



MARYLAND
DUALS CARE DELIVERY WORKGROUP
MANAGED FFS AND DUALS ACO PROPOSED MODELS

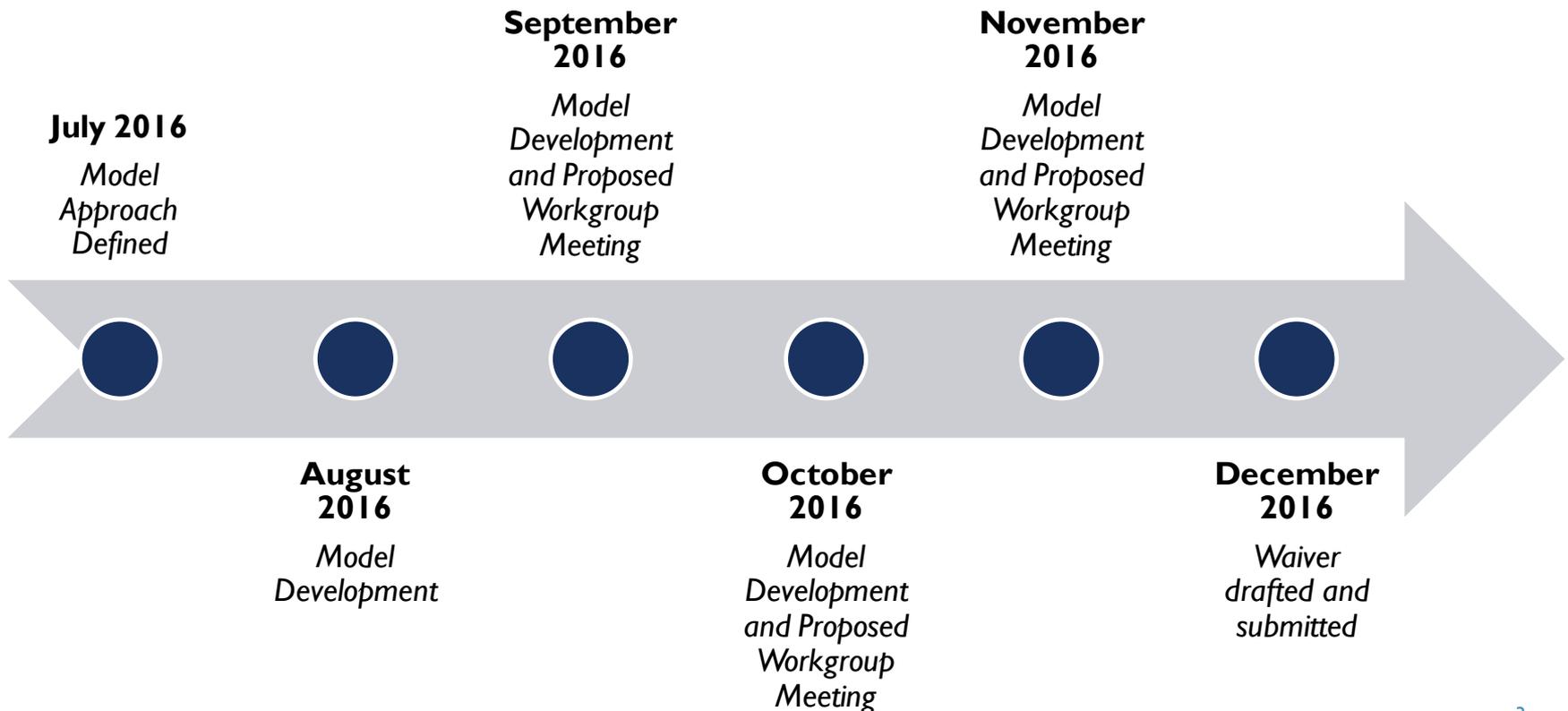


WHAT IS OUR GOAL?

- We want an innovation that promotes:
 - care coordination for dual eligibles,
 - that will use CRISP and feed into the HIE, and
 - that will link payment to the total cost of care for Medicaid and Medicare.
- An innovation that meets these requirements will be a success and it will offer more care coordination for duals than the population already receives
- The more integrated the system, the better

TIMETABLE

We have 6 months to complete work on a model and reach our goal. Our next phase will be focused on developing more programmatic and operational components of the model.



GUIDING PRINCIPLES

In designing new care delivery models for dual eligibles ...

For Beneficiaries

- Reach for whole-person care integration
 - Physical/Acute
 - Behavioral
 - LTSS
 - Social
- Follow a person-centered care model
- Aim for improved
 - Patient experience
 - Health outcomes
 - Quality of life
 - Access to care

For Providers

- Promote value-based payment to reward providers who help reach program goals
- Support providers via
 - Health information exchange
 - Analytics tools
 - Administrative simplicity
- Enable physicians to qualify for APMs under MACRA

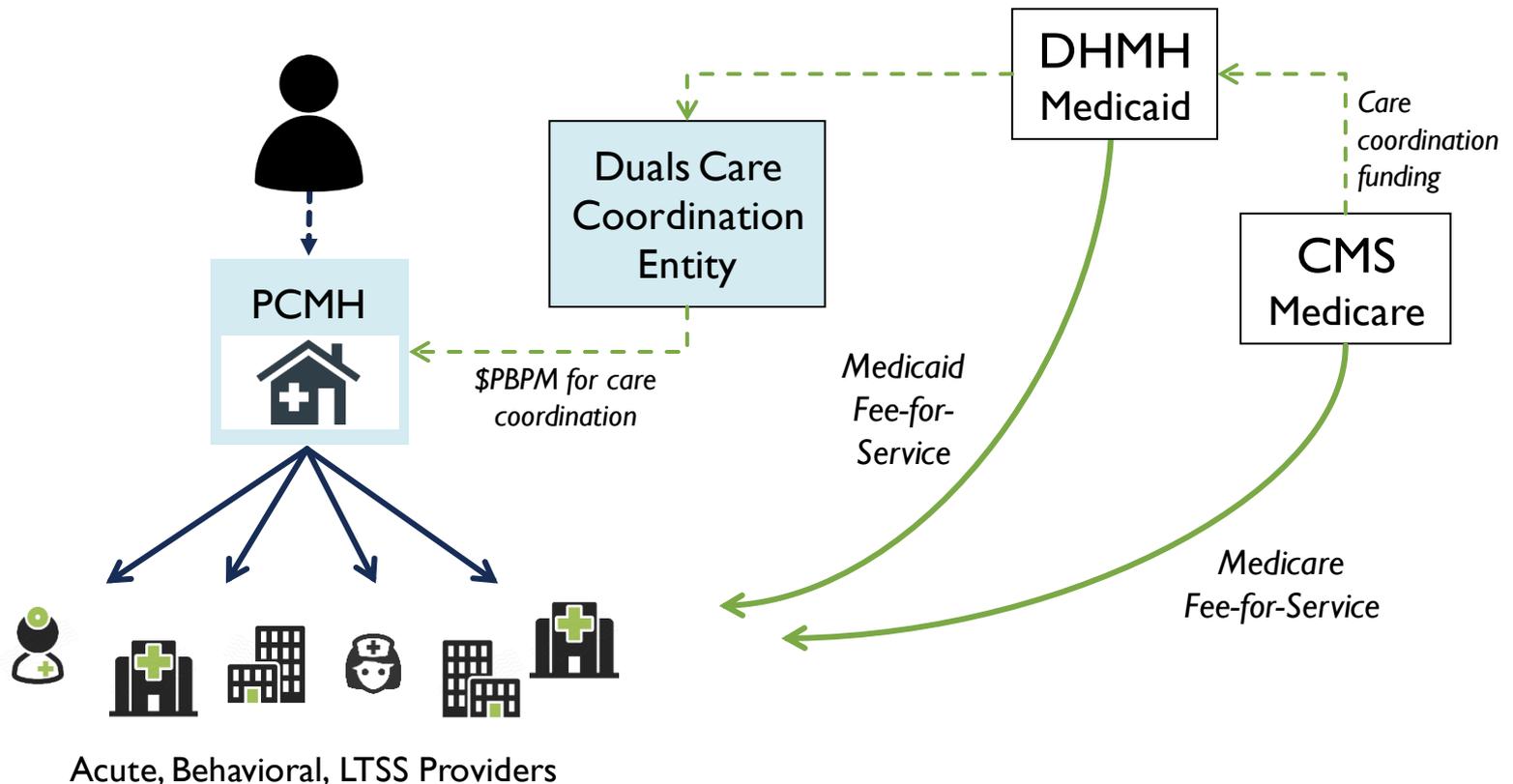
For the State

- Address total cost of care for both Medicaid and Medicare
- Make the program interoperable with the All-Payer Model

Cross Cutting

- Promote utilization of community-based resources

MANAGED FEE-FOR-SERVICE FOR DUALS



♦ PCMH = Patient-Centered Medical Home ♦ LTSS = Long-Term Services & Supports ♦ PBPM = Per Beneficiary Per Month

MANAGED FEE-FOR-SERVICE FOR DUALS

Beneficiaries to Be Covered by MFFS-D

- Full-benefit duals not with intellectual/developmental disabilities (I/DD)
- Those above not included in MFFS-D:
 - Medicare Advantage (MA) enrollees
 - PACE enrollees
 - Dual eligibles already aligned with pre-existing Medicare ACOs
 - Beneficiaries who disenroll from MA or PACE or who opt out of Medicare ACOs will be taken up by MFFS-D

MANAGED FEE-FOR-SERVICE FOR DUALS

Financial Provisions

- All provider payment is regular Medicare/Medicaid fee-for-service
- Regional Entity gets a PMPM care management fee, part going to PCMH
- CMS & DHMH set a joint Medicare-Medicaid total cost of care (TCOC) benchmark, against which Regional Entity performance is measured
 - Benchmark is region-specific and risk-adjusted based on population disease mix
- Agencies determine end-of-year surplus/deficit vs. benchmark
- Regional entities may be awarded bonuses for achieving surplus
 - Subject to a minimum savings rate to account for random chance
 - Possibility for PCMHs that contributed to savings to share in bonus awards

MANAGED FEE-FOR-SERVICE FOR DUALS

Entities and Functions

- DHMH, with CMS aid, contracts with Regional Care Coordination Entities, each serving as care management hub
 - Contractors could be entities organized by providers in communities, health plans furnishing only care management services, or private firms
 - Regional entity's scope of work entails ...
 - Assistance to PCMH and direct to beneficiaries in navigating all health services
 - Intensive case management for beneficiaries deemed high need or at risk of high cost
 - Pre-authorization of services judged overused or high cost and uncertain efficacy

Entities and Functions (continued)

- Primary Care Medical Home is chosen by each beneficiary and assumes responsibility for delivering primary care and coordinating use of other services
 - PCMH may be based in a nursing facility if beneficiary is in resident in NF
 - PCMH may be a specialty provider if beneficiary has chronic condition
 - Expectation that PCMHs will engage in Medicare Chronic Care Management for eligible beneficiaries, Transitional Care, other pay-for-outcome (P4O) efforts

MANAGED FEE-FOR-SERVICE FOR DUALS

Care Coordination Entity (CCE)

CCE contracted by DHMH, serves as care coordination hub

- CCE contractor could be ...
 - Organization formed by providers in communities (except PCMH providers)
 - Health plan furnishing only care coordination services
 - Private firm offering capabilities required of CCE
- CCE scope of work entails ...
 - Joint analysis with Hilltop of data on duals to identify greatest opportunities for improvements in care quality and cost savings
 - Facilitation of CRISP tools
 - Aid to PCMH and directly to beneficiaries in navigating all health services
 - Assurance that PCMH implements chronic care management
 - Appraisal of PCMH performance; technical assistance to improve effectiveness

MANAGED FEE-FOR-SERVICE FOR DUALS

Care Coordination Entity (CCE) - continued

- CCE scope of work may also encompass utilization management
 - Intensive case management for duals deemed high need or at risk of high cost
 - Pre-authorization of services judged overused or high cost and uncertain efficacy

MANAGED FEE-FOR-SERVICE FOR DUALS

Patient-Centered Medical Home (PCMH)

- Entities eligible to be PCMH may include:
 - Primary care practices capable of addressing needs of duals
 - Practices linked to LTSS providers for beneficiaries in LTSS (NF or HCBS)
 - Specialty providers for beneficiaries having dominant chronic condition, such as mental illness
- PCMH assumes responsibility for coordinating all beneficiary care
 - Whole-person perspective – preventive care, chronic care, acute care, etc.
 - Physician works with an ICT to direct care and support the needs of beneficiary
 - Care is integrated across health systems and providers via data exchanges
 - PCMH is accountable for quality performance

MANAGED FEE-FOR-SERVICE FOR DUALS

Beneficiary Linkage to PCMH

- Dual eligible beneficiaries are attributed to PCMHs:
 - First, beneficiary offered a choice of PCMH
 - Counseled toward regular primary care provider or a suitable and accessible PCMH
 - Those who don't choose are passively assigned to a PCMH using historical data
 - Beneficiaries without historical provider relationships assigned to appropriate PCMH based on location, other criteria for suitability
- Beneficiary is not locked into using PCMH
 - Care coordination entity (CCE) may engage to steer beneficiary toward PCMH, or redirect to a PCMH more suitable to beneficiary's needs

MANAGED FEE-FOR-SERVICE FOR DUALS

Payment for Care Coordination

- All provider payment for care is regular Medicare/Medicaid fee-for-service
- Care coordination funds for CCE and PCMH sourced from CMS & DHMH
 - Agencies allocate funds out of anticipated health cost savings
 - CMS adds chronic care management (CCM) fee to fund for affected duals*
 - Providers would agree to forgo claiming CCM fee
- CCE receives budget allocation from DHMH
- PCMH receives a care coordination payment per beneficiary per month
 - Amount PBPM to be stratified by beneficiary health status category

CMS has just announced an initiative called Comprehensive Primary Care Plus (CPC+) that has some similar features and is intended to be multi-payer. We will assess whether the concept proposed here can/should be built to match CPC+.

*Chronic Care Management: “At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.” CMS code 99490 – paid at \$42/month

MANAGED FEE-FOR-SERVICE FOR DUALS

Rewards for Positive Outcomes

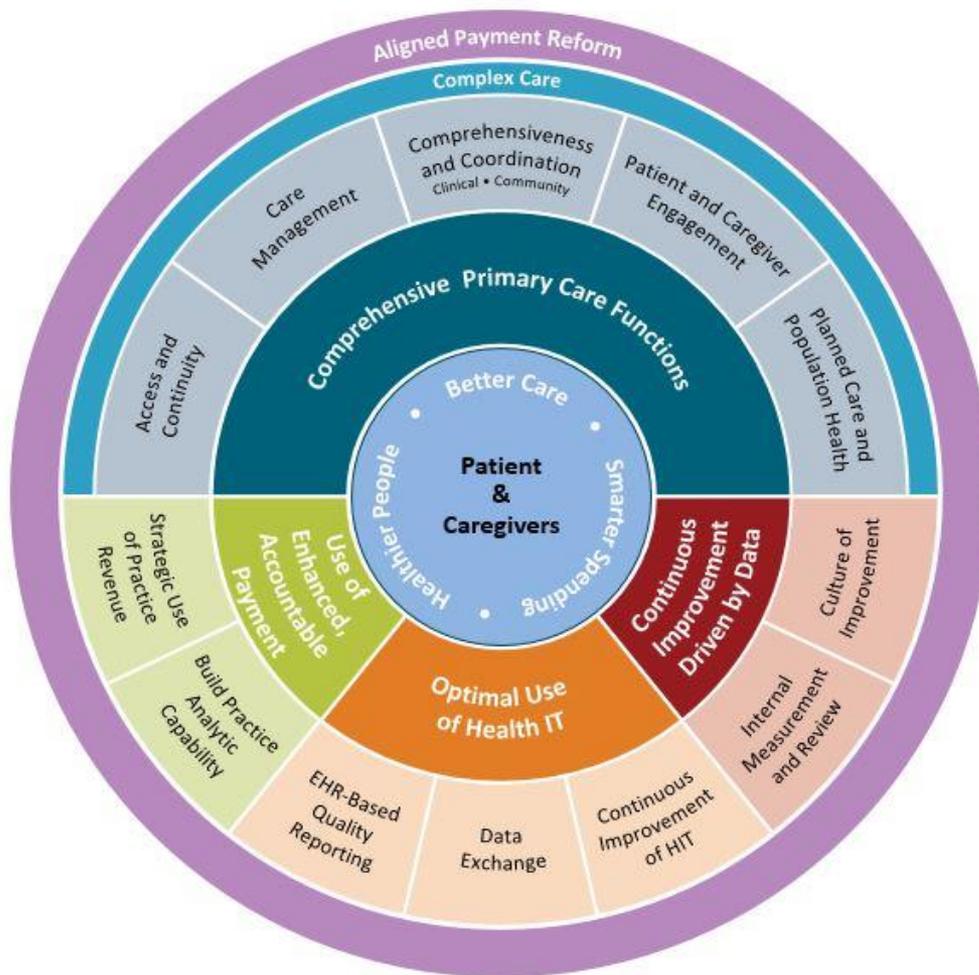
- CMS & DHMH set a combined Medicare-Medicaid total cost of care (TCOC) target, against which CCE/PCMH performance is measured
 - TCOC is government cost of all Medicare and Medicaid services used by duals
 - Target is computed as expected per capita cost,
... adjusted for health status/risk of covered individuals
... summed across the entire population
- After paying all claims, agencies calculate end-of-year surplus/deficit vs. TCOC target
- If there is a surplus ...
 - CCE awarded bonus for achieving surplus
 - PCMHs shown to have contributed to surplus may share in bonus awards

SIDEBAR: COMPREHENSIVE PRIMARY CARE PLUS

Advanced PCMH model: aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation

- Give practices greater financial resources and flexibility to make appropriate investments to improve quality and efficiency of care, and reduce unnecessary utilization
- Actionable patient-level cost and utilization data feedback, to guide practice decision making

CMS seeks payer proposals to partner with Medicare in CPC+ (due June 1, 2016)



SIDEBAR: COMPREHENSIVE PRIMARY CARE PLUS

Practice Functions	Examples for	Additional examples for
	Track 1	Track 2
Access and Continuity	24/7 patient access Assigned care teams	E-visits Expanded office hours
Care Management	Risk stratify patient population Short- and long-term care management	Care plans for high-risk chronic disease patients
Comprehensiveness and Coordination	Identify high volume/cost specialists serving population Follow-up on patient hospitalizations	Behavioral health integration Psychosocial needs assessment and inventory resources and supports
Patient and Caregiver Engagement	Convene a Patient and Family Advisory Council	Support patients' self-management of high-risk conditions
Planned Care and Population Health	Analysis of payer reports to inform improvement strategy	At least weekly care team review of all population health data

SIDEBAR: COMPREHENSIVE PRIMARY CARE PLUS

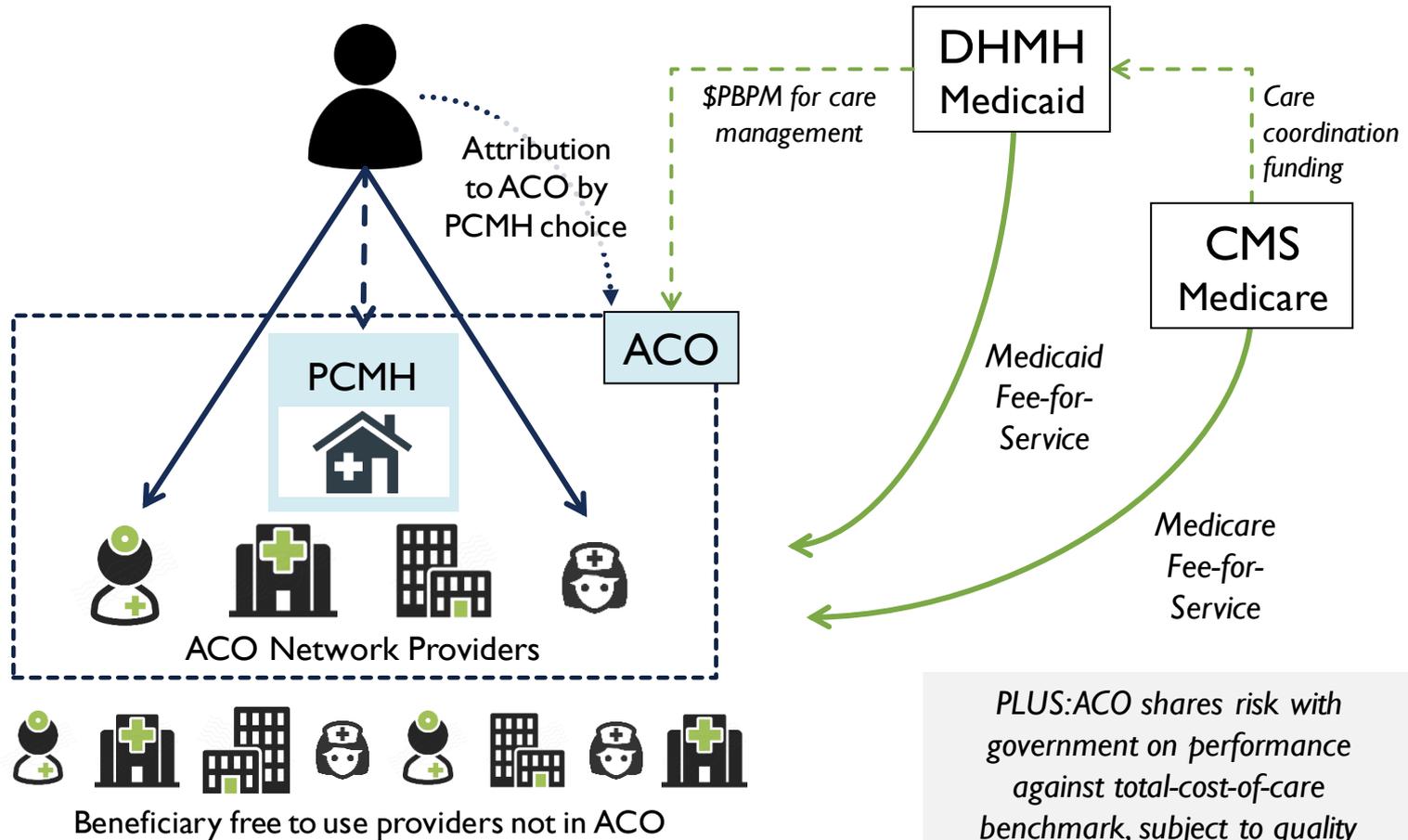
- Payment for care is FFS in Track 1, hybrid of FFS and per capita in Track 2
 - Track 2 practices will receive “Comprehensive Primary Care Payments (CPCP)” – a hybrid of Medicare FFS and a percentage of their expected Evaluation & Management (E&M) reimbursements upfront in the form of a CPCP. Practices will receive a commensurate reduction in E&M FFS payments for a percentage of claims.

- In addition to payment for care:

- Care management fee
- Performance incentive: Incentive payments are prepaid at beginning of a performance year, but practices may only keep these funds if quality and utilization performance thresholds are met.

	Care Management Fee (PBPM)	Performance-Based Incentive Payment	Underlying Payment Structure
Track 1	\$15 average	\$2.50 opportunity	Standard FFS
Track 2	\$28 average; including \$100 to support patients with complex needs	\$4.00 opportunity	Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)

DUALS ACO



DUALS ACO

Accountable Care Organizations - Background

- ACOs are groups of doctors, hospitals, and other health care providers – *and, for dual eligibles, LTSS providers* – who join together voluntarily to give coordinated high quality care to their aligned populations
- ACOs generally differ from managed care in 2 key ways:
 - Beneficiaries do not formally enroll and are not locked into using ACO providers
 - Payment is usually fee-for-service, not capitation, and risks are limited
- Since 2012, Medicare has run the Medicare Shared Saving Program
 - 433 ACOs participate in MSSP nationally, of which 22 are based in Maryland
 - CMS reports 17,400 full duals in Maryland are attributed to 33 ACOs (includes ACOs based in other states, having a Maryland presence)
- Some states have introduced ACO-like programs in Medicaid
 - May be more like MFFS or capitated plans, or embed ACOs inside MCOs
 - No evidence of other states having implemented ACOs for duals

DUALS ACO

Qualifications of Duals ACOs

- The Duals ACO (D-ACO) is a provider-sponsored network that covers part or all of Maryland
 - D-ACOs may define own service areas as long as those areas are contiguous and non-discriminatory
 - More than one D-ACO is allowed in any given area
- Sponsors may include any type of provider serving Medicare or Medicaid beneficiaries or a combination thereof
 - Sponsors must demonstrate capability to provide a network for all Medicare Part A or B and Medicaid services (no Medicare Part D – outpatient pharmacy)
- Pre-existing Medicare ACOs may elect to become D-ACOs
 - Augment capabilities, such as by adding LTSS providers to networks
 - Must apply to DHMH and receive approval for D-ACO designation
 - Secondary review by CMS
 - An MSSP ACO's participation as a D-ACO does not alter the MSSP-side model, but requirements on the D-ACO-side will differ from MSSP

DUALS ACO

Beneficiaries to Be Covered By D-ACOs

- Full-benefit duals not with intellectual/developmental disabilities (I/DD)
- Those above not included in D-ACO:
 - Medicare Advantage (MA) enrollees
 - PACE enrollees
 - Dual eligibles residing in areas of Maryland not served by D-ACOs
 - Dual eligibles already in pre-existing Medicare ACOs that do not attain D-ACO designation

DUALS ACO

Beneficiary Attribution

- If a beneficiary was already attributed by CMS to a Medicare ACO that becomes an D-ACO, that attribution holds unless the beneficiary affirmatively chooses another D-ACO
- All other qualifying beneficiaries are enrolled prospectively by DHMH, as follows:
 - Choose a PCMH attached to a particular D-ACO
 - Offered a choice of D-ACOs in which to enroll voluntarily
 - Auto-enrolled in a D-ACO for Medicaid purposes based on geography or needs
- Once attributed to a D-ACO by Medicaid, the beneficiary is attributed to the corresponding ACO by Medicare
- Prospective attribution to a D-ACO may be adjusted to reflect beneficiary's actual usage of care over time

DUALS ACO

Duals ACO Responsibilities

- Assist PCMHs with performance of PCMH functions
- Coordinate care for dual eligibles spanning acute care, behavioral care & LTSS as well as linking to social services
 - Duals ACO network must include all types of providers
- Receive and analyze data on attributed beneficiaries
- Report to providers and DHMH/CMS on activities and outcomes of care
 - Interconnection via CRISP required to enable both of above
- Bear a share of financial risk for beneficiaries' total cost of care
- Implement an internal incentive scheme for distribution of risks/rewards amongst D-ACO providers

DUALS ACO

Quality Measurement

- Quality measures tailored to dual eligibles
- D-ACOs are expected to meet quality measure performance benchmarks (e.g. 70% or higher scores on 80% of measures)
- Quality performance is factored into incentive award calculation

DUALS ACO

Care Coordination Fee

- D-ACO receives an up-front care management fee (PBPM) from DHMH to help cover administrative costs of care coordination/case management
 - Determined based on beneficiary assignment
 - Varied based on beneficiary need level

Provider Payment

- All provider payment is regular Medicare/Medicaid fee-for-service

Spending Target Established for Incentive/Risk Purposes

- Upon beneficiary's attribution to a D-ACO, CMS and DHMH allocate a TCOC PBPM target amount to a pool associated with that D-ACO

DUALS ACO

Risk Sharing

- Initially, D-ACOs are not at risk for net deficits; this will change over time
 - Downside risk will be phased in starting Year 2
 - Risk/Reward formula will be skewed more to incentive bonus than to penalty
- At end of performance year, Medicare and Medicaid payments are summed and compared to TCOC benchmark
 - Aggregate of care coordination fees paid to D-ACO is added to health costs
- D-ACO deemed eligible for award if surplus *and* quality threshold reached
 - Reduced/No award if deficit or if D-ACO failed to hit minimum quality score
 - Government may recoup share of loss
- D-ACO is expected to distribute a meaningful portion of any award (or loss share) to network providers – of all types – that contributed to result
 - Internal risk/incentive plan is reviewed by DHMH, not prescribed
 - D-ACO may retain some of award to offset operational expenses not otherwise covered by the care coordination fee

DUALS ACO

Risk Sharing and Risk Mitigation

- Pro-rata sharing between Maryland and D-ACO
- Greater reward opportunity than risk of loss
- Risk mitigation caps amount ACO may lose
- Derived from MSSP Track 2 model

Illustrative Example of Reward/Risk Arrangement

	Year 1	Year 2	Year 3
ACO's Share of Savings	50%	60%	60%
ACO's Share of Losses	0%	40%	40%
Shared Savings Cap As Percentage of Total Cost of Care Target	10%	15%	15%
Shared Losses Cap As Percentage of Total Cost of Care Target	NA	7.5%	10%

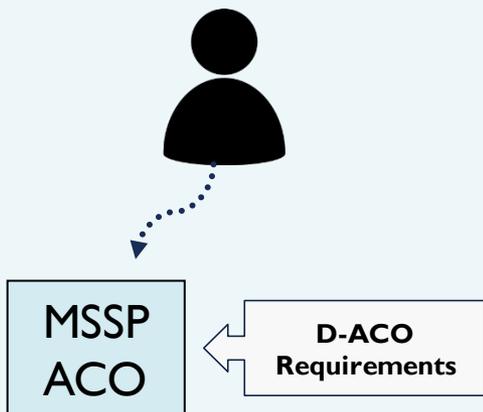
D-ACO COST TARGET CONSIDERATIONS

- Calculation of total cost of care target intended to be derived from claims experience of enrolled population or “like” population
- Risk adjustment is key to credibility
- Common approach used in Medicaid and Medicare is the application of risk scores for certain populations
 - Diagnostic-based risk score tools that identify chronic conditions (such as UCSD’s CDPS+Rx Medicaid tool, or CMS’s HCC risk score tool used for Medicare) have proven reasonably accurate predictors of health cost
 - Traditional risk adjusters do not work as well with LTSS
- Subsets of the duals population, with unique differences in risk, are:
 - Long Term Nursing Facility Residents
 - HCBS Waiver Recipients – Waiver and High-Waiver
 - Community Dwelling

D-ACO BENEFICIARY ALIGNMENT OPTIONS

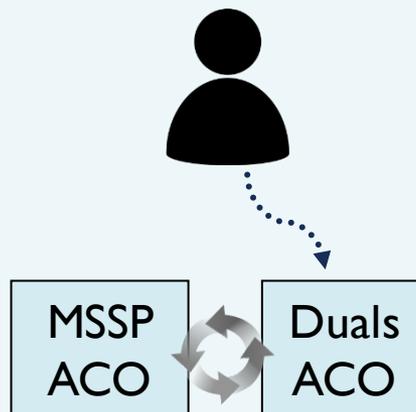
MSSP-Connected

Existing MSSP ACOs required to enroll a certain percentage of duals and comply with D-ACO requirements



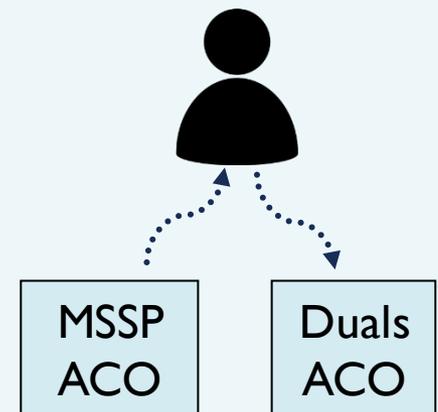
Passive MSSP Phase-Out

D-ACO enrolls duals not already attributed to MSSP ACOs; new duals go into D-ACO



Pure D-ACO

Maryland duals required to enroll in D-ACO, removing all 17k from current MSSP ACOs



CMS CHALLENGES WITH DUALS ACO VISION

- Restricting ACO choice may be viewed as restricting freedom of choice
 - Resolved by underlying provider network
- D-ACO differences with MSSP
 - D-ACO is unique, not MSSP; can be aligned with MSSP
 - National versus duals-appropriate quality measurement
- Alignment of D-ACOs and MSSP; possible solutions –
 - Begin with different models operating side-by-side
 - Possibility of “back room” administrative alignment through data reconciliation
 - Possibility of eventual total alignment, requiring MSSP-side change
 - D-ACO use of Track 2 risk sharing makes financial alignment possible