Maryland's State Innovation Plan –
A Community-Integrated Learning health System for Maryland
Advocates Comments
Submitted 15 April 2014 & Re-Submitted 28 April 2014 With Additional Signatories

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

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

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Maryland Coalition of Families for Children's Mental Health
Maryland Citizens' Health Initiative
Maryland Disability Law Center
National Alliance on Mental Illness (Maryland and 12 County Chapters)
National Council on Alcoholism and Drug Dependence

Primary Care Coalition of Montgomery County
Progressive Cheverly
Public Justice Center

Additional signatories (post 15 April 2014)

Baltimore Healthy Start
Institutes for Behavior Resources
League of Women Voters of Maryland
Maryland Association of Core Service Agencies
Maryland Association of Resources for Families and Youth
Maryland Chapter of the American Academy of Pediatrics
Maryland Clinical Social Work Coalition of the Greater Washington Society for Clinical Social Work
Maryland Environmental Health Network
Unitarian Universalist Legislative Ministry of Maryland
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Introduction

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

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

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

Each of these initiatives presents distinct challenges, some known and some unknown, as we have so recently learned from the first ACA-mandated Open Enrollment period. Our comments are informed by that experience and by our own work across the full and complex landscape of health care reform. We also build upon the comments that the Coalition originally submitted October 28, 2013. In those we recommended that the expertise and experiences of consumer advocates be incorporated throughout the planning and implementation process. We also proposed six core principles and proposed strategies to implement them[1].

The comments that follow are grouped in two specific buckets:

I. Areas that appear not to have been adequately addressed in the proposed plan, including:

A. Consumer Perspective

B. Consumer Protections

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

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

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

A. Consumers:
   1. Education and engagement
   2. Choice and access to services and supports

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

C. Definition of Target Populations

D. Quality and Cultural Competence

E. Adequate Safeguards for Vulnerable Populations

F. Program Evaluation

I. Comments and Recommendations: Areas Not Adequately Addressed

A. Consumer Perspective:

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

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

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

B. Consumer Protections:

In this area we have two specific concerns:

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

C. Governance and Oversight, and Legal Issues:

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

- The CIMH model reflects a "siloed approach" that we believe led to many of the failures with the MHBE's development of Maryland Health Connection where the lack of effective integration of operations became so apparent. In that regard, **we recommend the establishment of a central oversight group for all state-based health care reform initiatives**. This would support the goal of effective and efficient integration of the multiple initiatives. Central to this would be a **role for those who represent the needs and interests of consumers**. An example for such a model comes from Connecticut where the Governor has established a Health Care Cabinet[2]. This is somewhat analogous to Maryland's Health Care Reform Coordinating Council, but it provides for a strong and on-going consumer voice. In this regard, the Connecticut construct includes a Healthcare Innovation Steering Committee and a Consumer Advisory Board. These oversee the work of the Program Management Office.[3] We strongly recommend that Maryland consider such an approach.
- There is also a **lack of clarity around the use of the HSCRC Medicare Waiver workgroups**. The workgroups are included on the diagram of CIMH implementation and oversight, but there is very little discussion in the proposal of how the workgroups would be used in the CIMH implementation process. In addition, the HSCRC currently has authority over the Medicare Waiver alone. Therefore, it is unclear what the jurisdictional authority would be in regard to the use of these workgroups for the CIMH.
- The proposal, as written, also does not appear to take into account the fact that the **current Medicare Waiver ends in five years**. It is our understanding that the HSCRC will then transition to a broader waiver that puts all providers, not just hospitals, into a global budget. The development of that proposal will begin in the

[2] http://www.healthreform.ct.gov/ohri/lib/ohri/HealthCareCabinetMemberChart.pdf
[3] http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/ct_ship_2013_12262013_v82.pdf

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

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

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

A. Consumer Issues:

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

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

3. **Provider Choice:** Critical to empowering consumer choice is an effort to ensure that primary care and behavioral health providers are supported in their ability to participate. Consumers with established provider relationships should not be compelled to change providers in order to participate in the CIMH. HSIA must work to remove barriers for providers to participate including how to ensure that interested providers who do not currently have electronic medical record capabilities can participate.

B. Definition of Target Populations

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

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

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

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

Three areas should be addressed in a more comprehensive manner:

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

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

D. Quality and Cultural Competence:

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

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

E. Adequate Safeguards For Vulnerable Populations:

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

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

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

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

F. Program Evaluation:

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

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

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

Conclusion

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

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

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

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

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

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