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

<table>
<thead>
<tr>
<th>Dual Eligibles Population Cohorts</th>
<th>CY 2012</th>
<th>Population Count</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Person-Months</td>
<td>%</td>
<td>PMPM</td>
<td>PMPM</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td></td>
<td>136,663</td>
<td>19%</td>
<td>$5,586.79</td>
<td>$2,951.30</td>
</tr>
<tr>
<td>HCBS - Under 65</td>
<td></td>
<td>14,768</td>
<td>2%</td>
<td>$3,388.96</td>
<td>$1,677.00</td>
</tr>
<tr>
<td>HCBS - 65 and Older</td>
<td></td>
<td>59,011</td>
<td>8%</td>
<td>$2,693.94</td>
<td>$1,199.98</td>
</tr>
<tr>
<td>HCBS - Total</td>
<td></td>
<td>73,779</td>
<td>10%</td>
<td>$2,833.06</td>
<td>$1,295.46</td>
</tr>
<tr>
<td>Community Dwelling - Under 65</td>
<td></td>
<td>265,380</td>
<td>37%</td>
<td>$454.66</td>
<td>$1,244.50</td>
</tr>
<tr>
<td>Community Dwelling - 65 and Older</td>
<td></td>
<td>235,421</td>
<td>33%</td>
<td>$302.31</td>
<td>$1,147.13</td>
</tr>
<tr>
<td>Community Dwelling - Total</td>
<td></td>
<td>500,801</td>
<td>70%</td>
<td>$383.04</td>
<td>$1,198.73</td>
</tr>
<tr>
<td>All - Total</td>
<td></td>
<td>711,243</td>
<td>100%</td>
<td>$1,637.07</td>
<td>$1,545.52</td>
</tr>
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</table>
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.

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.

CY 2012 - $2.264 billion
How will we ensure appropriate and sustainable care?

GUIDING PRINCIPLES AND INTEGRATION WITH THE ALL-PAYER PROGRESSION
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, less administrative burden and more beneficiary contact, potential Advanced Alternative Payment Model qualification

• For the State: Interoperability with the All-Payer Model
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.
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

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

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