Aaron D. Larrimore -DHMH- <aaron.larrimore@maryland.gov>

Reminder: Duals Care Delivery Workgroup - Feedback on Straw Models

Ilene Rosenthal <irosenthal@alz.org> Tue, Jun 28, 2016 at 1:36 PM
To: "Aaron D. Larrimore -DHMH-" <aaron.larrimore@maryland.gov>

Aaron,

Thanks for reaching out to me. Here is my dilemma- the Alzheimer's Association doesn't have a particular preference for any one model. Our main concern is that whatever model is selected includes practice protocols specific to beneficiaries with dementia so that their needs may be met. This starts with routine cognitive screening during the annual wellness visit which should lead to earlier diagnoses. Right now, fewer that 50% of people with Alzheimer's or other dementia are aware of their diagnosis or even have it documented in their medical record.

We also need to ensure that health care providers and care coordinators who work with participants with dementia have competency to work with this population. It would also be highly desirable to have navigators assigned to work with this population in acute care settings, similar to those who work with patients with other high risk/high cost conditions.

Families of persons with Alzheimer's and related dementia are increasingly committed to maintaining loved ones at home for as long as possible. The right combination of services and supports can help them achieve this goal. The Alzheimer's Association is happy to have health care providers refer patients to us, as we offer a number of services that can support family caregivers, including Helpline (24/7 live information and referral), community education, support groups, care consultations, referrals to clinical trials, and limited respite support.

I am happy to include the above in the requested format. I have also included a number of materials and articles supporting care management, early detection, and information on medical costs associated with misdiagnosis. Thank you for this opportunity to provide feedback.

Ilene
[Quoted text hidden]
Ilene Rosenthal | Program Director | Alzheimer's Association Greater Maryland Chapter |
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5 attachments

- **care consultation.pdf**
  659K
- **Case for care management AD (1).docx**
  41K
- **Early Detection of Alzheimer's Disease - Alzheimer's Association.pdf**
  1638K
- **Medical Costs of Alzheimer's Disease Misdiagnosis.PDF**
  1284K
- **Wellness visit recommendations (1).pdf**
  429K

DHMH SIM -DHMH- <dhmh.sim@maryland.gov>

Duals Care Delivery Workgroup Comments - Recommended Model

Driggs, Jennifer H. <Jennifer.Driggs@amerigroup.com> Tue, Jun 21, 2016 at 3:57 PM
To: "dhmh.sim@maryland.gov" <dhmh.sim@maryland.gov>
Cc: "Hirsch, Leah C." <leah.hirsch@anthem.com>

The following comments are being submitted on behalf of Amerigroup Maryland, Inc.. Our workgroup member, Leah Hirsch, is out of the office this week, so I am submitting these comments on behalf of our organization.

We look forward to further dialogue with the Workgroup.

Sincerely,

Jennifer Hazen Driggs

Staff VP, Strategic Initiatives

Amerigroup Maryland, Inc. (Amerigroup) recommends the Department's Duals Care Delivery Workgroup adopt the Capitated Health Plan model as the delivery system used to advance the State's duals eligible strategy and ultimately deliver integrated care to dual eligible enrollees in an effective and efficient manner. Capitated Health Plans deliver a person-centered, fully integrated model that seamlessly links beneficiaries to the services and social support that meet their needs and improve their health outcomes.

Additionally, we believe that the key features of the proposed Duals ACO model could be implemented more sustainably within the structure of a Capitated Health Plan including: (1) extensive use of PCMHs, (2) provider collaboration and engagement in member care coordination, (3) value based purchasing arrangements that engage providers in efforts to reduce total cost of care and improve quality outcomes, and (4) robust data analytics and outcomes reporting, (5) provider involvement in program governance.

In support of this recommendation, we offer the following observations for the Workgroup's consideration:

· Of the three models proposed, Capitated Health Plans have proven success managing complex populations enrolled in state Medicaid programs; As the State's comparison acknowledges, this is a model with "known design with existing provisions"

· Capitated Health Plans bring the financial strength and stability, validated through Maryland Insurance Administration (MIA) oversight of MCO financial standards and/or HMO licensure, to bear the level of financial risk associated with the program models; Additionally, these Health Plans often have robust experience developing and

managing risk based reimbursement arrangements with various types of health care providers and can easily build on this infrastructure to support the value based reimbursement methodologies proposed through the Workgroup;

· The care coordination model required for the Dual Eligible population is very “hands on” and intensive in many cases. Significant infrastructure and resources are required to conduct initial assessments, convene an interdisciplinary care team, develop a person centered plan of care, and support the member in their plan of care on an ongoing basis as their needs may change. In the models proposed, it appears there is an assumption that existing PCMHs will be able to provide this level of resource/coordination. While this may be the case in some well-established PCMHs, it is unlikely that this capacity exists for the full scope of eligible members in the proposed program. The required care models and associated infrastructure required to successfully manage these services typically already exists within experienced health plans;

· Capitated managed care organizations have significant experience developing and expanding provider value based payment programs. As a result, experienced plans have made significant financial investments in support staff, data collection structure, data analytics functions, and technology tools to enable providers to participate fully in these programs and make meaningful progress towards quality measures and goals.

As outlined above, we believe that the Capitated Health Plan model addresses the concerns or “disadvantages” noted through the Workgroup’s comparison of each of the proposed Straw Models. Additionally, we believe that the primary cited disadvantage of the Capitated Plan model, a low participation rate, may be mitigated through program design elements that are distinctly different from the Duals Demonstration structure including provider engagement activities, flexible provider reimbursement requirements, and most critically, robust outreach and communication to potential enrollees and other stakeholders through all stages of implementation and operations.

Finally, while we believe that the Capitated Health Plan model offers the greatest opportunity for success with the Dual Eligible population, should the Workgroup determine that this model is not feasible, Amerigroup would support the Managed Fee-for-Service model as the first alternative. As noted above, we do not believe that the necessary infrastructure exists within the State currently to successfully implement and sustain a care delivery model for this population through an ACO model. While the Managed FFS model will not likely achieve the same level of success that a fully capitated model may offer, we believe it offers greater opportunities to impact health outcomes and greater member participation than the Duals ACO model.

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QUESTION: Which of the 3 major models presented does your organization prefer for Maryland's dual eligibles?

CareFirst's Response:

A **Managed Fee for Service (MFFS)** model is best suited to meet the needs of Maryland dual eligibles and to help achieve whole-person care that integrates physical, mental, and social components of health.

MFFS Offers Flexibility and Ease of Launch

The MFFS model has the best ability to allow dual eligible persons to access needed care and services, while providing needed coordination to help ensure appropriate services are provided at the appropriate time. Because this model offers patients the benefits of Patient Centered Medical Homes (PCMHs) and care coordination without the drawbacks of a more limited network, this model has the best ability to improve patient experience, health outcomes, and ultimately quality of life. Additionally, the MFFS model has the greatest potential to address total cost of care for both Medicaid and Medicare, as it allows for provider choice while giving beneficiaries the additional benefits of a designated PCMH and care coordination. This level of flexibility also makes the MFFS model interoperable with components of Phase II of the all-payer model.

Initiating a MFFS model would cost less and require less effort than development of an Accountable Care Organization (ACO) or Capitated model. This model also offers the most flexibility in terms of administration and contracting with providers. Leveraging current infrastructure, a MFFS model has the best opportunity to support providers via a health information exchange (HIE), analytic tools, and administrative simplicity. This model also presents the most transparent way to view and manage costs in both Medicaid and Medicare for dual eligible populations year over year.

ACO and Capitated Models Create Challenges

While the ACO and capitated models provide some incentive for care coordination, there is a lack of clarity around best practices, structural inflexibility, and a high barrier to start-up. In addition, the Dual ACO model has significantly high administrative and infrastructure barriers to entry, which would result in a significant lag time in qualification for the bonus. It is unclear how a Duals ACO would set up its

network, ensure comprehensive services for duals, and apply risk to providers. With limited data on other state ACO Medicaid program best practices, there is little evidence to inform the initiation of such a complex model.

The Capitated Model also demonstrates challenges. Its restrictive nature could limit provider choice, and also result in large numbers of dual eligibles opting out of the Medicare managed plan component (as has been seen in other states).

We Do Not Recommend Phasing from MFFS into an Alternative Model

Within an MFFS model, the following elements are essential for the success of implementation:

- A centralized coordinating entity to ensure that care plans are designed to appropriately address the health conditions of the dual eligible beneficiaries enrolled;
- Data analytics capable of presenting the information in an actionable format to providers and other care givers as well as receiving data entered by care coordinators themselves;
- Accountable providers or medical homes that work closely with care coordinators and the beneficiaries themselves to develop care plans that address health care as well as other social service needs; and
- Shared savings bonuses for achieving quality and cost targets, depending on the design of the model.

A medical home for dual eligibles will likely need involvement of more than just primary care providers, and the MFFS model is most likely to promote utilization of community-based resources, due to the incentive of the regional care coordination entity to promote use of the most effective providers and resources and lack of network limitations.

We do not recommend phasing from MFFS into another model. At this time, and for the foreseeable future, the MFFS model best serves the needs of dual eligible beneficiaries as it has the best ability to follow a person-centered care model that aligns with a dual eligible patient's goals and values. This model also gives beneficiaries the most flexibility in provider choice while still providing the benefits of a medical home and care coordination. If phasing is pursued by the state, any transition planning should include sufficient time for evaluation. It is essential that the state incorporate lessons learned from any model before phasing in another.

CareFirst Potential Engagement Limited to Managed Fee for Service

CareFirst has submitted an application to the Centers for Medicare and Medicaid Services'

Comprehensive Primary Care Plus (CPC+). Through this program, we see the potential to meld the payment methods proposed in the CPC+ initiative with the infrastructure and model CareFirst has pioneered through its PCMH Program. This melding would provide elements that would benefit the State of Maryland in its intent to create an all payer model inclusive of Medicare Parts A and B while increasing care management focus on community based dual eligibles.

Outside of the CPC+ program, CareFirst would consider contributing its expertise in a MFFS model that had a PCMH or PCMH-like component. Participation would depend on the structure of the program.

Additional Data Needed to Best Serve Duals

The limited amount of timely data is a concern as we move toward consensus on the model. Current Medicare and Medicaid data is needed to truly understand the population as it stands today as well as to understand recent trends. Though some data is available, there is a significant lag time in data and the unknowns created by that lag raise questions for the design of the delivery model. Additionally physicians participating in a PCMH may qualify as participating in an Alternative Payment Model (APM) for the purposes of Medicare Access and CHIP Reauthorization Act (MACRA), depending on payment set-up and shared savings structure with the regional care coordinating entity; however, more data is needed on the model, specifically around introducing risks. Stakeholders need to have a more comprehensive understanding of the level of risk included in the model, as well as what risk is currently allowed within Maryland insurance regulation.

June 17, 2016

Shannon McMahon
Deputy Secretary, health Care Financing
Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, MD

Dear Shannon:

On behalf of our 53 members, I write to urge the Department of Health and Mental Hygiene (DHMH) to adopt a Managed Fee-for-Service Model for the Duals Care Delivery Initiative, with the requirement that community behavioral health agencies be permitted to act as Patient Centered Medical Homes (PCMHs) for individuals with serious mental illness (SMI).

The Community Behavioral Health Association's 53 members serve about two-thirds of the individuals receiving publicly-funded behavioral health services in Maryland. We work with our members to improve the quality of care and expand access to treatment. In support of that mission, we write today to describe the reasons that a managed fee-for-service model will better meet the unique healthcare needs of people with serious mental illness.

I. **Reasons for Supporting a Managed FFS Model.** We advocate for this model for the following reasons:

A. **It provides the best opportunity for community behavioral health agencies to act as the central care coordination entity**. Evaluative research regarding the Missouri Health Home Program has demonstrated that community mental health agencies (CMHAs) are the entities best positioned to be the medical home for adults with SMI. There are several reasons for this, many of which recognize that the major barriers to the physical health of people with SMI emanate from the mental illness, including but not limited to lack of skills and motivation to: i) access primary care; ii) comply with treatment recommendations; iii) maintain healthy lifestyles; and iv) manage co-occurring chronic conditions:

1) CMHAs have the expertise to teach these skills and facilitate this motivation.

2) Most importantly, CMHAs have the most frequent contact and the closest relationships with the consumers, both of which can be uniquely leveraged to help consumers develop the skills and motivation most effectively.

COMMUNITY BEHAVIORAL HEALTH
CBH
ASSOCIATION OF MARYLAND

3) CMHAs provide or directly coordinate more of the consumers' basic services than any other entity, so they are in the best position to perform care coordination in the most holistic and effective manner.

B. Achievement of the Triple-Aim goals is best achieved when the care coordination entity is in the greatest leadership position and has the most oversight and responsibility for all aspects of the care. In an ACO or Managed Care model, the CMHAs will continue to be a small piece of the network, rather than the central care coordination entity. While DHMH could stipulate that ACOs could be formed and led by CMHAs, it is not feasible to expect this to happen given the aggressive timeline of the Initiative's start-up and the many eligibility requirements that may evolve.

C. It thwarts the effectiveness of care coordination to have more than one care coordinating entity for individuals with SMI. Since CMHAs are already doing care coordination for the SMI population, it would be duplicative and overlapping to place another care coordination entity on top. This duplication doesn't just waste money; it also creates uncertainty, ambiguity, and fragmentation for individuals who already struggle with internal and external uncertainty, ambivalence and fragmentation.

D. The FFS model is the most consistent with DHMH's newly implemented Chronic Health Home Option. This model most effectively leverages the existing infrastructure and provider network within the Medicaid Health Home Program for individuals with SMI who are eligible. For those people, their Health Home agencies would be in the best position to act as the PCMHs. The Duals Initiative can offer these agencies additional resources, incentives, and oversight to serve the Dual population even more effectively.

II. <u>Additional Thoughts</u>

A. We strongly discourage the idea of phasing from one model to another. Systems change is hard enough to implement, and always fraught with unforeseen consequences. Doing systems change twice, exponentially increases the challenges and the consequences, and dilutes the limited resources, focus, and energy of stakeholders.

B. Variations of the Model.

1. As noted, we urge the requirement that CMHAs be permitted, in fact, encouraged to be PCMHs for individuals with SMI.

2. We would support PCMHs doing modest risk sharing – starting with shared savings, and then after the first or second year, adding the sharing of negative risk.

Thank you for considering our input.

Sincerely,

Shannon Hall

Executive Director

cc: Scott Rose, CEO, Way Station
Lori Doyle, COO, Mosaic Community Services

The Coordinating Center

The Coordinating Center would like to thank the Department and the workgroup for requesting feedback in the planning of a new model to support people who have dual eligibility for Medicare and Medicaid. Based on the models described both the FFS model and the ACO model would require a well-defined and comprehensive care coordination delivery model. The D-ACO raises some concerns about choice for the participant. Further detail regarding what entity or type of entity would administer the proposed model would influence any specific preference in terms of design.

- Do you endorse the idea of phasing from one model to another, and if so, over what spans of time? We would need to understand more detail regarding this strategy and the specific phased approach. A pilot in one or two diverse regions would likely be beneficial for creating learning prior to a full implementation.

- Are there any variations or specific features you would propose that would make your preferred model most effective? For any of the models suggested, a community based care coordination approach with emphasis on addressing medical, social, behavioral and social issues would be essential for improved outcomes and cost savings. In addition, understanding how the model will be supported by information management systems and strategies is essential to planning and implementing such a large scale program. A clear Quality Plan and evaluation strategies with detailed metrics and sources would be necessary especially in any risk share agreement.

- Would your organization and your organization's members engage or participate in the model when implemented? The Center would be willing to participate in any of the models described to support the improved outcomes and lower costs for quality care.

Are there any conditions/caveats in implementation that would increase/decrease the degree of participation or engagement? It will be essential for the care coordination entity to be able to demonstrate value to participants of the program using a meaningful person centered approach with motivational strategies. The newly designed program should be cautious not to layer too many administrative requirements for consumers and providers that would distract from a value based service delivery model.

- What questions still need to be answered to strengthen confidence in the viability of the decision that ultimately must be taken?

1. What is the impact of the clients with chronic health needs?

2. How would risk be assessed for high utilizers?

3. What predictive analytics or stratification strategies will be used to identify those at greatest risk?

4. Define the current baseline for the targeted population and identify realistic goals for outcomes prior to implementation of a program.

5. What is the impact on the tracking system now to better meet the clients; especially the clients getting out of the nursing home? How will a new system integrate with that existing system? Currently reports are limited in the state LTSS system, how will this be addressed?

6. How will these models support the current effort for community integration vs. institutional care? How flexible will the programs be to non-traditional services and supports that will ultimately serve the participant and address factors contributing to high utilization?

7. How would participants of the current LTSS programs be integrated into any of these models?

8. The presentation indicates that it will support providers through the Health information exchange, analytic tools and administrative simplicity. Is there a plan for an information system to support the workflow? If so, what is the system and will there be access to reports that provide adequate support to operationalize and administer such a program. Who will support the technology system?

DHMH SIM -DHMH- <dhmh.sim@maryland.gov>

duals workgroup

Adam Kane <Adam.Kane@erickson.com> Mon, Jun 20, 2016 at 7:24 AM
To: "dhmh.sim@maryland.gov" <dhmh.sim@maryland.gov>

I support a dual ACO model.

The ACO model provides the incentives and the structure to align with the hospital GBRs.

An ACO model helps providers organize around a network, collect and analyze data and have the waivers necessary to share infrastructure and incentives.

Adam Kane
SVP, Corp Affairs

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HFAM
Health Facilities Association of Maryland
Partners in Quality Care

The Health Facilities Association of Maryland (HFAM) is a leader and advocate for the long-term care provider community, representing 150 of the 230 skilled nursing and rehabilitation centers in Maryland. HFAM member centers provide over 70 percent of the Medicaid support care for Marylanders with complex medical conditions in need of long-term care.

On behalf of our members, HFAM offers the following comments for consideration in our shared work on the Duals Care Delivery Workgroup. We are excited about the possibility of continuing to play a key role and partnering to help Marylanders with complex medical needs to be stronger and healthier.

We have considered the three straw models and along with the majority of workgroup members around the table, we strongly oppose the capitated financial alignment model. HFAM cannot support any model that uses a managed care approach that reallocates dollars from rates for providing care to fees for managing care.

Based on our research of other states that have pursued this model, it has not been successful. The impact on long-term services and supports (LTSS) in particular, both for providers and people served, has been negative. Many of the weaknesses have already been highlighted in the workgroup's discussions: there has been lower than expected enrollment and retention of duals in health plans, historical data has underestimated the costs of the LTSS population with insufficient risk adjustment, and many LTSS providers inexperienced with managed care struggle financially to adapt to lower rates and more stringent billing practices.[1]

Additionally, in states that have used managed long-term services and supports (MLTSS), quality outcomes have been mixed. For example, in a 1996 evaluation of the Arizona Long Term Care System (ALTCS), nursing home residents were more likely to experience decubitus ulcers, fever and improper catheter insertion compared to neighboring New Mexico's traditional Medicaid program.[2]

Minnesota and Massachusetts, which have Medicare-Medicaid integrated MLTSS programs, both showed quality improvements. Massachusetts's Senior Care Options performed better at caring for frailer individuals in the community than traditional Medicaid. Minnesota's Senior Health Options (MSHO) program, which may be the closest example of what a Duals ACO program would

[1] Burwell, Brian and Jessica Kasten. "Transitioning long term services and supports providers into managed care programs." Prepared by Truven Health Analytics for the Centers for Medicare and Medicaid Services, May 2013.
[2] American Health Care Association. "Future spending fear spur managed care for older adults: A risky business with challenges and uncertainties for all parties." 2013.

look like, had positive outcomes, such as fewer hospital admissions and days and fewer emergency room visits, although cost savings were minimal.[2]

We can and do support skilled nursing and rehabilitation centers in Maryland partnering with other providers in sharing risk, or assuming a degree of risk alone, and taking a leadership role to coordinate and better integrate care to produce better healthcare outcomes, while ultimately saving resources. Some key observations:

- The deliberate phase-in is important and seems on track.
    - January 1, 2018 – effective date for Managed FFS duals model
    - January 1, 2020 – effective date for Duals ACO model (upside risk only)
    - January 1, 2021 – add downside risk to Duals ACO model
- As discussed in meetings and displayed in the graphics from presentations on the Straw Models, rates MUST NOT be cut to support any new healthcare management or coordination entity.
- The limited data at this point from other states experimenting with similar care demonstrations seem to indicate that attention must be given to the tension between utilization and authorization of care. Clearly duplicative care must be eliminated; however, duals are beneficiaries entitled to Medicare and supported by Medicaid and cannot be denied access to care that has been deemed necessary by health care providers.

In regards to the managed FFS or Duals ACO (D-ACO) approaches, there are pros and cons to each. Although the novelty of a D-ACO model is appealing, the unpredictability of entities that would apply to become a D-ACO, or existing Medicare ACOs that would absorb a percentage of duals and comply with the D-ACO model clearly presents a challenge. It is concerning to learn that existing ACOs would rather dissolve than accept downside risk, a central component of this model.

A managed FFS approach would be the easiest to implement on a short timeline and the least disruptive to providers and patients. We envision a way forward under such a model in which skilled nursing and rehabilitation centers form entities to coordinate care. However, with accountability limited to the patient centered medical home (PCMH) entity, the financial incentives may not be enough to put pressure across all providers to improve utilization efficiency and care outcomes.

With these key observations considered, we support the phase-in and the provisions most recently presented. One thing to consider: Does there have to be a one-size-fits-all plan? The point was made very early on and consistently throughout the workgroup process that dual eligibles are not a "population," but rather a diverse group of individuals categorized by their

eligibility for both Medicare and Medicaid services. Not all duals are alike and therefore financial incentives may have different results across cross sections of people with dual coverage.

Skilled nursing and rehabilitation centers are obviously experienced in providing much needed complex medical care to Marylanders who are Medicare beneficiaries and also on Medicaid. These centers would be in a much better position to provide care coordination to these patients and may even appreciate having greater control of service utilization outside their building, given that they are often held accountable for events that happen after patients are discharged from their center.

For example, CRISP attributes a rehospitalization to the nursing home where the patient was discharged to, even if they had transitioned to the community with home health services before rehospitalization. Would it be possible to carve out separate risk structures for different groups of duals with the understanding that the opportunity for cost savings may vary?

We look forward to our continued conversations on this subject. Please let me know if we can offer any other information or insight that will help DHMH develop and polish an integration model that will achieve the desired effects for dual eligibles.

Joseph DeMattos, Jr.
President and CEO, HFAM

6704 Curtis Court
Glen Burnie, MD 21060

June 20, 2016

Shannon M. McMahon
Deputy Secretary, Health Care Financing
Department of Health and Mental Hygiene
Office of the Secretary
201 West Preston Street, 5th Floor
Baltimore, Maryland 21201-2301

Dear Ms. McMahon:

Johns Hopkins appreciates the opportunity to respond to the Department's request that we indicate our preferred model to best meet the needs of Maryland's dually eligible. As the Workgroup has discussed, individuals who are eligible for both Medicare and Medicaid benefits are one of the most vulnerable populations in our State. As has also been discussed, the dually eligible can have challenges accessing quality, coordinated health care; indeed, their health care is often fragmented, unmanaged, and episodic. Patients may have difficulty accessing the medical care they need, and information about their care can be scattered among providers and settings. Further, their care is funded by two or more different payment systems and sets of program rules, again making it difficult for providers to coordinate the care required. With complex patient needs in a complex payment model and within a fragmented health system, patient care is simply not optimized for this population. We applaud the State's efforts to develop and implement a strategy to improve the health and welfare of this very important population.

Which of the 3 major models presented does your organization prefer for Maryland's dual eligibles?

We have seriously considered the models proposed: Managed Fee-for-Service, Dually-Eligible Accountable Care Organizations, or Capitation. Based on what we know to be the needs of this particular population, and because we believe that it is critically important to ensure an

alignment of incentives between the payment system, the delivery system, and the patient; Johns Hopkins prefers the Dually Eligible Accountable Care Organization, or "D-ACO" model. By definition, this model is provider driven, system based, and is aimed to align incentives across providers to optimize patient care for the dually eligible.

The provider-driven ACO approach is best positioned to address the immediate and long term needs of these particular patients. When providers are responsible for providing or securing necessary care for a participant, there is an incentive to develop strong relationships with a broad set of providers who accept and embrace a similar value and quality based approach to participant care. This "system-based" D-ACO approach recognizes the opportunity for both primary care and other providers such as those providing behavioral, specialty and long term care to play a significant role in meeting the overall needs of the patients, and it aligns the incentives for the delivery system to make the investments necessary to achieve the goals of population health management. Finally, pursuant to the D-ACO approach, current ACOs --- both Medicare Shared Savings Program (MSSP) ACOs as well as other clinically integrated networks --- can be leveraged to meet the needs of the duals. In short, the D-ACO model has the opportunity to align the broader delivery system to address the complex needs of the dually eligible population and to accelerate the pace of the transformational change necessary for the State and Federal payors to meet their ultimate goals.

In selecting the D-ACO model, Hopkins specifically considered and rejected the Managed Fee-for-Service model proposed. While Managed Fee-For-Service may be easiest for the State to start up, it is neither innovative nor integrated. As many on the Duals Workgroup have noted, the dually eligible are often not connected to a primary care provider and their health care needs often drive them to other settings and providers. Enhanced care coordination and primary care fees will not sufficiently accelerate the creation of the connected system the dually-eligible population requires, and will likely not result in a return on investment in transforming the delivery of care to duals. Johns Hopkins supports patient-centered medical home models and agrees that they are key to any system of care. But a PCMH-centered model that is managed by an entity not sufficiently integrated into the care delivery model will not drive the accelerated changes necessary for this population. Further, a managed fee-for-service model does not provide the flexibility necessary to innovate around other social support services that are outside the realm of health care and not necessarily covered per the benefit plans of either the Medicaid program or the Medicare program. This type of innovation is only possible by more risk-based models that allow for different types of innovations within the broader "premium dollar" to truly achieve broad-based, permanent change in health care delivery and outcomes. It is for these reasons that we reject Managed Fee-For-Service as the innovative and transformational model the State is looking for.

Do you endorse the idea of phasing from one model to another?

Johns Hopkins does endorse the potential phasing from one model to another. By definition, ACOs should evolve over time, as clinically integrated systems of care become more and more enabled to provide connected, coordinated health care across the continuum, with engaged patients living in an engaged community. The critical first step under the D-ACO would be for payments by Medicare and Medicaid to be sufficient to support the enablement of the system of care and to ensure that the delivery systems are prepared to assume more risk. If through adequate up-front payments a true system of care designed specifically for the unique needs of the dually-eligible population begins to develop, a successful D-ACO could eventually transition towards a capitated model, with flexibility built in to allow for the funding of other necessary services not usually covered by fee for service health care. This capitated model could evolve into a comprehensive managed system more directly aligned with provider-based systems with experience in or ready to accept capitated risk.

A capitated model that integrates Medicare and Medicaid funding allows for the creation of a comprehensive model that allows providers to focus on the best way to design and provide benefits to dual-eligible so they receive the right care in the right setting. A capitated model allows for the creation of a care provider and a managed care benefit plan that use a combination of inter-disciplinary care management and the unique ability to merge Medicare and Medicaid funds to meet the needs of the patient. This funding model allows program to devise care plans that use services in a manner not possible under the benefit rules of Medicare or Medicaid. This cohesive approach to care delivery and the administration of Medicare and Medicaid benefits not only permits greater flexibility but also benefits the participant by removing many of the inconveniences of the typical provider – insurer relationship. However, under any circumstance, the speed at which the State transitions from shared savings to downside risk to eventual capitation must be thought through very carefully, so as to not prematurely shift risk to a system not fully prepared and able to support the needs of the population to be served.

Are there any variations or specific features you would propose that make your preferred model most effective?

Essential to a successful D-ACO are sufficient up-front care management fees (PBPM) that reflect the needs and varying complexity of the dually eligible and those whose health care needs are likely met outside the traditional patient centered medical home. The PBPM payment also needs to evolve beyond care coordination so that interdisciplinary teams (IDTs) and additional benefits are supported.

In an IDT model, the patient is at the center. This model is necessary to optimally improve patient care for a highly complex and diverse patient population like the duals. Through its

broad participation across many providers and disciplines, an IDT is not only able to routinely assess the health and social needs of the patient, but to also deliver services to the patient in the setting that is most beneficial to the patient, which for the duals population is often not a primary care setting. Adequate support for an IDT is essential to make the D-ACO model most effective.

Would your organization engage or participate in the model when implemented?

Johns Hopkins would be quite enthusiastic to participate in a D-ACO model that aligns incentives and sets forth a path for the development of integrated systems of care to meet the broad set of needs of the dually eligible population. Johns Hopkins has extensive experience and a long standing commitment in serving the dually eligible through Hopkins ElderPlus/Program for All-inclusive Care for the Elderly (HEP/PACE) and our geriatric research and clinical programs at Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. For 20 years HEP/PACE has demonstrated the ability to successfully manage costs and achieve outstanding patient care and satisfaction for the high risk, nursing home eligible duals population. Additionally, Johns Hopkins is experienced in managing risk-based programs for both Medicaid and Medicare populations: Hopkins has been a co-owner and manager of Priority Partners Managed Care Organization for twenty years, has recently launched a Medicare Advantage product, and is the owner of a Medicare Shared Savings ACO, Johns Hopkins Medicine Alliance for Patients (JMAP), which currently serves 2,268 non-disabled dual eligible individuals. Finally, expanded provider engagement in all aspects of health care delivery and financing is an obvious next step as hospitals assume a greater risk and responsibility for population health under global budgets. It is through our mission and experience that Johns Hopkins welcomes the opportunity to participate in an appropriately designed D-ACO program.

Are there any conditions in implementation that would decrease the degree of participation?

As noted above, the PBPM payments must be sufficient enough to accelerate the connected care necessary for the dually eligible population. The Department has noted that the PBPM payment are intended help cover administrative costs of care coordination and case management; however, we do believe that traditional primary care based care coordination is not sufficient for this very complex population. Indeed, based on our PACE experience, we believe a "PACE-light" model could be developed which could support the creation of IDTs and encourage innovation around other, less costly "types of services" to optimize the dually-eligible member's health.

What questions still need to be answered to strengthen confidence in the viability of the decision that ultimately must be taken?

Data shared with the workgroup is from 2011. Determining the needs of and risk associated with the dually eligible in Maryland requires more contemporary data. There also needs to be better understanding regarding the future timeliness and flow of data from CMS and DHMH to those engaged in serving the duals.

While we appreciate the concerns raised regarding the uncertainty of how D-ACO with work with global budgets and how shared savings will be determined at the intersection of global budgets and a D-ACO, this is an existing reality that must already be addressed with the existing ACOs in Maryland. It is likely that a provider based D-ACO is in fact best positioned to assess and transfer any savings due to reduced hospital spending to other partners within the D-ACO.

As the State continues to develop a dual model, we think that it is essential that the stakeholder community continue to have input, particularly in defining and establishing "upfront fees and payments" for services beyond care coordination.

SUMMARY

Few dual eligible recipients currently receive care in a managed environment, let alone in an at-risk provider setting. There is a need to develop the skills and tools necessary to identify the high risk populations and develop the teams capable of effective risk management. A phased in approach that aligns incentives and thoughtfully increases the level of risk assumption by a provider system would allow providers to build robust programs through demonstration and experimentation. Such an approach also has enormous potential to greatly improve the quality of care for the dually eligible population while also achieving savings to both the state and federal government. A provider driven approach is best positioned to ensure the long term success of the duals model.

Important Issues to Be Addressed

Through Johns Hopkins extensive experience and standing commitment in serving the dually eligible population, we have identified the following factors that are essential to developing a successful duals model:

1. Delivery system is designed so that care can be customized to reflect the vastly different needs, values and choices of each patient served by the duals program.
2. The population risk stratified in a manner that permits the provider to develop the specific approaches needed to manage the population.
3. The funding is sufficient to allow the provider to invest in atypical resources and care solutions that produce overall costs savings.
4. The populations under the care of the at-risk provider are large enough to provide a reasonable actuarial basis to absorb fluctuations in utilization.

5. Funding is sufficient to cover the administrative expenses of establishing the infrastructure needed to create an integrated system for serving the duals population program.

Key Components of An Effective Dually Eligible Program

Risk Identification: The health care needs of the dually eligible population vary greatly in complexity. A duals model must have the necessary tools to assess the health care needs of and risk associated with each dual participant. With a wide range of risk profiles, there must be an appropriate selection process that can cohort populations according to some basic similarities and challenges, allowing for the development of provider and care management responses suited to this population.

1. **Interdisciplinary Care Management**: An interdisciplinary team (IDT) is essential to any duals model that aims to improve patient experience, health outcomes, quality of life and access to care. The composition of an IDT is designed to include a wide range of individuals involved in the care of a participant including, professional and lay personnel such as medical practitioners, social workers, therapists, personal care aides, drivers and the participant. This broad IDT creates a holistic view of the participant.
2. **Risk Management:** A duals program or provider will generally be addressing the needs of an actuarially unsound population base. To remain fiscally sound in meeting the health care needs of the duals requires effective multi-discipline assessment in risk identification, use of preventive care to avoid acute episodes, redirection of care to more cost effective solutions and close communication with participants and caregivers to identify early warnings of changes in condition.
3. **All Inclusive Care**: A person-centered integrated model for the duals is best achieved through both capitation and the ability to blend Medicare and Medicaid dollars. When a provider is at risk for all care provided to a participant, the dual capitation paid to the provider is able to be allocated to meet a participant's needs without the need (or opportunity) to generate additional revenue through the provision of services. As such the provider has a strong incentive to seek the most cost-effective approach and settings for care. When Medicare and Medicaid dollars are blended, services or equipment not typically covered by Medicare or Medicaid may be used by the provider to offset the risk of more expensive care.
4. **Provider Based:** A provider based program is best positioned to successfully meet the needs of the duals. When providers are responsible and at risk for providing or securing all care provided to the participant there is an incentive and need to develop strong relationships with external providers who accept and embrace a similar value and quality

based approach to participant care. With a provider based approach, the control of a participant's care plan is retained by the core IDT, and the IDT directs and manages the participant's care in any setting.

We trust you find this letter responsive to your request. We look forward to working with the State to develop an innovative model in Maryland that bring together the benefits of both the ACO and capitated model and builds on the experience and expertise of programs already in place.

Sincerely,

Patricia M.C. Brown, Esq.
Senior Vice President of Managed Care and Population Health of Johns Hopkins Medicine
President
Johns Hopkins HealthCare LLC

Laura Herrera Scott, M.D., M.P.H.
Medical Director, Population Health and Community Health Programs
Johns Hopkins HealthCare LLC

QUESTION:

Which of the 3 major models presented does your organization prefer for Maryland's dual eligibles?

LIFESPAN NETWORK ANSWER: As a preliminary response, LifeSpan would support the 2-part phase-in between the Managed Fee for Service (MFFS) and the Duals Accountable Care Organization (D-ACO) delivery model. This answer is predicated on the examination of further information, mainly related to a D-ACO model. Regardless, a phase-in is needed given that ACOs typically are not currently contracting with long-term care providers. It is also important to maintain both systems even after a phase-in of a D-ACO given that in some of the rural areas it could be difficult to build the network for a D-ACO due to lack of long-term care providers.

In addition to implementing through a phase-in schedule, in developing a new delivery system for duals, it is imperative that it complements the activities being pursued by the HSCRC under the new Model Waiver, including the alignment of any performance requirements, etc. In addition, given the timeline for the new Model Waiver, a timeline of 2018 would give the State greater insight into programs developed between hospitals, physicians and other post acute care providers and make any necessary adjustments to the duals program to align the goals of both the waiver and a duals delivery system.

Other issues that need to be taken into consideration in order to make a final determination on a delivery model include those below. LifeSpan recognizes that these are operating issues but, regardless, these issues will affect the determination of a model.

1. Care benefits – How would this new delivery system interact with current benefits and programs under Community First Choice, Community Options and other waiver programs? Would duals still have access to these programs? If a dual was currently receiving services through a waiver provider, would they continue to receive services and how would the coordination of care operate with current systems?

2. Utilization Review – During discussions, there were comments regarding utilization review for services. This can be problematic for providers subject to OHCQ licensure requirements (and federal surveys), especially skilled nursing facilities when there is an outside entity making care decisions. In the past, there have been incidents when the outside entity made a care decision that resulted in a "bad outcome" and the facility was then cited and fined by either the State or CMS. The facilities by regulation remain responsible for the care provided in the facility regardless of whether the individual is receiving long-term care or short-term rehab. So, while there can be an integration of care planning, care decisions must remain within the facility or provider.

On a similar note, there needs to be greater explanation as to the roles of a PCMH and a RCCE? Typically a PCMH is a model of care that emphasizes care coordination. To have a PCMH and a RCCE could be redundant. How does the State envision each operating to eliminate redundancy and who does the State envision as being classified as each?

3. Streamlining of Care Planning Requirements - Substantial resources have been implemented over the last few years to streamlining assessments and care planning for providers (e.g., InterRai). How would these be affected? Would they continue? Similarly, each facility has its own care planning requirements either through Medicaid or licensure requirements. If the purpose of this new delivery system is to integrate and coordinate care, this needs to flow down to the forms, etc. Providers should not be responsible for multiple forms and additional reporting requirements.

4. While we understand that these are more detailed issues, it is difficult to decide a model without having more information on funding mechanisms and guidelines for entities outside of providers (who will still be paid fee-for-service). Will there be State guidelines for gainsharing under the ACOs? In addition with regard to the PCMH and ACOs, would providers be able to participate in more than one?

DHMH SIM -DHMH- <dhmh.sim@maryland.gov>

Reminder: Duals Care Delivery Workgroup - Feedback on Straw Models

Aaron D. Larrimore -DHMH- <aaron.larrimore@maryland.gov> Tue, Jun 28, 2016 at 9:17 AM
To: DHMH SIM -DHMH- <dhmh.sim@maryland.gov>

---------- Forwarded message ----------
From: **Matthew Celentano** <matthewcelentano@gmail.com>
Date: Tue, Jun 21, 2016 at 12:57 PM
Subject: Re: Reminder: Duals Care Delivery Workgroup - Feedback on Straw Models
To: "Aaron D. Larrimore -DHMH-" <aaron.larrimore@maryland.gov>

Hey there Aaron -

I had conversations about this with a few folks on our Board, as well as some of our national policy folks, and we're not sure that we are in the position to choose one. I guess our position would be that if the state chooses a model, we are fine with it as long as it incorporates the principles we indicated as priorities within design.

Talk soon.

Matt

Matthew Celentano
443 253 7988 (C)
443 212 5456 (H)
410 235 9000 (W)
Sent from my iPhone
[Quoted text hidden]

<Duals Staw Model Details 6.6.2016.pdf>

<Duals Organizational Response 6.6.2016.docx>

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Aaron Larrimore
Division Chief, Innovation and Delivery System Reform
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Maryland
Hospital Association

June 27, 2016

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

Dear Deputy Secretary McMahon,

Thank you for the opportunity to provide our views on the state's request for a preference of integrated care delivery models for Maryland's dual eligible population – managed fee-for-service, capitation, or a Duals Accountable Care Organization (D-ACO). This has been a primary focus of the Duals Care Delivery Work Group, on which we participate, and selecting the right model is critical to providing care to dual eligibles in an efficient and effective manner.

The importance of choosing the right model cannot be overstated, which is why a commitment to one of the three proposed concepts at this time would be premature. Please know that hospitals are supportive of the development of initiatives to address the unique needs of dual eligibles and look forward to working with you to address the outstanding issues that preclude a stated preference at this time.

At the May 2 work group meeting, the state noted that it is seeking a no-cost extension to the State Innovation Models (SIM) grant, which would extend the design report due date to the end of the calendar year. This additional time could be used to address the two outstanding issues needed to articulate a preference among models:

- The need for timely data
- The interplay of the proposed models with the state's all-payer model

These outstanding issues are echoed in the responses you have received from Johns Hopkins HealthCare, MedStar Health, and University of Maryland Medical System.

Available Dual Eligibles Data Are Insufficient to Select a Preferred Model

The work group began with an overview of data from calendar year 2012. Although the state is now in the process of receiving more current reports from the Center for Medicare and Medicaid Innovation (CMMI), without timely data, the viability of any of these models cannot be assessed. Put another way, with the data currently available, hospitals and other entities cannot determine the risk associated with the dual eligible population, or the interventions and support systems necessary to be successful in managing care for that population. As noted by several work group members, this population heavily utilizes long-term support systems, but we do not have information about the use or cost of those services for dual eligibles. Without these data, we do not know what services are needed, for how long, or their cost, making it impossible to select an appropriate model for managing those costs.

Once the state receives more current data from CMMI, for example, entities could be invited to file a letter of intent to acquire a limited data set, which would allow them to analyze the dual eligible population's use of services and identify potentially avoidable utilization. This exercise would help entities better understand the total cost of care for the dual eligible population, where challenges and gaps remain, and what characteristics of the population necessitate broadening service capacity. A more accurate understanding of the risks and opportunities for this population would allow for an assessment of how each model might address the areas identified, and for the selection of a preferred model.

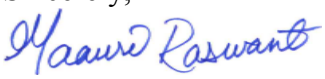
Interaction with Global Budgets Unclear

It is uncertain how the proposed models will interact with the hospital global budget system under Maryland's all-payer model. The Department of Health & Mental Hygiene (DHMH) has noted that at least one model, the D-ACO, may conflict with the all-payer model. Without understanding and diagramming this interaction more fully, choosing a model that is at odds with Maryland's all-payer model could create unanticipated problems for both global budgets and a dual eligible model. Hospitals welcome the opportunity to use the state's extension of the SIM grant to gain a better understanding from DHMH and the Health Services Cost Review Commission of the interplay between the all-payer model and the three proposed integrated care models.

A Path Forward

Hospitals have a strong incentive to manage high-risk, complex populations and broadly support the state's desire to enhance the alignment of Medicare and Medicaid care provided to the dually eligible population. The models presented offer significant conceptual differences in the manner by which the incentives and support are provided. While Maryland's hospitals share the vision of providing high-quality care for this population, their individual experiences with the care delivery structures presented in the models greatly vary. We hope you will consider our request to use the remainder of the calendar year to further the development of more detailed proposals so that a preference among models can be articulated.

Sincerely,



Maansi K. Raswant
Director, Policy & Data Analytics

Maryland Learning Collaborative

Duals Care Delivery Workgroup

In order to progress the discussion on model development, Duals Care Delivery Workgroup members are being asked to announce their organization's preference for one of the three models (Managed Fee-For-Service, Dual Eligible Accountable Care Organization, or Capitated Health Plans for Duals). Please send submissions to dhmh.sim@maryland.gov by COB **Monday, June 20th, 2016**. The table below has been created to help your organization compile a response.

Written submissions will help the Workgroup move the discussion along at the June 29th meeting. They will not be used to supplant discussion or dialogue at the meeting on the models. The submissions and an analysis of the submissions will be made available to Workgroup members before the June 29th meeting.

Workgroup members are encouraged to describe their organization's reasons for supporting a particular model in whatever level of detail your organization prefers. There are no formal specifications for this request, though the questions below may help guide you in providing a robust response.

- Do you endorse the idea of phasing from one model to another, and if so, over what spans of time?

Since most practices are set up for Fee for service at this time, I think this is the logical starting point with a preparation time spent training practices before moving to the ACO model. Majority of collaboratives run for 18 months, so I think having a 12-18 month transition timeframe may make sense.

In sum I suggest:

start with Managed FFS DUALS and include all practices in a 12-18 month collaborative during which implementation requirements are flushed out in implementation phase. Here is where variations in implementation will start to become evident and these can be factored into payments or into considerations when calculating performance indicators that are reimbursable.

Roll out the DUALS ACO at 12-18 months.

- Are there any variations or specific features you would propose that would make your preferred model most effective?

Managed fee for service Duals model should have an upfront fee paid to practices for services rendered and additionally, consideration for shared savings for high performing practices based on process metrics or utilization outcomes.

- Would your organization and your organization's members engage or participate in the model when implemented? Are there any conditions/caveats in implementation that would increase/decrease the degree of participation or engagement?

On behalf of the University of Maryland Family Medicine, I can say yes. However, many of the Maryland Learning Collaborative practices are already in ACO's and other alternative payment arrangements. These practices will be harder to recruit.

I propose that we have almost no barriers to participation so that we can have all practices in Maryland participate.

- What questions still need to be answered to strengthen confidence in the viability of the decision that ultimately must be taken?

- Clear guidance to practices on what is required
- An opportunity and willingness to allow practices to shape the implementation of the model in the field using 12-18 month collaboratives where the practices provide feedback that is actionable by Medicaid
- Transparency of timely data made available to all practices and stakeholders
- Timely payments and quality data sharing
- Celebrating every success with practices that do the work

Thank you for your active participation in the workgroup to date. We look forward to receiving your remarks and to continuing the dialogue at our next meetings.

QUESTION: **Which of the 3 major models presented does your organization prefer for Maryland's dual eligibles?**
Maryland Learning Collaborative ANSWER: **Starting with Managed FFS DUALS and transitioning over 12-18 months to the DUALS ACO**

QUESTION:

Which of the 3 major models presented does your organization prefer for Maryland's dual eligibles?

Maryland Department of Aging

[YOUR ORGANIZATION'S] ANSWER:

The Department remains neutral on the three straw models. A hybrid model that blends certain desirable characteristics of each model, it is recommended. Additionally, the Department recommends that, regardless of which scheme is chosen, robust consumer engagement and participation are made a fundamental trait of that model.

- Consumer engagement strategies
  - Significant and substantive role on implementation committee
  - Ongoing advisory committee with regular stakeholder meetings
  - Potentially assist with ensuring quality assurance in person-centered planning and decision-making support for service plans.
- Administrative alignment (such as under capitated health plan)
  - Unified enrollment, appeals, and other processes where possible
  - From the perspective of an entity that provides hundreds of thousands of "application assistance" units of service annually, bureaucracy is a significant barrier for many consumers, especially those who frequently require services and assistance *across* systems. Unified applications, single customer service contact points, aligned documentation and deadlines are all changes that help reduce this paperwork barrier.
- Incentives
  - Provider incentives as described under ACO model, including under MACRA
  - Participant – what is the participant incentive to enroll in the duals model and not opt-out of the Medicare part?
- Management

  An ACO model that has certain minimum characteristics:
  - Provides acute/primary care coordination. Works with entity experienced in community LTSS coordination.
  - Community services coordination is not an "add-on" task for acute/primary or LTC providers, but an independent service.
  - Connected to existing NWD/ADRC system so that consumers may continue to receive objective and independent benefits counseling, community LTSS identification and service plan development, and enrollment assistance.
  - Discharges back to the community includes collaboration with an

interdisciplinary and interagency team that *must* include participation from the NWD agency triad -- AERS, social services, and Aging/MAP -- especially for individuals who are, or may, receive public program services (e.g. CFC, Senior Care, IHAS, National Family Caregiver Support, etc.). Hospital discharge planners only work with people who touch that system and do not have the expansive knowledge base, access to computer systems, or objectivity necessary to be a primary or sole source of community services support.

- Provider choice
- Conflict free case management for LTSS in that NFs, ALFs, and home health agencies do not provide both services and care coordination.

Given that most ACOs tend to follow catchment areas, there must be an effort to better align all ACOs within each county. It will be immensely frustrating for local public systems to have to understand and work with different ACOs whose catchment areas do not encompass the entire county/jurisdiction boundaries.

Ideal Model:

TCOC
Provider collaboration
Medicare-Medicaid administrative processes alignment
Payment incentives to meet Triple Aim and provider collaboration
Participant incentives to keep Medicare participants from dropping out
Treatment coordination
Community services coordination
Collaboration between treatment and community services
Consumer involvement (implementation committee, advisory, stakeholder)
Consumer satisfaction via person-centered approach to development of treatment and service plans.

Do you endorse the idea of phasing from one model to another, and if so, over what spans of time? Phasing from one model to another over any span of time will cause disruption and require a level of repeated clear communication and training to front-line staff that may expend resources and energy that could be better directed towards a single, but smoother implementation model. Natural staff attrition and the current systems changes with which they are already dealing will make a shift from one model to another much more confusing.

Are there any variations or specific features you would propose that would make your preferred model most effective?

Coordination of services related to social determinants is outside the ken of acute, primary, and institutional long term care providers. Certain services – home delivered meals, chronic disease self-management, falls prevention, and home modifications – may be directly tied to coordination with a medical team; for example, to ensure that the meal meets the person's chronic disease management needs. Other services – applications for home energy assistance and food stamps, caregiver support, rental subsidies and property tax credits to maintain housing, socialization activities – that are not directly related, but critical social determinant. Any care coordination entity must have expertise in order to access and coordinate a wide range of services, including social determinants. The PCMH (and RCCE in the managed care

model) model needs clarity in how the State will ensure that it will include a specialist in community service coordination. Finally, it is laudable that person-centeredness is an integral and guiding principle across the three models. Details on how the State will ensure that person-centered planning is occurring, including training, monitoring, quality assurance, and performance measures tied to provider payment has to be detailed in each model.

Would your organization and your organization's members engage or participate in the model when implemented? Are there any conditions/caveats in implementation that would increase/decrease the degree of participation or engagement?

Yes. The Department's statutory mandate is to advocate on behalf of older adults. Since 2003, the Department' work has expanded to include adults with disabilities. The implementation of any model will undoubtedly have an impact on the 19 local, public Area Agencies on Aging, including in their capacity as the single entry point for Medicaid community long term services. A major consideration for the Department is that any implementation includes direct consumer participation and feedback, especially from older adults, persons with disabilities, and their family caregivers. The process thus far has engaged professionals and professional advocates. Consumers must be substantively included in the development and implementation of any system that is ostensibly being designed and implemented for their benefit.

We intend to be at the table to ensure that the identified model is implemented and fine-tuned in a fashion that has the least negative effect on older adults, individuals 18+ years of age with a disability, and their family caregivers. The network historically has assisted hospital and health systems staff with discharge planning activities such as identifying appropriate and available community services and post-discharge social services coordination (whether the hospital systems realize it or not!). The network assists individuals to transition out of NFs via Money Follows the Person, provide supports planning service coordination for waiver, CPAS, and CFC, manage Medicaid "diversion" programs under the Department's statutory authority, and annually triage an additional approximately 54,000 unduplicated individuals who directly contact us through the NoWrongDoor/MAP network to access public and private home and community based services. We have a responsibility to ensure that we are appropriately positioned and integrated into the duals model to manage the NWD critical pathways.

The Department seeks to ensure that professionals supporting individuals in the community adequately understand person-centered planning principles and use appropriate skills. The Department has, under a cooperative agreement with the Administration for Community Living, designed, received federal approval of, and implemented a proven person-centered planning curriculum and training for approximately 350 public (LHD, DSS, DDA, AAA, etc.) and private staff over the past two years. We intend to extend this training to those professionals who may be providing person-centered care coordination under any of the three models.

What questions still need to be answered to strengthen confidence in the viability of the decision that ultimately must be taken? It would be helpful to story board each proposed model against the existing interactions between the acute/primary care field and the long term care field and with the public health and social services system. What changes will be necessary on the public sector side (Local Health Departments, Area Agencies on Aging, Departments of Social Services, Core Service Agencies) in order to best support and implement any new model? What type of public-private partnerships will be most effective and supportive of providers to meet their outcomes? Which public staff duties, roles, and conflicts of interests will be affected?

Solutions are not required for these questions today, but at least identifying affected areas will lead to a smoother planning and implementation process.

The philosophical difference about conflict-free case management between acute/primary and long term services also needs to be reconciled. Care coordination of medical services by acute/primary care providers is understandable and fits well within the PCMH model. However, care coordination and services provided by a single entity (e.g. home health agency, in-home meal service provider) is a conflict of interest for long term services.

QUESTION:

Which of the 3 major models presented does your organization prefer for Maryland's dual eligibles?

MD Department of Disabilities ANSWER: D-ACO

- What if a beneficiary likes a PCMH, but not the D-ACO affiliated with it? Is it possible that PCMH networks have relationships with multiple D-ACOs to address the problem of limited provider choices? The linkage between the PCMH and D-ACO, however, does allow for relationship development and familiarity between processes.
- There also is a concern that D-ACOs won't cover rural populations leaving beneficiaries unable to access this model of service provision.
- Referrals to evidence-based health promotion programs should be a focus of D-ACOs.

QUESTION:

Which of the 3 major models presented does your organization prefer for Maryland's dual eligibles?

REVISED MEDCHI ANSWER (6/27/16):

After further review, MedChi would be supportive of a duals ACO delivery model, with the understanding that a managed care fee for service (MFFS) delivery model may need to be employed as a preliminary step.

MedChi would like to present certain principles that need to be considered in the development of any model. It is imperative that the delivery model for the duals aligns with the provisions of the new hospital waiver. It is clear nationally that value-based payment models driven by physician innovation have been the most successful in achieving the goals of the Triple Aim. In this regard, there needs to be opportunity for physicians to participate and organize as a PCMH and for physicians to be able to participate in more than one, including ACOs.

Equally important is the need to ensure that the chosen delivery model allows physicians to satisfy the requirements of MACRA, both on cost and quality measures. The HSCRC has already recognized this need by requiring hospitals to "work with physicians with the goal of developing and enhancing value based approaches that are applied under MACRA." On this note, we do have concerns that a managed fee for service may not allow physicians to satisfy the requirements of MACRA due to the absence of downstream risk opportunities, an issue not present in the D-ACO model. We implore the Department to further examine how a MFFS delivery model can incorporate the requirements of MACRA.

MedChi recognizes that there are many operational issues that need to be examined and determined regardless of model. MedChi appreciates the opportunity to present this preliminary feedback and we look forward to further development of a model.

MedStar Health

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Debora Kuchka-Craig, FHFMA
Corporate Vice President

June 24, 2016

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

Dear Deputy Secretary McMahon,

Thank you for the privilege of serving on the Duals Care Delivery Work Group, and the opportunity to comment on the three models of care under consideration. While your request to Work Group members to choose a preferred model was clear, it is difficult to comply with that request for several reasons which are outlined below.

As discussed in prior meetings, the lack of data on the Duals population is troubling. The significant changes in Maryland's healthcare landscape over the last several years suggest that 2012 data is not adequate to base the foundation for a new model of care. The complexity of this population is unlike other at-risk populations being managed by most providers, making the need for relevant, timely data essential.

The timing of this initiative coupled with other major changes in the industry is a real concern. We have discussed the significant investments that continue to be made by Maryland providers to manage their patient populations. The number of ACOs and Medicare Advantage plans in Maryland has increased just recently, making it premature to evaluate their potential impact on the Duals population. The implementation of various HSCRC transformation grants throughout the state is also expected to have some positive impact on the management of Duals. Given the significant focus required by the industry to reap the full potential of these existing initiatives, there is risk in simultaneously launching yet another major model. In my opinion, band-width is a real issue that spans the industry.

Given Maryland's unfavorable history with down-stream risk, it would be prudent to conduct some assessment of providers' and payers' readiness to accept risk for such a challenging population. The three models under consideration each present some risk to the industry and most importantly, to the Duals population directly. More insight into Maryland's readiness for risk is strongly recommended for these reasons.

Other concerns discussed with staff and the Consultant include, potential provider access issues, beneficiary choice vs. ability to direct care, and provider confusion regarding ACO participation options. If the desire is to narrow the number of models for further analysis, it appears the Managed Care Capitation Model is least preferred given feedback from MedStar leaders, prior Work Group meeting discussions, and given the feedback reported from CMMI.

In summary, MedStar Health supports further evaluation of the proposed models, which I believe is consistent with the position outlined by MHA in their response.

Thank you again for the opportunity to comment. I look forward to continued work on this important initiative in support of the Duals population.

Sincerely,

Debora Kuchka-Craig
Vice President Managed Care

cc: Eric R. Wagner, MedStar Health
Maansi Raswant, MHA

QUESTION:

Which of the 3 major models presented does your organization prefer for Maryland's dual eligibles?

[YOUR ORGANIZATION'S] ANSWER:

Overview

As a representative of both the The Mental Health Association of Maryland (MHAMD) and Consumer Health First (CHF) on the Dual Eligibles workgroup all comments below should be considered endorsed by both organizations. MHAMD and CHF agree that investments in delivery system reforms can lead to better results for consumers and appreciates the inclusion of consumer representation in the process to consider possible reforms. The primary focus of a new model of care should be improving health care and health status for enrollees. Cost-savings is a logical consequence of improved health status and decreased inefficiency of care, but should not be the driver of health system redesign efforts. The ultimate goal should be to provide high-quality, well-coordinated, clinically appropriate care, and this is the best recipe for long-term health and cost-containment. In particular, for the populations with disabilities (including physical health, behavioral health, etc.) and older adults, the opportunity to meaningfully increase prevention and coordination of care hold the most potential to reduce long-term system costs. The new model of care will succeed to the extent that it improves prevention and care coordination.

For this reason, based on the information we have available to us, at this time we recommend Maryland pursue the managed fee-for-service model (MFFS). A simple summary of our analysis is as follows (and further analysis appears below):

- The MFFS model has a clear upside for the behavioral health population we serve and all dual eligibles – increased investment in prevention and care coordination. It has very little risk of harming their access to providers or needed treatments. The cost-benefit analysis is clearly positive. We support such a model.
- We recognize there may be *potential* virtue in an Accountable Care Organization (ACO) model. However, we cannot fully evaluate an ACO model without a significantly more detailed design. In the abstract, it has some theoretical benefits, but in practice it clearly poses significant risks to the consumers we represent, in large part because providers have not demonstrated their ability to take on risk in the near term. The cost-benefit analysis is totally uncertain. At this point we cannot support the ACO model. However, we recognize it may merit further study and have suggested some ideas for that below.
- The managed care organization model (MCO) has now been piloted by the Medicare-Medicaid Coordination Office in about ten states. Those models would appear to have some virtues, but there is evidence that they have also created a number of problems for

consumers. We do not believe that anyone has identified any significant value add to justify such a transition. We do not support pursuing such a model at this time.

Consumer Priorities

Before further considering the proposed models, we would like to set out two priorities.

First, one of the most consistent themes with all of the duals demonstrations launched in other states has been the size and speed of transitions outpacing preparedness for transitions. This has resulted in enrollment problems, delays in required assessments, difficulties accessing long-standing providers, and other problems for consumers. No matter the model the state chooses (but particularly for ACOs and MCOs), the state must commit to an implementation timeline that is gradual and achievable. The state should err on the side of caution, avoid passive enrollment systems, and engage in extensive up-front education for consumers, caregivers, and providers. For an ACO model, the state must engage in an iterative readiness review process to ensure that providers are ready to bear risk.

Second, whatever model the state chooses (but again, particularly for ACOs and MCOs), the state must rely upon more than vague "incentives," which cannot on their own guarantee improved care systems and consumer protections. The state must create strong minimum standards and infrastructure for prevention and care coordination (and with ACOs and MCOs, may create incentives to use that infrastructure). In MFFS systems, direct payments are made to support care coordination. The state should be explicit about what those care coordination activities should be, including establishing clear performance measures must be designed that will allow for accountability in implementation. The state should also create a program that enables community providers and those who serve this vulnerable population to participate as both patient centered medical homes and the care coordination entities. To be successful for dual eligibles, care coordination should include standards for: regular preventive screenings (including behavioral health, cognitive impairment, and functional status), initial and ongoing assessments, development of care plans, development of care teams, outreach and patient communication, social services coordination, transportation planning, evaluation of home health care needs, and discharge/transition planning. If the state pursues an ACO or MCO model, those coordination activities should be *required*, and not merely incentivized.

In addition, any model of care implemented by the state should have strong standards around core consumer protections, such as:

- Patient-centeredness: This means more than simply surrounding the enrollee with healthcare providers and care managers, but instead is demonstrative of the patient-centered care definition in the HSCRC Advisory Council Report (May 16 Draft). This is predicted on four principles: patient engagement; working with a primary care coordinator; meaningful care; and the patient as the center of the hub, which enables the enrollee to set goals, enlist in joint decision with their caregivers, and ensures they receive meaningful care coordination.
- Enrollee choice: Enrollees should enroll voluntarily, with full knowledge of their options, rather than be assigned to a new health care delivery system via passive enrollment and must be allowed to opt-out at any time..
- Provider continuity: Enrollees should not lose access to trusted providers upon enrollment. This is a well-established problem in MCO transitions, and may also occur in an ACO model..
- Network adequacy: The new model should be transparent as to the network limitations

consumers would face, and there should be standards ensuring all needed provider types are included. We note this is especially critical for MCO and ACO models, since they have less historic experience serving the complex populations in the dual eligible categories of Medicaid.

- Continuity of care: New enrollees should have continuous access to their existing treatment plans, including access to medications, , without the need for re-authorizations, exceptions, or any additional steps.
- Access to care: Enrollees should not be denied *needed* care based on poorly designed incentive structures. MCOs and ACOs on limited global budgets may deny access to needed care because of budgetary pressures. The state must have a system to prevent and monitor such care rationing.
- Risk Adjustment: The state would need to publicly vet the risk adjustment methodology for any new model of care based on a capitation-like payment. We represent vulnerable consumers who would be avoided by ACO (or MCOs) that are not properly risk adjusted.
- Transparency: The system should be transparent and navigable, so that enrollees and their caregivers can understand and effectively engage in the system, enabling them to be self-advocates.
- Care giver inclusion: The new model of care should explicitly allow consumers authority to include care givers in care teams and authorize various levels of care giver decision-making authority.
- Ombuds support: In a MFFS system, the enrollee should have a case manager that effectively acts as an ombudsperson. In MCO and ACO systems, the state must create and fully fund a robust ombudsperson system to support consumers. This has been a very successful component of the duals demonstrations to date.
- Quality: All systems should have strong quality standards, including both outcomes and process measures. However, formal quality measures should not be the sole source of quality evaluation. The state should also use EQRO processes, monitor and report on utilization of services, monitor and report on complaints/appeals filed, and all data should be stratified by race, ethnicity, age, disability status, gender, etc., to identify disparities in care and outcomes.
- Due Process: The state must ensure the integrity of due process standards in any system redesign. MFFS systems tend to create few due process problems, though the state will need to clarify the authority of care coordination entities and any related new appeal bases that may arise. For ACOs, the state will need to publicly detail the appeals system, which includes how and when notice of denials is provided and how appeals proceed. In ACO systems the state will need to consider mitigating strategies such as requirements to provide treatment options in writing or rights to second opinions. In MCO systems, we recommend the state to use the integrated appeals system of the New York duals demonstration as a starting model. Ultimately, an enrollee using an integrated appeals system should be no worse off than they would be in the Medicaid (or Medicare) appeals system alone.
- Social Determinants: The state should specify how the new model of care will help address social determinants that may dramatically impact health outcomes (environment, psychosocial needs, behavior, etc.). At a bare minimum, the state must detail how the Medicaid health care system will connect to and work with parallel social supports systems, such as housing, public health, education, etc. More ideally, the new model should create opportunities to fund supports at the intersection of health and other social needs, such as housing and transportation supports.

ACO Models

As stated above, while we understand the potential value of an ACO model, we believe the idea must be must significantly refined before we can provide meaningful feedback or support the design. Additionally, any move to an ACO system must be done incrementally and with consideration of provider readiness for risk. Before we could support an ACO proposal the state would need to refine many key questions, such as:

- How would risk be placed on providers? We would not a support any model that placed too much risk on providers too quickly. We would also oppose any model that automatically increased risk. Instead, we would recommend an approach in which risk slowly increased only when established benchmarks were hit.
- What is the relationship between the ACOs and managed care plans? We believe the state must detail what (if any) relationship there would be.
- What will be the parameters of ACO networks and network usage policies? We believe the state will have to first explain what providers will be required for ACO inclusion. We would not approve an ACO model unless it was firmly grounded in primary care, and included a full range of supportive providers – including community-based providers specializing in underserved communities, such as community behavioral health providers, Federally Qualified Health Centers, and local health departments among others.). An ACO model that was dominated by hospitals, both in terms of control and receipt of shared savings, and excluded smaller community based providers would be unlikely to be transformative and could have a negative impact on consumers. Once a network policy was established, the state would also need to detail the formal and informal authority will the ACO would have to restrict access to providers. We would not support a model where ACO providers could exert undue pressure on patients to sever long-standing relationships or steer them away from community based providers.
- The state should clarify what the care coordination requirements on the ACO would be. Would the ACO include PMPM payments to support care coordination? If not, what assurances would there be that ACOs actually coordinated care? We would only support an ACO model if it had clear standards around care coordination.
- Prior to engaging in any ACO payment system, the state would need to explain how it would adjust payment based on the acuity of the population. We are very concerned that risk-based ACOs would avoid complex patients, or otherwise target ACOs towards healthy patients and retain dual eligibles in FFS systems.
- The state will need to clearly articulate how this new model of care would interact with (1) the existing Medicaid ACO structures and (2) the all payer hospital reforms. We cannot support an ACO model without understanding the impact on currently enrolled consumers as well as the consequences for how shared savings might be distributed.

We do not believe that Maryland should establish a MFFS model with the presumption of eventual move to the ACO model. If Maryland implements a MFFS model, the results should dictate the move to ACO. If the MFFS model is successful, the MFFS should continue and the state should put all of its efforts into improving that model rather than simultaneously using resources to establish the ACO model. If the MFFS is less successful in improving health outcomes of enrollees, then we could potentially support an incremental approach of phasing in ACO pilots with robust evaluations and eventual comparison of the outcomes to the MFFS program. Over time the state could then shift the expansion towards the model producing the best health outcomes.

<u>Governance</u>

Whatever model chosen, the state should require an on-going governance structure to include: a transparent process with appropriate accountability; a comprehensive evaluation process based on health outcome measures to assess the impact on enrollees, and a structure to capture the results of the evaluation in a timely manner to address issues that arise. Such a model must include opportunities for enrollee and consumer stakeholder input in the design, implementation, evaluation and oversight stages. In addition to an advisory body for the newly designed model of care, important decision points should be discussed in other advisory settings, such as the Maryland Medicaid Advisory committee and the newly formed HSCRC Consumer Standing Advisory Committee.

Conclusion

We look forward to continuing the discussion on the specifics of the model chosen and appreciate the opportunity to provide feedback. We urge the state to continue its transparency in the design process, as this will result in a better model of care with more complete stakeholder buy-in.

Mid-Atlantic Association of Community Health Centers

Duals Care Delivery Workgroup

In order to progress the discussion on model development, Duals Care Delivery Workgroup members are being asked to announce their organization's preference for one of the three models (Managed Fee-For-Service, Dual Eligible Accountable Care Organization, or Capitated Health Plans for Duals). Please send submissions to dhmh.sim@maryland.gov by COB **Monday, June 20th, 2016**. The table below has been created to help your organization compile a response.

Written submissions will help the Workgroup move the discussion along at the June 29th meeting. They will not be used to supplant discussion or dialogue at the meeting on the models. The submissions and an analysis of the submissions will be made available to Workgroup members before the June 29th meeting.

Workgroup members are encouraged to describe their organization's reasons for supporting a particular model in whatever level of detail your organization prefers. There are no formal specifications for this request, though the questions below may help guide you in providing a robust response.

- Do you endorse the idea of phasing from one model to another, and if so, over what spans of time? - Yes, we believe phasing of the models is the most logical choice – beginning with Managed FFS and phasing to a Duals ACO. At this point, I believe that we are too far away to discuss with certainty the timing of a capitation model. We agree with the proposed implementation timeline which would begin with a managed fee-for-service model in 2018 and then transition to a full D-ACO model by 2021.

- Are there any variations or specific features you would propose that would make your preferred model most effective? - We are concerned about the significant number of unknowns in the models. With the Managed FFSD model, there is a statement that "Care coordination entity (CCE) may engage to steer beneficiary toward PCMH, or redirect to a PCMH more suitable to beneficiary's needs." With the current lack of detail about these organizations and who they may be, we are concerned about special interests or other factors unfairly influencing the steering of beneficiaries to particular PCMHs. We would recommend more information be proactively given regarding requirements and oversight for these organizations.

MACHC also recommends that more information about the specific tasks of the CCE and the PCMH regarding care coordination. It seems that much of the true care

coordination efforts will be occurring at the PCMH with no provision for reimbursement for these costs. MACHC recommends a full description of the responsibilities of the CCE and potentially proactive PMPM payments to the PCMH for the care coordination activities which will still occur at the PCMH.

Regarding year end savings bonuses in the Managed FFSD model, it is stated "PCMHs shown to have contributed to surplus **may share** in bonus awards." This too seems to warrant further clarification describing the requirements and oversight of those savings sharing plans in order to ensure equitable distribution to those PCMHs who are generating the savings as a result of their efforts.

There was also mention at least during the workgroup discussions about having the CCEs potentially be responsible for making determinations on prior authorization requests. MACHC again recommends further clarity on who will be making these decisions and the credentials of those decision makers.

Regarding the ACO model, as noted in the presentation, risk adjustment will be a key factor in a successful program. MACHC recommends consideration of incorporating social determinants of health in the process. We recognize that this information is not necessarily available or is incomplete at best, but feel strongly that SDoH is will be increasingly important as alternative payment methodologies and care delivery transformation progresses.

The final concern with the ACO model was mentioned with regard to CCEs above. MACHC recognizes that care coordination efforts are not currently a reimbursable activity but are necessary to successfully reaching the goals of better outcomes at a reduced cost. MACHC recommends proactive PMPM payments be made to PCMHs for their role in care coordination efforts.

- Would your organization and your organization's members engage or participate in the model when implemented? Are there any conditions/caveats in implementation that would increase/decrease the degree of participation or engagement?

It is imperative that the delivery model for the duals aligns with the provisions of the new hospital waiver. It is clear nationally that value-based payment models driven by physician innovation have been the most successful in achieving the goals of the Triple Aim. In this regard, there needs to be opportunity for physicians to participate and organize PCMH and ACOs and for physicians to be able to participate in more than one.

- What questions still need to be answered to strengthen confidence in the viability of the decision that ultimately must be taken?

1. What will be approval process for CCE or ACOs allocation of cost/bonus sharing for PCMH?

2. How will social determinants of health be factored into risk stratification?

3. Attribution could be very messy, can we more specifically define?

Thank you for your active participation in the workgroup to date. We look forward to receiving your remarks and to continuing the dialogue at our next meetings.

QUESTION: **Which of the 3 major models presented does your organization prefer for Maryland's dual eligibles?**
Mid-Atlantic Association of Community Health Centers Please see narrative above.

QUESTION:

Which of the 3 major models presented does your organization prefer for Maryland's dual eligibles?

Joint Answer from Scott Rose on Behalf of Sheppard Pratt Health System and Lori Doyle on Behalf of CBH

We strongly urge DHMH to adopt the Managed Fee-for-Service Model (MFFS) for the Duals Care Delivery Initiative, with the requirement that community behavioral health agencies be permitted to act as Regional Care Coordination Entities (RCCEs) and Patient Centered Medical Homes (PCMHs) for individuals with serious mental illness (SMI). Our position has also been officially endorsed by the Community Behavioral Health Association of Maryland (CBH) which represents 53 community behavioral health agencies.

I. **Reasons for Supporting MFFS Model.** We advocate for this model for the following reasons:

A. **It provides the best opportunity for community behavioral health agencies to act as the central care coordination entity**. Evaluative research regarding the Missouri Health Home Program has demonstrated that community mental health agencies (CMHAs) are the entities best positioned to be the medical home for adults with SMI. There are several reasons for this, many of which recognize that the major barriers to the physical health of people with SMI emanate from the mental illness, including but not limited to lack of skills and motivation to: i) access primary care; ii) comply with treatment recommendations; iii) maintain healthy lifestyles; and iv) manage co-occurring chronic conditions:

1) CMHAs have the expertise to teach these skills and facilitate this motivation.

2) Most importantly, CMHAs have the most frequent contact and the closest relationships with the consumers, both of which can be uniquely leveraged to help consumers develop the skills and motivation most effectively.

3) CMHAs provide or directly coordinate more of the consumers' basic services than any other entity, so they are in the best position to perform care coordination in the most holistic and effective manner. .

B. **Achievement of the Triple-Aim goals is best achieved when the care coordination entity is in the greatest leadership position and has the most oversight and responsibility for all aspects of the care.** In an ACO or Managed Care model, the CMHAs will continue to be a small piece of the network, rather than

the central care coordination entity. While DHMH could stipulate that ACOs could be formed and led by CMHAs, it is not feasible to expect this to happen given the aggressive timeline of the Initiative's start-up and the many eligibility requirements that may evolve.

C. **It thwarts the effectiveness of care coordination to have more than one care coordinating entity for individuals with SMI.** Since CMHAs are already doing care coordination for the SMI population, it would be duplicative and overlapping to place another care coordination entity on top. This duplication doesn't just waste money; it also creates uncertainty, ambiguity, and fragmentation for individuals who already struggle with internal and external uncertainty, ambivalence and fragmentation.

D. **The MFFS model is the most consistent with DHMH's newly implemented Chronic Health Home Option.** This model most effectively leverages the existing infrastructure and provider network within the Medicaid Health Home Program for individuals with SMI who are eligible. For those people, their Health Home agencies would be in the best position to act as the RCCEs or PCMHs. The Duals Initiative can offer these agencies additional resources, incentives, and oversight to serve the Dual population even more effectively.

E. **Too Many Other Negative Aspects of the Other Two Models**. In its comments, MHAMD articulates very well the numerous other negative aspects, risks and consequences of the ACO and Managed Care Models.

II. <u>Additional Thoughts</u>

A. We strongly discourage the idea of phasing from one model to another. Systems change is hard enough to implement, and always fraught with unforeseen consequences. Doing systems change twice, exponentially increases the challenges and the consequences, and dilutes the limited resources, focus, and energy of stakeholders.

B. Variations of the Model.

1. As noted, we urge the requirement that CMHAs be permitted, in fact, encouraged to be RCCEs and PCMHs for individuals with SMI. Of course, we understand that a particular CMHA could not act as both the RCCE and PCMH for the same consumer.

2. We would support CMHAs doing modest risk sharing as either RCCEs or PMCHs– starting with shared savings, and then after the first or second year, adding the sharing of negative risk.

C. **Participation**. Many CBH agencies would be willing to participate when this model is implemented, including Way Station and Mosaic.

DHMH SIM -DHMH- <dhmh.sim@maryland.gov>

Reminder: Duals Care Delivery Workgroup - Feedback on Straw Models

Fredia S. Wadley -DHMH- <fredia.wadley@maryland.gov> Wed, Jun 22, 2016 at 7:25 AM
To: DHMH SIM -DHMH- <dhmh.sim@maryland.gov>

I apologize. I thought my response had already been sent.

The ACO model

This model holds the best potential for achieving the goals for duals.

One comment also needs to be stated. Throughout the process statements have made clear that clinical services need to be integrated with community social services. I also believe that no plan can duplicate these community services and produce a savings. However, my team is working hard to provide gap services through Senior Care and I have just had to add an RN to meet the case management needs. I used county funds to help fund this position. If hospitals fully utilized all social and health community services, for their complex patients with many social needs, local agencies would not always have the staff to meet the demand. Once we proved to the hospitals that we can manage these cases, they refer more often (as they should).

With the ACO model the plan will have incentives to select the providers to do the best job in the care coordination area which could mean local agencies could be reimbursed for services. My next concern is having the data to demonstrate the value of services. Currently I am asking for modifications of our system to collect this data to document the level of need, the services provided, and the outcomes. It will not be the best software for this purpose. ACOs are more likely to purchase such software and have their contractors use it. This would help local service agencies to participate with care coordination.

Fredia Wadley

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June 28, 2016

Ms. Shannon McMahon
Deputy Secretary, Health Care Financing
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201

Dear Deputy Secretary McMahon,

Thank you for the opportunity to provide feedback regarding the three models currently under consideration by the Dual Eligible Workgroup convened by the Department of Health and Mental Hygiene (DHMH). I also want to take this opportunity to thank you and your staff for all of the work that has gone into this process.

Workgroup members, and the organizations that they represent, have been asked by DHMH to indicate a preference for one of three models currently being considered – Managed Fee For Service, Duals Accountable Care Organization (D-ACO), and Duals Capitated Health Plans. Although substantial questions remain regarding the financial and operational implications of each model, the University of Maryland Medical System (UMMS) supports additional study and due diligence of the D-ACO model. UMMS believes that the D-ACO model, at least in concept, is better positioned to potentially be successful because:

1. The D-ACO model aligns all providers within the D-ACO network. Given the long term care and behavioral health spend of this population, alignment with a broader network of providers will be key to success.

2. The D-ACO model can be built upon existing infrastructure. The majority of hospitals within the state have invested in establishing the infrastructure necessary to perform under the Medicare Shared Savings Program (MSSP). These MSSP investments can be leveraged to provide an integrated network of care for dual eligible individuals.

UMMS would also like to express its concerns regarding the Managed Fee for Service model. UMMS does not believe that this model will ultimately be successful, with success being defined by better care for patients at lower cost for the broader health care system, for the following reasons:

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1. Dually eligible individuals often do not have a primary care medical home that this model is premised upon enhancing. As many of these individuals engage with the health care system outside of a medical home, the model will be less likely to be able to effectively engage with these individuals.

2. Care coordination provided by a 3rd party entity that is not directly integrated with the provider community will not be successful.

In order to decide whether or not to participate in a D-ACO model, UMMS needs to better understand the implications for the Global Budget Revenue system and how this model would interact with other payment models currently being proposed by the Centers for Medicare and Medicaid Services and the Health Services Cost Review Commission. It would also be helpful to have more recent data with which to make a more informed decision.

Thank you again for the opportunity to provide feedback on the models under consideration by the workgroup. If you have any questions, please do not hesitate to contact me at (410) 562-3682 or pdooley@umm.edu.

Sincerely,

Patrick Dooley
Senior Director, Population Health Management