



MARYLAND DUALS CARE DELIVERY WORKGROUP

JUNE 1, 2016 | 1:00-4:00 PM



AGENDA

- Welcome and Introductions
- Recap of the Previous Meeting
- Federal Developments
 - MACRA – Ramifications for Duals Initiative
 - CPC+ Update and Implications
- Review/Discussion of Straw Models
- Wrap-up, Takeaways and Next Steps
- Public Comment

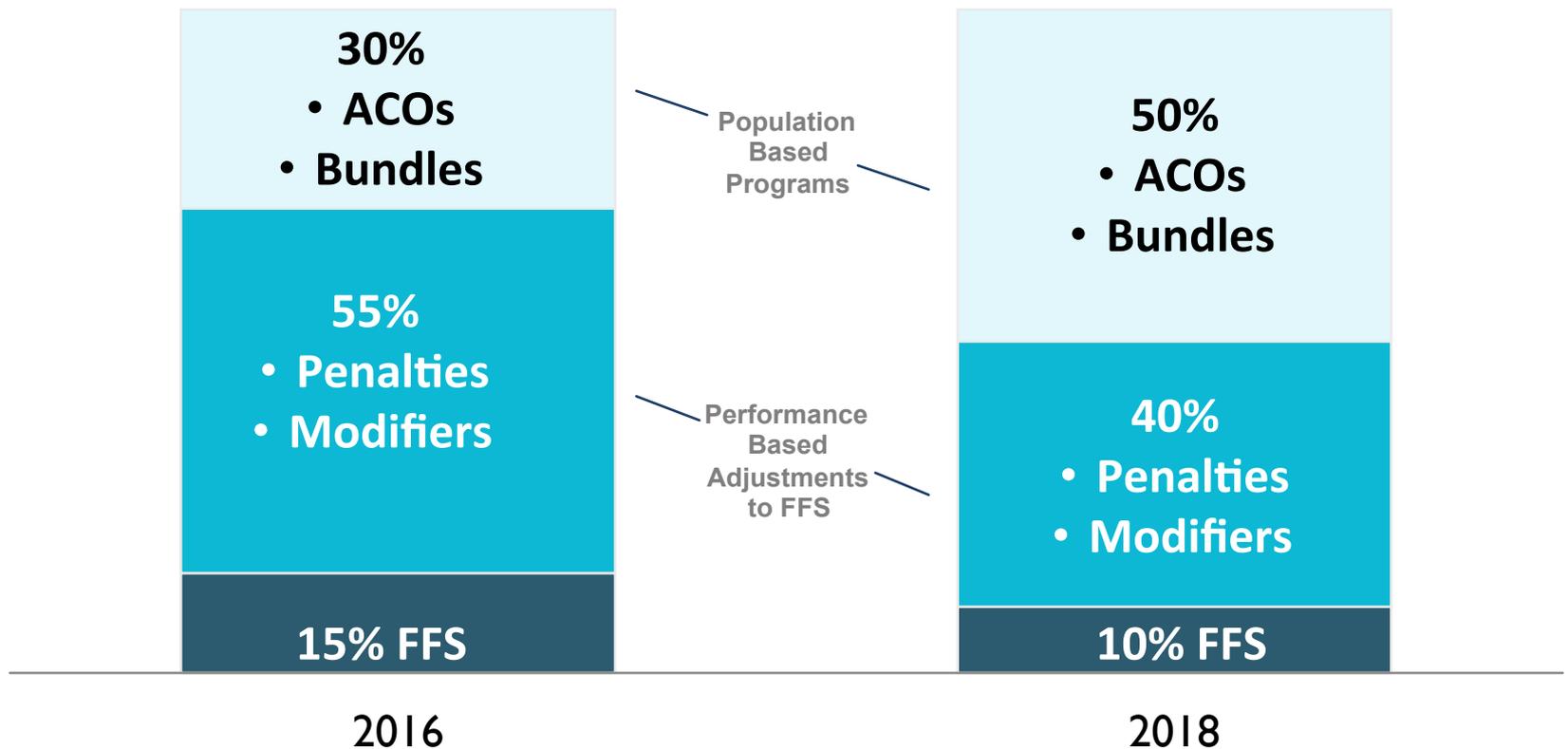
RECAP OF MAY 2 MEETING

- Reviewed stakeholders' input on which models speak best to guiding principles
- Pursued consensus definition of care coordination and care management as may be applied in any potential model for duals
- Discussed CMS initiative: Comprehensive Primary Care Plus
- Considered quality measures
 - Follow-up question: How well does NQF's duals set match other extant measure sets?
- Revisited straw models, with added specifications, and compared advantages/disadvantages of the models
- Considered possible implementation timing

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- Federal Developments
 - MACRA
 - Comprehensive Primary Care Plus

CMS VALUE-BASED PAYMENT GOALS

January 2015: Sec Burwell sets Medicare FFS value-based payment goals

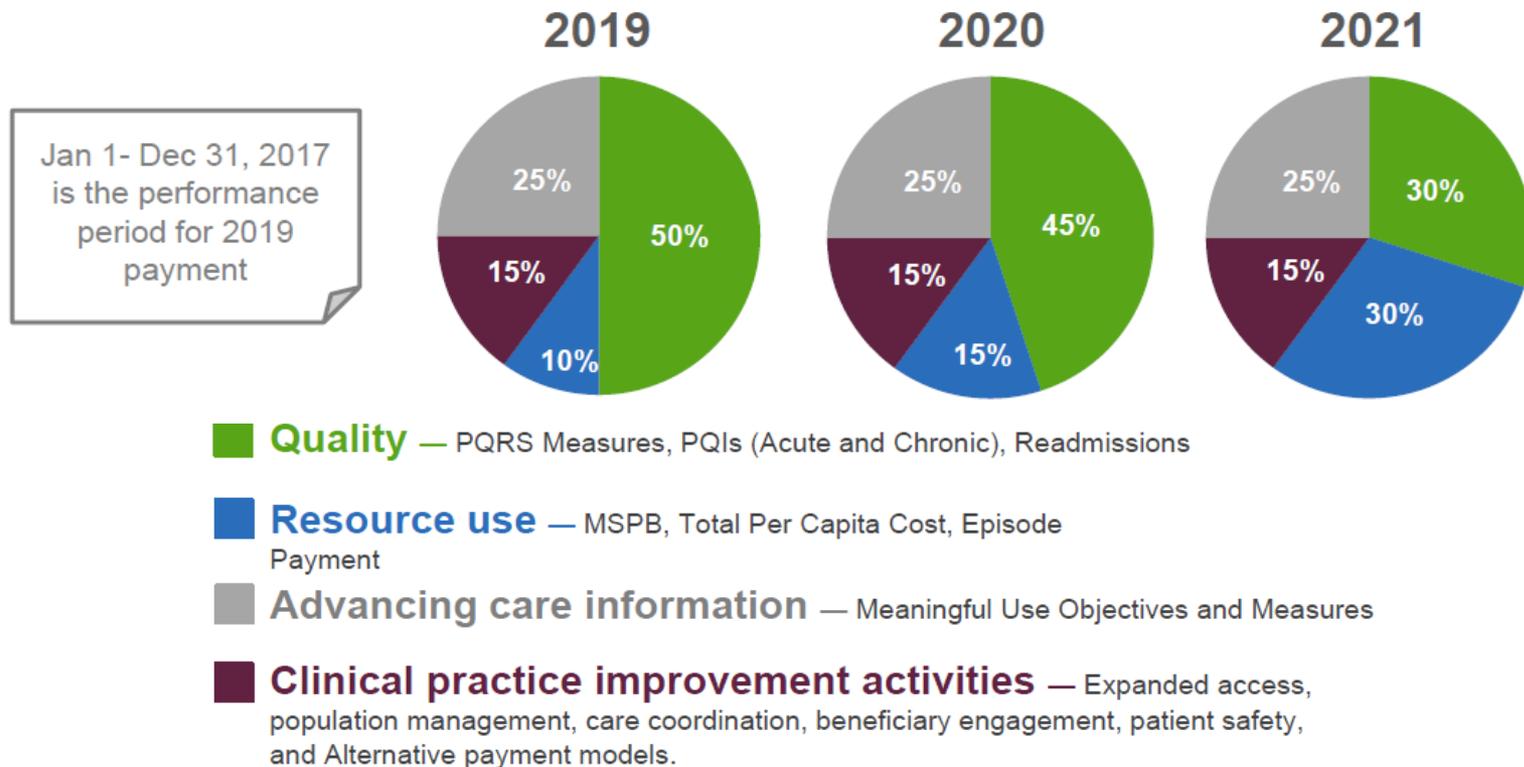


MACRA

- Under Balanced Budget Act of 1997, Congress enacted the Sustainable Growth Rate (“SGR”)
 - Designed to contain cost of care through Part B physician fee adjustments
- In May 2015 Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”)
 - Repeals and replaces SGR
 - Emphasizes value over volume
 - Combines multiple existing physician and hospital quality reporting systems into the Merit-Based Incentive Payment System (MIPS)
 - Provides bonus payments for participation in Alternative Payment Models (APMs)
 - Physicians will either be qualifying participants in APM entities or subject to MIPS

MERIT-BASED INCENTIVE PAYMENT SYSTEM

- 4 category measures constitute a Composite Performance Score (“CPS”)
- Part B payment to clinicians is automatically adjusted based on the CPS



Under the proposed MACRA rule, MIPS will not apply to clinicians (1) in their first year of Medicare Part B participation; and (2) those billing less than \$10,000 in Part B claims or providing care for less than 100 Part B patients in one year.

ALTERNATIVE PAYMENT MODELS

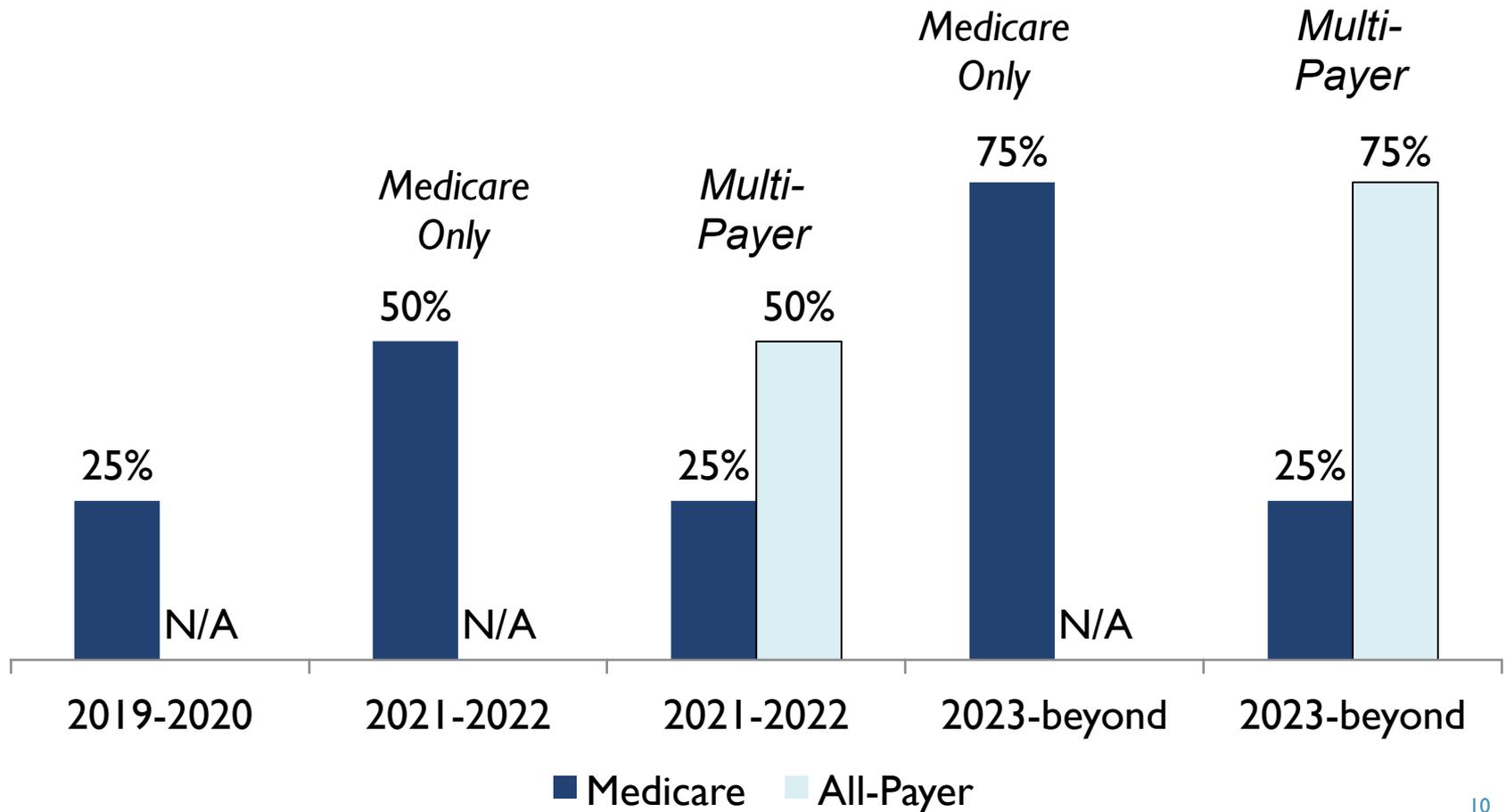
- APMs emphasize value and quality. APMs include:
 - CMS Innovation models (other than a Health Care Innovation Award)
 - Medicare Shared Savings Program (MSSP)
 - Demonstrations under the Health Care Quality Demonstration Program or required by federal law
- Providers participating in an APM:
 - Remain subject to MIPS
 - Receive favorable scoring in certain MIPS categories
 - May receive APM-specific rewards

ADVANCED APMs

- Under MACRA, “Eligible” or “Advanced” APMs:
 - Base payment on MIPS-comparable quality measures
 - Require use of certified EHR technology
 - Either
 - (1) bear more than nominal financial risk for monetary losses; OR
 - (2) be a medical home model expanded under CMMI authority
- Qualifying advanced APM participants (QPs) are exempt from MIPS
 - Must meet risk-based revenue percentage
 - May receive APM-specific rewards
 - Receive a 5% lump sum bonus in 2019-2024
 - Receive a higher fee schedule update in 2026 – 0.75% vs. 0.25%
- Starting in 2021, private payer or Medicaid APM participation will qualify if APMs meet CMS criteria (quality measurement, EHR, financial risk)

ADVANCED APMs

Qualifying Participant Risk-Based Revenue Percentage Requirements



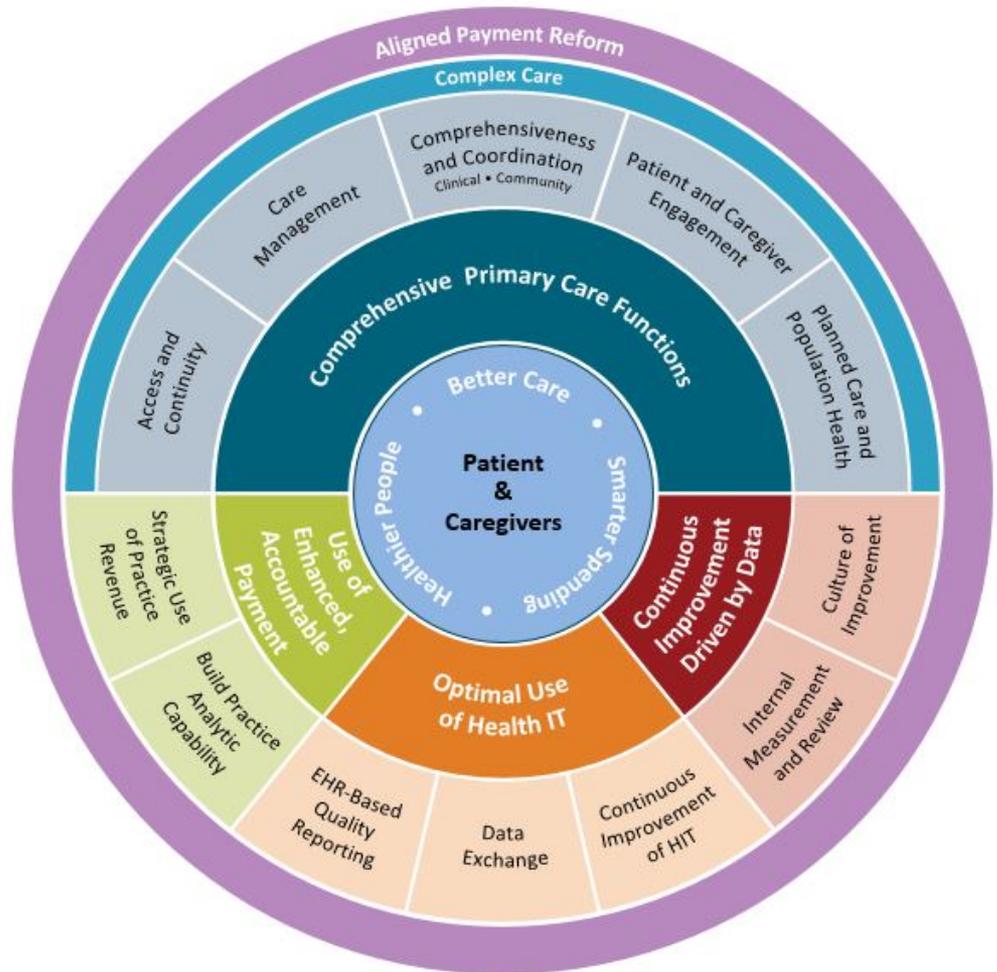
PAYMENT VARIABILITY FOR PHYSICIANS

- Up and down adjustments to fees make MIPS budget neutral
- Providers participating in eligible APMs excluded from MIPS, get bonuses
 - After 2025, no bonuses but higher annual fee update percentage

	2019	2020	2021	2022	2023	2024	2025	2026+
MIPS Fee Adjustment Range	+4%	+5%	+7%	+9%	+9%	+9%	CONTINUES →	0.25% fee update
	-4%	-5%	-7%	-9%	-9%	-9%		
Qualifying APM Bonus (MIPS-exempt)	+5%	+5%	+5%	+5%	+5%	+5%		0.75% fee update

COMPREHENSIVE PRIMARY CARE PLUS

- Part of CMS strategy to move to paying for value, get other payers aligned
- Builds upon Comprehensive Primary Care initiative
 - Launched Oct 2012; currently 445 practices in 7 localities
 - Initial findings: health costs saved, though negligible net savings after care management payments
- Payments for care a blend of FFS and per-beneficiary-per-month
- 2nd track calls upon practices to perform advanced PCMH functions



COMPREHENSIVE PRIMARY CARE PLUS

Practice Functions	Examples for	
	Track 1	Additional examples for Track 2
Access and Continuity	<ul style="list-style-type: none"> 24/7 patient access Assigned care teams 	<ul style="list-style-type: none"> E-visits Expanded office hours
Care Management	<ul style="list-style-type: none"> Risk stratify patient population Short- and long-term care management 	<ul style="list-style-type: none"> Care plans for high-risk chronic disease patients
Comprehensiveness and Coordination	<ul style="list-style-type: none"> Identify high volume/cost specialists serving population Follow-up on patient hospitalizations 	<ul style="list-style-type: none"> Behavioral health integration Psychosocial needs assessment and inventory resources and supports
Patient and Caregiver Engagement	<ul style="list-style-type: none"> Convene a Patient and Family Advisory Council 	<ul style="list-style-type: none"> Support patients' self-management of high-risk conditions
Planned Care and Population Health	<ul style="list-style-type: none"> Analysis of payer reports to inform improvement strategy 	<ul style="list-style-type: none"> At least weekly care team review of all population health data

COMPREHENSIVE PRIMARY CARE PLUS

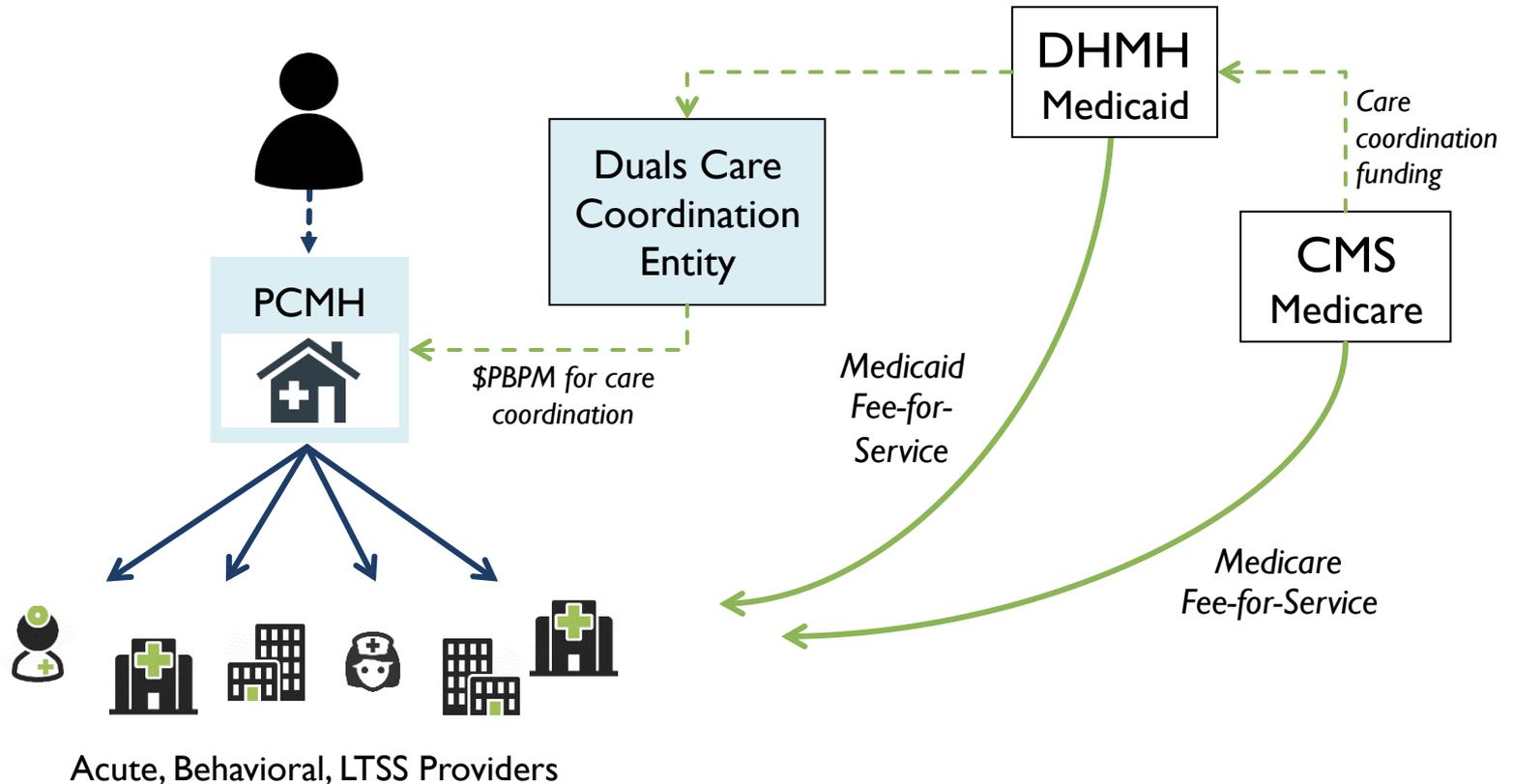
- Payment for care is FFS in Track 1, hybrid of FFS and per capita in Track 2
 - Track 2 practices will receive “Comprehensive Primary Care Payments (CPCP)” – a hybrid of Medicare FFS and a percentage of their expected Evaluation & Management (E&M) reimbursements upfront in a fixed PMPM sum. Commensurate 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)

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- Straw Models Review
 - Managed Fee-for-Service
 - Focus on Washington State
 - Duals Accountable Care Organizations
 - Capitated Health Plans for Duals

MANAGED FEE-FOR-SERVICE FOR DUALS



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

FOCUS ON ... WASHINGTON'S HEALTH HOME MANAGED FEE-FOR-SERVICE DEMONSTRATION

- Health homes serve as central point for directing person-centered care and act as bridge to integrate care across services and delivery systems.
 - Health Home Lead Organizations takes responsibility for the member.
 - Health Home Lead Organizations contract with Care Coordination Organizations (CCOs) or Care Coordinators. The Care Coordinator is the primary person who provides Health Home services. CCOs can be ...
 - MCOs, hospitals, FQHCs, regional support networks, area agencies on aging, community mental health agencies, substance use disorder treatment providers, home health, specialty providers, specialty care and primary care providers.
- Administered by Washington Health Care Authority (Medicaid agency) and Department of Social and Health Services, which is responsible for the delivery of LTSS, developmental disabilities, and behavioral health.
 - Medicaid mental health services are delivered statewide through a 1915(b) specialty managed care plan, administered through Regional Support Networks.

FOCUS ON ... WASHINGTON'S HEALTH HOME MANAGED FEE-FOR-SERVICE DEMONSTRATION

- For an enrollee, service integration is initiated through the development of a Health Action Plan (HAP).
- Health home care coordinator confers with enrollee; together they develop a HAP by prioritizing health action goals, specifying personal actions to achieve the goals, and identifying needed interventions and supports.
- HAP is created during a face-to-face initial visit with the beneficiary and updated at 4, 6 and 8 months, and when beneficiary circumstances change, such as hospitalization or ER visits.
- HAP is entered into the web-based clinical support tool, Predictive Risk Intelligence System (PRISM), which integrates individual-level information from payment (information on utilization of services) and assessment data systems.

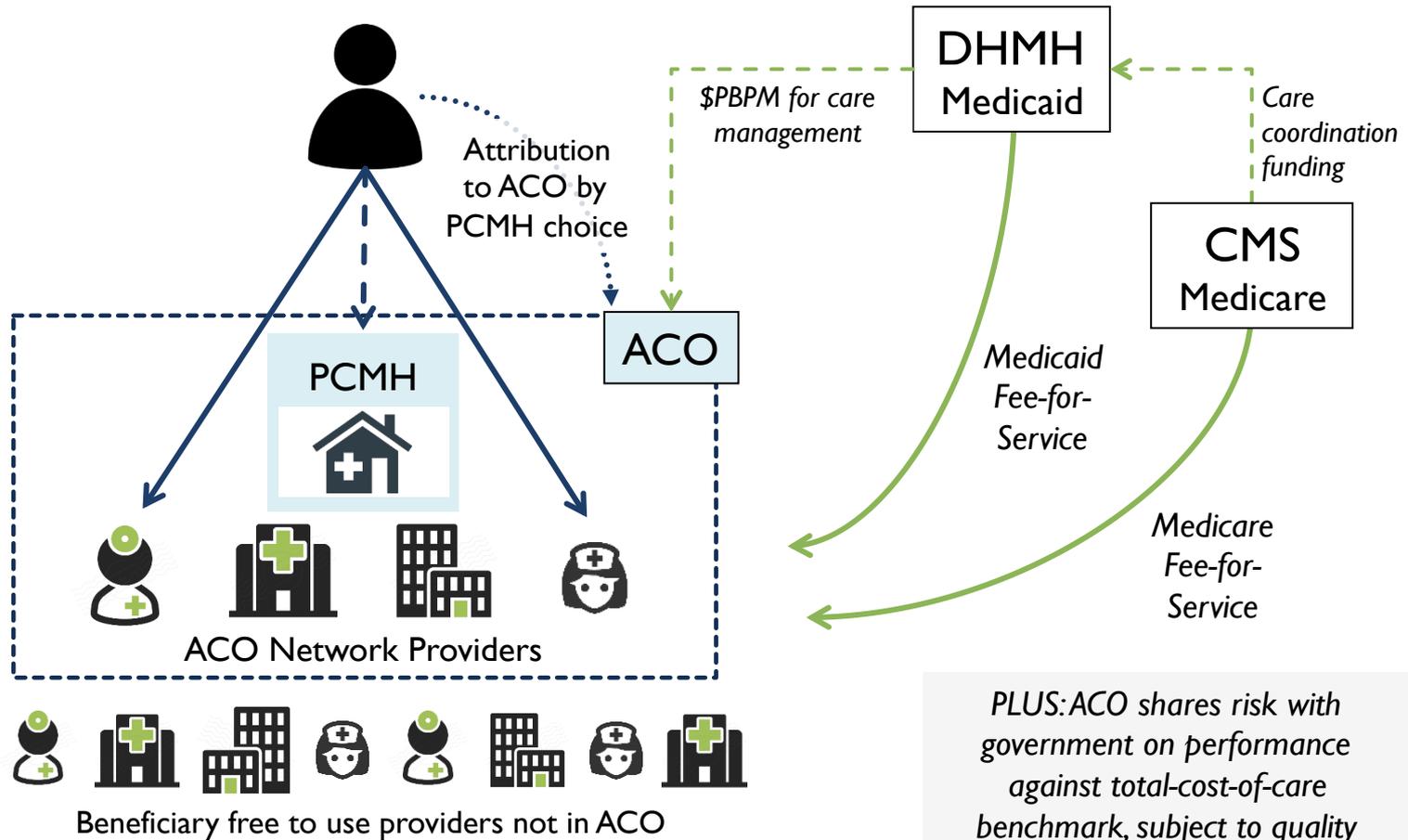
FOCUS ON ... WASHINGTON'S HEALTH HOME MANAGED FEE-FOR-SERVICE DEMONSTRATION

- State pays Health Home Lead Organizations for delivery of health home services on a PPPM basis (one encounter per participant, per month) using 3 payment tiers:
 - Initial outreach and engagement: One-time fee of \$252.93 for health screening, assessment for self-management, and development of the enrollee's HAP.
 - Intensive care coordination: A fee of \$172.61 for months in which the highest level of face-to-face care coordination is provided to an enrollee.
 - Low-level care coordination: \$67.50 for months that face-to-face visits are combined with telephonic outreach.
- All 3 tiers have a mix of clinical and non-clinical staffing elements. Encounters can occur via mail, phone, or home/doctor visits.
- Payments go to the Lead Organization. The Lead Organizations retain 10% of the payments for administration. Remainder is paid to CCO.
- Washington designed the program with a 2% quality withhold for the last 2 payment tiers. The State recently removed this provision.

FOCUS ON ... WASHINGTON'S HEALTH HOME MANAGED FEE-FOR-SERVICE DEMONSTRATION

- Initial findings favorable: Between July 2013 and December 2014, Washington observed \$21.6 million, or 6.1%, in Medicare savings.
 - Savings for a cohort of members that were enrolled in the program the longest:
 - \$75 PMPM for professional services
 - \$41 PMPM for home health services
 - \$24 PMPM for inpatient services
 - Expenditures rose for outpatient services and skilled nursing facility services.

DUALS ACO

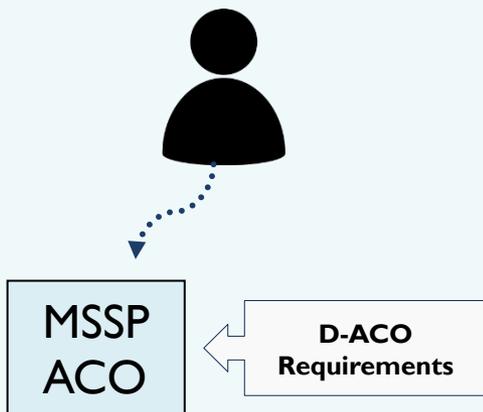


PLUS: ACO shares risk with government on performance against total-cost-of-care benchmark, subject to quality

D-ACO BENEFICIARY ALIGNMENT OPTIONS

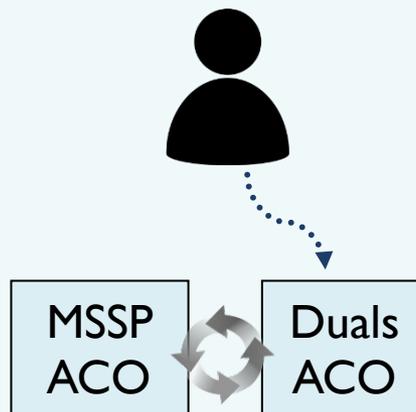
MSSP-Connected

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



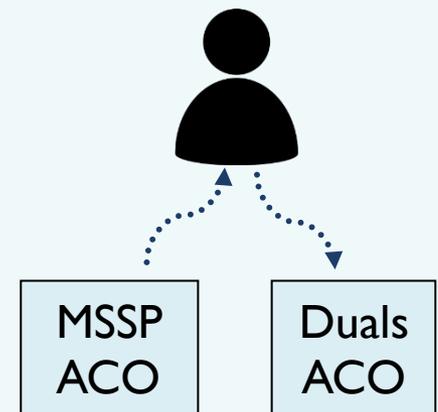
Passive MSSP Phase-Out

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



Pure D-ACO

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



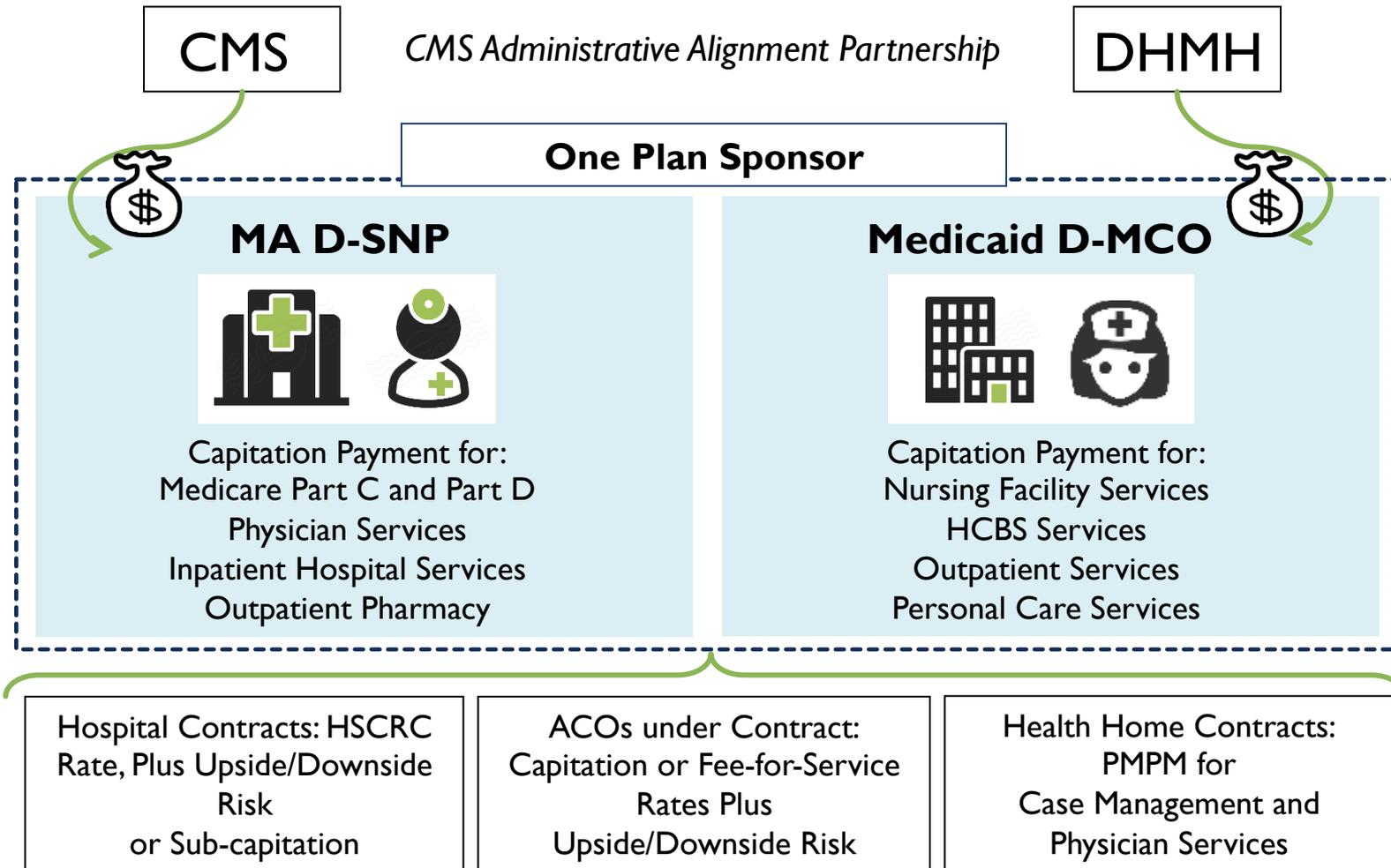
D-ACO COST TARGET CONSIDERATIONS

- 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

BLENDING OF MEDICARE & MEDICAID TARGETS

- Preferred approach, subject to CMS approval:
 - Combine Medicare and Medicaid spend into one pool for both TCOC and end-result calculation
 - Measure surplus or deficit in aggregate and settle gain/loss shares same way
 - Apportion government programs' shares (Medicare/Medicaid) based on percentage of combined target, not separately by Medicare gain/loss and Medicaid gain/loss
- Alternatively, calculate Medicare and Medicaid gains/losses separately
 - Combined savings not available for sharing if federal government portions have loss

DUALS CAPITATED HEALTH PLANS



COMPARISON OF DUALS STRAW MODELS

Model	Care Coordination Entity	Care Coordination Payment
Managed Fee-for-Service	<ul style="list-style-type: none"> Contracted entity – single statewide or several regional (TBD) CCE supports PCMHs 	<ul style="list-style-type: none"> Allocate funds from anticipated savings - including chronic care management CMS code 99490 Per Beneficiary Per Month payment - stratified by beneficiary health status
Duals ACO	<ul style="list-style-type: none"> ACO supports participating PCMHs 	<ul style="list-style-type: none"> Allocate funds from anticipated savings - including chronic care management CMS code 99490 Per Beneficiary Per Month payment - stratified by beneficiary health status
Capitated Health Plans for Duals	<ul style="list-style-type: none"> Contracted through health plans 	<ul style="list-style-type: none"> Embedded within health plan full-service capitation Health plan pays PCMH appropriately for role

- All models coordinate full range of care: physical & behavioral health, social supports, long-term services
- Interdisciplinary care teams (ICTs) are a desired feature in all models

COMPARISON OF DUALS STRAW MODELS

Model	Attribution	Provider Payment	Target Cost PBPM	Incentive	Risk Sharing	Quality
Managed Fee-for-Service	Beneficiary selection of PCMH	<ul style="list-style-type: none"> • Medicaid FFS • Medicare FFS 	Medicare-Medicaid TCOC target, adjusted by population characteristics	<ul style="list-style-type: none"> • CCE bonus if surplus • PCMHs share in award 	<ul style="list-style-type: none"> • No downside risk 	Quality strategy tailored for each model
Duals ACO	Beneficiary selection of PCMH within D-ACO	<ul style="list-style-type: none"> • Medicaid FFS • Medicare FFS 	Same as above; plus possible regional variation	<ul style="list-style-type: none"> • ACO bonus if surplus, tied to quality score 	<ul style="list-style-type: none"> • Downside risk starting Yr 2, with stop-loss 	
Capitated Health Plans for Duals	<ul style="list-style-type: none"> • Mandated enrollment for Medicaid • Voluntary or passive enrollment for Medicare 	<ul style="list-style-type: none"> • Capitation to health plans • Plans pay providers negotiated rates, with VBP features 	Risk-adjusted combined Medicare-Medicaid capitation, calculated in same fashion as TCOC target	<ul style="list-style-type: none"> • Incentive implicit in capitation • Capitation adjusted by quality score after Yr 1 	<ul style="list-style-type: none"> • Risk implicit in capitation 	

COMPARISON OF DUALS STRAW MODELS

Model	Advantages	Disadvantages
Managed Fee-for-Service	<ul style="list-style-type: none"> • Easiest for State to start up • No investment required of providers for network formation • Most flexibility for beneficiaries • Very compatible with all-payer model 	<ul style="list-style-type: none"> • Doesn't give providers greater accountability for TCOC and quality • Limited evidence of return on investment
Duals ACO	<ul style="list-style-type: none"> • Introduces care integration and accountability for TCOC and quality • More palatable to providers and consumers than managed care • Potential MACRA benefits for physicians • CMMI interested: novel model in FFS 	<ul style="list-style-type: none"> • Uncertain if today's ACOs/providers ready to step up, especially to take risk • Mechanical challenges: beneficiary attribution; measuring cost and quality, especially in LTSS • Potential all-payer model conflict
Capitated Health Plans for Duals	<ul style="list-style-type: none"> • Fully shifts risk for cost, plus quality accountability, to licensed entities, giving taxpayers budget predictability and possible savings • Known design with existing provisions 	<ul style="list-style-type: none"> • Without Medicare enrollment mandate, low likelihood of sustainable participation • Most confining to beneficiaries • Little CMMI interest: not truly novel, not FFS

MARYLAND-CMS MODEL ALIGNMENT

		<i>Major Qualifiers</i>				
		Medical Home	Financial Risk	APM	Advanced APM*	
MSSP Track 1		-	-	●	-	} CMS analysis according to MACRA proposed rule
MSSP Tracks 2 & 3		-	●	●	●	
Next Generation ACO Model		-	●	●	●	
CPC+		●	●	●	●	
Maryland All-Payer Hospital Model		-	-	-	-	
Maryland Straw Models	Managed FFS for Duals	●	○	●	○	} EBGA analysis
	Duals ACO	●	●	●	●	
	Duals Capitated Model	Dependent on CMS Classification				

*Advanced APM eligibility is also dependent on payment tied to MIPS-comparable measures and the use of EHR certified technology.

APPENDIX

- Quality Measures
 - Crosswalk
 - Future Steps

QUALITY MEASURES CROSSWALK

Quality of Care Measures – Dual Eligibles (Preliminary List) – Crosswalk to Selected Extant Measure Sets

NQF#	Measure Title	CMS/AHIP	MSSP	Part C	IMPACT
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
0006	CAHPS Health Plan v 4.0 – Adult questionnaire	✓		✓	
0018	Controlling High Blood Pressure ♦	✓	✓	✓	
0022	Use of High-risk Medications in the Elderly				
0032	Cervical Cancer Screening	✓			
0101	Falls: Screening, risk-Assessment, and Plan of Care to Prevent Future Falls		✓		
0104	Adult Major Depression Disorder (MDD); Suicide Risk Assessment				
0105	Antidepressant Medication Management				
0201	Pressure Ulcer Prevalence (Hospital Acquired Also consider other settings) ♦				✓
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan		✓		
0421	Adult Weight Screening and Follow-up	✓	✓	✓	
0553	Care for Older Adults (COA) – Medication Review			✓	
0554	Medication Reconciliation Post-Discharge				
0576	Follow-Up After Hospitalization for Mental Illness				
0648	Timely Transmission of Transition Record (Discharges from Inpatient Facility to Home/Self Care or Other Site)				
1768	Plan All-Cause Readmissions			✓	
2380	Rehospitalization During First 30 Days of Home Health ♦				✓
2456	Medication Reconciliation Number of Unintentional Medication Discrepancies per Patient ♦				
2502	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities ♦				✓
2505	Emergency Department Use Without Hospital Readmission During the First 30 Days of Home Health ♦				
2510	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) ♦		✓		✓
2512	All-Cause Unplanned Readmission Measure for 30-Days Post Discharge from Long-Term Care Hospitals ♦				✓
2597	Substance Use Screening and Intervention Composite				
2599	Alcohol Screening and Follow-Up for People with Serious Mental Illness				
2600	Tobacco Use Screening & Follow-Up for People with Serious Mental Illness or Alcohol /Other Drug Dependence		✓		
2601	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness				
2602	Controlling High Blood Pressure for People with Serious Mental Illness ♦				
2603	Diabetes Care for People with Serious Mental Illness Hemoglobin A1c (HbA1c) Testing				
2604	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy				
2605	Follow-Up after Discharge from Emergency Department for Mental Health or Alcohol or Other Drug Dependence				
2606	Diabetes Care for People Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg) ♦				
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ♦				
2608	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%) ♦				
2609	Diabetes Care for People with Serious Mental Illness: Eye Exam				

♦ = Outcome measures

FUTURE STEPS ON QUALITY MEASURES

- Which quality measures will best demonstrate performance and improvement in the preferred model of care delivery?
- Data collection feasibility and existing data and information flows – Hilltop, CRISP, HSCRC and stakeholders.
- National HHS Priority Area – Affordable/Cost of Care, Care Coordination, Health and Well-being, Patient Safety, Person- and Family-Centered Care, Prevention and Treatment of Leading Cause of Mortality
- Technical specifications and considerations
 - Sample size/reliability
 - Ease of data collection (encounter, episode)
 - Baseline or comparison data available
 - Ease of attribution to clinician or entity
 - Risk adjustment – adequacy
 - Interoperability – Is the measure defined identically across continuum?