CHANGING
Maryland
for the Better

Maryland's Accountable Care Model for Dual Eligibles

Health Enterprise Zone Sustainability Summit

November 3, 2016

Overview

- Background on Dual Eligibles
- Guiding Principles and Integration with the All-Payer Progression
- Overview of Proposed Model
- Discussion

Who are the dual eligibles?

BACKGROUND

SIM Project

- Maryland received a design grant through CMMI's State Innovation Model (SIM) program to complement the HSCRC health reform work.
- 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

- There are approximately 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

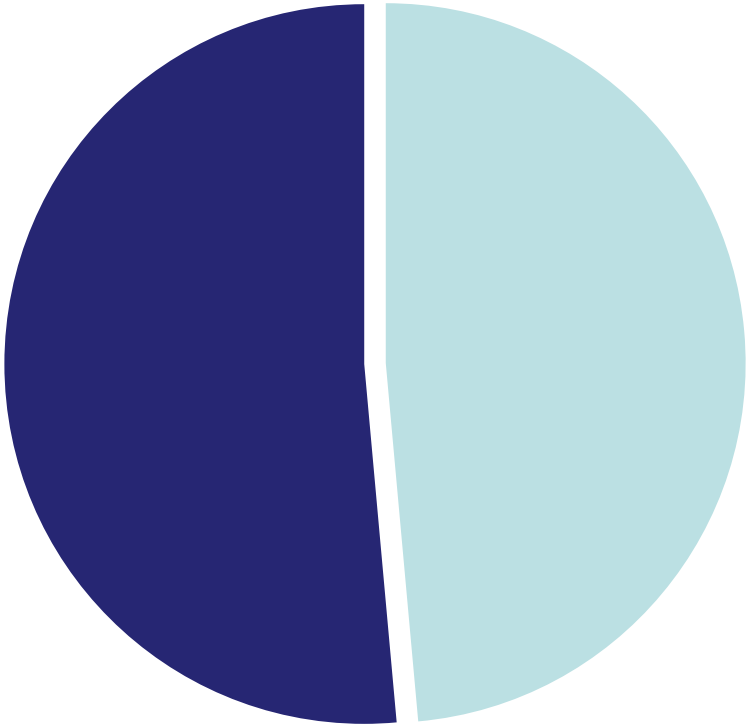
Dual Eligibles Population Cohorts CY 2012	Population Count Person-Months	%	Medicaid PMPM	Medicare PMPM	Total PMPM
Nursing Facility	136,663	19%	$ 5,586.79	$ 2,951.30	$ 8,538.09
HCBS - Under 65	14,768	2%	$ 3,388.96	$ 1,677.00	$ 5,065.96
HCBS - 65 and Older	59,011	8%	$ 2,693.94	$ 1,199.98	$ 3,893.92
HCBS - 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.

How will we ensure appropriate and sustainable care?

GUIDING PRINCIPLES AND INTEGRATION WITH THE ALL-PAYER PROGRESSION

- 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, less administrative burden and more beneficiary contact, potential Advanced Alternative Payment Model qualification
- *For the State*: Interoperability with the All-Payer Model

Duals Initiative is Integrated with Maryland's Wider Health Care Transformation Efforts

The Duals Accountable Care Organization (D-ACO) Model aligns with principles of the **primary care model** and refinements to the **all-payer model**. It tests a different payment mechanism and introduces entities that may take broad accountability for these high-risk beneficiaries.

Duals Accountable Care Organizations

- Primary Care Model
- Regional Partnerships
- Complex and Chronic Care Program and Hospital Care Improvement Program
- Geographic Model
- Medicare (MSSP) ACOs

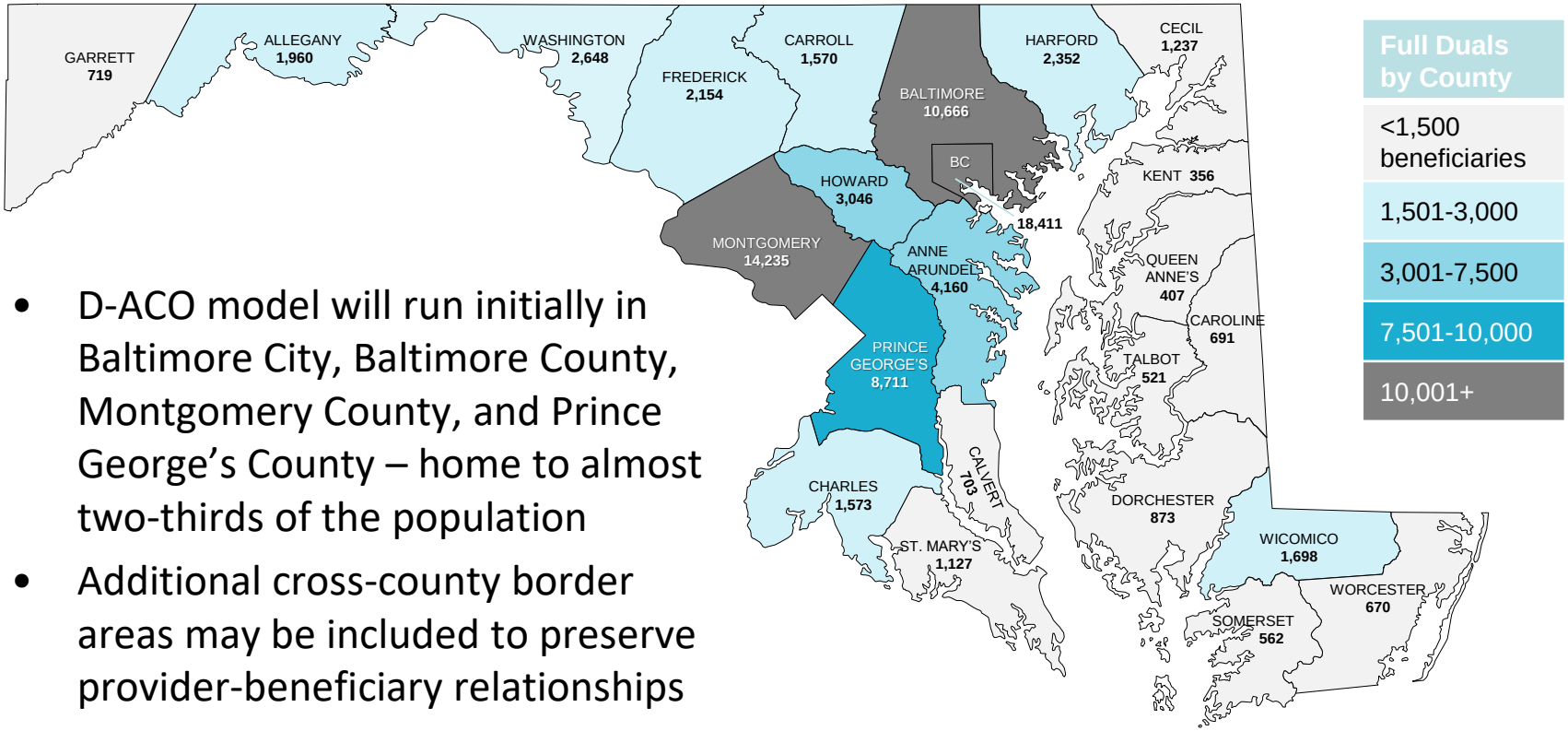
Features in Common

- Person-Centered Health Home
- Data Exchange and Analytics
- Care Coordination
- Population Health
- MACRA: Advanced APMs

How will we improve care for the duals?

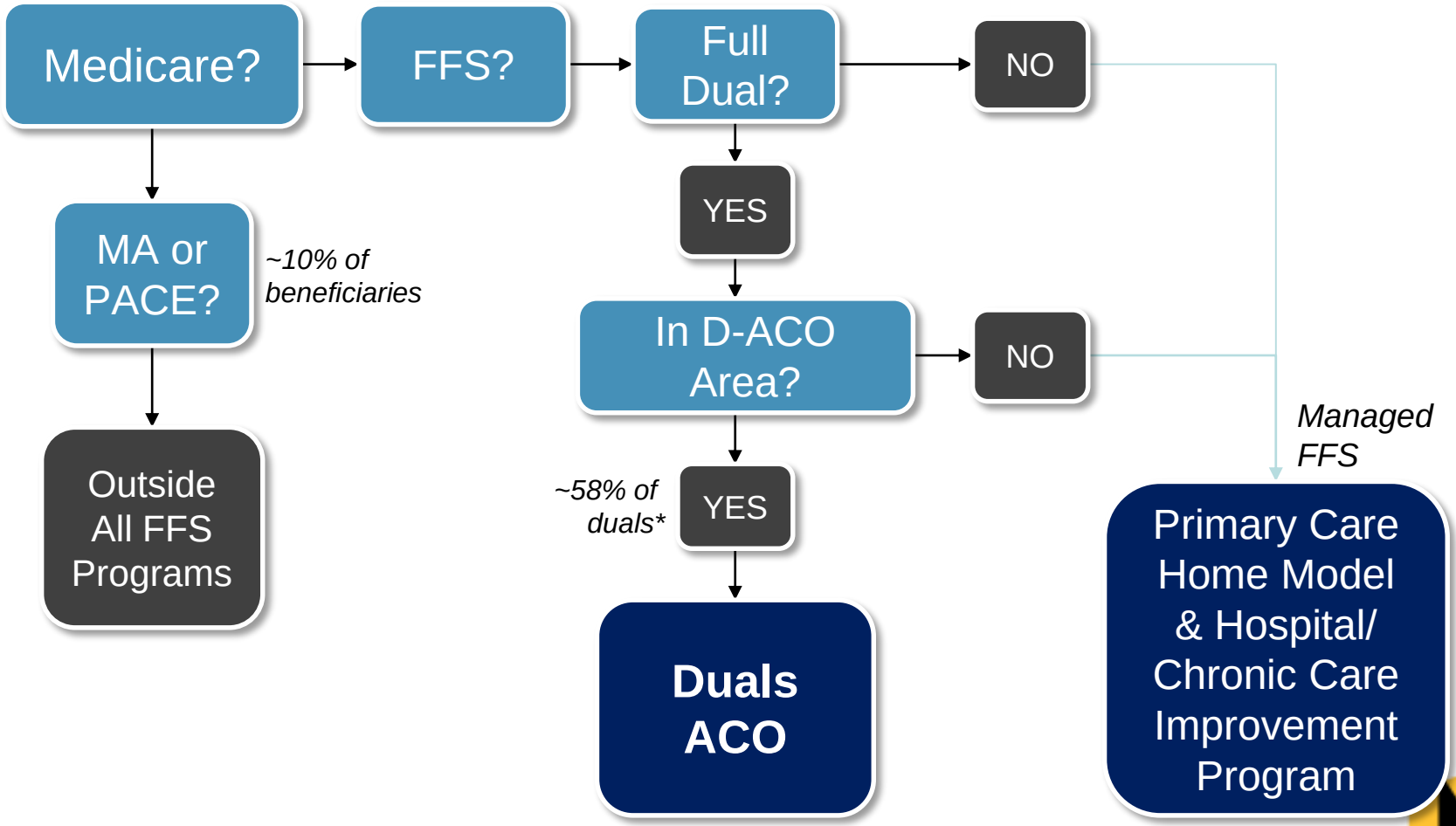
THE MODEL: DUALS ACCOUNTABLE CARE ORGANIZATIONS

D-ACOs Will Operate in the Most-Populous Areas, Covering Approximately 52,000 Fully-Dual Eligibles



- D-ACO model will run initially in Baltimore City, Baltimore County, Montgomery County, and Prince George's County – home to almost two-thirds of the population
- Additional cross-county border areas may be included to preserve provider-beneficiary relationships
- Potential expansion to wider area once concept proven viable

Most Full Duals Will Go into a D-ACO



* 90% of full duals are in FFS Medicare; 64% reside in D-ACO area

Theory of Change: D-ACOs Drive Accountability for Quality and Efficiency

Current FFS System		Duals ACO Model
Beneficiaries lack a go-to provider	-------	Beneficiary-designated provider who is care coordination quarterback
Discontinuity in care, especially across physical, behavioral, LTSS and social domains	-------	Seamless coordination across health care settings and spanning to social supports
Provider incentives reward volume and intensity of services	-------	D-ACO materially accountable for total cost of care plus quality
Repetition of assessments, testing, procedures	-------	Care coordination tools enable access to data -- assessments, tests, medical encounters Promote standardized processes and assessments
Lack of provider capacity to coordinate care	-------	Incentivize providers and offer resources to coordinate care

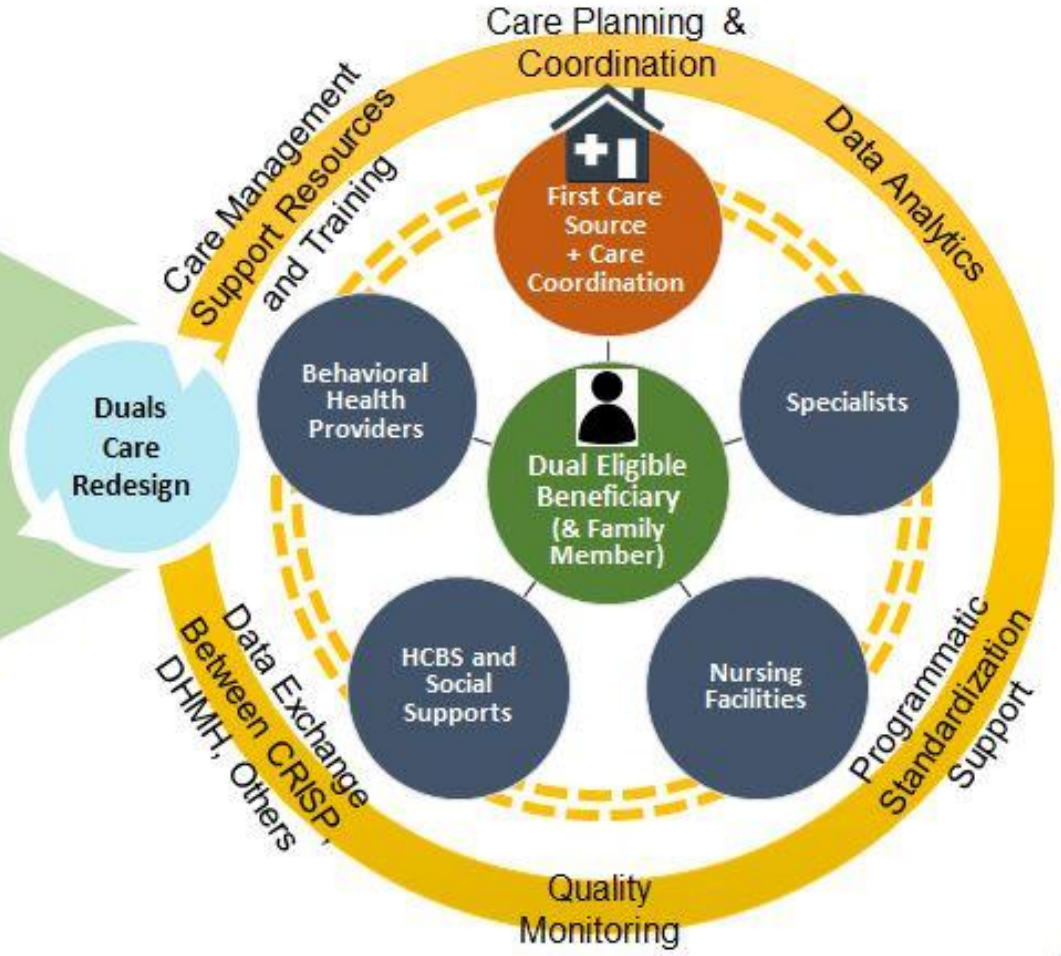
D-ACO's Person-Centered Health Home (PCHH) Leverages Planned Primary Care Transformation

- PCHH blends elements of Primary Care Medical Home, Chronic Health Home
  - Serves as person's designated source of care and care coordination quarterback
  - Specialty (including BH) providers and NF-based providers allowed as PCHHs
  - Will follow standards set by PCM; may be enhanced to serve distinct needs of duals
  - Structural and performance expectations will align with MACRA standards for Advanced Alternative Payment Model

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



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TIMELINE & DISCUSSION

Next Steps

- 2016
  - Duals Care Delivery Workgroup meetings through November
  - Continued focus on linkages and building interoperability with other components under the All-Payer Progression
  - Negotiations with CMMI
- 2017-2018
  - Model refinement and program development
  - Waiver negotiation
- 2019
  - Program Implementation

How can the duals model leverage the Health Enterprise Zones, and vice versa?