Improving Care Delivery for Maryland's Dual Eligibles

Advisory Council Meeting

September 12, 2016

Overview

- Background on Dual Eligibles
- Overview of Proposed Model
- Timeline
- Linkages with the All-Payer Model, Primary Care Strategy and others

BACKGROUND

SIM Project

- Maryland received a design grant through CMMI's State Innovation Model (SIM) program.
- There are three main project components:
  - **Dual Eligible Model;**
  - Skilled Nursing Facility Connectivity; and
  - Population Health Planning.
- CMMI has insisted from the outset that the duals model be integrated with the All-Payer Model.

The Dually-Eligible

- This project focuses mainly on Maryland's ~73,000 citizens* who receive full benefits under both Medicare and Medicaid.
- Average age: 66 years
- Majority demographic: Aged, blind and disabled
- Major cohorts:
  - Individuals residing in nursing facilities
  - Individuals receiving home- and community-based long-term services and supports (LTSS)
  - Individuals residing in the community without LTSS

** Excludes the I/DD population and Medicare Advantage enrollees*

The Dually-Eligible

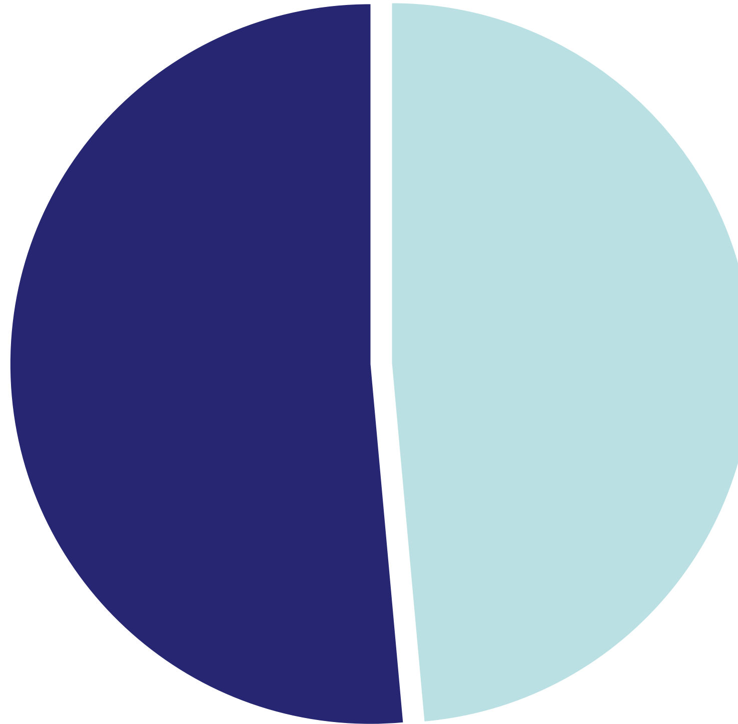
	Population Count		Medicaid	Medicare	Total
Dual Eligibles Population Cohorts CY 2012	Person-Months	%	PMPM	PMPM	PMPM
Nursing Facility	136,663	19%	$ 5,586.79	$ 2,951.30	$ 8,538.09
HCBS - Under 65	14,768	2%	$ 3,388.96	$ 1,677.00	$ 5,065.96
HCBS - 65 and Older	59,011	8%	$ 2,693.94	$ 1,199.98	$ 3,893.92
HCBS - Total	73,779	10%	$ 2,833.06	$ 1,295.46	$ 4,128.53
Community Dwelling - Under 65	265,380	37%	$ 454.66	$ 1,244.50	$ 1,699.16
Community Dwelling - 65 and Older	235,421	33%	$ 302.31	$ 1,147.13	$ 1,449.45
Community Dwelling - Total	500,801	70%	$ 383.04	$ 1,198.73	$ 1,581.77
All - Total	711,243	100%	$ 1,637.07	$ 1,545.52	$ 3,182.59

Total Cost of Care for the Duals

Medicaid
$1,164,357,094
51%

- Medicaid covers long-term services and supports (LTSS) – long term nursing facility stays and home and community based services (HCBS).
- Medicaid pays Medicare deductibles, coinsurance and copayments for dual eligibles when they qualify, as well as Medicaid services not covered by Medicare.

CY 2012 - $2.264 billion



Medicare
$1,099,237,200
49%

- Medicare-covered services include primary, acute, and post-acute care services such as physician, hospital, pharmacy, short-term skilled nursing facility care and home health services.

Total Cost of Care for the Duals

Example: When Medicare payment ends, Medicaid payment often takes over, especially in the post-acute space.

- Medicare beneficiaries are being discharged earlier than before (would be even earlier if Maryland is able to waive the three-day rule):
- 70 percent of full-benefit duals were eligible for Medicare before obtaining Medicaid coverage, meaning that their health needs caused them to spend down and become eligible for Medicaid.

THE DUALS MODEL

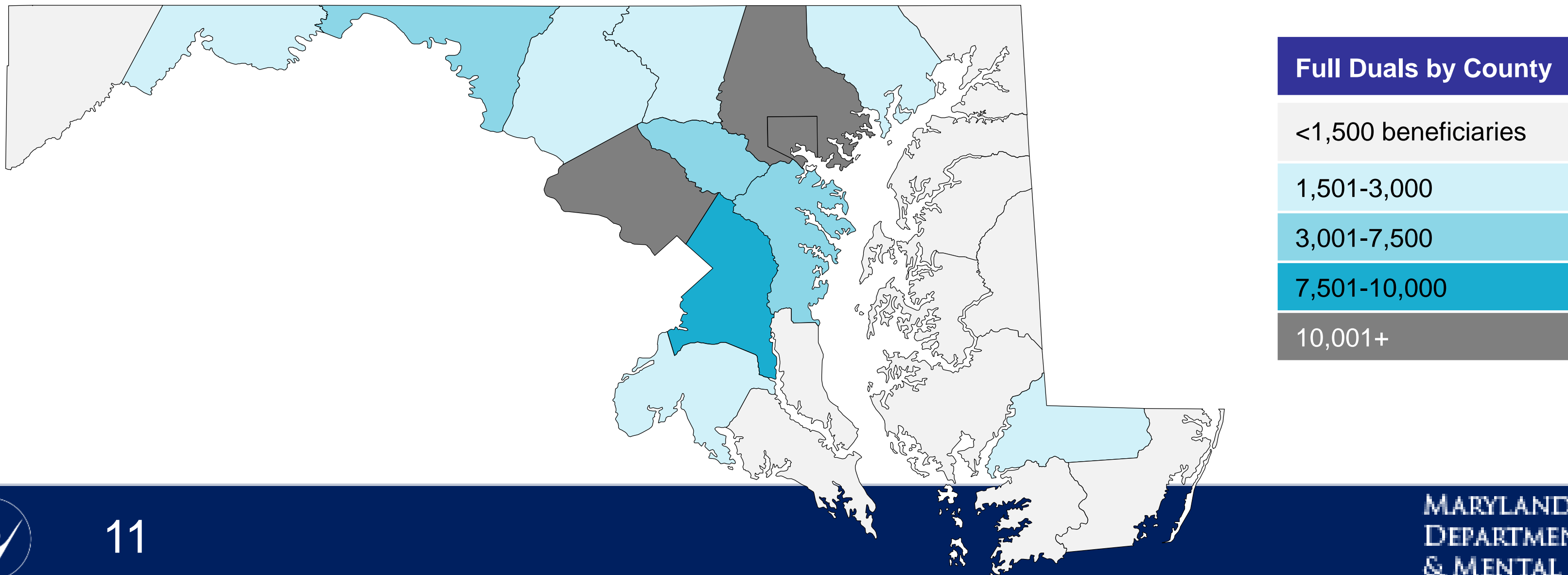
Guiding Principles

- The resulting model will promote:
  - Care coordination for dual eligibles;
  - Utilization of CRISP and other health IT tools; and
  - Linkage of payment to the total cost of care for Medicare and Medicaid.
- *For beneficiaries*: Whole-person, person-centered care
- *For providers*: Value-based payment, administrative simplicity, potential Advanced Alternative Payment Model qualification
- *For the State*: Interoperability with the All-Payer Model

Proposed Model

Hybrid Duals Accountable Care Organization (D-ACO) and Managed Fee-for-Service (MFFS) Model

- Person-Centered Health Home (PCHH) to form the cornerstone of both models
- Two-part delivery network: D-ACO for densely-populated areas and MFFS for other areas, utilizing Medicaid authority to mandate enrollment



Person-Centered Health Home

PCHH blends elements of the Primary Care Medical Home and Chronic Health Home programs:

- Serves as person's first source of care and constant care coordination resource
- Fosters integration of primary care, behavioral health, long-term care and other specialty care to coordinate care
- Focused on beneficiary's health and social needs, thus phrasing person-centered instead of patient-centered and health home instead of medical home
- Supported by real-time data and needs assessments
- Expectations and requirements for accreditation will align with MACRA

Person-Centered Health Home

Guiding Principles

Whole-person care integration | Person-centered care | Beneficiary experience and Triple aim

Value-based payment | Real-time data and analytics | Administrative simplicity | Alignment with MACRA

Total Cost of Care | Interoperability with All-Payer Model

Community-based resources

Duals Care Redesign

Care Planning & Coordination

Data Analytics

Programmatic Standardization Support

Quality Monitoring

Data Exchange Between CRISP, DHMH, Others

Care Management Support Resources and Training

First Care Source + Care Coordination

Behavioral Health Providers

Specialists

Dual Eligible Beneficiary (& Family Member)

HCBS and Social Supports

Nursing Facilities

Duals Accountable Care Organizations

Long-term care providers, behavioral health clinics or MCOs may qualify as D-ACO sponsors, along with hospitals and physician groups, so long as they:

- Furnish a strong provider network of acute care, behavioral health, LTSS, specialty and social supports providers;
- Embrace and incorporate the PCHH model of care;
- Use a distinct governance body, when the D-ACO is made up of multiple entities;
- Maintain provider leadership over clinical policy;
- Perform care coordination, care management and quality improvement activities and measure their efforts;
- Accept a minimum enrollment of at least 2,000 full dual beneficiaries; and
- Take on staged risk for the population.

MSSP ACOs may qualify as D-ACOs, provided they adhere to anticipated waivers of certain MSSP provisions to better serve the duals.

Managed Fee-for-Service

- Dual eligibles in geographic areas without D-ACOs will elect a PCHH to serve as a first source of care
- The PCHH will provide enhanced care coordination, receiving a per beneficiary, per month (PBPM) amount
  - PCHHs will be eligible to receive shared savings, if cost and quality targets are achieved
- PCHHs will be supported by a Program Coordinating Entity (PCE) in care planning and coordination

TIMELINE

Next Steps

- 2016
  - Duals Care Delivery Workgroup meetings through November
  - Topic-level discussions on care redesign, risk and data exchange and analytics
  - Continued focus on linkages with All-Payer Model and primary care initiatives
  - Negotiations with CMMI
- 2017 and beyond
  - Implementation-level planning
  - Waiver negotiation

LINKAGES

Discussion

- Linkages with the All-Payer Model Progression, including the Model Amendment (Complex & Chronic Care Improvement, Hospital Care Improvement)
- Linkages with the Primary Care Strategy
- Linkages with other existing programs (MSSP ACOs, MACRA requirements, Regional Partnerships, single-payer programs, care coordination and social services providers, etc.)

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