Appendix H. Summary of Public Comments Received

Introduction

The Health Care Reform Coordinating Council (HCRCC) solicited public comments on two key questions: (1) What are the critical decisions for Maryland and the HCRCC to consider in implementing reform? and (2) What workgroups should be convened? Approximately 160 comments were submitted via the HCRCC website from individuals, organizations, and coalitions of organizations. Organizations and coalitions which submitted comments are listed at the end of this document. While comments addressed a broad range of issues, there was concentration on some major themes. There is a high degree of overlap among these different topics, pointing to the need for coordination among the HCRCC workgroups. This summary is an attempt to capture the essence of these comments, but necessarily it may miss some of the emphasis and nuance of the originals.

Workforce Capacity

Maryland's health care workforce capacity was a major issue raised. As reform increases health care coverage, it will increase demand for services. Primary care in particular received attention. Reimbursement, licensure, scope of practice, administrative simplification of insurance, and education incentives were suggested as potential tools for increasing capacity. Inadequate levels of reimbursement for primary care physicians, and the lack of reimbursement for components of a visit such as taking a comprehensive medical history, were cited as key contributors to the shortage. It was noted that reimbursement rates in Maryland are low relative to other geographic areas. Barriers to recruitment and retention were also identified, including the administrative burdens of insurance. It was noted that primary care shortages are pronounced in areas with higher proportions of racial and ethnic minorities and lower income individuals. Racial and ethnic diversity is needed in the primary care workforce.

Several comments suggested the need to reinstate Maryland's "primary care plan," which could help meet the need for better information on the demographics of shortages and help Maryland position itself for federal health center expansion funding. The issue of understanding if physician panels are open, not just whether physicians are in an area, was provided as an example of the need for better data.

Commenter's recommended key roles for physician assistants, nurse practitioners, certified nurse midwives, pharmacists, and federally qualified health centers (FQHCs) in bolstering the primary care workforce. Scope of practice, reimbursement, adequate staffing, and workplace safety were cited as issues needing attention in these areas. It was suggested that improving efficiency in community health clinics could help retain primary care providers in underserved areas.

Many commenters mentioned the patient centered medical home model. It was lauded as a path to elevating primary care, with the caveat that it is not a panacea and will need adequate reimbursement to match its new responsibilities for primary care physicians. The characteristics of Maryland's provider community—with most physicians in individual or small practices—create challenges for some of the potential solutions, including the patient centered medical home initiative as well as health information technology (HIT).

Several commentators discussed the need to take a long term view of a solution, by building the pipeline of providers through education incentives, and engaging institutes of higher education and targeting students even earlier, in secondary education. Loan repayment programs were suggested as a potential tool. It was suggested that financial aid and scholarship support be tools to attract a diverse health care workforce, and primary care residency slots in underserved areas be developed. In addition, training programs should target low-income workers.

While most comments on workforce focused on primary care, other provider types were raised. These include specialist physicians, dentists and dental hygienists, medical and clinical laboratory technologists, respiratory therapists, surgical technologists, behavioral health providers, occupational therapists, registered dieticians, occupational therapists, developmental disability providers, rehabilitation counselors, other allied health professionals, and public employees.

Major themes were similar to those raised regarding primary care workforce, and included the need for higher reimbursement levels to make Maryland more in line with other states. In addition, scope of practice, workplace safety related to staffing, coordination among providers, the need to address defensive medicine, medical malpractice, and tort reform, and access in rural areas, particularly access to specialist physicians. A specific issue raised was the need for providers to be trained in serving individuals with disabilities. It was recommended that Maryland take advantage of new federal funding for training of direct care workers.

A HCRCC health care workforce workgroup will address issues identified in public comments. It will address primary care as well as the broader workforce. It was suggested that the workforce workgroup include representatives from hospitals, private practice, professional societies, community clinics, educators, primary care residency programs, employers of health care providers, and local health departments.

Benefit Design

Multiple aspects of benefit design were highlighted in comments. The most frequently raised topics included behavioral health, other services, and new models of service delivery to promote prevention and chronic care management.

- **Behavioral Health**

  Behavioral health was the topic of many commenters' submissions. Achieving mental health parity through benefit design and oversight was a key issue. Recommendations were provided regarding the addition of addiction treatment services to the essential benefit package in individual and small group market plans, and for Medicaid. Concerns were raised about cuts to the behavioral health system. Several commenters addressed the continued need for a behavioral health safety net to fill in the gaps in Medicaid and private coverage. Other issues raised included the need for a health home that integrates behavioral health with primary care and other services, the need for recovery oriented systems of care, the importance of confidentiality balanced with clinical coordination, the importance of culturally appropriate behavioral health services, the relationship between behavioral health and emergency department and inpatient use and costs, and the need for

behavioral health services among returning military personnel. Commenters recommended that behavioral health representatives be included in each of the different workgroups. Because workgroups are open to the public, representatives from the behavioral health community are welcome to participate in all of the different workgroups. It was also suggested that the court system be involved given its role in referral to behavioral health services.

A HCRCC workgroup on the safety net and special populations will address issues related to the behavioral health safety net. Because the federal government has not yet issued specific benefit design rules, it is premature to address some of the issues raised. Once the federal benefit guidance is released—likely in 2011—it will be timely to pursue specific benefit design issues. Some of the issues identified fall within the jurisdiction of existing initiatives to improve behavioral health service delivery within Maryland, and the HCRCC will share the public comments with those existing initiatives.

- **Other Services**

Behavioral health received much more attention from commenters than any other single category or services. However, the need to pay special attention to other services was raised. The next largest category of services identified was community based long term services and supports for older adults, adults with disabilities, and children with special health care needs. Federal reform creates a number of new opportunities to shift from institutional to community based services. Several commenters encouraged Maryland to take advantage of new federal opportunities for coverage of home and community based services. The need to balance safety and oversight of home and community based services was raised. The Independence at Home initiative was one specific model of service delivery mentioned. Ease of implementation of the new federal voluntary long term care program CLASS was also raised.

While most emphasis was on community-based long term care services, a few comments focused on the need to increase funding for institutional services, particularly State residential centers. In addition to long term care, commenters advocated for adequate coverage of a broad range of different services. Services identified include psychological and neuropsychological testing, autism-related services such as developmental screenings and training for families, HIV testing, dental services (particularly for older adults), rehabilitation counseling, broadly defining prevention to include habilitative and rehabilitative services, and using State residential centers to provide outpatient services and respite. End of life care, the promotion of advance directives, and preventable trauma (such as home modification to reduce the risk of broken hips) were identified as areas where quality improvement could also be associated with cost savings. It was also recommended that Medicaid offer the current package of benefits to new enrollees. One set of comments recommended that any defined benefit should cover a broad range of services, and benefits should be structured to encourage innovation and support choice.

A large number of commenters advocated for prohibition of government funding for abortions, ensuring the Hyde Amendment is applied to the use of all federal funds;

conscience protections for providers, insurers, personnel, employers; prohibition on funding for embryonic cell research; and law and policies to respect rights, especially of patients who are elderly, terminally ill, or medically fragile.

Services related to long term services and supports will be addressed by DHMH's existing long term care reform workgroup, as suggested by some commenters. As mentioned above, because the federal government has not yet issued specific benefit design rules, it is premature to address some of the issues raised. Once the federal benefit guidance is released—likely in 2011—it will be timely to pursue specific benefit design issues.

- **Prevention and Chronic Care Management**

  Many commenters highlighted the opportunity to promote wellness, prevention, and chronic care management through new service delivery models. Medical home models were a common theme in this area, including health homes in Medicaid. Many of these comments were closely tied to workforce issues. Components of new delivery models mentioned include team-based care, consumer-focused care, care coordination particularly for individuals with complex health needs or post-hospitalization, standards of care, and data for management and quality reporting. Provisions of the federal law create incentives for plans participating in the exchange to undertake care coordination and chronic disease management. Commenters raised the need to address growing rates of obesity and lifestyle issues, and suggested a role for individual responsibility. It was suggested that by targeting social, environmental and behavioral patterns and adopting evidenced based prevention practices, Maryland can promote health behaviors, reduce premature death, disability, and disease, and bend the cost curve on health care.

  The Maryland Health Quality and Cost Council is already addressing some of the issues raised, through the implementation of the patient-centered medical home demonstration project and other wellness and prevention strategies. In addition, a HCRCC workgroup focused on delivery system changes will maximize the use of new reform tools to improve quality and contain costs. It will coordinate with the Health Quality and Cost Council to prevent duplication of efforts.

Health Insurance Market Reforms

Multiple comments can be organized under the category of health insurance market reforms. Some of these focused on costs and affordability, including recommendations for cost containment initiatives, efforts to maintain the affordability of insurance for small businesses, and the affordability of premiums and cost sharing for individuals, particularly in light of the growth of high deductible plans. There was also a recommendation to increase the transparency of costs to consumers.

Other comments focused on compliance and oversight, including recommendations to increase regulation of commercial and self-insured plans, and physician-owned medical facilities. Several commenters discussed the need to ensure that coverage is meaningful and meets health care needs. The need to mitigate adverse selection was also raised, for example by introducing a

stronger personal coverage mandate in Maryland. Commenters suggested the market could be improved for consumers by simplifying referral processes.

Some comments were more technical in nature, including the need to make sure Medicaid managed care organization rates accurately reflect the experience of new expansion populations, that medical loss ratio standards avoid unintended consequences, and that rate review requirements are driven by actuarially based review and relevant experience and are assessed against the federal law's "reasonable" standard.

Other comments addressed the importance of the high risk pool, the need to synchronize state laws with federal reforms, and the effect of employer mandates and penalties on developmental disability providers who employ people. One commenter stated the need to avoid including unrelated products in the scope of new insurance requirements.

The HCRCC workgroup on the exchange and insurance markets will address many of these issues.

Payment Reforms

Payment reforms such as bundled payments and incentives for providers were identified as essential to new delivery models. Principles of paying for value, and value based insurance design were specifically noted. Bundled payments were recommended as a method to increase efficiency of care and reduce waste and duplication, but it was also pointed out that these approaches need to be carefully designed, balancing payments to hospitals versus physicians. The new option to form Accountable Care Organizations with shared savings was identified as an opportunity.

Commenters addressed the need for cost containment initiatives. It was recommended that the HCRCC focus on the core clinical drivers of health care, looking to emergency rooms to understand the drivers. Key drivers identified include end of life care, addiction, chronic care and special needs, preventable trauma, mental health, and obesity and lifestyle issues. The new Center for Medicare and Medicaid Innovation is designed to test innovative payment and delivery arrangements to improve quality and reduce costs. It was suggested that Maryland be active in these types of pilots, particularly with Healthcare Innovation Zones.

Modernization of Maryland's Medicare waiver for the all-payer hospital system was cited as a payment reform issue. It was recommended that the waiver be updated to move the locus of health care toward outpatient care and less costly environments. It was noted that clarity is needed on how new payment options will interact with the Medicare waiver.

Stakeholders have been convened to discuss whether changes to the all-payer waiver are needed. An initial report is anticipated in November. The HCRCC workgroup on delivery system changes will address other payment reform issues raised, while coordinating with the efforts around the Medicare waiver as well as the Health Quality and Cost Council.

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Health Information Technology (HIT)

HIT was an issue that was raised multiple times. Commenters stated HIT could help improve quality by increasing care coordination and contain costs by reducing duplication. It was suggested that ERs are a good place to begin HIT work. Several commenters raised the theme that HIT is only helpful if it's used in a meaningful way. The complexity of different systems, different templates for data entry, the risk of mis-entering data, and the steep learning curves associated with each new system are caveats pointing to the need for standardization and the involvement of users in design. The use of individual identifiers and the need for confidentiality was raised.

Although HIT holds much potential, its costs were identified as a barrier for physicians. Multiple commenters stated the need for financial support and front-end incentives for physicians to adopt HIT, particularly in Maryland's many individual and small practices. It was recommended that the challenges of implementing HIT in the primary care setting receive special attention. Commenters encouraged the HCRCC to work to roll back federal implementation timeframes and penalties associated with the adoption of HIT.

HIT is relevant to government agencies as well as health care providers; several commenters described the inadequacy of the State's MMIS and CARES systems.

The Maryland Health Care Commission currently oversees HIT initiatives in Maryland to adopt electronic health records and establish a health information exchange. Issues raised in public comments will be shared with these existing efforts. HIT infrastructure that is more specific to entry to coverage and the exchange will be discussed in those workgroups.

Safety Net

As discussed above, commenters identified a continued need for a behavioral health safety net to fill in the gaps in Medicaid and private coverage. Other commenters addressed the need for a safety net for populations for whom coverage expansions would not apply, such as undocumented immigrants, or those who would have a five-year waiting period, such as some lawfully present immigrants. It was suggested that some aspects of the safety net could result in cost savings, for example by preventing costs of premature births by extending coverage of prenatal care to undocumented women. The need to protect safety net providers and the role of FQHCs was raised.

Several comments related to local health department (LHD) operations were closely related to safety net issues. Variation in LHD services by jurisdiction creates some challenges. Key public health services were described as integral to implementation of health reform. These include monitoring health status, diagnosing health problems and environmental hazards, mobilizing community partnerships, developing policies and plans to support individual and community health efforts, enforcing laws and regulations, linking people to services, assuring a competent workforce, evaluating, and researching. A need was identified for enhanced communication and coordination among LHDs, community health centers, and private practices serving the uninsured. The swine flu was provided as an example of the need for greater public health and private practice communication. Commenters stated that public/private communication

regarding service delivery and program eligibility is important across the delivery system, not just within the safety net, and especially for pediatric services. In order for Maryland to compete for federal health center funding, it was suggested the HCRCC foster active dialogue between the State and FQHCs.

The HCRCC safety net and special populations workgroup will address issues raised in this area. It was recommended that LHDs participate in workgroups. Because workgroups are open to the public, representatives from LHDs are welcome to participate in all of the different workgroups.

Exchange

The exchange is a major new component of health reform, and a number of different questions and recommendations related to its development were raised. Topics raised from very general to very specific, and addressed the structure and responsibility of the exchange; which plans, employers, and consumers would be allowed to participate; variation of insurance products inside and outside of the exchange; affect on small businesses; and role of third party administrators. Examples of questions include: Who will run the exchange? What plans will be selected for the exchange? How will products vary inside and outside the exchange? Will there be separate exchanges for the individual and small group markets? Will Maryland's benefit mandates apply to exchange products? Will individuals who cannot afford employer sponsored insurance have access to coverage through the exchange? How to encourage products that emphasize evidence-based treatment and healthy lifestyles?

Small businesses had questions about how the exchange would impact business, how eligibility and tax credits would be coordinated, and how responsibilities would be divided between employers and the exchange. Employers cited their need to be educated so they could provide information to employees; exchanges would need to be set up ahead of time to have the required information.

The exchange is viewed by some as an opportunity to increase transparency and simplify insurance for consumers by standardizing insurance products and increasing their access to web-based information. Others recommended that the exchange include as many insurance products and options as possible. There were recommendations for and against allowing large employers into the exchange. It was recommended that purchasing power be aligned within the exchange,

public programs, and public employees/retirees; that a public option be available in the exchange; and that Maryland develop the CO-OP option.

It was suggested that the exchange be designed in the context of the broader market, with the same rules inside and out, and rules/incentives for continuous coverage. Another design element suggested was the need to manage risk and adverse selection through a risk-adjustment mechanism.

The need to track enrollment across the exchange and Medicaid was identified, as well as need for IT to support this and other operations.

These and other issues will be addressed by the HCRCC workgroup on the exchange and insurance markets.

Entry to Coverage and Outreach

Several commenters identified the need to simplify processes to gain entry to coverage and maintain seamless coverage. The complexity and cumbersome nature of current Medicaid eligibility and redetermination processes was cited. It was stated that LHDs have a unique role in helping Medicaid consumers navigate the system.

Recommendations related specifically to Medicaid included expanding Medicaid eligibility to the new income levels as soon as possible, rather than waiting until 2014. Passage of an alcohol tax was suggested as a revenue source to fund this. Other Medicaid eligibility suggestions include introducing presumptive eligibility and continuous enrollment.

Multiple commenters addressed the need for outreach and education on new coverage options. Commenters recommended that outreach target local communities and employers as well as consumers. The example of past success of radio ads featuring Governor O'Malley and football stars was provided. The point that outreach needs to be culturally and linguistically sensitive was also made. The new coverage model needs to work for vulnerable populations least likely to enroll.

A HCRCC workgroup will address issues around seamless entry into coverage. Another HCRCC workgroup will work on outreach and education efforts for health reform. Whether Maryland creates new revenue sources and chooses to expand Medicaid coverage earlier than federal reform are budget and policy issues to be addressed in the Governor's budget and considered by the General Assembly.

Cross-Cutting

Commenters identified many cross-cutting issues that did not fall into one of the major themes above. These include:

- Need to address racial and ethnic health disparities;
- Needs of individuals with disabilities;
- Needs of vulnerable populations;
- Maintenance of employer sponsored insurance;
- Pursuit of new federal funding opportunities to support the costs of reform;
- Maryland's active participation and representation in federal rulemaking and national initiatives;
- Increased efficiency of government;
- Public health system capacity and population health goals;
- Balance of local and state infrastructure;
- Coordination and communication between the public and private sectors;
- Mobilization of community-based organizations, faith-based organizations, and employers to promote access and wellness;

- Access and prevention in rural communities;
- Effective use of data for planning, evaluation, and improvement; and
- Need for input from front-line health care workers, as well as State and local public health leaders;
- Workplace bullying;
- Changes to the REM program;
- Children with special health care needs transitioning to adult systems;
- Desire to minimize taxes; and
- Choice and wait time for developmental disability services;

Attention to many cross-cutting issues will be part of the charge to each of the workgroups or referred to the appropriate agency to consider.

Coalitions and Organizations That Submitted Comments

All together over 160 comments were received via the HCRCC website, some from individuals representing coalitions and organizations and others representing themselves. Below is a list of coalitions and organizations that provided comments.

- Coalition of Maryland State Medical Society, Maryland Chapter of the American Academy of Pediatrics, Maryland Academy of Family Physicians, Maryland Chapter of the American College of Physicians, Mid-Atlantic Association of Community Health Centers, and Maryland Hospital Association
- Coalition of The Legal Aid Bureau, Inc., Maryland Disability Law Center, Public Justice Center, and Homeless Persons Representation Project
- Access Carroll
- Advocates for Children and Youth
- AFL/CIO, Maryland State and District of Columbia
- Alliance, Inc.
- America's Health Insurance Plans
- American Academy of Home Care Physicians
- American Cancer Society Cancer Action Network
- Anne Arundel Health System
- Arc of Maryland
- Atlantic General Hospital
- Baltimore County Association of Senior Citizens Organizations, Inc.
- Baltimore Medical System
- Baltimore Substance Abuse System, Inc.
- CareFirst
- Casa de Maryland
- Community Behavioral Health Association of Maryland
- Community Health Integrated Partnership
- Commission on Rehabilitation Counselor Certification with the Council on Rehabilitation Education
- Doctors for America

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- Drug Policy and Public Health Strategies Clinic of the University of Maryland School of Law
- Evangelical Lutheran Church in America
- Health Care for All! Coalition
- Health Care for America Now with Progressive Maryland
- Health Care for the Homeless
- HMS
- Johns Hopkins University School of Nursing
- Kaiser Permanente of the Mid-Atlantic States
- Kelly & Associates Insurance Group
- Knott Mechanical, Inc.
- LifeBridge Health
- LifeSpan Network with the Maryland Association of Adult Day Services
- Maryland Addiction Directors Council
- Maryland Alliance for the Poor
- Maryland Association of Community Services
- Maryland Association of Core Services Agencies
- Maryland Association of County Health Officers
- Maryland Association of Nonprofit Organizations
- Maryland Catholic Conference
- Maryland Chapter of the American Academy of Pediatrics
- Maryland Citizen's Health Initiative
- Maryland Hospital Association
- Maryland Nurses Association
- Maryland Occupational Therapy Association
- Maryland Senior Citizens Action Network
- Maryland Women's Coalition for Health Care Reform
- MD/D.C. Chapter of the National Academy of Elder Law Attorneys
- MedChi
- Medicaid Matters! MD
- Medstar Health
- Mental Health Association of Maryland
- Mid-Atlantic Association of Community Health Centers
- Montgomery County Department of Health and Human Services
- NCADD-Maryland
- People on the Go of Maryland
- People's Community Health Center
- Pharmaceutical Research and Manufacturers of America
- Priority Partners
- Restaurant Association of Maryland
- SEIU, Maryland/DC Region
- St. Luke's House, Inc.
- United Seniors of Maryland

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- UnitedHealth Group
- University of Maryland, College Park
- University of Maryland Division of Community Psychiatry
- University of Maryland, Office of the President
- Worcester County Health Planning Advisory Council
- Workforce Tactix, Inc.