

Dual Care Delivery Workgroup

February 29, 2016

The meeting was called to order at 1:07 pm. Mr. Bob Atlas (Principal, EBG Advisors) welcomed and thanked the group for attending. Mr. Atlas provided information about the scheduled upcoming stakeholder meetings. To frame the goal of the meeting, Mr. Atlas stressed the importance of the workgroup and how it will be a collaborative effort between workgroup members and the Department in mapping and identifying a solution for this complex task. The next workgroup meeting will be April 4, 2016.

Mr. Atlas introduced Ms. Shannon McMahon (Maryland Medicaid Director) as the next speaker. Ms. McMahon thanked and acknowledged the team who worked to put together the meeting. She recognized the great efforts of Medicaid and HSCRC staff, and thanked everyone for participating. Ms. McMahon stressed the value and importance of each person's role in this project. The purpose of the workgroup will be to help inform a care delivery strategy that would increase the care coordination for individuals eligible for Medicaid and Medicare and increase the use of health information technology.

After Ms. McMahon framed the goals of the meeting, members from the workgroup introduced themselves.

Mr. Atlas re-identified that the population being discussed for this project will be the full dual eligible population. These individuals receive full benefits for Medicaid and Medicare services. This population will not include those individuals with developmental disabilities.

Dr. Dale Schumacher (EBG Advisors team) led the group in discussing data about the duals population in Maryland. The data was prepared by the Hilltop Institute at University of Maryland Baltimore County.

Data Discussion:

- Dr. Schumacher: Behind each of these numbers is an individual—keep this thought in mind as we go through these data
- Workgroup Member: The data seem to be lagged by a few years; will there be more recent data? Dr. Schumacher explained though there is a lag, the current seems to be following the same trend as the previous year's data. Additionally, with large sets of data, more lag time is needed—specific cohort breakouts can represent more recent years.
- Some of the wealthiest counties (Baltimore, Montgomery, Howard) have highest proportion of duals
 - Workgroup Member: Allegany County results not surprising—there are fewer hospital resources out there but pretty good post-acute capacity
- The Medicaid program spends about 3,000 dollars per member per month for the duals.
- Home health and nursing facility comprise 40% and 45% of Medicaid expenditures, respectively—for Medicare, 43% and 38% are inpatient and outpatient, respectively.
- Workgroup Member: The pharmacy budget looks very low. (Clarification from The Hilltop Institute): The reason for the lower numbers is because the Medicaid program does not

currently receive Medicare Part D data from CMS. This is a known a limitation of the data. Mr. Atlas: Most of pharmacy for duals is Part D, which will be outside our scope.

- Workgroup Member: What falls in the category of special programs? Hilltop: This category includes some laboratory data, radiology, and anything that doesn't fit into the other categories. The exact data points could be provided to the workgroup members for those that are interested.
- The annual per capita cost increases with the number of chronic diseases
 - Workgroup Member: In looking at the age breakdown by multiple chronic conditions it would be helpful to show the data based on the total number of people in each group.
- Number of hospital stays
 - Workgroup Member: What are number of dual eligibles that were classified with "no admissions"? Dr. Schumacher responded that number to be approximately 60,000 individuals.
 - Workgroup Member: Would more up-to-date data from HSCRC the curve differently, given the rate of admissions are coming down under the All-Payer Model? Additionally, would the shape of the curve and scale of data look the same? Would we would be able to remove the number of re-admissions and transfers?
 - Workgroup Member: Do we have data on what kinds of chronic conditions are leading to this?
- Overall, distributions are complex, with episodes flowing thru the system varied and therefore constitute a challenge
- Quality measures will be part of this discussion
- Workgroup Member: On slide 12 and 13- Is cost growth due to population growth? Mr. Atlas: There was a year or two when at least Medicare cost growth was zero; it will be interesting to see how that's changed.

Discussion of types of care models:

In framing the discussion about care coordination among the duals population, one major difference between Medicaid and Medicare is that Medicaid can mandate individuals to participate in managed care, and Medicare cannot. The furthest Medicare will go is passive enrollment.

- Workgroup Member: Is this the menu of options, or are they just the options that CMMI would not reject? Mr. Atlas: CMS has expressed interest in an ACO model, because they haven't seen it in other states and would like to see how it would work, but this does not limit what this group would include and what Maryland brings forth.
- Workgroup Member: Along those lines, do we have information on how that is working for Medicare-only? Mr. Atlas: First, duals are being served by them on the Medicare-only side; the experience is bi-modal. Not only have to generate savings but have to surpass 2% across TCOC metric and hit benchmarks on 33 quality measures. Many ACOs are generating savings; we could show charts on gains, losses, expenditures and CMS payouts—pretty much a wash for the first

three years of MSSP. Pioneer ACOs (little more aggressive)—a number have pulled out. NextGen ACOs (kind of between ACO and MCO on the chart)—just in January; more energetic attribution.

Mr. Atlas provided the example of the Program of All-Inclusive Care for the Elderly (PACE) model. This program is like a comprehensive duals eligible program. Congress passed the PACE Innovation Act last year to allow more individuals to participate in a PACE model. Prior to the act, PACE participants had to be 55 years or over, certified to meet needing nursing home level of care, live a PACE service area, and be able to live in a community with the support of PACE services at the time of enrollment. These guidelines were expanded to include more individuals, including those less than 55 years of age.

Mr. Atlas also discussed the Financial Alignment Demonstration, also known as the “Duals Demo.” Overall, enrollment for this program is about 28%. The lower enrollment rates may be due to the ability for individuals opting out of the program though they are initially automatically enrolled. Virginia recently announced that it is exiting the program.

- Washington State Example
 - Workgroup Member: Basically, is this just a care management fee? Mr. Atlas: Yes, targeted to high utilizers
 - Workgroup Member: Who funds the fee? Mr Atlas: I believe it’s a combined federal-state source...savings-based like an ACO.
 - Workgroup Member: Are patients tiered, how do you approach or identify them? Mr. Atlas: This is a good discussion to put out to the group. HSCRC is addressing this in the Advisory Council.
 - Audience Member: How long has Washington State been doing this? Mr. Atlas: A few years—RTI just released a report on this; some numbers suggest savings around 6% but are not prepared to say it has been a success
 - Workgroup Member: Some elders bounce in and out of assisted living. Advanced directives not really advanced in Maryland—how about in Washington? Mr. Atlas: More information is needed to answer this question.
- Colorado Example
 - Quality indicators are more utilization-based and do not really indicate a return to wellness
- Florida Example
 - D-SNP: Florida used procurement levers to favor plans with a D-SNP option
 - Workgroup Member: Is the MLTC an MCO? (Yes) What triggers enrollment? (NF level of care)
- Minnesota Example
 - Difference from Florida: Have to enroll in companion plans offered by one company (i.e. not United for Medicare, Anthem for MLTC)
 - Distribute MOU between CMS and Minnesota (shows high level of items that need to be synced for this to work)

Discussion

- Whatever we determine needs to be incorporated into the All-Payer Model
- Workgroup Member: Any consideration surrounding the health home model?
- Workgroup Member: Is there any understanding of how many chronic diseases a patient would have to be able to grouped? This is should be brought up for discussion as some of these high costs are occurring at the end stages of life.
- Workgroup Member: Patient Attribution is a critical part of this discussion. Mr. Atlas: It is a journey. ACOs have complained that retro is too late. CF did their own demo and found the same. Massive barriers to get it done right...would be good for it to look like enrollment but not go all the way to enrollment. This will be a key part of our agenda. Workgroup Member commented that she has good feedback from the national association that she could share, then asked: Is there a way to develop an attribution model that doesn't look like an enrollment model? Mr. Atlas: It should be an attribution for both providers as well as the beneficiaries.
- Workgroup Member: How will the Rare and Expensive Case Management (REM) program participants be accounted for in this work? Would there be a possibility to ensure that the REM clients are tracked. Ms. Tricia Roddy (Maryland Medicaid): Currently the REM program participants are included as part of our Health Choice program. As we think about our design we will need to keep these REM clients in mind.
- Workgroup Member: It seems like some of the states that reviewed looked at various populations, so is this process open to looking for solutions that are not one size fits all? Also looking at the data is there a way to look at how these people landed in their disease classification? Mr. Atlas responded that we are looking at a program that is broadly applicable, but understanding that the needs of this population are not one size fits all. There has to be a general umbrella of coverage that looks at these individuals needs. We need to really take into consideration the total population that we are serving and where they are located across the geography of the state.

Discussion of Existing Efforts, including the All-Payer Model

Donna Kinzer (Executive Director, HSCRC) gave a brief presentation on the timeline for state transformation efforts, including a description of two programs under development for creating additional alignment across hospitals and providers: Internal Cost Savings (ICS) and Pay for Outcomes (P4O).

- Mr. Atlas: CMS is concerned about sharing the same savings twice—what we develop for the duals will need to take this into consideration.
- Workgroup Member: What is the timing on the ICS/P4O? Ms. Kinzer: Hoping to have amendment approved by mid-summer. The timeline of when hospitals and providers could be ready to operationalize is under development with HMA and other consultants.
- Ms Roddy: Encourages everyone to learn what's going on at the HSCRC level—will be integrated and impact whatever we are designing.
- Ms. Kinzer: The HSCRC is getting ready to do webinars (MedChi, post-acute community, MHA) on these models—will push information thru this venue as well.

- Workgroup Member: There is so much going on—the challenge we have is not just the what and how but making sure we don't have unintended consequences on other areas. Duals are already attributed to ACOs; MedStar has a D-SNP; others are being developed—how do we carve all this out?
 - Ms. Kinzer: Significant impact potential for savings on LTSS. Mr. Atlas: HSCRC's initiatives are focused on FFS recipients—Ms. Kinzer: Clarified that work is all-payer but focused on those who don't have some kind of care management.
- Workgroup Member: Behavioral health—VO data (1-6/15)...almost 9000 for MH and 1800 for SUD—significant number of duals accessing the Public Behavioral Health System. Behavioral health cannot be an afterthought. Ms Roddy commented that the group will talk about the Department's work with Chronic Health Homes.
- Workgroup Member: Can you address this in terms of the regional partnerships? Ms. Kinzer: When we start looking at utilization of complex and hi-needs patients—want to make sure we don't duplicate services, person-centered execution, plans that include non-hospital providers).
- Workgroup Member: Will implementing P4O and ICS be expected of the regional partnerships? Ms. Kinzer: The hospitals have asked this of us. It could work across the different systems and models—they do not need to fit just into one space but are a special set of permissions for involvement of non-hospital providers; also to get data for care coordination.

Discussion of initial design consideration:

- Mr. Atlas: We do not want to carve anything out.
- Workgroup Member: Risk might work differently depending on the parties (i.e. other MCOs that have been unsuccessful in the past).
- Workgroup Member: In thinking about the 20% enrollment, we should be looking at what is the patient getting out of this so that we could get patients to want to enroll the whichever program is designed. We could and should be thinking about activities where more telehealth options are available.
- Workgroup Member: Why was it decided earlier on to exclude individuals with developmental disabilities? Ms. Roddy: The reason is because they are such a different group with complex needs. So they may be considered in the future but for now the consideration will be for the full duals.
- Workgroup Member: Piggy-backing on the other question about patient focus, it seems that of the models presented; only Colorado that has more of a patient-centered approach, building on needs outside of the medical. Mr. Atlas: We might have left out some of these features in the presentation, but the patient-centered/holistic approach ought to be an objective.
- Mr. Atlas: The following is my view and not that of the Agency. My opinion is that this should be statewide with regional aspects. Balancing regional diversity with risk pool.
- Workgroup Member: With an umbrella organization, DOA has used federal guidance related to no wrong door. Want to make sure that is being considered. Maybe this is around coordination or maybe it's being an umbrella organization.

- Ms. Kinzer: Part of what we are thinking about is also administrative—how to put together savings pools, how to coordinate the data of who is receiving shared savings and who is not, monitoring quality benchmarks—common standards of administration (CRISP as an example of success for this approach)
- Ms. Roddy: Under the agreement with HSCRC, CMMI is moving toward total cost of care. Within all the programs HSCRC discusses, there is a cost of care guardrail. With the duals, would we calculate something different for Medicare? No—we would want to calculate the same as HSCRC.
- Ms. Kinzer: Providers have the same needs as the HSCRC and DHMH—can we have common access and not duplicate expenditures on administrative resources. This is where the term ICN comes from—currently CRISP, but could this be broadened to encompass others.
- Workgroup Member: Looking preliminary it would be nice to have a statewide model. This will help to eliminate the fragmentation that goes on at this time. We also need to look at the social determinants of health because not addressing them may potentially increase our costs. There are some states that are looking at a program called PREPARE and would should do more research to find out which would be best to use. There are also some states that are even integrating these standards within their electronic health records (EHRs). The newly-developed model should have a plan for better communication between coordinating agencies. CRISP is doing a lot of work in trying to connect the dots for care coordination between providers. Primary care calls for a complexity scale, not risk stratification. On a scale of 1-5, let's focus on the 4s and what got them there. A basic question to ask and understand is what is the definition of care coordination? This term means various things to different players.
- Workgroup Member: CRISP and care coordination—spring 2015 watershed moment for deepening of the functioning of CRISP. Lots of work to share data for more effective care coordination.
- Workgroup Member: Do we have some cost estimates or goals that we are trying to hit? Is there a threshold of the cost savings we will try to attain within a specified period?
 - Ms. Roddy: We do not have that information yet, but some of the things we may need to think about should be setting certain principles that we would want to follow regardless of what design we go with. Right now, when we say total cost of care, it is from the perspective from Medicare savings, but when Medicaid is at the table we want to look at cost of care savings for Medicaid. In the next meeting we may want to write down a few topics that we would want to focus on. We may want to focus on quality measures that translate into quality of care for patients which would ultimately decrease costs for both programs.
 - Ms. Kinzer: Some of these principles translate well to the P4O conversation. Can we identify common issues and work together to avoid hospitalization? This is part of where the benefit to the patient comes from—better care, outcomes and situation for the patient.

- Workgroup Member: Begin with the end in mind—Quality is the primary driver. What can we do together to make the biggest difference in clinical quality and outcomes while reaching the depth of coordination? Pay for the coordination with savings, not with the cost of care. Leaning toward ACO; does not mind carve-outs. This model could be implemented statewide, but has some regional parameters.
- Workgroup Member: We have a lot of information on chronic home model that we have not been able to test. So not to duplicate the effort, we should keep that program going, and maybe carve them out. Eliminating the program now would not have allowed enough time to see the success of these home health programs. Ms. Roddy: We would not pull them out but have them participate in both—the Chronic Health Homes do not focus on primary care.
- Workgroup Member: We should be cognizant of the current quality measurements that are available nationally instead of creating new ones unnecessarily. Use technology resources to extract without increasing burden.

Discussion of Next Steps

- Workgroup Member: Whatever materials are developed during the designing states, there as a request if the workgroup members could have the draft visions at least a week prior to the meeting. A suggestion may be that we would give the questions out and provide a deadline so that people can choose to answer or wait with their written answers to provide them verbally.
- Ms. McMahon: We are open to conversation in the interim. As you come up with thoughts, we are open to discussing them.
- Ms. Roddy: Regarding the questions Mr. Atlas went through, send us your thoughts—this is an open dialogue.
- Mr. Atlas: We will do our best to honor information requests.

Public Comment

No public comments were offered.

The meeting was adjourned at 3:49 pm.