition. The term should be defined to specify the terms as meaning both mental health and substance use disorders. In some areas the term appears to be used interchangeably with mental health. It is imperative that there be a definition included that makes it clear that behavioral health includes substance use disorders (SUD) as well as mental health.

2. In the goal section on *Behavioral Health Integration with Primary Care*, we recommend that Screening, Brief Intervention and Referral to Treatment (SBRIT) for substance use be expanded for adults and adolescents. SBIRT is discussed at length earlier in the report as a tool that will be used. This should be included as a goal as well. The goal that is included discusses BHIPP for children. Although the title is Behavioral Health in Pediatric Primary Care (BHIPP), the program description is primarily focused on mental health needs.



The Maryland Addictions Directors Council

3. *Appendix, 8.4 Health Quality Partners Advanced Preventive Service Model Interventions & Management Elements*, provides a chart listing recommended preventive service interventions which should be utilized. Again, although mental health screening and assessment and counseling for behavior change is noted, there is not specific reference to SBIRT or any other substance use screening except interventions to quit smoking. SUD screening should be added to this chart as an intervention to be utilized by community providers.
4. The plan notes that the State will be expanding patient-centered medical homes and chronic health homes and that chronic health homes are available for the treatment of opiate addictions. However, currently health home status is only available to SUD providers who are licensed Methadone providers. There are many SUD providers who service people with opiate addictions and other SUDs that are not licensed as Methadone providers. These agencies have the capacity to provide integrated health home services, but are not eligible to receive the support and benefits of being a designated chronic health home by the Department of Health and Mental Hygiene (DHMH). We recommend that all SUD providers be eligible to become chronic health homes.
5. The plan includes significant information regarding the innovative hospital payment model system and other innovative systems in Maryland. However, there is no explanation or information regarding the decision to “carve out” mental health and addiction services from the managed care Health Choice system. In fact, there is information regarding the value of adopting a hospital payment system that is not volume based. However, the behavioral health Medicaid system that is managed by an ASO is a fee for service system which is volume based. There should be more attention given to how health and behavioral health services will be integrated within a “carved out” model.
6. Figure 2-3 and 2-4 charts the number of people with chronic diseases in Maryland and does not include SUD. This figure lists the most prevalent chronic diseases including depression. One reason SUD may not be included is that many people do not report their condition or get the treatment they need. Increased use of screening tools may change that. If the State has these numbers, we recommend that they be included in the chart even if they are being under-reported-with the appropriate footnote.
7. In Strategy A: A Foundation of Effective Public Health and Primary Prevention (p. 23) it is noted that DHMH will pursue accreditation and that “DHMH also remains committed in its support of Local Health Departments in their own pursuit of voluntary accreditation.” Please clarify what support means. Would this include financial support? Resources are needed to support health departments and other behavioral health providers



The Maryland Addictions Directors Council

that have not had the opportunity for federal support that has been available to primary care providers to implement electronic medical records as part of the Affordable Care Act (ACA).

8. MADC supports the State's efforts and plan to support a robust Data Infrastructure for healthcare. We recommend that the plan specifically address the unique challenges that behavioral health providers have in implementing electronic record systems given the federal and state laws requiring a higher level of privacy protections for mental health and SUD records. These challenges can be overcome with the implementation of policies to ensure protections and the technology necessary to effectively implement these policies.
9. We are encouraged that the State recognizes and begins to address the workforce challenges related to implementing an effective plan. –MADC would want to ensure that the development of a new category of “community health workers” with independent certification provides for additional opportunities and not replace existing behavioral health providers including social workers, licensed professional counselors and certified addiction counselors. There is a shortage of behavioral health professionals in Maryland who are needed to provide direct SUD and mental health services, particularly in rural areas of the State. We recommend the plan include recommendations to reduce barriers to entering behavioral health professions including updating the education requirements for licensing and certification by professional boards and collaborating with educational institutions to ensure educational offerings align with board requirements.
10. *Section 4.1, Evaluating the Community-Integrated Medical Home Model* includes a comprehensive table charting the objectives and measures of success. (p. 91-93) We recommend that under the section on Mental Health and Substance Abuse, the column for children should include category for *Initiation and engagement in substance use disorder education and treatment*. It must be recognized that children and adolescents are engaging in substance use and treatment is most effective when treated and addressed early. This is particularly important given that there is a shortage of SUD providers for children. There should also be categories for screening of childhood depression and mental health disorders other than ADHD.
11. In the discussion of the *Goal: Behavioral Health Integration with Primary Care*, the focus is primarily on collaboration with mental health providers and primary care providers. SUD providers should be included in the training of primary care providers and in the consultation and collaboration plans. As noted above, primary care providers



The Maryland Addictions Directors Council

should be trained in SBIRT and referrals should be made to SUD providers when appropriate.

We appreciate the opportunity to provide further input into the plan and hope the comments we have regarding SUD are given careful consideration. If you have any questions or concerns, please contact Lynn Albizo at madpublicaffairs@gmail.com



802 Cromwell Park Drive
Suite V
Glen Burnie, MD 21061
410.761.8100 phone

April 15, 2014

Karen Matsuoka, Ph.D
Director, Health Services Infrastructure Administration
Department of Health and Mental Hygiene
300 W. Preston St.
Baltimore, MD 21201

We support the goal to improve health outcomes of super-utilizers by providing coordinated health services and wrap-around social services. The report indicates that the children with asthma may be among the first targeted super-utilizer population. Thus, school-based health centers (SBHCs) could be involved with the initial implementation of the CIMH model. Indeed the report states that, "Maryland's school-based health centers will also be supported in developing their capacity to provide advanced primary care services and function as a medical home for their students, and potentially their broader community where primary care shortages persist" (pages 25-26). We would appreciate further discussion with DHMH about the role of SBHCs in the CIMH model, as we have the following questions:

- **Role of SBHCs as a Student's Medical Home:** SBHCs are currently structured to provide primary care services in coordination with the student's medical home. The report seems to contemplate changing the model and developing SBHCs as full-fledged medical homes. This change would require significant restructuring of the SBHC model, including regulations, financing, and staffing. Does DHMH intend to explore transforming SBHCs into medical homes?
- **Role of SBHCs as a Medical Home for the Broader Community:** Expanding the SBHC patient base to include the broader community is also a significant change in the SBHC model; and it would likewise require significant regulatory, financing and staffing restructuring. Does DHMH plan to evaluate expanding the patient bases of SBHCs?
- **The definition of "advanced primary care":** We would like to know more about what DHMH envisions as advanced primary care. What does advanced primary care encompass and how should SBHCs begin thinking about expanding clinical capacity?
- **Expanding the number of SBHCs:** The report focuses on expanding the depth of services to include advanced primary care. Would DHMH also support expanding the number of SBHC sites in collaboration with the communities they serve?

- **Funding support for CIMH Model:** The report indicates that funding will be focused on supporting the community health hubs. Expanding the capacity or number of sites of SBHCs will require investment of resources. How does DHMH envision supporting the expansion of SBHC capacity? Will the funding be local, State, or a combination?

Thank you for your consideration of our comments. MASBHC looks forward to working with DHMH on integrating SBHCs into the CIMH model. If you need any additional information, please contact Donna Behrens, chair of our Public Policy Committee, at dbehrens@gwu.edu.

Sincerely,
Barbara Masiulis
President

April 28, 2014

Dear Deputy Secretary Herrera and Dr. Matsuoka,

On behalf of the Maryland Association for the Treatment of Opioid Dependence (MATOD), I am writing with comments on Maryland's State HealthCare Innovation Plan as submitted to the Centers for Medicare and Medicaid Services.

Having witnessed the tremendous amount of work and energy that everyone involved gave to the SIM planning process last summer and since, this final plan wonderfully pulls all that together and is a great achievement. It clearly and appropriately puts public health at the center of the Community-Integrated Learning Health System, builds on many of the exciting and innovative healthcare reform efforts happening in Maryland, and addresses vertical and horizontal integration across systems.

Of particular interest to MATOD is integration as this has been a key focus in behavioral health for several years now. One item raised in discussions with DHMH over that time is the issue of the relationship between behavioral health and the rest of healthcare – because behavioral health is healthcare. For chronic illnesses such as opioid use disorder, schizophrenia, and other similar conditions, the healthcare provider that patients with these disorders may see the most are not in typical primary care settings, but in community behavioral health practices.

MATOD, therefore, is extremely pleased that the SIM Innovation Plan expands the Chronic Health Home initiative currently in its first year of implementation. Anecdotally, the MATOD members participating in this effort have seen increased engagement of their patients in all aspects of wellness and health. However, the message repeatedly heard from patients is that they would like all their primary care needs to be met through the Health Home. Even with intensive care coordination and nonjudgmental primary care providers, they see the value of truly integrated care. Currently, the initiative primarily supports the work of Nurse Care Managers. MATOD would urge the Department to carefully review what is needed for participating entities to become full “medical” homes. In addition, it is not clear why Chapter 6 of the SIM plan does not include expansion of the Chronic Health Home Initiative among the levers available to achieve the goal of integrating behavioral health and primary care.

MATOD is also pleased that the SIM Innovation Plan includes a focus on Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Patient-Centered Medical Homes, particularly for Quadrants III and IV patients. We would like to point out, though, that SBIRT is not treatment for substance use disorders as the Plan perhaps might seem to imply (p. 47). Rather, SBIRT is a systematic way of identifying individuals with harmful levels of use that have not yet reached DSM-5 diagnostic criteria for substance use disorders (SUDs), and provides

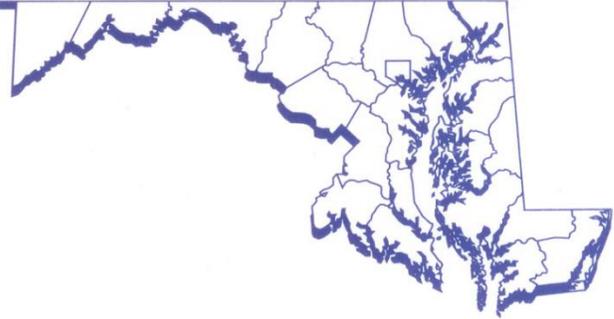
interventions that can help prevent further progression to such conditions. For individuals with DSM-5 diagnoses of SUDs, techniques such as motivational interviewing used in SBIRT can help engage patients in effective treatment. These typically combine medications and more intensive counseling services than provided in brief interventions. While SBIRT is an important tool, having it form the basis of substance use treatment even in these low behavioral health need categories is confusing and misses the importance of treatment for moderate to severe SUDs.

We applaud you on a thorough, clearly articulated, and comprehensive plan and look forward to continuing to work with you and others on its implementation in Maryland.

Sincerely,



Yngvild Olsen, MD, MPH
President



Local Health Improvement Coalition (LHIC) Role and Structure MACHO Position Statement

April 14, 2014

The history of Local Health Improvement Coalitions (LHICs) in Maryland varies by jurisdiction in terms of their birth, stage of development, leadership, and roles. All LHICs reflect local decision-making and include diverse community partner engagement. Most, if not all, LHICs exist because of the ongoing resources, technical assistance, and leadership provided by the Health Officer and/or Local Health Department.

As they reflect local needs and local community dynamics, LHICs by both their very nature and intent are products of local decision-making. The majority of existing LHICs have in place organizational by-laws or charters that have been developed with the input of local partners and account for local dynamics. Many of these LHICs are influenced by local regulations or responsibilities set forth by the local government, are utilized to satisfy varying committee/coalition requirements from different DHMH grants or programs, function as coalitions or boards required by various state and local statutes or regulations, and/or are linked to requirements for different grant funding streams outside of DHMH. In addition, different counties have different resources, available partners, and health priorities. Thus, given the need to respect the varying factors influencing different counties in Maryland while allowing the local Health Officer to fulfill his/her delegated and natural responsibilities as the local public health authority for his/her county, **MACHO opposes mandatory statewide charters or regulations that would decide the organizational structure, governance, or functioning of these local products.** The dynamics of different counties and LHICs in Maryland suggest that a “one size fits all” approach to LHICs would endanger the success and long-term viability of these locally-driven partnerships.

Maryland law designates Health Officers as the public health authority in their jurisdictions. Local Health Departments (LHDs) are the local health planning authority unless another body is designated as such by the Health Officer. The specific citations for these authorities can be found in the following:

- Md. Code Ann. Health-Gen (“HG”) Section 1-10(g) defines a “Local health planning agency” to mean “the health department of a jurisdiction or a body designated by the local health department to perform health planning functions.”; and
- HG Section 2-401 addresses the responsibilities and funding of a local health planning agency (“LHPA”).

MACHO strongly recommends that the Maryland Department of Health and Mental Hygiene (DHMH) recognize and support the delegated authority of the Local Health Officer and the roles of the Local Health Department/local health planning agency in communications describing the creation and function of LHICs. Current national best practices in public health, the national public health accreditation board and the well-recognized Ten Essential Services of Public Health put forth by the Centers for Disease Control and Prevention, already serve as guidance for local public health systems (and, by default, the local public health authority providing oversight of this system locally); these are referenced regularly as local health departments engage and mobilize community partners in addressing population health priorities, including through partnership entities such as the LHIC.

However, local Health Officers understand DHMH’s need to ensure some consistency of effort across local health improvement coalitions. Thus, if DHMH needs a specific construct in order to verify LHICs, MACHO recommends a **document of recommendations** in which the LHICs agree to:

- Participate in a collaborative process resulting in a comprehensive community health assessment at least every five years.
- Participate in a collaborative process resulting in a community health improvement plan.
- Meet and communicate on a regular basis.
- Establish its own by-laws or charter document to describe its organizational structure, governance, and functions.
- Facilitate coordination and communication among local partners in Community Health Improvement Planning (CHIP) activities.
- Advocate for and promote the use of evidence based health policies and practices.
- Include representation from the local health department, hospitals, health care providers, community-based organizations, vulnerable populations, public agencies and services, business sector, community leaders, and residents.
- Maintain minutes of their meetings.
- Develop subcommittees when appropriate.

- Receive leadership, staff support and technical assistance from the local Health Officer and/or local health department in jurisdictions covered by the LHIC.

In addition, MACHO recommends the following:

- The Maryland Secretary of Health designates the local Health Officer, as the delegated local public health authority, to:
 - Assure Community Health Assessments (CHAs) are conducted at regular intervals for their jurisdictions, and that they account for input by a variety of partners and residents.
 - Assure the identification of local health priority areas based on the local CHAs.
 - Assure development of a Community Health Improvement Plan (CHIP) with priority areas that may, if warranted by the local CHA, align with the State Health Improvement Plan (SHIP) but are not restricted to such.
 - Convene (and/or Chair) an LHIC to function and fulfill roles as set forth by the local decision-making process.
- Allocation of funding from DHMH to local health departments to bolster local efforts to engage and mobilize community partners in local health improvement planning.
- DHMH staff discuss with each local Health Officer any specific concerns or suggestions they may have on the functioning, roles, and leadership of the concerned LHIC rather than instituting generalized statewide approaches that may not account for dynamics and needs in certain jurisdictions.
- DHMH identify ways to strengthen Maryland's existing local public health departments so that these LHDs can continue to improve their service in an evidence-based manner.
- DHMH continue to work with its separate programs and grant-funding streams to remove/consolidate individual coalition/committee requirements in order to allow greater utility of the LHIC model.
- DHMH advocate for changes to federal community benefit requirements to allow community benefit service area needs assessments to be completed every five years instead of every three years so as to encourage collaborative community health assessments with the local health improvement process.
- DHMH work with the Maryland Hospital Association partners to recommend that hospital systems allow their local affiliates to work collaboratively with their local public health partners in implementing community health needs assessments (vs. implementing a system-wide approach that may not allow locally driven needs assessments).
- DHMH provide adequate resources to local health departments so that these LHDs can in turn provide optimal technical assistance to LHICs. This technical assistance offered by the LHD to the LHIC may include, *at the discretion of the local public health authority*:
 - Epidemiology and Community Health Assessment
 - Development, implementation and evaluation of CHIP

- Guidance on evidence-based practices in community coalition development, leadership/management, and sustainability
- Guidance on evidence-based public health practices, including those addressing:
 - Health policies (public & organizational)
 - Health systems change
 - Environmental change
 - Community-clinical linkages
 - Health communications
 - Programming addressing key population health disparities
- Grant proposal development
- Serving as fiscal sponsor for the LHIC
- Providing coordination and resources to support LHIC success.



April 28, 2014

In re: Comments on DHMH CIMH proposal

Karen Matsuoka, PhD
Director, Health Systems and Infrastructure Administration
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Dr. Matsuoka:

The Maryland Board of Nursing appreciates the opportunity to comment on the Department of Health and Mental Hygiene's (DHMH) proposal dated March 31, 2014, that establishes a Community Integrated Medical Home (CIMH) as part of Maryland's State Healthcare Innovation Plan. Following are the Board's comments.

1. **Certification of Patient Centered Medical Homes.**

The Board worked extensively with the Maryland Health Care Commission in 2010 to ensure that Certified Registered Nurse Practitioners (CRNP) would be able to head up a Patient Centered Medical Homes (PCMH). One of the barriers for CRNP's was the certification process. Although a solution was found it still remains very restrictive and the certification requirements are not conducive to encouraging more CRNP's to start PCMH's. The requirement that a PCMH have at least 1,000 Medicare patients is restrictive. We have one CRNP led PCMH in Maryland. We approve the proposal to create a simplified certification process to encourage a diverse group of providers.

2. **Utilization of Local Health Improvement Coalitions, Community Health Hubs, and Patient Centered Medical Homes.**

The Board anticipated that a Patient Centered Medical Home (PCMH) would have a large preventive health component and is encouraged to see that the plan recognizes that

community resources need to be utilized to that end. However, the Board does have concerns about the community resources and how they will be integrated into the plan.

The proposal seems to give authority to Local Health Improvement Coalitions (LIHC) to coordinate community resources but on the other hand subordinates the LIHC's function to a new entity called a Community Health Hub (CHH). In turn the PCMH's are required to collaborate with the CHH and work with the LIHC. We see no reason for the CHH other than to be the employer and supervisor of the Community Health Workers (CHW) and direct the Community Health Teams (CHT). The CHT's will provide wrap around services and support to their most vulnerable patients and complement the work of the primary care providers.

Is an additional entity such as the CHH really necessary? If many of the LHIC's are under local health departments or hospitals why would they not supervise CHW's and direct CHT's in coordination with the primary care providers? The functions of LHIC's and CHH's appear to be duplicative.

3. How will this impact existing PCMH's?

The proposed target population for PCMH's is that group of Fee for Service Medicare patients and dual-eligible patients who are "super-utilizers". Each PCMH is expected to target at least two chronic diagnosis that will be analyzed for measurable results. The goal is to eliminate preventable hospitalizations. The Board is in agreement that we need to address the expense of care and preventable hospitalizations. Analyzing results will provide a basis for an evidence based analysis of the outcomes and any possible cost savings.

The targeted population will create a case load that could require all of the time and skill of the providers leaving little time for care of those with lesser needs. PCMH's should be able to serve the entire population, not just the most expensive chronically ill patients. This may not be conducive to providing preventive health care for the entire population.

4. Integrating mental health treatment.

The Board does not believe that asking primary care providers to integrate mental health services is going to have a meaningful impact on relieving the shortage of mental health providers. The Board does not speak for other health occupations as to what they

might require to meet this challenge but we will not permit CRNP's to provide mental health counseling and treatment without the appropriate training. A CRNP who is a primary care provider but is not certified as an APRN/PMH nurse will be required to take additional training at a Master's or higher graduate level to be able to provide mental health care as part of the primary care. The Board is supportive of CRNP's integrating mental health services into their primary care as long as they are qualified.

5. Community Health Workers.

The example of community-based interventions provided by CHW's for treating asthma on page 25 include teaching inhaler technique, monitoring the appropriate use of medications, use of a flow peak meter, and determining when to go to the emergency department versus seeing the patient's primary care provider are clearly clinical interventions. These are nursing functions. Some can possibly be delegated. These services are to be delivered by community outreach workers (CHW's) led by public health nurses based on the Health Quality Partners Advance Preventive Services model (HQP).

These functions cannot be performed under the supervision or even with the consent of a nurse unless the outreach workers are certified by the Board of Nursing. Further, nurse case managers cannot be responsible for CHW's who perform ongoing assessments and screening, educate and teach patient self-management of their health, perform assessments and counseling for behavioral changes and provide stress management education and counseling (page 65). These are nursing functions performed by licensed registered nurses. Our certified nursing assistants and licensed practical nurses do not do assessments and behavioral health counseling. These are services that require extensive training and experience if they are to be performed correctly and safely.

CHW's have a valid role as "connectors" between providers and community resources but they should not be utilized as health care providers. They should be used to complement clinical interventions: not provide clinical interventions. Tasks such as assisting with timely renewal of enrollments, keeping appointments, refilling medications, and meeting basic needs such as housing and income are suited to the role of a non licensed or uncertified individual.

CHW's, if they are going to perform delegated nursing functions, must be trained and certified if they are going to be supervised in a nurse led community outreach program. That training program should be determined by professional health educators and the

regulatory boards who oversee health care providers. Training and scope for CHW's should not be determined by insurers or health care organizations.

As proposed, a licensed nurse would be in violation of the Nurse Practice Act if they supervised the proposed scope of practice for a CHW.

6. **Community Health Hubs (CHH).**

There is some concern that we are going to be launching multiple programs at once instead of expanding the roles of PCMH, Chronic Health Homes, LHIC's, and Local Health Departments to encompass community outreach. They may be better suited to coordinating patient care than a CHH. The CHH structure bifurcates responsibility for care instead of leaving the responsibility for coordinating with the providers. Further, the role of the CHH will add to communication requirements resulting in the need for more staff time.

7. **Goals for Primary Care.**

The stated goal on page 37 is for 80% of all Marylanders to have a primary care physician who is participating in an accredited medical home program. The Board objects to the exclusion of Certified Registered Nurse Practitioners as primary care providers. They are qualified and should be encouraged to provide primary care services. There are currently about 6,500 CRNP's in Maryland. Abolishing the Maryland multi-payer Patient Centered Medical Home Program (MMPP) and substituting multiple single carrier programs, as proposed on Page 41, will create a barrier to establishing more CRNP led PCMH's.

8. **Chronic Health Homes.**

We agree that more community outreach is needed for improved care for patients with mental illness or substance abuse. However, the failure is not an administrative one but rather a shortage of providers. We fail to see how this proposal will increase mental health service providers.

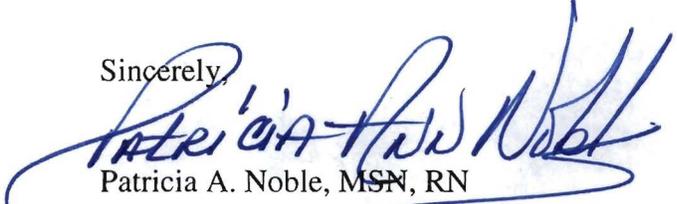
9. **Summary.**

Because the proposal suggests a unique experimental plan that encompasses nursing scope of practice the Board is concerned that it was not included as a stakeholder in the planning meetings nor on the mail distribution list for the SIMS grant.

The Board appreciates the need to save \$330 million in Medicare spending over the next 5 years as a condition of the approval of the Center for Medicare and Medicaid Innovation (CMMI) of Maryland's all-payer hospital payment system. That saving should not come at the cost of patient safety. The regulatory boards provide oversight to ensure safety. The proposal does not address oversight of CHW's and patient safety. Better access to poor care does not ensure safety. It should be noted that the health occupation regulatory boards that are most effected by this proposal were not included in the stakeholder group.

The Board agrees that Maryland's health care system should evolve into one that includes preventive care, however, it cannot completely support the community integrated model presented in this proposal. Going forward, the Board is willing to assist DHMH in developing the scope and a training model for CHW's and serving on the CIMH Advisory Board to develop Maryland's plan for preventive health care.

Sincerely,



Patricia A. Noble, MSN, RN
Executive Director

cc: Nancy Adams
Maryland Policy Partners
Maryland Nurses Association
Maryland Coalition for Advanced Practice Clinicians
Nurse Practitioners Association of Maryland

TDD FOR DISABLED MARYLAND RELAY SERVICE 1-800-735-2258



April 15, 2014

Karen Matsuoka, PhD, Director
Health Services Infrastructure Administration
Department of Health and Mental Hygiene
300 W. Preston Street
Baltimore, MD 21201

Dear Dr. Matsuoka:

Thank you for the opportunity to submit comments on the document "A Community-Integrated Learning Health System for Maryland – Maryland's State Healthcare Innovation Plan." With the state in the midst of modernizing the Medicare waiver, we support efforts to consider how to make the health care delivery system more focused on consumer health outcomes and well-being.

We encourage the Department of Health and Mental Hygiene (DHMH) to work with a broad range of stakeholders to continue to develop the community-integrated medical home (CIMH) model. The report offers some interesting ideas for consideration. We believe that the model presented in the report cannot be successful without some restructuring.

We strongly support the CIMH project's core goal of improving the health outcomes of the "super-utilizers." Coordination of both clinical and social services for the super-utilizers will improve the health outcomes of those individuals and move Maryland closer to its population health goals. We look forward to working with DHMH to accomplish these goals.

CIMH model needs a component for supporting care coordination at the provider level

Maryland has been advancing steadily in its use of patient-centered medical homes (PCMH) to increase the capacity of primary care providers (PCPs) to coordinate services for their patients. These models have supported efforts of federally qualified health centers, other community health centers, and private practices to expand capacity for service coordination for their patients. Just recently, DHMH established a complementary model to the PCMH Program with the Maryland Medicaid Health Home Model. The Health Home Model is designed to increase the capacity of behavioral health providers to provide service coordination for individuals with severe and persistent illness. The SIM

report acknowledges the promise of the medical home model in that “the overall evidence for medical homes suggests improved care processes and patient experience . . . (Page 39).”

We are deeply concerned that the CIMH model contemplates reversing the progress made by PCMH and Health Home models by *only* supporting service coordination outside of the PCP setting. Although the model allows “flexibility” in the arrangements that a PCP makes with the community health hub (CHH), there is no additional support for PCPs that want to expand their service coordination capacity.

We also question whether there is enough evidence to support constructing an external care coordination system statewide which is outside of the provider community. The SIM report stated that “the only care coordination program in Medicare’s Coordinated Care Demonstration Project to improve health outcomes and reduce net health costs was health Quality Partners (HQP) Advanced Preventative Services Model (Page 39).” The HQP Model offers some interesting lessons for Maryland to study for the Medicare population it served. However, we found no evidence in the SIM Report to support developing a statewide external care coordination model for all super-utilizer populations. Some super-utilizer populations are markedly different in terms of their provider and social support networks. For example, would children with asthma in low-income households benefit from coordination from an external CHH? Or would they be better served by enhancing the capacity of a school-based health center and/or school nurse to work with a child’s primary care provider? We think these questions should be thoroughly explored before assuming that a statewide external care coordination model is the answer.

The external care coordination model is also based on the assertion that the target populations “typically receive poor quality care” (page 22). We are deeply concerned by this statement, especially given that DHMH cites no evidence to support it. It is true that uninsured patients suffer because the lack of coverage restricts access to services, particularly to specialty services. However, the statement that the CIMH target population receives “poor quality care” is particularly baffling because the target populations are those *insured* through Medicaid, Medicare, the State Employees Health Plan, and private carriers. Federally qualified health centers are committed to providing the highest quality services to their patients – both insured and uninsured.

We strongly recommend that the CIMH model be revised to support the capacity of PCPs to coordinate services. Such support could come from the CIMH model directly and/or through linkages to PCMH and Health Home Programs. Service coordination by the provider makes sense because providers have the ultimate responsibility for clinical decisions in coordination with patients and their families. If the responsibility for implementing those decisions is removed from the provider, then it will create confusion as to who has the authority and responsibility to make clinical decisions. There is a distinct possibility that this confusion could result in discrepancies and gaps in what the provider orders and what is “coordinated” by the CHH. If this occurs, external care coordination would have a negative impact on patient outcomes.

It is also important to note that FQCHs and certain other community providers already provide coordination of, and linkages to, non-clinical services. As these health centers are already trusted providers in the community, it makes sense to enhance the capacity of existing providers to offer comprehensive coordination of non-clinical services.

While we are supportive of ensuring there is support for care coordination at the provider level, we recognize that not every provider will have the capacity for comprehensive care coordination. Therefore, we would be deeply interested in continuing the discussion about which circumstances would warrant external care coordination. However, because of the issues that we have outlined with care coordination outside the provider setting, we recommend being cautious, thoughtful, and incremental in implementing a separate and distinct care coordination model. Under any model, we recommend support for providers with the capacity or interest in developing the capacity for comprehensive coordination of clinical and non-clinical services.

Lack of provider support will result in low participation rates

DHMH has set a goal a goal of a participation rate of 80% of PCPs. We question whether this is achievable, given that CIMH model does not contain any firm support for providers who participate in the program. This concern is supported by a recent finding in the Maryland Health Care Commission's (MHCC's) Annual Report on the Evaluation of the Maryland Multi-Payor Patient-Centered Medical Home Project: "Respondents emphasized that the resources provided by the program, such as the MLC, were significant features of the program. Many respondents thought that without the resources from the MHHC, both financial and nonfinancial, transformation would be considerably more challenging if not impossible. (Page 18)"

Despite the lack of firm support, DHMH anticipates that participating providers in the CIMH model will have significant increased responsibility in:

- **Coordinating with the CHHs:** There is no information on the HQP model in the report that speaks to the level of interaction between coordinators and providers, but we would expect that coordination of services for super-utilizers would be intense on both the provider and CHH sides. In terms of expectations on the providers, the SIM report states that as part of the "meaningful floor" for participation, the "PCP can begin working with their hospital and other community partners to proactively design an effective discharge plan to prevent readmissions [after receiving an real-time alert from the ENS system] . . . PCPs may review a variety of patient information that will be helpful in care coordination such as medical records from a patient's visits to other providers, lab results, radiology reports, and discharge/transfer summaries" (pages 40-41). This is intensive work for the participating provider, yet there is no definite funding support envisioned for the provider;
- **Data Collection and Submission:** Participating providers will have substantial data collection and submission requirements, yet there is no consideration of support for providers to meet

those requirements. Even the SIM report acknowledges that the data responsibilities are so substantial that they will need to be phased-in: “Reporting requirements will be staged so that practices may enter the program even if they are unable to initially report all metrics . . . At a future date, requirements will expand” (page 42);

- **Unclear Liability Protections:** If a provider has an arrangement with a CHH, it is unclear who bears the legal liability for the provision of services. Do the CHHs have to carry malpractice insurance? Does a provider need additional malpractice coverage for the arrangement with the Hub? For FQHCs, this question is particularly complicated because FTCA has strict parameters about coverage of clinical functions; and
- **Unclear Certification Standards:** The SIM report discusses establishing “a meaningful floor for PCMH certification” (page 40). As we discuss further in this comment, the actual standards and process for setting these standards is unclear; and just this lack of clarity around the standards may dissuade providers from even considering participation.

Based on the feedback provided to DHMH at the stakeholder meetings, we believe that many providers share our concerns about creating an external care coordination system and the administrative burden on the provider participating in the CIMH model as currently constructed. Without addressing the need for support for the provider, we do not think it is feasible for DHMH to achieve an 80% participation rate in the program; and in reality, DHMH may struggle to recruit a sufficient number of providers to even test the model. We note that the other models implemented by the State – PCMH and Health Home – have been able to move forward because the programs were structured to at least partially provide the resources that PCPs needed to implement the program. We question whether a model that offers no guaranteed support to providers can be successful. The only mention of support is a bonus from the Local Health Improvement Coalitions for providers if “they contribute meaningfully to the health of their communities at the LHIC level” (page 44). This statement seems like a very tentative commitment at best and will likely not be sufficient to entice providers to make the up-front and ongoing investments needed to participate.

CIMH Model should support current Medicaid reforms

The Maryland Medical Assistance Program is currently implementing many major initiatives that will transform the Medicaid/CHIP programs. These initiatives include: 1) Expansion of Medicaid to adults without dependents under the Affordable Care Act (ACA); 2) Implementation of Behavioral Health Integration to combine the financing and administration of mental health and substance use disorder services; and 3) Implementation of the Community First Choice Program to provide self-directed services for the dually eligible in least restrictive settings.

It appears as though the Maryland Medical Assistance Program may be one of the primary payors to participate in the CIMH model. This is supported by the SIM report’s assertion that one of the

targeted super-utilizer populations will be the dually eligible. Therefore, it is imperative that the CIMH model be integrated with the Medicaid initiatives to expand eligibility, implement Behavioral Health Integration, and implement Community First Choice.

We are concerned that there has not been sufficient discussion about the integration of the CIMH model with other DHMH initiatives. The SIM report notes that “the SIM model will initially focus on Medicare FFS and dual-eligible patients, given that there is no systematic care management offered to these individuals despite the need. SIM will fill this much needed gap” (page 27). This statement makes it seem like the SIM project is unaware of all the initiatives throughout DHMH to work towards that goal.

We recommend that the SIM report be expanded to include discussion of all three of these initiatives. We noticed that there was some acknowledgement of behavioral health integration, but it was not clear how the CIMH model would support this initiative. We did not see any mention of the Community First Choice Program, which is of particular concern given that older adults are identified as one of the likely target super-utilizer populations.

Furthermore, we think it is important to have the opportunity to review and analyze the financial impact of the CIMH model on Medicaid. With DHMH committed to other initiatives, it is important to evaluate whether the CIMH program is sustainable and if its funding needs will impact the level of resources available for other programs.

CIMH Model success is dependent on availability of non-clinical services

We have been fully supportive of implementation of the ACA, as we believe that access to insurance coverage is a major part of the answer to improving health outcomes. With a larger insured population, care models – including the CIMH, PCMH, and Health Home models – have a greater chance of success. The CIMH model is particularly intriguing because it focuses on access to non-clinical services, such as housing, environmental health, and social support services. As our FQHC members have long recognized, access to these non-clinical supports is essential in improving health outcomes. For the CIMH model to be successful, it will be critical to determine how we can ensure that these services are available. During the stakeholder meetings, we spent a considerable amount of time discussing the need for these non-clinical services. It is unclear if all of these services will be available at a sufficient level for a statewide program to work. We are fully supportive of ensuring all of our patients have access to these non-clinical services and look to DHMH and our community partners in determining what investments may be needed.

Consumer choice should be incorporated into CIMH Model

FQHCs highly value the rights of the consumer to make decisions about their clinical care. In other PCMH and Health Home models, consumers have the right to decide whether to participate. In

models of care for older adults and individuals with disabilities, the trend is toward self-directed care. We would recommend that the CIMH model be modified to incorporate the principle of consumer choice and self-directed care in alignment with other DHMH initiatives.

Future of PCMH Models should be clarified.

The SIM report raises many questions about the future of the state's PCMH Program. The report states that "Moving forward, Maryland's approach to certification will be flexible until we gather enough evidence around which standards most reliably lead to improved health outcomes and lower cost . . . While allowing for greater flexibility, we will also establish a meaningful floor for PCMH certification" (pages 39-40). We are unclear of the implications for these policy statements on the existing PCMH and Health Home models. These statements seem to blend the CIMH and PCMH programs together, yet there is no information about how these programs will be merged; and since the CIMH model has yet to be established, it seems premature to revise the existing PCMH program entirely as there is no evidence on how well the CIMH model will work.

We also have questions about the statement that, "basic PCMH design features may be just as likely to result in improvements as highly structured national standards" (page 39). Does this statement mean that the MHCC and carriers are going to move away from NCQA certification requirements?

We are also unclear about the ongoing governance of the PCMH models. The SIM report states that the "CIMH Advisory Body will work with primary care providers to minimize disruption as we streamline the MMPP into this single-carrier framework" (page 41). Does this mean that the CIMH Advisory Body will advise the MHCC on the structure of the PCMH program? Who will have ultimate authority for the PCMH program? Will it be MHCC or DHMH?

Governance structure should be consistent, understandable, and transparent

The SIM report contemplates creating a Public Utility to regulate Hubs. It also considers creating some type of joint MHCC-DHMH governance over CIMH and PCMH models. It appears as though the Local Health Improvement Coalitions will continue to fall under both local authorities and DHMH.

The governance chart on page 110 is confusing and likely conflicts with existing statute:

- The CIMH Advisory Board appears to have governance over the Health Services Cost Review Commission (HSCRC) workgroups for the Medicare Waiver. Under current statute, the HSCRC has purview over the Medicare Waiver. Is the SIM report suggesting that jurisdiction for the Waiver will be shifted?
- The CIMH Advisory Board appears to have authority over two CIMH workgroups. Does this mean that the Advisory Board will have implementation authority?

- The Public Utility appears to have authority over the MHCC and HSIA. Earlier in the document, it appeared as though the Public Utility had some type of certification authority over the Hubs.

The chart makes it appear as though the Public Utility will have authority over the MHCC instead of the Commissioners of MHCC. It also makes it appear as though the Public Utility will have authority over HSIA instead of DHMH.

Given that so much of our health care delivery system is in transition, we recommend that there be further consideration given to the governance structure. The structure should be efficient, transparent, and consistent. As it appears in the report, it is very confusing; and we fear that the confusion will damage implementation efforts of the CIMH model.

Conclusion: CIMH model should be implemented in a scalable manner

We have raised many questions in our comments on the SIM report. We understand that sorting through these issues is time-consuming and difficult without concrete, implementation data. We urge DHMH to consider the comments of stakeholders in adjusting the model. We also urge consideration of a different roll-out plan to allow for data collection, careful analysis, and appropriate adjustments to the model. The goal of enrolling a significant number of PCPs statewide seems unachievable, given all the policy and implementation questions to be addressed. However, if the model were scaled differently with perhaps participation of one or two urban, suburban, and rural jurisdictions, then we would have a chance to learn from the implementation process and construct a model that can be successful statewide.

Thank you for the opportunity to submit these comments. If you have any questions, please contact Ms. Salliann Alborn at salborn@chipmd.org or (443) 557-0258 or Ms. Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

Sincerely,



Salliann Richardson Alborn, CEO

802 Cromwell Park Drive, Suite V, Glen Burnie, MD 21061
Telephone: (443) 557-0259 Facsimile: (410) 766-2286
www.chipmd.org

cc: Laura Herrera, M.D., Deputy Secretary of Public Health Services
Charles Lehman, Acting Deputy Secretary of Health Care Financing
Ben Steffen, Executive Director of the Maryland Health Care Commission
Donna Kinzer, Executive Director of the Health Services Cost Review Commission
Tricia Nay, M.D., Director of the Office of Health Care Quality

April 15, 2014

Karen Matsuoka, PhD
Director, Health Services Infrastructure Administration
Department of Health and Mental Hygiene
300 W. Preston Street
Baltimore, MD 21201

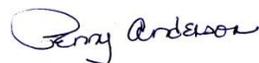
Dear Dr. Matsuoka:

The Maryland Dental Action Coalition (MDAC) is a statewide partnership of more than 250 individuals and organizations committed to improving the health of all Marylanders through increased oral health prevention, education, advocacy and access to dental care. We are grateful for this opportunity to comment on the community-integrated medical home (CIMH) model developed with a Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Design grant, as described in your Mar. 31 submission to CMMI.

We strongly support the concept of community-integrated care that acknowledges a broad range of determinants of health status and brings together the supports necessary to overcome barriers to access and improved outcomes. To be successful, a CIMH model must include dental care services. However, the SIM Report does not address the need for improved oral health outcomes and access to dental services. As development of the model moves forward, it is critical to incorporate dental services because there is a strong link between oral health and systemic diseases. MDAC is keenly aware of the relationship between dental disease and other illnesses: our coalition was created after a 12-year-old child whose family could not afford dental care tragically died from a bacterial infection in an abscessed tooth that spread to his brain.

We have not had sufficient time to review the SIM Report to provide feedback on implementation questions, given the short turn-around time for public comments. We understand that the project will still require significant development before DHMH submits a grant to CMMI for implementation. We would be glad to work with the Department to incorporate oral health as an integral part of the continuum of care provided in the CIMH model and look forward to such collaboration. Please feel free to contact me if MDAC can be of further assistance.

Sincerely,



Penny Anderson
Executive Director



SIM Feedback <marylandsim@gmail.com>

SIM Public Comment

Teja Rau -MDOA- <teja.rau@maryland.gov>

Fri, Apr 11, 2014 at 4:35 PM

To: marylandSIM@gmail.com

Cc: Karen Matsuoka -DHMH- <karen.matsuoka@maryland.gov>, "Judy R. Simon -MDOA-" <judy.simon@maryland.gov>, "Stephanie A. Hull -MDOA-" <stephanie.hull@maryland.gov>, Bernice Hutchinson -MDOA- <bernice.hutchinson@maryland.gov>, "Mayer, Devon" <devon.mayer@maryland.gov>

Over the past several years, the Department of Health and Mental Hygiene and Department of Aging have invested millions of dollars into the statewide Aging and Disability Resource Center network of 20 sites, known as **Maryland Access Point (MAP)**.

This partnership has created a new **long term care service access system** through which people living in the community with long term care needs may access information and connect to programs and services that will help them avoid nursing home care, thereby reducing costs for the State Medicaid program. Specifically, **MAP is the gateway through which individuals will enter to access Medicaid community long term care programs such as Community First Choice and the Community Options waiver.**

The MAP and Area Agency on Aging network should be an integral part of the SIM in order to further leverage the local and state interagency relationships built to streamline access to community-based long term care services in Maryland. As described below, our network is a **significant component of the Community Integrated Health Care System.**

SIM will be improved by adding the MAP network because:

- 1) MAP is a local, transparent, and **trusted entry point** for individuals seeking information and access **to long term care services** in the community, get connected to Medicaid programs, and avoid costly nursing facility care. The Area Agencies on Aging, who are the leading agency for MAP, also provide supports planning/case management services for Medicaid waiver and Community First Choice participants.

2) MAP staff already serve as **social service navigators** for individuals with long term care needs, including for **care transitions**. The Department of Aging has spent the past two years working with Johns Hopkins on a care transitions project to integrate long-term care services planning and support with medical care. We teamed MAP staff with nurses to provide holistic support to individuals discharged from a hospital or physician practice back home. All of our MAP sites also work with individuals in the community to navigate across agencies and programs by providing program information/education, application assistance, and decision support.

3) Through the **Living Well/Chronic Disease Self Management Program**, MDoA has developed a robust, evidence-based self management program throughout the state which is: 1) proven to positively impact the **Triple Aims**, 2) developing **partnerships with major hospital hubs**, and 3) developing a model for integrating **Community Health Workers**, trained in self management, to collaborate effectively with the MAP network.

We believe that the MAP network will add significant value to the SIM for these reasons and its inclusion will take the State's investment in Maryland's long term care system to the next level. The addition of our social services and preventive health programs will strengthen the SIM proposal to better meet the triple aims. Our service delivery systems, several of which are in partnership with the Medicaid, Office of Chronic Disease, Minority Health and Health Systems Infrastructure Administrations within DHMH should be included and highlighted within the **Community Integrated Medical Home's Pillars of Social Services and Public Health**.

Thank you for considering our comments. Please feel free to contact me for any additional information.

TEJA RAU
Acting Chief, Long Term Services and Supports
Maryland Department of Aging
301 W. Preston Street, Suite 1007
Baltimore, MD 21201
410.767.1266

<http://www.aging.maryland.gov>
<http://www.marylandaccesspoint.info/>



MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

April 15, 2014

Karen Matsuoka, Ph.D.
Director, Health Systems and Infrastructure Administration
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201

Dear Ms. Matsuoka:

On behalf of the Maryland Hospital Association's (MHA) 66 member hospitals and health systems, and as a participant in the stakeholder engagement process, I appreciate the opportunity to comment on the State Healthcare Innovation Plan that was submitted to the Centers for Medicare & Medicaid Services as the main product of the "SIM Model Design" planning grant.

Hospitals have much at stake under the hospital Medicare waiver demonstration referenced in the report. The modernized hospital waiver limits annual all-payer hospital revenue growth to no more than 3.58 percent per capita, requires \$330 million in Medicare savings over five years, and sets aggressive targets to reduce complications and readmissions. We welcome a visionary plan that supports the dramatic changes that will be required to succeed under the new hospital payment demonstration model. The final report describes a far-reaching and inspired plan for transformation that could provide the framework on which to build.

By design, the scope and scale of the State Healthcare Innovation Plan is bold; many of the ideas have not been tried on a statewide scale and will require active engagement and partnerships with stakeholders. As an example, expanding existing health information technology data infrastructure in Maryland from its current state to fit the vision described in the report is beyond the scope of state government alone. It will require incremental steps by providers to maximize the use and interoperability of electronic health records, as well as coordination with existing data resources and the development of new resources and capabilities.

To be a trusted asset, the data tools must be transparent and must allow all key stakeholders access to the data. We believe this is best accomplished through a shared governance structure with clear guidelines about which individuals and institutions can access what level of data—a plan that will require much more work to bring to reality. MHA is eager to begin work on a data infrastructure and shared data governance plan with the Department of Health and Mental Hygiene, the state agencies that hold or collect data, and care providers that would use data to improve health care delivery.

We appreciate that the report acknowledged the previous comments from MHA and other stakeholders; particularly the need to ensure that care coordination among hospitals, payers, Accountable Care Organizations, and others does not overlap or duplicate communication to patients.

MHA also appreciates the report's note of, the need to thoughtfully plan the roll-out to ensure that local public health and private providers are truly forming effective partnerships. Deploying Community Health Teams in a way that integrates with current activities would build on relationships that already exist between providers and local health departments. Because the working relationships between providers and local health departments are not uniform across jurisdictions, a uniform approach to integration is not likely to be well accepted. In areas where there is a history of working well together, less intervention may be necessary and in areas where there is little experience working together, trust and accountability will need to grow.

We also appreciate the recognition of the need for additional behavioral health resources. Hospitals share this concern and are acutely aware of the need for expanded access to behavioral health services.

We look forward to continuing the dialogue in each of these areas.

Maryland hospitals have committed to rates of spending growth far below historic growth rates, with a specific goal of \$330 million in Medicare savings Medicare alone under the new waiver. Historic per capita growth rates in the range of 6 percent to 7 percent will be replaced with rates of growth no higher than 3.58 percent, generating system-wide savings for all payers on the order of \$800 million over five years.

By supporting the waiver agreement, hospitals have already contributed to achieving dramatic savings for the state, the federal government, and all other payers of health care. It is unrealistic to expect additional savings from hospital care to support the State Healthcare Innovation Plan, particularly after only two years. We are not as confident as the report indicates that we can "meet – and beat" the hospital waiver savings targets.

Maryland hospitals' commitment to lower health care spending for the entire state is unprecedented and will not be easy to achieve. Hospitals will need to redesign care delivery to better manage chronic conditions outside the hospital, to engage patients and families in their care in new and meaningful ways, and to address social determinants of health — all of which are needed to achieve better outcomes for their communities. As this transition to population health management matures over the next five to 10 years, it's conceivable that additional savings beyond the 3.58 percent cap will be within reach. However, it is overly optimistic to expect additional hospital savings beyond the roughly \$800 million that is already projected.

We appreciate the time and efforts you and your staff have put into this report. We look forward to continuing this important work with you. Please contact me at 410-540-5087 or by email at tla_valle@mhaonline.org if you would like to discuss this further.

Sincerely,

Traci La Valle,
Vice President, Financial Policy & Advocacy
Maryland Hospital Association



**Maryland Rural Health Association
(MRHA)**
 P.O. Box 5603
 Baltimore, MD 21210
 410-302-4650

April 15, 2014

Laura Herrera, MD
 Deputy Secretary Director
 Public Health Services
 201 West Preston Street, 5th Floor
 Baltimore, MD 21201

Re: Comments on Community Integrated Learning Health System for Maryland

Dear Dr. Herrera,

Maryland Rural Health Association (MRHA) is a non-profit member organization comprised of local health departments (LHDs), hospitals, community health centers, area health education centers, health professionals, and community members in rural areas and throughout Maryland. We count 57 organizations and over 10,000 individuals within our membership. Of Maryland’s 24 counties, 18 are considered rural by the state, and with a population of over 1.4 million they differ greatly from the urban areas in Maryland. The MRHA appreciates the opportunity to provide comments on Maryland’s State Healthcare Innovation Plan. Many of our members served in the stakeholder engagement process and we see this as an exciting opportunity to develop an approach to integrating primary care and community health.

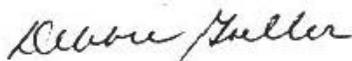
Rural areas have a strong history of working cooperatively across systems with strong local partnerships between hospitals, clinicians, public health departments, and other stakeholders, strategically sharing and using data to improve health. This effective model of community-clinical partnerships that lead to innovative solutions is robust. Rural communities understand collaborative partnership between community and traditional clinical health is a necessity for survival—rural health care agencies have less administrative staff and even fewer clinicians to address the health of their population. To this regard our membership has concerns that some components of the Community Integrated Medical Home Model (CIMH) may be counterproductive to strong collaborative partnerships and relationships that already exist in rural communities and would be overly burdensome to rural communities, with fewer resources, to create new administrative structures to support the model.

Proposal	Concerns	Recommendations
Community Health Hubs (CHH)s	<ul style="list-style-type: none"> • Local Health Officers (LHO)s are designated as the local public health authority in their communities. CHHs should include LHOs and LHDs as central component. • CHHs may be redundant, or even counterproductive, to the process some Local Health Improvement Coalitions (LHIC)s are already serving in 	<ul style="list-style-type: none"> • As the local public health authority, the LHO should determine if the LHD, or LHIC, should be the CHH or if there should be a competitive process for their communities. • Provide technical assistance to those communities that are identified as not ready for implementation or have weaker LHICs before any

	<p>the community.</p> <ul style="list-style-type: none"> • New layer of CHH administration will cause confusion and resource drain at the local level. • Competitive process for hub may pit local partners against each other and have unintended consequences of separate planning processes and draining of multiple resources and assets in a rural community. 	<p>competitive process.</p> <ul style="list-style-type: none"> • Ensure diverse rural representation from leadership in rural LHICs and LHDs in the Community Integrated Medical Home Program Advisory Board
<p>Statewide Training of Community Health Workers (CHW)s</p>	<ul style="list-style-type: none"> • The Affordable Care Act (ACA) clearly states the Area Health Education Center (AHEC) role in CHW training "...mandates Area Health Education Centers to provide interdisciplinary training of health professionals, including CHWs." AHECs should be allowed an opportunity or participate in curriculum development or pilot. 	<ul style="list-style-type: none"> • Recognizing some parts of state do not have an AHEC (Southern Maryland and Suburban Counties) capitalize on rural AHEC expertise in development of statewide curriculum. • Grandfather in CHWs that are currently getting trained and integrate existing curriculum. <ul style="list-style-type: none"> • Recognize organizations like AHECs as potential training sites for statewide implementation. • Ensure AHEC and rural representation on new Workgroup for CHW Workforce Development

Thank you for the work you do on behalf of Maryland's rural communities. If you or your staff have any questions please do not hesitate to contact me.

Sincerely,



Debbie Goeller, RN, MSN
President, Maryland Rural Health Association
Worcester County Health Officer

Cc: Michelle Clark, Executive Director, MRHA
Earl Stoner, MRHA Legislative Chair, Health Officer, Washington County

April 15, 2014

Laura Herrera, M.D.
Deputy Secretary, Public Health Services
Maryland Department of Health & Mental Hygiene
201 West Preston Street
5th Floor
Baltimore, MD 21201-2301

Dear Deputy Secretary Herrera:

On behalf of MedChi, the Maryland State Medical Society, this letter is submitted in response to a request for public comment on the Maryland State Healthcare Innovation Plan (Plan), which was submitted by the Maryland Department of Health & Mental Hygiene (DHMH) to the Centers for Medicare and Medicaid Services on March 31, 2014, and subsequently released to the public for comment on April 1st.

MedChi understands the Plan document submitted is required pursuant to the SIM Model Design award, the planning grant DHMH received in February 2013 and for which the stakeholder process was held during the 2013 interim. MedChi is aware that CMS has not yet announced when it will release the Funding Opportunity Announcement (FOA) for the Model Testing award but understands that if further funding opportunities are announced, and DHMH is awarded an implementation grant, its intention would be to utilize that funding to implement the "Community Integrated Medical Home" (CIMH) as reflected in the Plan. To that end, MedChi is concerned that while the Department is soliciting public comment, the program in effect has already been proposed. Thus raising the question of how much modification to the proposed program is legitimately open to stakeholder input.

To date, DHMH has engaged in a broad stakeholder dialogue during the planning grant process. While MedChi would have preferred for the Department to have solicited public comment prior to submission of the currently proposed Plan, we will assume that the current solicitation of public comment is intended to generate a robust stakeholder dialogue to be addressed through the soon-to-be appointed Advisory Board. Given that the Advisory Board is charged with advising the Department on program development, MedChi urges the Department to remain open to substantive revision of the Plan pursuant to the Advisory Board process.

Because MedChi anticipates substantive consideration of all elements of the Plan during the Advisory Board process, the following comments reflect principles that MedChi believes to be critical to the successful development of CIMH model as broadly envisioned by the Department in its Plan.

- **Integration with Other Reform Programs:** MedChi supports the Department's commitment to the integration of primary care with other community health initiatives. However, the success of the CIMH program will require deliberative consideration of how CIMH will integrate with other health delivery system reform initiatives such as implementation of the Medicare All-

Payor Model, the HEZ program, behavioral health and long term care reform efforts as well as the continued efforts to complete implementation the ACA. Accountable Care Organizations that are truly physician-led and committed to improving quality regardless of care setting are directly aligned with the Plan principles and should be integrated as well.

- **Utilize Existing Resources to Achieve CIMH Objectives:** Several components of the Plan expand upon or mirror existing initiatives such as the Patient Centered Medical Home administered by the Maryland Health Care Commission (MHCC) and the HEZ Program and Community Health Resource grant program administered by Community Health Resources Commission (CHRC). Where appropriate, the strengths and existing infrastructure of these programs should be utilized in the development and implementation of the Plan. To that end, MedChi assumes the CHRC, while not reflected in the Plan will be an active participant in the Advisory Board process.
- **Maintain the Physician as Head of the Medical Home:** Throughout the stakeholder process, MedChi has reiterated its concern about fragmentation of the health care delivery system as greater authority for the provision and management of health care services is granted to non-physicians. Fragmentation of authority runs directly counter to the stated objective of the Plan. Maintenance of the physician as the “team” leader is essential to program success.

With these broad principles in mind, MedChi welcomes the opportunity to continue to work with the Department on the development of the CIMH through the Advisory Board process and will be seeking appointment to the Board. Thank you for the opportunity to provide these initial comments.

 Sincerely,

Gene M. Ransom, III
Chief Executive Officer

cc: The Honorable Joshua Sharfstein
Karen Matsuoka
Racquel Samson
Ben Steffen
David Sharp
Mark Luckner
Patrick Dooley

MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS

Serving Maryland and Delaware

4319 Forbes Boulevard
Lanham, Maryland 20706

April 27, 2014



(301) 577-0097
Fax (301) 577-4789
www.machc.com

Laura Herrera, M.D.
Deputy Secretary, Public Health Services
Maryland Department of Health & Mental Hygiene
201 West Preston Street
5th Floor
Baltimore, MD 21201-2301

Dear Deputy Secretary Herrera:

On behalf of Mid-Atlantic Association of Community Health Centers (MACHC), this letter is submitted in response to a request for public comment on the Maryland State Healthcare Innovation Plan (SIM Plan), which was submitted by the Maryland Department of Health and Mental Hygiene (DHMH) to the Centers for Medicare and Medicaid Services on March 31, 2014, and subsequently released to the public for comment on April 1, 2014.

MACHC and its members applaud the State's commitment to integrating primary care with the broader community health initiatives and are excited about the potential this process holds for strengthening partnerships, enhancing primary care access and leveraging the transformative initiatives the State is currently undertaking that is inclusive of the Maryland Health Benefit Exchange (MBHE), the All-Payor Hospital System Modernization (Medicare Waiver) and the integration of mental health and primary care services. MACHC further commends the department in involving multiple stakeholders, including the Federally Qualified Health Centers (FQHCs), in the formation and planning process of the Community Integrated Medical Home (CIMH) model as reflected in the Plan and further support a population health management approach. MACHC would encourage the Department to include to solicit public comment and feedback from various stakeholders through the Advisory Board, which are charged with advising the Department on the program development. MACHC urges that the Department remain open to any substantive revisions of the Plan pursuant to the Advisory Board process.

MACHC anticipates that there are certain elements of the Plan during the Advisory Board process that may be suggested. The points below reflect some principles that MACHC believes to be critical to the successful development of the CIMH model as broadly envisioned by the Department in its Plan:

- *Integration with Other Reform Programs:* MACHC supports the Department's commitment to the integration of primary care with other community health initiatives. However, the success of the CIMH program will require deliberate consideration of how CIMH will integrate with other health delivery system reform initiatives such as the implementation of the Medicare-All-Payor Model, the HEZ program, behavioral health and long term care reform efforts, meaningful use efforts, as well as the continued efforts to complete implementation of the ACA. Moreover,

FQHCs are all participating in Patient Centered Medical Home certification and will be critical partners in the implementation of the CIMH model. Our point is to ensure that alignment and integration of other reform efforts should be considered and coordinated wherein possible for effectively implementing the CIMH model.

- *Utilize Existing Resources to Achieve CIMH Objectives:* Several components of the Plan expand upon or mirror existing initiatives such as the Patient Centered Medical Home administered by the Maryland Health Care Commission (MCC) as well as National Center for Quality Assurance for FQHCs, and the HEZ program, and the Community Health Resources grant program administered by Community Health Resources Commission (CHRC). Where appropriate, the strengths and existing infrastructure of these programs should be utilized in the development and implementation of the Plan. To that end, MACHC assumes the CRHC, while not reflected in the Plan will be an active participant in the Advisory Board Process.
- *Encourage Involvement with Key Stakeholders with the Emphasis on Partnership:* We encourage the department to continue to ensure effective stakeholder involvement that emphasizes partnerships with all stakeholders to decrease the likelihood of fragmentation of the health care delivery system. We encourage the Department to continue to encourage hospitals, local departments of health, Federally Qualified Health Centers, long term care facilities, urgent care facilities, managed care organizations and private practices to partner in providing their feedback in the CIMH model development.
- *MACHC's Appointment to the Advisory Board:*

Thank you for providing MACHC and its members the opportunity to provide these comments and we welcome further dialogue on the development of the CIMH Plan.

We look forward to next steps in the process.

Most Sincerely,



H. Duane Taylor, Esq., MPP, MCPH
Chief Executive Officer

cc: The Honorable Joshua Sharfstein
Karen Matsuoka
Raquel Samson



SIM Feedback <marylandsim@gmail.com>

Fwd: SIM feedback

Karen Matsuoka -DHMH- <karen.matsuoka@maryland.gov>

Wed, Apr 9, 2014 at 10:07 AM

To: SIM Feedback <marylandsim@gmail.com>

Christina -- can you add this to the mix? Thanks.

Karen Matsuoka, PhD
Director, Health Systems and Infrastructure Administration
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201
410-767-4268

----- Forwarded message -----

From: **Laura Herrera -DHMH-** <laura.herrera@maryland.gov>
Date: Wed, Apr 9, 2014 at 9:45 AM
Subject: Re: SIM feedback
To: Karen Matsuoka -DHMH- <karen.matsuoka@maryland.gov>

Marla Oros.

She is a consultant (Mosaic). Sent her the SIM grant because of all the work she has done on SBIRT and BH in general.

On Wed, Apr 9, 2014 at 9:23 AM, Karen Matsuoka -DHMH- <karen.matsuoka@maryland.gov> wrote:

Thanks -- who is this from?

Karen Matsuoka, PhD
Director, Health Systems and Infrastructure Administration
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201
410-767-4268

On Wed, Apr 9, 2014 at 8:59 AM, Laura Herrera -DHMH- <laura.herrera@maryland.gov> wrote:

Thanks so much for the opportunity to review the proposal. Congratulations for putting together such an innovative new model of care that responds to both population health and individual health needs by bridging public health and private health care systems. It is a very exciting opportunity.

Of course, the devil will be in the details as far as I can see from the proposal. The concepts and ideas are all very sound, however, the implementation on the ground must be carefully executed to fill in the important protocols and processes that will support building and sustaining relationships with

the range of provider and community organizations critical to success. Because so much about this model's success will rely on the careful execution of systems and processes that have yet to be developed, I offer the following "food for thought":

1. As you know and is stated in the proposal, there is a significant amount of activity happening in the private sector health care market supportive of many of the goals of this proposal. Hospitals are aligning with FQHCs, case management entities and home care services in order to respond to the new hospital payment system and avoid 30 day readmissions. FQHCs and hospitals are creating partnerships with community organizations to address social determinants as part of their PCMH and other efforts to improve outcomes and reduce costs. Many hospitals and other providers have received large grants, such as Hopkins, CMS Innovation grant to hire community workers and deliver data driven interventions to promote overall health improvement and reduce costs. I know that you know all of this but in order for CIMH to be successful, the hubs will need to develop very strong relationships and systems to assure that the appropriate patients are referred and that strong coordination with the provider care delivery team is established. I think this will be an important challenge that will need to be carefully solved.
2. Consistent with my above illustration of the multitude of activity happening around the state, I am sure you have given thought to the hub organization selection. Ideally this organization not only needs to have sophisticated and strong capacity to be able to deliver the services described in the proposal, but must be viewed as a "neutral" party in order to develop and sustain the range of relationships necessary to truly deliver the services to the target patient population. My limited experience with the West Baltimore HEZ demonstrates that this can be a challenge, especially when you have a private provider as the hub. Perhaps in smaller, rural communities where the integrated systems are already being fostered, this may not be so much of an issue, but in larger areas, this must be again carefully navigated for success. Clearly public health departments are the right choice in lots of cases to be the hub, but the capacity for this could be extremely uneven across the state.
3. I like how you have risk stratified the super-utilizers that would be appropriate for the CIMH teams. Clearly lots of thought and protocol must be developed to determine how best to get these referrals and assure good coordination with the care delivery teams. As indicated above, I think so much is already happening around PCMH and other team-based care and clearly providers still need to "own" the care of their patients, therefore, how best to develop the protocols for this new extended team in CIMH that still supports the provider will be essential.
4. For the less risky patient population, but still key to success, we need to rely on PCMH to do its job in managing the care of patients so that they do not hopefully progress to become a super-utilizer. I love PCMH as an idea but I have yet to see it successfully implemented in my many travels with FQHCs around the state. Adding a nurse and social worker to the team does not make for a PCMH model of care. I believe we have a significant amount of work to do to have centers really put the systems in place for interdisciplinary team care and disease management.
5. Finally, we will need to clearly rely on other community partners in the behavioral health and social service sectors to help respond to the important co-morbid conditions and social determinants of health. As you know the hub teams will most likely encounter an imperfect system of support. Behavioral health has yet to be fully integrated and significant gaps in treatment options exist in many areas. Critical service supports such as housing, food, etc. are difficult to obtain and sustain for individuals in need. Development of true networks of care supported by clear strategic alliances with the hubs will be essential for success. Bringing providers together to collaborate and work to mutually coordinate and address the whole person is hard work that requires strong leadership skills.

The financing model is still a bit unclear to me, seems like it is a demonstration project and that if we show savings and we can look at reform of the payment system in support of CIMH? Maybe just not getting it from the proposal.

I think that about summarizes my thoughts. I think it is an exciting idea but as indicated above so much of the success depends on the details of the execution.

--

Laura Herrera, MD, MPH
Deputy Secretary of Public Health
Department of Health and Mental Hygiene
201 W Preston Street
Baltimore MD 21201
laura.herrera@maryland.gov
Phone: 410-767-6525

CONFIDENTIALITY NOTICE: This message and the accompanying documents are intended only for the use of the individual or entity to which they are addressed and may contain information that is privileged, confidential, or exempt from disclosure under applicable law. If the reader of this email is not the intended recipient, you are hereby notified that you are strictly prohibited from reading, disseminating, distributing, or copying this communication. If you have received this email in error, please notify the sender immediately and destroy the original transmission.

CONFIDENTIALITY NOTICE: This message and the accompanying documents are intended only for the use of the individual or entity to which they are addressed and may contain information that is privileged, confidential, or exempt from disclosure under applicable law. If the reader of this email is not the intended recipient, you are hereby notified that you are strictly prohibited from reading, disseminating, distributing, or copying this communication. If you have received this email in error, please notify the sender immediately and destroy the original transmission.

--

Laura Herrera, MD, MPH
Deputy Secretary of Public Health
Department of Health and Mental Hygiene
201 W Preston Street
Baltimore MD 21201
laura.herrera@maryland.gov
Phone: 410-767-6525

CONFIDENTIALITY NOTICE: This message and the accompanying documents are intended only for the use of the individual or entity to which they are addressed and may contain information that is privileged, confidential, or exempt from disclosure under applicable law. If the reader of this email is not the intended recipient, you are hereby notified that you are strictly prohibited from reading, disseminating, distributing, or copying this communication. If you have received this email in error, please notify the sender immediately and destroy the original transmission.

CONFIDENTIALITY NOTICE: This message and the accompanying documents are intended only for the use of the individual or entity to which they are addressed and may contain information that is privileged, confidential, or

exempt from disclosure under applicable law. If the reader of this email is not the intended recipient, you are hereby notified that you are strictly prohibited from reading, disseminating, distributing, or copying this communication. If you have received this email in error, please notify the sender immediately and destroy the original transmission.



April 28, 2014

Karen Matsuoka, Ph.D.
Director, Health Services Infrastructure Administration
Department of Health and Mental Hygiene
300 W. Preston St.
Baltimore, MD 21201

Re: Comment on Maryland's State Healthcare Innovation Plan submission to the Center for Medicare and Medicaid Innovation (CMMI), March 31, 2014

Dear Dr. Matsuoka:

I am writing on behalf of the National Association of Social Workers-Maryland Chapter (NASW-MD). We are very appreciative of the opportunity to comment on the SIM plan.

We have reviewed the plan and we are very impressed with the goals and the tremendous effort which has been expended in the development of the many facets of the proposed program.

We have also reviewed the comments submitted by two other groups: The Maryland Nurses Association and a group composed of Advocates for Children and Youth, the Maryland Women's Coalition for Health Care Reform and The Mental Health Association of Maryland. We are in agreement with the comments and concerns submitted by these two organizations.

Specifically, we would like to focus on a concern which was #2 in the letter submitted by the Maryland Nurse's Association (**Provision of direct care by CHWs violates the scope and standards of practice for nursing and other health professions**) and which is of particular concern to us as well.

A significant portion of the plan focuses on the new position defined as a Community Health Worker (CHW). As we read the description of the CHW and the core competencies associated with this contemplated new professional, we could not help but notice the obvious similarities with a workforce which is already trained and a curriculum which is already clearly delineated and time-tested- that of the BSW or Bachelor of Social Work. If you compare the core competencies on pg. 62 of the plan with the ten competencies required for accreditation by the Council on Social Work Education (<http://www.cswe.org/File.aspx?id=13780>) you will notice the similarities for yourself.

In addition, LBSW's (Licensed Bachelor Social Workers) are already licensed health care professionals regulated under the auspices of the Board of Social Work Examiners.

While we understand the desire to create a position which is specific to your needs and to save money for the program, we believe that the creation of a para-professional position based on a curriculum which would be two years or less puts the patients who would be served at risk.

- The CHW Functions and Core Competencies envisioned on page 62 of the plan require a person who is well-trained and skilled.
- The CHW will encounter complex issues which require broad education and understanding.
- The CHW will be part of an interdisciplinary team; one of the hallmarks of a 4 year institution is the interdisciplinary environment.
- BSWs graduate from nationally accredited programs which are well defined. They also have the backing of their licensing boards and professional associations for lifelong continuing education.

There are already nine accredited BSW programs in the state of Maryland; they are located at Bowie State University, Coppin State University, Frostburg State University, Hood College, McDaniel College, Morgan State University, Salisbury University, University of Maryland Baltimore County (UMBC) and Washington Adventist University. It is our opinion, that the creation of a community health worker certificate within these BSW programs would be much less cumbersome than the elaborate curriculum development foreseen on pages 62-65 of the plan.

In summary, we support health care reform in Maryland and the goals of improved health and greater access for our citizens. However, since we were advised that “**In the absence of comments or questions, the Department will assume that you or your organization have no concerns with the Innovation Plan,**” we want to make it clear that we are concerned that the plan creates a new profession or para-professional whose function overlaps significantly with the scope of practice of a bachelor-level social worker [§ 19-101(m) (1)].

Thank you for considering our concerns. If you have any questions, please contact me at (410) 788-1066 ext. 16 or nasw.md@verizon.net.

Sincerely,

Daphne L. McClellan, Ph.D., MSW
Executive Director
NASW- Maryland Chapter

April 15, 2014

Karen Matsuoka, Ph.D
Director, Health Services Infrastructure Administration
Department of Health and Mental Hygiene
300 W. Preston St.
Baltimore, MD 21201

Re: Comment on Maryland's State Healthcare Innovation Report submission to the Center for Medicare and Medicaid Innovation (CMMI), March 31, 2014

Dear Dr. Matsuoka:

The nursing community, represented by the organizations that have signed onto this letter, appreciates the opportunity to comment on the above-referenced State Innovation Model Report (SIM Report). The Department of Health and Mental Hygiene (DHMH) has submitted this report to the Center for Medicare and Medicaid Innovation (CMMI) as a final report for the planning grant. As we understand, DHMH plans to submit an application to CMMI for implementation funds.

We endorse many of the goals embedded in the SIM Report regarding improved patient outcomes, and we share DHMH's commitment to developing innovative care delivery models to meet the challenges facing our health care delivery system. As nursing representatives discussed with the Department in the fall, we urge DHMH to make a more careful delineation of the roles of the health care delivery team members. The SIM Report raises a number of significant patient safety and patient outcome concerns that we have outlined in this letter.

1. The role of nurses is insufficiently addressed or integrated into the model

According to the SIM Report, the CIMH design is derived from the Health Quality Partners' Advanced Preventive Services (HQP) model developed and implemented for the Medicare coordinated care demonstration program. HQP is a community-based nursing approach in which nurses develop a care plan based on a comprehensive needs assessment that includes social, economic, and environmental determinants of health. Nurses conduct the assessment, prepare the plan, and then manage, administer, and deliver interventions through office, home visit, or telephone contacts with the client, as appropriate. The SIM Report envisions straightforward adoption of the HQP model as the "minimum standard for all community-based clinical care coordination for Medicare FFS or dual-eligible patients," and that it "will be replicated or adapted in its entirety" for other patient populations. (SIM Report, p. 51.)

Although nurses play a central role in the HQP concept, the SIM Report focuses almost exclusively on community health workers (CHWs). We believe that there needs to be an increased focus on registered nurses and other licensed health care practitioners in order for the model to be successful. Indeed, registered nurses are rarely mentioned in the SIM Report outside of sections describing the HQP program and its evaluation results, or in passing references where their specific contribution within the CIMH

framework is unclear. The asthma intervention example, for instance, includes an “RN” (not otherwise defined) providing unspecified “services” as a member of the community health hub team. (SIM Report, pp. 85-87.) A single sentence refers to supervision by “a licensed clinician, nurse, or social worker” of a CHW providing direct care. (SIM Report, p. 61.) The structure and staffing of care teams, supervision requirements, and financing of the team are not addressed. Registered nursing roles—including functions such as clinical care coordination—are either not discussed or reassigned to CHWs (see SIM Report, p. 115, which gives participating CIMH practices the option of employing a nurse or CHW to coordinate clinical care). Also missing is consideration of how the existing array of allied health care professionals, such as certified nursing assistants and certified medical technicians, fits into the model and the extent to which they already provide, or may be trained to provide the services foreseen for CHWs. There is almost no discussion of other licensed health care professionals – including physicians, licensed certified social workers, license certified social worker – clinical, and dietetic practitioners – who would be critical members of the health care team. Instead, the workforce discussion is entirely confined to the training, certification, and employment of CHWs.

The full and thoughtful integration of registered nurses in the CIMH framework is critical to its success, as is an acknowledgement of the contributions of other health care professionals who are part of a care team. Optimal use of the existing health care workforce at all levels in the new delivery model will safeguard patient welfare, capitalize on established systems and relationships, and avoid inappropriate or overlapping assignment of responsibilities that would jeopardize attainment of program goals.

2. SIM Report is Not Implementable: Provision of direct care by CHWs violates licensure laws for health care practitioners

The SIM Report contemplates permitting community health workers to perform certain tasks that do not require “extensive clinical skills and knowledge” as a way of lowering costs. (SIM Report, p. 107.) Those tasks include “ongoing assessments and screenings,” “education and self-management training,” “assessment and counseling for behavior change,” and “stress management education and counseling.” (SIM Report, p. 65.) However, the report fails to recognize that each health occupation has a detailed scope of practice whose parameters are strictly determined by statute and regulation. Delegation of clinical duties to CHWs—and oversight of CHW performance of these duties—would violate Maryland law governing the registered nursing scope and standards of practice, in addition to the scope and standards of practice pertaining to other health occupations.

COMAR 10.27.11 sets out the requirements for delegation of registered nursing functions. It expressly prohibits delegation of “evaluation of the client’s progress, or lack of progress, toward goal achievement.” (COMAR 10.27.11.05(A)(5).) In instances where delegation is permitted, the registered nurse must make a determination that takes into consideration specified factors. For treatments of a routine nature, for instance, the delegating nurse must weigh whether the nurse staffing ratio allows for close supervision. (COMAR 10.27.11.05(B)(3)(b).) Most importantly, delegation is permitted only on case-by-case basis: a delegated task may not become a part of regular job duties. (COMAR 10.27.11.05(E).) The requirements for supervision by the delegating nurse are also outlined in detail, and include the registered nurse’s ready availability, regular visits to reassess whether the client’s health status warrants someone

other than a registered nurse to perform a delegated act, and an evaluation of the competence of the person to whom a task is delegated. (COMAR 10.27.11.04.) These rules apply to all registered nurses who supervise unlicensed and/or certified individuals, regardless of the program or facility in which they are employed (see, e.g. Medicaid Living at Home waiver, COMAR 10.09.55.14; Increased Community Participation Program, COMAR 10.09.81.14).

It would appear that the regulatory restrictions on the delegation of nursing tasks conflicts with a delivery model that authorizes CHWs to provide direct care under registered nursing supervision. This will likely also be the case for the other “licensed clinicians” and social workers foreseen as CHW supervisors. The SIM Report as currently drafted cannot be implemented without significant statutory and regulatory amendment to align the registered nursing (among others) scope of practice and licensure standards with the proposed duties of this new health professional. **It should be emphasized that the overarching purpose of these laws is to protect the public, and any revisions must contemplate the ramifications for patient safety, as discussed further below.**

3. Patient safety is subordinated to cost considerations

The SIM Report deems certain direct care tasks performed by registered nurses or allied health professionals not to “require extensive clinical skills and knowledge” and, therefore, potentially suitable for reassignment to CHWs in the interest of lowering intervention costs. This approach, which subordinates patient safety to financial considerations, is contrary to the purpose of state regulation of health care occupations. Health care professional laws establish standards for education, training, and skills necessary for the safe and effective provision of care within a given scope of practice. The law does not accommodate concepts such as “extensive”—rather, clinical skills and knowledge must be sufficient, as determined by the regulatory boards and accreditation bodies, to ensure positive outcomes. It should be noted that some of the tasks suggested for CHWs are explicitly reserved for certain licensed professionals precisely because patient safety is the primary concern. The inference that the performance of “ongoing assessments and screening” does not demand clinical judgment, or that “ongoing medication reconciliation and adherence monitoring” (SIM Report, p. 27) is relatively undemanding of professional expertise is inconsistent with the determinations made by health occupation boards, accepted standards of care, and the guidance of national health care quality entities. For example, the Agency for Healthcare Research and Quality (AHRQ) considers medication reconciliation to be a patient safety issue and emphasizes the importance of instituting a sound, systematic process of medication comparison, unintended discrepancies, and resolution to the achievement of patient safety goals. (See the MATCH Toolkit published by AHRQ.) The Joint Commission (TJC) National Patient Safety Goal on Reconciling Medication, which applies to all types of accredited programs, was revised in 2011 to include as an element of performance that medication comparison is conducted by a qualified individual. (NPSG .03.06.01.)

Furthermore, it is important to note that the statutory authority for community health hubs is not yet in place, and that appropriate supervision will additionally require the promulgation of regulations. The SIM Report takes into consideration the establishment of a basic operating infrastructure for the CIMH program, the Public Utility, development of the Operational Management System, and an RFP process. (SIM Report, p. 122.) However, the Report does not consider associated statutory and regulatory steps in its

timeframe. We are looking forward to the CHW workgroup authorized by the General Assembly, but the workgroup has yet to be established. Any rules, whether statutory or regulatory, must be in place for effective oversight of the CIMH model prior to implementation. Therefore, we highly recommend taking into account existing statutory and regulatory frameworks when shaping the SIM Model.

Finally, the SIM Report proposes “applied R&D trials,” one aspect of which will be “to thoughtfully experiment with adjusting workforce roles, in particular greater use of CHWs to deliver community interventions.” (SIM Report p. 64.) This is also described as determining “the substitutability of CHWs” in the nursing-led ASP model (SIM Report, p. 96). Moreover, there is a “ramp up” period foreseen that implies continued testing of the model during an initial implementation phase. (SIM Report, p. 124.) Testing that involves “intentional variations to staff models” (SIM Report, p. 64) would breach existing scope of practice laws—by definition, jeopardizing patient safety, in addition to creating irreconcilable conflicts for professional staff who could face disciplinary action—and, therefore, would be impermissible.

4. Insufficient and inconsistent regulatory structure

Equally troubling from a patient safety perspective is that the community health hubs responsible for oversight, management, and deployment of community health teams—and, in some cases, direct hiring and training of staff—will be certified by a specially created CIMH Public Utility that is jointly administered by the Health Systems and Infrastructure Administration in DHMH and the MHCC. This would set up a fragmented regulatory system in which certain entities providing in-home services would have to meet standards and comply with protocols established by the Office of Health Care Quality (OHCQ), while those licensed as community health hubs would not.

OHCQ regulates home health and residential services agencies under a system that encourages informal as well as formal comments on policy, provides for public participation through workgroups, and incorporates a complaint and investigation process. The regulatory framework governing ambulatory care services in the home is not only well established, but it is designed to be patient centered—a stated purpose of the CIMH model. Creation of a comparable system for community health hubs under the CIMH Public Utility would demand a significant investment of resources that is not contemplated in the SIM Report. Nonetheless, having two separate regulatory structures is unnecessarily complicated, confusing for clients (particularly given the similarity of functions for home health aides and CHWs) as well as providers, and will undermine the efficacy of oversight intended to protect public welfare. The regulation of in-home services should be under a single jurisdiction—namely, OHCQ.

Conclusion

We reiterate our support for the concept of an integrated community-health care model that incorporates interventions designed to address socio-economic, demographic, and environmental influences on health status and thereby improve outcomes. However, the SIM Report in its current form raises numerous concerns and leaves many questions unanswered on aspects that are essential to its success. We strongly recommend engaging the participation of a broad range of registered nursing professionals (just 1 nursing representative was included among the total 58 stakeholders consulted

during development of the Report), representatives of the other health care professions, and the health occupations boards to explore solutions to the issues we have identified.

Thank you for considering our comments. Should you have questions or need additional clarification, please feel free to contact Ms. Robyn Elliott, public policy consultant for the Maryland Nurses Association (MNA), at (443) 926-3443 or relliott@policypartners.net. MNA will coordinate with the other signatories on gathering any information needed by DHMH.

Sincerely,

Maryland Nurses Association
American Psychiatric Nurses Association – Capital Chapter
Maryland Academy of Advance Practice Clinicians
Nurse Practitioner Association of Maryland
Philippine Nurses Association, Maryland Chapter

cc: Dr. Laura Herrera, Deputy Secretary of Public Health Services
Ms. Patricia Noble, Executive Director of the Maryland Board of Nursing
Ms. Gloria Jean Hammel, Executive Director of the Board of Social Work Examiners
Ms. Tracey DeShields, Executive Director of the Board of Professional Counselors
Ms. Marie Savage, Executive Director of the Board of Dietetic Practitioners
Ms. Lorraine Smith, Executive Director of the State Board of Psychological Examiners
Dr. Tricia Nay, Executive Director of the Office of Health Care Quality

DOUGLAS F. GANSLER
Attorney General



WILLIAM D. GRUHN
Chief
Consumer Protection Division

KATHERINE WINFREE
Chief Deputy Attorney General

JOHN B. HOWARD, JR.
Deputy Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

WRITER'S DIRECT DIAL NO.

410-576-6515

April 28, 2014

Laura Herrera, M.D.
Deputy Secretary
Maryland Department of Health
and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201

Re: **State Healthcare Innovation Plan**

Dear Dr. Herrera:

I am writing to express the Office of the Attorney General's Health Education and Advocacy Unit's ("HEAU") concerns about potential privacy issues arising out of the proposed State Healthcare Innovation Plan ("the Plan"). The lengthy Plan document describes unprecedented data sharing arrangements among healthcare providers, school personnel, social services providers, local health departments, and others, which appear to exceed the scope of data sharing presently allowed under Maryland and federal law. HEAU respectfully requests that the following questions be addressed before the Plan's design phase ends.

1. When are consumers going to be informed that the fee for service ("FFS") payment model is being replaced by a "global payment" model, and how is that model going to be explained to them?
2. When are consumers going to be informed about the scope of data being collected about them and their healthcare (all-payer claims database, CRISP, and the proposed data integration), and how are the proposed uses of the data going to be explained to them?
3. How can consumers give informed consent to data collection and data sharing without full disclosure about how their data will be used in this experimental Plan?

200 Saint Paul Place ❖ Baltimore, Maryland 21202-2021

Main Office (410) 576-6300 ❖ Main Office Toll Free (888) 743-0023

Consumer Complaints and Inquiries (410) 528-8662 ❖ Health Advocacy Unit/Billing Complaints (410) 528-1840

Health Advocacy Unit Toll Free (877) 261-8807 ❖ Homebuilders Division Toll Free (877) 259-4525 ❖ Telephone for Deaf (410) 576-6372

4. Has a CMS-style Privacy Impact Assessment (“PIA”) been done or is one planned?
The step-by-step analysis employed in PIAs seems necessary for proper protection of consumers’ privacy rights because the Plan contemplates such a broad distribution of protected health information up, down and across so many systems.
5. Will there be a system for consumer complaint resolution that affords due process to participants?

HEAU asks that there be full consideration and analysis of consumers’ privacy rights before conclusion of the Plan’s design phase, so that all necessary consumer protections can be included in the Plan before any implementation commences. Thank you for your consideration.

Sincerely,



Patricia F. O’Connor

Assistant Attorney General

Deputy Director

Health Education and Advocacy Unit



primary care coalition
of Montgomery County, Maryland

making
health care
happen

8757 Georgia Ave.
10th Floor
Silver Spring, MD
20910

T: 301.628.3405
F: 301.608.2384

Comments and Questions on

**A Community-Integrated Learning Health System for Maryland
Maryland's State Healthcare Innovation Plan**

April 28, 2014

1. *Page 58: The CHH is meant to literally wrap around the PCMH and assist the medical home in meeting the non-medical needs of the patient as well as the medical needs that can effectively be served in the community setting. Primary care providers that meet the CIMH PCMH minimum threshold will be able to partner with their CHH.*
 - Is it the state's intention that the CHH's activities would focus exclusively on PCMH's that meet the new minimum standards? Many super-utilizers may not be connected with a PCMH or they may be connected to a PCMH that does not meet the minimum standards. Will the CHH serve these individuals?
2. We did not see a clear description of how the CHH will be notified of the "super-utilizer's" in their area.
 - What reports will be sent by the state to the CHH so the CHH can begin the initial assessment?
 - Will the state provide access to Medicare claims and CRISP data for HUB grantees so that they can assess the needs of super-utilizers before conducting an assessment?
 - Having access to the Electronic Notification System, the system that provides notice of a hospital admission, will be important for the CHH to manage patient needs in real-time. Will the CHH's have access to this system?
3. *Page 118: Working with our partners in behavioral health, health care providers, and social services, we will develop a uniform patient consent form that will work across all systems, as well as a mechanism for tracking which patients are shared between different care managers so that care coordinators can share their notes with each other and ensure that their care plans are aligned and seamless from the point of view of the patient.*
 - Will state-identified super-utilizer patients have to agree to participate? How and when will they sign a consent form?

4. *Page 123: Applicants will also be required to target at least one other super-utilizer patient population and justify that selection based on demonstrated prevalence and need. Data about super-utilizers will be provided at the county level to assist in their planning efforts.*
 - When will the data be provided – before the selection of the CHHs or after?
 - Once the other population is selected, will the state notify the CHH of patients who meet the criteria for inclusion the special population and have 3 or more hospitalizations in a year?
5. *Page 124: A chart shows that roll out of CHH grants will be staged over time.*
 - How will the state roll out the HUB grants?
 - Will three CHHs be selected first, then six months later another three?
 - Will six CHHs be selected at first, with three in the Model Testing phase and three in the Pre-Testing phase?
6. We note many activities that need to occur before the CIMH program is fully operationalized as envisioned in this document. Examples include: creation of the minimum PCMH standards, expansion of PCMH participation, development of CHW training and certification requirements, training of CHWs, development of an operational management system, creation and adoption of a uniform consent form, creation of performance metrics and payment models.
 - How will all of these prerequisites affect the implementation date? Are there activities that can be worked on while the CIMH begins its Model Testing?
 - When do you anticipate that DHMH will release an RFP? What is the anticipated start date? Do you plan to release the RFP through the Maryland Health Resources Commission?
7. The design of payment models will significantly impact the short-term viability and future sustainability of CHHs.
 - How will cost savings be calculated and documented?
 - How will funds be redistributed throughout the grant period?
 - How will ROI studies be conducted? Will there be efforts to determine ROI throughout the grant cycle or only at the end of year 3?

8. The CHH concept is aligned with or builds on many programs that already exist including the DHMH Health Enterprise Zone program, MCO care coordination programs, and ACOs.
 - How would CHH fit with entities that are already in place? (i.e. care management/coordination programs established by hospitals, MCOs and ACOs) What relationship will CHHs be expected to have with Health Enterprise Zones or other state-funded initiatives within their geographic regions?

Comments and Questions developed by Steven M. Galen, President and CEO, and other senior staff at the Primary Care Coalition of Montgomery County.



SIM Feedback <marylandsim@gmail.com>

FW: Maryland State Healthcare Innovation Plan: Public Comments Accepted Until April 15

Henningsen, Jean (Baltimore) <JHenningsen@seedco.org>
To: "marylandSIM@gmail.com" <marylandSIM@gmail.com>

Tue, Apr 15, 2014 at 3:42 PM

To Whom It May Concern,

The integration presented in Maryland's State Healthcare Innovation Plan is promising. Having extensive experience in benefits access and workforce development, Seedco understands it is critically important to coordinate efforts among many stakeholders and partners in order to successfully reach vulnerable populations.

My feedback/question is, re: page 40 #2, what metrics will be used to measure the work of community health teams? Further in the document, when Community Health Hubs are discussed specifically, some of the metrics noted include "first visit following enrollment, time to first visit after hospital discharge, time to completion of an initial assessment, etc." Given that as noted on page 6 many patients forgo medications because they struggle to afford them, and are eligible for benefits like SNAP and others which could supplement their household income, are there plans to track connection to those benefits as well?

Thank you,

Jean E. Henningsen, MSW

Deputy Director, EarnBenefits

Seedco

217 E. Redwood Street

Suite 1500

Baltimore, MD 21202

www.seedco.org

This message has been scanned for malware by Websense. www.websense.com

SIMPlanFinal3_31_14.pdf

 5039K

Response to Request for Input: Maryland's State Healthcare Innovation Plan

Submitted by The Institute for Innovation & Implementation,

University of Maryland School of Social Work

April 15, 2014

Thank you for giving The Institute for Innovation & Implementation (“The Institute”) at the University of Maryland School of Social Work the opportunity to provide comment on Maryland’s State Healthcare Innovation Plan (SHIP). This is an exciting initiative for the State of Maryland and we appreciate being included in the review process. There are many very innovative components outlined in the SHIP. We have highlighted areas that could be strengthened and have included recommendations to ensure that the plan is as effective as possible for children with behavioral health needs and their families for your consideration.

Below, you will find a table sorted by Chapters in chronological order that details our comments and recommendations. Broadly speaking, we have three overarching comments.

1. Wraparound is referenced throughout the SHIP. While used generically throughout the plan, Wraparound is a practice model used to serve children with serious behavioral health needs and their families as recognized in the Information Bulletin issued jointly by the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) on May 7, 2013, entitled *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*, available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>. For a more clear definition of Wraparound and the research base, please visit National Wraparound Initiative (NWI)’s website: <http://www.nwi.pdx.edu/wraparoundbasics.shtml>. Wraparound training and coaching guidelines can be found at: <http://www.nwi.pdx.edu/pdf/wrap-training-guidelines-2013.pdf>.
2. The SHIP speaks of integration but the focus is largely from a public health and physical health perspective. There did not appear to be examples of integration with primary behavioral health (BH) or substance use disorders (SUD).
3. The SHIP does not reference the pending Behavioral Health Home and 1915(i) State Plan Amendments (SPAs) and does not speak to how these SPAs will be incorporated into care coordination for youth with behavioral health needs and their families. Detail on the Health Home SPA is available at: <http://dhmh.maryland.gov/bhd/SitePages/Health%20Homes.aspx>
Information on the 1915(i) is available at:

<http://dhmh.maryland.gov/bhd/SitePages/1915i%20State%20Plan%20Amendment%20-%20Community%20Options%20for%20Children,%20Youth,%20and%20Families.aspx>

In addition to our comments, we have attached the PDFs for the following documents to assist in the further development and implementation of the SHIP:

- Center for Health Care Strategies' *Identifying Opportunities to Improve Children's Behavioral Health Care: An Analysis of Medicaid Utilization and Expenditures*, available at: http://www.chcs.org/usr_doc/Identifying_Opportunities_to_Improve_Children's_Behavioral_Health_Care.pdf
- The Institute's *Evaluation of the Baltimore Child and Adolescent Response System (B-CARS) Emergency Department Diversion Program*, available at: http://origin.library.constantcontact.com/download/get/file/1114009451637-266/BCARSReport_Final_Feb2014_3.pdf
- The Maryland Coalition of Families for Children's Mental Health's report: *Listening and Learning from Families: The Physical Health and Health Care of Children and Youth being served by Care Management Entities in Maryland*, available at: http://mdcoalition.org/images/stories/publications/Listening_and_Learning_from_Families.pdf
- *Maryland CHIPRA Quality Demonstration Grant Children, Youth and Families' Crisis Response and Stabilization Report*, including Maryland's Core Components of a Crisis System, which is available at: <http://theinstitute.umaryland.edu/topics/soc/crisis.cfm>

Chapter	Issue	Recommendation
1. Executive Summary	Coordination without duplication between CHW and care coordinators for individuals receiving wraparound.	Flow chart or graphic depicting various anticipated/projected hand offs across systems, with distinction between care managers and CHWs
2. Introduction	Super-utilizers (Page 18)	Clarify whether the hospitalizations include psychiatric hospitalizations. If you have any data breaking the age groupings apart by psychiatric versus general hospitalizations, it might assist in formulating responses.
	Figure 2-12: Strategies (p.21) [First mention of strategies—recommendations would carry throughout]	Consider using a word other than “wraparound” to describe strategy C, as it is a defined practice model. The word “comprehensive” may be more appropriate. May also want to emphasize utilization of individualized services and strategies in both B and C.
	Figure 2.2 Strategy C (p. 24-25)	BH example (MH or SUD primary dx) might also be useful.
	Figure 2.14	See issue from Executive Summary above –distinction between care managers and CHWs.

<p>3. The Community Integrated Medical Home</p>	<p>Behavioral Health & Primary Care Integration (p44), Menus of Community-Based Services and Supports (p.50); Behavioral Health Coordination (p.52 and 53): For children on Medicaid, behavioral health challenges are the primary drivers of increased costs of care, even for children with chronic health conditions. Parents of children with health and behavioral health problems have indicated that they need the behavioral health challenges addressed.</p> <p><i>See information below from CHCS study and see report on BCARS' emergency department diversion program, as well as report by the Maryland Coalition of Families for Children's Mental Health (MCF).</i></p> <p>Elements of a medical home model are crucial for youth with serious behavioral health problems (e.g., ensuring every child has an identified primary care provider (PCP), receives an annual well-child visit, has metabolic monitoring if on psychotropic medications; asthma protocols). However, the medical home design is not the most effective model for improving physical and behavioral health for youth in foster care with serious emotional disturbance: in one study, youth with BH problems were the only population that did not have improved access to primary care through a medical home and were more likely to have difficulties in accessing specialty care through the medical home (Sheldrick &</p>	<p>Grimes, Kapunan & Mullin (2006) suggest that patterns of service use for youth with behavioral health needs can be impacted at the service delivery level through integration, coordination, and the availability of in-home services.</p> <p>Recommend expanding the strategies to focus on behavioral health as the primary focus, not a secondary focus to somatic health, for youth with identified behavioral health problems. For these youth, access to intensive care coordination using a Wraparound practice model (including ratios of 1 care coordinator to ~7 youth) and availability of home and community-based services (HCBS) such as respite care, mobile crisis response and stabilization services, peer support (including family peer support/ parent support partners), intensive in-home services (including EBPs like Functional Family Therapy), and expressive therapies (e.g. art, equine, drama, music, dance).</p>
---	---	---

	<p>Perrin, 2010)</p> <p>Health home models for individuals with serious mental illness (SMI) have been primarily designed with adults in mind, and integrated care models and care coordination models that are designed for adults are typically less effective for children and youth. Children with serious behavioral health problems are often involved with multiple public systems in addition to Medicaid: child welfare, juvenile justice, education, and the courts. Integrated primary and behavioral health care models designed for adult populations often fail to adequately incorporate the complex multi-system service and fiscal coordination required to effectively and efficiently serve children with complex behavioral health needs and their families (Pires et al, 2013).</p>	
	<p>Building Upon Behavioral Health Models Already Underway in Maryland— This section does not include Care Management Entities (CMEs) or the 1915(i) SPA that was submitted to CMS, nor does it include the interventions identified in DHR’s Title IV-E Waiver Application.</p>	<p>Recommend expanding this section to discuss the utilization of CMEs to support youth with serious behavioral health problems in their homes and communities. Building upon the successes of the Residential Treatment Center (RTC) Waiver, the 1915(i) SPA and simultaneously revisions to the targeted case management regulations (as well as the Children’s Cabinet-funded CME) will enable more children and youth to access intensive care coordination using the Wraparound practice model. The 1915(i) SPA will also enhance access to HCBS such as mobile crisis response and stabilization, respite care, intensive in-home services, peer support, and expressive therapies. These services are in line with the above referenced CMS-SAMHSA joint bulletin on HCBS that are effective in maintaining children with serious behavioral health problems in their homes and communities (CIB-05-07-2013).</p>

		<p>In addition to B-HIPP, the 1915(i) SPA includes mental health consultation to primary care providers as a Medicaid service on behalf of children enrolled in the 1915(i).</p>
		<p>In recognition of the importance of better integrating physical and behavioral health, as part of the CMS-funded CHIPRA Quality Demonstration Grant, the University of Maryland has developed a series of training modules on physical health, EPSDT, wellness, and oral health that will be available on The Institute’s online training center (for free). These modules were designed for a workforce that is more behavioral health focused and provides care coordination to youth with serious behavioral health problems. https://theinstitute.umaryland.edu/training/onlinetraining.cfm</p>
		<p>Add information about early childhood mental health initiatives, including partnerships and collaborations across Maternal & Child Health, MHA, and the Maryland State Department of Education.</p>
		<p>Include interventions identified in the Title IV-E Waiver Application (including specific EBPs) and those identified by Maryland State Department of Education (MSDE), Department of Juvenile Services (DJS), Department of Human Resources (DHR), and the Children’s Cabinet as being effective in serving youth and their families, including those at-risk for entering into a Voluntary Placement Agreement.</p>
	<p>What will change under SIM (p. 45)— Children who are not Medicaid beneficiaries cannot access many of the innovative programs</p>	<p>One option for consideration is to move more of the proposed 1915(i) services and supports, as well as EBPs (including those proposed in DHR’s submitted Title IV-E Waiver Application), into the Medicaid State Plan so that youth who are enrolled in Medicaid or MCHP but are over 150% FPL can access the services. Additionally, may want to create a “Medicaid lookalike” such as is done in New Jersey to ensure that all children and youth have access to crisis response services, not just those on Medicaid, as a primary public health initiative.</p>

	Behavioral Health Coordination (p. 52)	<p>See above comments regarding care coordination via the Wraparound Model as an effective intervention for diverse youth populations through the pending 1915(i)SPA and Maryland's CME Model. HQP is well structures but is designed around older chronically ill populations.</p> <p>Additionally, the MATCH (Making All The Children Healthy) program provides health care coordination for all children in foster care with Baltimore City Department of Social Services (BCDSS), including youth with co-morbid chronic health/mental health issues. MATCH also provides targeted medical/behavioral case management for those children identified as having intensive medical or behavioral health needs. The program's goal is to ensure the health needs of children in foster care are being met by increasing coordination, education, and advocacy. MATCH staff work collaboratively with the BCDSS caseworkers, foster/kinship care parents, private foster care agencies and medical, dental and behavioral health care providers. For more information, go to http://www.healthcareaccessmaryland.org/programs.</p>
	P. 65 – The Local Health Improvement Coalitions (LIHCs)	<p>The LIHCs should be connected to and coordinated with the work of the Local Management Boards (LMBs) as well as the local Core Service Agencies (CSAs - local public mental health authorities).</p> <p>The establishment of LMBs was originally provided for in Article 49D that was enacted in 1990 and sunset on June 30, 2005. In response to the sunset of Article 49D, Executive Order 01.01.2005.34 was issued on June 9, 2006, establishing the Children's Cabinet and the Governor's Office for Children (GOC). During the 2006 Legislative Session, the General Assembly passed Senate Bill 294/HB301 that re-codified the LMBs. Bills were signed into law on May 2, 2006, re-establishing the LMBs in</p>

		<p>Article 49D (now Human Services Article §8-301-305).</p> <p>LMBs serve as the coordinator of collaboration for child and family services. They bring together local child-serving agencies, local child providers, clients of services, families, and other community representatives to empower local stakeholders in addressing the needs of and setting priorities for their communities. There is an LMB in each county and in Baltimore City. For more information, on LMBs, see: http://goc.maryland.gov/LMBhistory.html. For a full list and contact information for the LMBs, see: http://goc.maryland.gov/lmb_map_contacts.html.</p> <p>LMB membership includes representation from the local CSAs.</p>
	Quality Preventive Care Table– reduced ER visits due to mental health conditions - measure is not on track to meet 2014 target (p. 56)	Please see the above referenced and attached report on the BCARS Emergency Department Diversion Program. Also please see the attached <i>Maryland CHIPRA Quality Demonstration Grant Children, Youth and Families’ Crisis Response and Stabilization Report</i> , which includes emergency department and inpatient utilization and cost data from the Hilltop Institute.
	Community Health Hubs (p. 57 & 58)— CHHs will be permitted to hire staff directly	This may be problematic if they are expected to train, monitor fidelity, and report outcomes. May want to consider having an intermediary to play some of these roles, such as The Institute plays for EBPs and Wraparound for the Children’s Cabinet. The organizations that are best able to implement some of the EBPs may be less well-equipped to provide some of the larger workforce development activities. Additionally, you may lose some economy of scale with purveyor or implementation costs.
	Workforce Development (p. 60)	<p>Consider use of Mental Health First Aid training for CHWs – both adult version and child versions.</p> <p>Recommend children’s behavioral health system training -(e.g. service array) for PCP practice groups, CHWs, etc.</p> <p>The partners for curricula development are identified. What will</p>

		<p>the training model/curricula be based on? What is written that will be further developed?</p> <p>Has a practice model for care coordination been identified? Will it be patient/family driven? Include a team of people? Will it function more like case management vs team based planning? Will the model vary based upon populations?</p> <p>Motivation Interviewing is referenced – how will the workforce be trained and coached to use this EBP? If this is being organized through community colleges, will participants be required to pay a tuition fee or is that covered through another means if an individual is hired?</p> <p>Additionally, the SEEK approach, which has demonstrated ability to prevent child abuse in two RCTs—could be adapted more generally. SEEK asks families if they have experienced any major family problems (substance abuse, hunger, threat of homelessness, violence, depression, etc.) on a very brief checklist that they complete before going in to see their pediatrician. The pediatrician helps them to address some of these problems and also offers a referral to a social worker. Many families take up this opportunity and benefit from it. The positive results are well-documented; SEEK training materials are available on The Institute’s website: https://theinstitute.umaryland.edu/seek/.</p> <p>Other than aligning with other training initiatives and building curricula, the plan does not appear to address how the workforce will be developed.</p>
	Curriculum Development-p. 62	In addition to training (which should be in-person and online, if possible), recommend ongoing coaching in addition to requiring re-certification.

	<p>HQP Model Functions Crosswalk-p. 65 References screening and assessment as a function.</p>	<p>Recommend utilization of trauma-informed screening and assessment tools and cross-walking tools to those in use or under consideration by Maryland State Agencies and contractors prior to implementation. Greater standardization of tools will be of benefit in data analysis as well as serving as communication tools for care coordinators and providers.</p>
	<p>Strategic Use of Data –p.65</p>	<p>Add Department of Juvenile Justice as non-traditional part of the health care system (as well as Maryland Department of Public Safety and Corrections for adult populations).</p> <p>Please also see comments about CME funded by the Children’s Cabinet.</p>
	<p>Trilogy/Network of Care to be able to link health indicators with “evidence-based models of practice that have been shown to be effective in improving those indicators” (p. 68-70)</p>	<p>Similar to what is being developed by Trilogy, the PracticeWise (PW) Managing and Adapting Practice (MAP) model is being used to improve outcomes for children with behavioral health needs. https://www.practicewise.com/#services</p> <p>The PW MAP Model, as used in Maryland, is intended to impact two specific areas:</p> <ol style="list-style-type: none"> 1. Workforce Development: Training the workforce to access EB practices and “elements” of those EBPs that have data to show their effectiveness in a specific problem area. 2. Improve access for youth and families to evidenced based services (EBS). <p>The MAP model assists clinician in both the process and practice elements of their work with youth and families. The MAP model trains clinicians how to use the PWEBS search tool to find specific evidenced based clinical practices that have been shown to be effective with the specific problem area(s) the youth is experiencing. MAP provides a framework to conceptualize treatment, provides tools to monitor the process side of clinical practice to assist clinicians to “stay on track” and identify when things are not progressing. Lastly, through the use of a spreadsheet, data is collected, monitored, and analyzed to give a</p>

		<p>visual representation of progress (or lack of progress) toward goals. This is done on the individual client level and based on the individual clinical presentation of each client.</p> <p>Similar to the Trilogy Network of Care technology that links EBPs to specific health outcome markers, the PWEBS links EBPs to the specific clinical presentation of individual youth.</p>
	<p>Page 69 “Collaborative Learning: The Interactive Atlas feature (see figure 3-14) makes it much easier for LHICs to see how they are doing relative to the state, to other counties, and to SHIP and Healthy People benchmarks. Our hope is that LHICs can use this information to learn from each other and share best practices.”</p>	<p>It is great that local groups will be paying attention to the data from the Trilogy/Network of Care to link health indicators with evidence based models. Concern is that they also have a mechanism to map the EBPs/best practices that already exist in their communities or in neighboring communities and they look to those first before implementing another practice on top of an existing practice.</p> <p>It appears from the language around the OMS and Data Integration that the LHICs may have access to fidelity and outcome data for particular practices so that they can support implementation of those practices. However due to the complexity and importance of monitoring EBP fidelity measures, the described process seems a bit over simplified to be able to effectively pull all the required data together. The Institute has experienced the difficulty in pulling pieces of information together for a just small number of behavioral health EBPs. Doing the same for a large number of EBPs across populations will be complex.</p>
	<p>Data Systems (p. 73)—includes CRISP, OMS, APCD, data, but does not include the other public child- and family-serving systems (e.g., ASSIST, CHESSIE)</p>	<p>The systems utilized, particularly CRISP and information contained within E-Medicaid should permit interoperability with providers, care coordinators and Care Management Entities (CMEs)/ Care Coordination Organizations (Targeted Case Management providers to be operating as CMEs in the pending 1915(i) SPA) to interface with other systems, such as pharmacy utilization to allow for an open flow and sharing of current information on a regular basis. Connectivity with Wrap TMS should also be enabled—Wrap-TMS is a web-based behavioral and integrated health record software product that is being</p>

		<p>customized for use in Maryland by CMEs to serve as a single point-of-entry system to meet the needs of youth and families served using the Wraparound service delivery model. The system provides a real-time display of youth's plans of care, including reminders, quick-links and dashboard to allow care coordinators to make current decisions. The systems used should support connectivity with state systems such as DHR's CHESSIE data system and DJS's ASSIST data system to insure multi system involved youth are receiving appropriate care coordination, services, and supports.</p> <p>Additionally, the LINKS data system that we have developed at the University of Maryland School of Social Work has the capacity to identify children and families who are involved with several systems of care (e.g., child welfare, juvenile services, and special education). These are the children most likely to need increasing levels of behavioral health care. We would see much value in using these data—linked to vital statistics (i.e., birth) data to help identify families that would benefit from outreach and the offer of home visiting. Using birth records is an approach taken by the Durham Family Initiative which has shown, in a recent article, to have reduced child abuse reports and emergency room use for very young children in Durham, NC.</p> <p>We are also configuring these data by family so we can start to understand, for example, if a child who was maltreated or in foster care has become a teenage parent—we know from new research done in California, that these child welfare involved adolescent parents have a very high chance of failing to adequately care for their children. There are many possible program initiatives that could arise from using linked data, although we recognize that there will be some operational challenges in using these data to inform direct services.</p>
	<p>Quality & Outcome Measures (throughout, esp. p. 77)—measures are limited in reference to measures related to children,</p>	<p>Utilize measures from the Innovation Center's HCIA Round 2 list of Recommended Awardee Self-Monitoring Measures (http://innovation.cms.gov/Files/x/HCIATwoAwrdsMsrs.pdf).</p>

	<p>as well as behavioral health or to integration of physical and behavioral health, particularly for children and youth.</p>	<p>Examples are:</p> <p><u>38: Asthma: Pharmacologic Therapy for Persistent Asthma</u> (Percentage of patients aged 5 through 50 years with a diagnosis of persistent asthma and at least 1 medical encounter for asthma during the measurement period who were prescribed long-term control medication)</p> <p><u>48: Follow-up after hospitalization for mental illness</u> (Percentage of discharges for members 6 years of age and older hospitalized for treatment of selected mental health disorders & who had an OP visit, intensive OP encounter, or partial hospitalization with mental health practitioner.)</p> <p><u>55: Annual Dental Visit</u> (Percentage of members 2-21 who had at least 1 dental visit during the measurement year)</p> <p><u>130: CAHPS-ECHO</u> (The Experience of Care and Health Outcomes Survey is designed to collect consumer's ratings of their behavioral health treatment.)</p> <p><u>143: ED Visit Rate</u> (Hospital ED Visit Rate, by Condition)</p> <p>Adding a measure on percentage of youth on psychotropic medications is strongly recommended. The CMS Informational Bulletin, dated August 24, 2012, entitled <i>Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations</i>, highlights the need to focus on this measurement. See http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-24-12.pdf. In this bulletin, the Center for Medicaid and CHIP Services (CMCS) informs states about additional opportunities and resources to address the use of psychotropic drugs in vulnerable populations. The collaborative efforts and technical assistance resources highlighted in this bulletin provide states with additional tools and mechanisms to promote the appropriate use, and enhance oversight of, psychotropic medications for children in foster care and individuals living in nursing facilities. This Informational Bulletin continues the tri-agency coordinated effort between CMS, ACF and SAMHSA to explore, identify, and support effective</p>
--	---	--

		<p>strategies for states in overseeing and monitoring the use of psychotropic medications with youth in the foster care system. See <i>Tri-Agency Letter on Appropriate Use of Anti-psychotic Meds</i>, dated November 23, 2011, jointly signed by leadership at CMS, ACF and SAMHSA, describes the cross-agency collaboration and the commitments to address this important issue. The letter can be viewed at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-11-23-11.pdf.</p> <p>Through The Institute’s technical assistance contract with SAMHSA, a series of issue on briefs on psychotropic medication monitoring will be issued later this year. Covered topics will include: why is this important, what should be monitored (identification of indicators agreed to by 6-state national quality collaborative) and how the quality indicators are defined; consultation models & how to finance; and red flag systems & informed consent structures. Additionally, as part of the CMS-funded CHIPRA Quality Demonstration Grant, an analysis of psychotropic medications prescribed for youth served by Maryland’s CMEs is currently underway.</p> <p>Additional custom measures could include:</p> <ul style="list-style-type: none"> • Percentage of youth with co-pharmacy • Percentage of youth with poly-pharmacy • Percentage of Category B & C individualizing utilizing crisis response services that do not result in hospitalization • Percentage of youth demonstrating improvement on the Child and Adolescent Needs and Strengths (CANS) tool • Percentage of youth with a psychiatric inpatient hospitalization
--	--	--

<p>4. A Learning System to Monitor Progress and Spread What Works</p>	<p>Measures of Success (p. 91)—Although there are some specific measures for children and, in particular, the Objective #6 goal areas have several pediatric measures. However, particularly under mental health, the measures are lacking.</p>	<p>See above comment regarding measures, including those related to crisis service utilization, psychiatric hospitalization, and psychotropic medications/poly-pharmacy.</p>
	<p>4.1 Table – Evaluating CIMH Model (p. 91) See above comment regarding measures, including those related to crisis service utilization, psychiatric hospitalization, and psychotropic medications/poly-pharmacy.</p>	<p>For mental health and substance abuse – there does not appear to be comprehensive screening recommended for children or adults; ADHD is only mentioned for children, while for adults it just indicates depression screening. Suggest expanding measures.</p> <p>The Plan also indicates ‘initiation and engagement of alcohol and other drug treatment’ but does not say how the need is screened/assessed for either age group. SBIRT is mentioned earlier in doc on pg. 47 re: PCMHs, but not here for CIMH.</p> <p>How will the Plan address the need to ensure routine, standardized screening of BH within CIMHs/PCMHs?</p>
	<p>4.1 Table – Quality Preventive Care (p. 93)</p>	<p>Please see the above referenced and attached report on the BCARS Emergency Department Diversion Program. Also please see the attached <i>Maryland CHIPRA Quality Demonstration Grant Children, Youth and Families’ Crisis Response and Stabilization Report</i>, which includes emergency department and inpatient utilization and cost data from the Hilltop Institute.</p>

5. Managing the Transformation Through Effective Governance	Ongoing Governance—There is no explicit reference to including family members, consumers or youth in committees or boards.	Family members, consumers and youth should be supported to participate, not just through broad stakeholder activities, but as full members of boards and committees.
	CIMH-Specific Workgroups (p.110)—membership un-defined.	The CIMH workgroups should include representation of individuals and organizations with expertise in children’s systems and transition-aged youth. Membership should include family members and youth, as well as policy makers and providers, depending on the purpose of the groups. This will be critical for both of the CIMH-specific workgroups, as well as the advisory board and the HSCRC workgroups.
6. Getting From Here to There	Training and Peer Supports (BH Integration w/ Primary Care) (p. 113)	Recommend Mental Health First Aid for primary care practice staff and community health workers.
	Support for Care Coordination (p. 115)	Recommend creating regional implementation teams that utilize implementation science to ensure that information-sharing occurs and the teams work together to course-correct when problems arise.
	Goal-Effective Care Coordination (p. 117)—State level coordination is critical, but it must also translate to a local/regional level. This is particularly true for those systems that have more local control rather than state (e.g. school systems).	Please see above comments about LMBs and CSAs. Additionally, effective care coordination models for serving children with behavioral health needs are strength-based (as opposed to deficit-based), family-driven and youth guided. As referenced above, families, consumers, and youth should be represented at all levels (local/regional, state, national) of systems building initiatives.

Additional information on Medicaid utilization of by children using behavioral health services

Children in Medicaid who use behavioral health services have higher mean Medicaid expenditures (physical health and behavioral health care) than Medicaid children in general. Expenditures are driven more by behavioral health service use than by physical health service use except for children on SSI/Disabled for whom mean physical health expenditures are slightly higher.¹

Children with mental health and substance abuse disorders represent less than 10% of the overall Medicaid child population but an estimated 38% of the total Medicaid child expenditures. Children with serious behavioral health problems are often involved with multiple systems: child welfare, juvenile justice, education, and the courts. Integrated primary and behavioral health care models designed for adult populations often fail to adequately incorporate the complex multi-system service and fiscal coordination required to effectively and efficiently serve children with complex behavioral health needs and their families.¹

	All Children Using Behavioral Health Care	TANF	Foster Care	SSI/ Disabled**	Top 10% Most Expensive Children Using Behavioral Health Care***
Physical Health Services	\$3,652	\$2,053	\$4,036	\$7,895	\$20,121
Behavioral Health Services	\$4,868	\$3,028	\$8,094	\$7,264	\$28,669
Total Health Services	\$8,520	\$5,081	\$12,130	\$15,123	\$48,790
* Includes children using behavioral health services who are not enrolled in a comprehensive HMO, n = 1,213,201 ** Includes all children determined to be disabled by SSI or state criteria (all disabilities, including mental health disabilities) ***Represents the top 10% of child behavioral health users with the highest mean expenditures, n = 121,323 Source: Pires, S., Grimes, K., Allen, K., Gilmer, T. & Mahadevan, R. (2013). <i>Faces of Medicaid: Examining children's behavioral health service use and expenditures</i> . Hamilton, NJ: CHCS.					

Top Three Highest Expenditure Services

- **Residential treatment and therapeutic group homes** account for largest percentage of total expenditures – 19.2% of all expenditures for 3.6% of children using behavioral health services
- Outpatient treatment second highest – 16.5% of all expenditures for 53.1% of children using behavioral health services
- **Psychotropic medications** third highest – 13.5% of all expenditures for 43.8% of children using behavioral health services

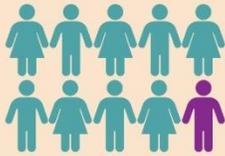
Total Medicaid expense for child and adolescent psychotropic medication use in 2005 was \$1.6b, with 42% of expense represented by anti-psychotic use

¹ Pires, S., Grimes, K., Allen, K., Gilmer, T. & Mahadevan, R. (2013). *Faces of Medicaid: Examining children's behavioral health service use and expenditures*. Hamilton, NJ: CHCS.

Faces of Medicaid

Children's Behavioral Health Care

Just 10% of children in Medicaid use behavioral health care.



This accounts for an estimated 38% of total spending for children in Medicaid.



Children Using Residential Treatment/ Therapeutic Group Care



Of kids using behavioral health

Of behavioral health costs

Half Of Children with Prescriptions for Psychotropic Medications



Receive no accompanying behavioral health treatment.

Opportunities For States to Improve Quality

1

Expand Access

to appropriate and effective behavioral health services, beyond psychotropic medications.

2

Invest in Care Coordination

models—especially those using the wraparound approach.

3

Enhance Collaboration

between behavioral health, primary care, child welfare, and other systems.

Made possible by the Annie E. Casey Foundation.

For complete study findings, access the full report, *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures*, at www.chcs.org

CHCS Center for Health Care Strategies, Inc.



Importance of Mobile Crisis Response & Stabilization Services – excerpt from *Maryland CHIPRA Quality Demonstration Grant Children, Youth and Families’ Crisis Response and Stabilization Report*

The evidence demonstrates that comprehensive crisis response and stabilization systems help improve behavioral health outcomes, deter emergency department and inpatient admissions, reduce out-of-home placements, reduce lengths of stay and costs of inpatient hospitalizations, and improve access to behavioral health services.² There also is evidence that effective mobile response and stabilization services can help to reduce placement disruption rates in child welfare (Wraparound Milwaukee). Investment in comprehensive crisis response and stabilization systems for children, youth and young adults is a particularly wise public health strategy given that the risk factors for behavioral health needs are well established with clear windows of opportunity to prevent mental and behavioral health disorders and related problems before they occur.

The component that often is missing in states is effective mobile response and stabilization capacity. Milwaukee County and the State of New Jersey are implementing similar and “newer generation” models of mobile response and stabilization that allow for teams to work with children, youth, families, schools, etc. to provide crisis intervention and ongoing stabilization services, often using one-to-one crisis stabilizers, over a thirty day period. Milwaukee’s crisis response system is particularly noteworthy, with a requirement that all psychiatric inpatient admissions first be assessed by a crisis response and stabilization team. This practice results in significant inpatient diversion. In the wake of the recent tragedy at Sandy Hook Elementary School in Connecticut, Wraparound Milwaukee’s Mobile Urgent Treatment Team (MUTT) was highlighted as a crisis response system that intervenes effectively in the lives of children, youth, and young adults to avert tragedy.³

In conjunction with site visits and technical assistance from Wraparound Milwaukee and the State of New Jersey, Maryland’s Children’s Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant Crisis Workgroup conducted an analysis of crisis response systems and best practices literature and made a series of recommendations that are not applicable only to Maryland. They identified three broad components and seven core services that should be incorporated within a comprehensive and effective crisis response and stabilization system. The Crisis Workgroup observed that the services are most effective when interwoven as functions within an entire continuum of care and are not likely to be as effective when implemented as stand-alone programs. The seven proposed *Core Services* are:

- *Core Service #1* - Hotlines and Online Resources
- *Core Service #2* - Mobile Crisis and Stabilization Services Teams
- *Core Service #3* - Urgent Care Services
- *Core Service #4* - Emergency Respite
- *Core Service #5* - Crisis Beds
- *Core Service #6* - Emergency Department and Detention Center Diversion Programs
- *Core Service #7* - Care Coordination and Stabilization Error! Bookmark not defined.

See also The Institute’s report for Catholic Charities on the BCARS Emergency Department Diversion Program.

http://origin.library.constantcontact.com/download/get/file/1114009451637-266/BCARSReport_Final_Feb2014_3.pdf

² Technical Assistance Collaborative (2005). *A community-based comprehensive psychiatric response service: An informational and instructional monograph*. Available from the TAC website: <http://www.tacinc.org/media/13106/Crisis%20Manual.pdf>.

³Cherkis, J. (2012, December 19). Sandy Hook Mental Health: Program gaps may be easier to fix than gun laws. *The Huffington Post*. Retrieved from <http://www.huffingtonpost.com>.



6095 Marshalee Drive, Suite 200
Elkridge, MD 21075

April 28, 2014

Via Electronic Transmission
karen.matsuoka@maryland.gov

Karen Matsuoka, PhD
Director, Health Systems and Infrastructure Administration
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Re: Comments on Maryland's State Healthcare Innovation Plan

Dear Ms. Matsuoka:

First, let me thank you for extending the comment period. UnitedHealthcare believes this is an important initiative, and as a stakeholder, we appreciate the opportunity to provide our feedback.

“A Community-Integrated Learning Health System for Maryland—Maryland’s State Healthcare Innovation Plan” submitted by Maryland Department of Health and Mental Hygiene (DHMH) represents a comprehensive review of Maryland’s delivery system.

The proposal is exceedingly ambitious, proposing the creation of a training program for a new type of health care worker, the development of a case management model based on having local case managers, the building of a data system to house a broad set of data including developing analytic capabilities, and developing an accreditation program for primary care practices.

The proposal presents a broad outline of weaknesses in the delivery system that call for improvement. We believe the proposal could further expand upon work already occurring in the Maryland care environment thereby lowering the risk of layering additional interventions on what is already available. In addition further detail is needed on the financial impacts to better ensure that what is developed can be paid for and is sustainable.

1. Financing of a community integrated medical home initiative based on achieved savings is problematic.

We believe that the CIMH model holds promise. However, for commercial and other payers who already have developed programs in place, the States’ CIMH program should be voluntary. We feel

that the proposed places an undue burden on payers that choose not to participate in the CIMH program by requiring them to prove their existing programs have achieved an undefined benchmark by year 2, and if that benchmark is not met, they are required to participate in the CIMH program at their own cost even though the programs' ROI will not be determined until year 3. Any benchmarks that are set for payer programs that are not part of the CIMH should likewise apply to the CIMH programs.

In addition, we need to better understand how these programs will interact with PCMH providers and payer specific programs. We are concerned that layering programs for potentially the same populations creates additional cost. Specific detail on attribution, measures, risk selection and reporting will be necessary to completely evaluate the CIMH proposed program.

Lastly we need a better understanding on how the proposed CMS demonstration project for hospital reimbursement impacts the ROI for these programs. Our concern for hospitals reimbursement, for example, as provided by the HSCRC's new Global Budget model approach seems inconsistent on how utilization improvement will be shared in the future.

2. Creating and financing a public utility to support the CIMH model has the potential to add expense where effective programs already exist.

We agree that better use of data is a key to an improved health care system. As described in the proposal, the State has an All Payer Claims Database, Chesapeake Regional Information System for our Patients (CRISP) health information exchange and a repository for public health data. To make this data useful to clinicians, the build out must include interoperability of the data as close to real time as possible. We believe the State is underestimating the time, expense and expertise that will be required to get to a fully integrated program. For example, the current CRISP ENS is able to provide an ER visit diagnosis for less than 50% of the ER encounters based on the data that our plan receives. To be truly useful, the system needs to be improved.

More detail into developing a usable clinical health information system should be undertaken that focuses on the actual content of clinical information that is useful and interoperability of data. It may be necessary to focus more on the building block or even gradually develop a fully functional small geographic subcomponent.

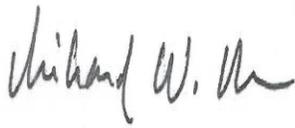
3. The State plans to increase the number of Maryland primary care practices participating in an "accredited PCMH program."

We agree with the State's assessment that highly structured national standards and program for PCMH are not likely in of themselves to result in improvements. We agree that more focus should be placed on access to care and use of information. We believe that increasingly PCMH will not be viewed as a periodic certification or comparison to standards, but will be viewed as a set of daily/ongoing activities and performance measures. We believe that continuing a care coordination model that is not linked to performance measures is not likely to produce results. We agree with the State's decision to dissolve its multi-payer pilot in which a fixed payment was made for care coordination without any performance requirements. Rather, care coordination payments should be linked to activities that a practice should perform or measurable results that show that the care coordination is effective. Care coordinators should not be funded without having periodic performance measurement.

In summary, we would recommend further review of the existing programs both public and private to lower the risk of layering new programs onto the existing system resulting in an unintentional increase in costs, careful consideration of how the proposed programs can be sustained without adding cost to an already expensive delivery system and, further evaluation / description of how savings will accrue for each program and what impact the savings will have on the cost of healthcare.

We look forward to continuing to work with DHMH throughout this process, allowing Maryland to continue to advance the delivery of healthcare.

Sincerely,



Richard W. Reeves
President, CEO
UnitedHealthcare of the Mid-Atlantic
Community Plan



James P. Cronin
President & CEO
UnitedHealthcare of the Mid-Atlantic, Inc.



SIM Feedback <marylandsim@gmail.com>

Maryland's State Healthcare Innovation Plan

Barth, Rick <RBARTH@ssw.umaryland.edu>
To: "marylandSIM@gmail.com" <marylandSIM@gmail.com>

Sat, Apr 26, 2014 at 8:52 PM

Dear SIM Leadership Team,

Although I recognize that there is promise in the idea that community health workers (CHWs) can provide significant benefit to underserved community populations I believe that the greatest benefit will occur if the training for CHWs is integrated into Bachelor's in Social Work programs, as well. Many BSW students have characteristics very much like CHWs but have made a commitment to a four year degree that has additional training in the policy and practice of human services. The design of the CHW population should be done in conjunction with the many strong BSW programs that now exist so that we can ensure that these BSWs have the designated training and that the CHW workforce is supported not only by community college education but also by bachelor's education. In the current plan, there seems to be no recognition of the opportunity that the BSW programs represent to strengthen the quality of community-based care.

Sincerely,

Richard P. Barth, PhD, MSW

Dean and President of the American Academy of Social Work and Social Welfare

University of Maryland School of Social Work

Baltimore, MD 21210

410.706.7794



Comments/Questions on SIM

Susan Stewart <sstewart@wmahec.org>

Fri, Apr 4, 2014 at 8:41 AM

To: marylandSIM@gmail.com

Cc: "Baquet, Claudia" <CBaquet@som.umaryland.edu>, Jake Frego <jfrego@esahec.org>

To Whom It May Concern:

I was one of the Community Health Worker stakeholders during SIM planning, and I have some questions regarding the proposal that was submitted.

My organization is training CHWs, using the 160+ hours Texas AHEC East Curriculum with enhanced modules that the Western Maryland Health System Nurse Educators added on various chronic diseases that are prevalent in the Western MD region. The CHWs engaged in practice home visits with nurses.

I also know that the Eastern Shore AHEC is training CHWs via another highly vetted program.

1. Will these CHWs be grandfathered?
2. If so, will they be required to eventually take the training again or a modified version?
3. Will AHEC be deemed an "eligible organization" to provide the training?

Thanks in advance for your attention to my questions.

Regards,

Susan K. Stewart
Executive Director
Western Maryland Area Health Education Center
39 Baltimore Street
Suite 201
Cumberland, MD 21502

301-777-9150 Office
301-777-2649 Fax

Visit our Website at <http://www.wmahec.org>

"Like" us Facebook at <https://www.facebook.com/pages/Western-Maryland-AHEC/132988616755607>

To become a member of Maryland Rural Health Association and support rural health in Maryland please visit: <http://mdruralhealth.org/membership.html>