

Duals Care Delivery Workgroup

April 4, 2016

Introduction

The meeting was called to order and began at 1:09 pm. Tricia Roddy (Director, DHMH Office of Planning) announced that Shannon McMahon (Maryland Medicaid Director) apologizes for not being present in today's meeting as she was called away to another meeting in DC about the new federal Manage Care regulations. Ms. McMahon may join the meeting via teleconference.

Ms. Roddy explained that since the last meeting the Department has been very busy with working with Health Service Cost Review Commission (HSCRC) and their contractors- Health Management Associates (HMA) to discuss possible care delivery models for the duals population. Ms. Roddy announced that along with discussing those potential models, today's meeting will cover some of the common themes from the survey that went out after February's meeting. Mr. Bob Atlas (Principal, EBG Advisors) began the discussion by introducing his colleague Dr. Shumacher to present refined data from last meeting.

Data Overview

- Dale Schumacher (Consultant, Rockburn Institute) led a discussion of utilization patterns of non-I/DD duals, commenting that additional information can be found at hilltopinstitute.org. A discussion of the quality approach will be forthcoming; some example measures can be found at the back of the slides.
- Marie Grant (CareFirst): The percentages do not add up (Dr. Schumacher confirmed there was double-counting and that the columns are exclusive).
- Mr. Atlas: The two columns on the right-hand side are more frail—going to the left are less in long-term care (LTC) facilities—demonstrates that duals population is not homogeneous.
- Lori Doyle (Mosaic): What is the size of the group we're looking for? (Mr. Atlas: It's too early to say. The more full-risk the model, the larger the group we would want. High need doesn't equate to high-risk.) (Ms. Roddy: What sets Maryland apart is our integration with the HSCRC and their initiatives with the Medicare population—increases the risk pool.) Ms. Roddy also mentioned that with whichever model of service we determine we will be working with HSCRC to ensure the work integrates with the All Payer activities within HSCRC.

Stakeholder survey (Aaron Larrimore and Brendan Loughran, Office of Planning, DHMH)

- Aaron Larrimore (Chief, Medicaid Office of Planning) and Brendan Loughran (Health Policy Analyst, Medicaid Office of Planning) provided an overview of a stakeholder survey that was conducted since the first workgroup meeting. The survey was conducted to get a better understanding of the workgroup's opinion on issues facing the dual population and potential solutions. Mr. Larrimore commented that the survey is part of effort for stakeholder engagement and collaboration, highlighting the diversity of the responses and lack of easy solutions. Mr. Loughran reviewed the slides.

- Ms. Grant: Not everything is encompassed in these slides—how will everything be shared? (Ms. Roddy: We can share the whole set of responses. We may to redact the author’s name given some people may not want their comments to be shared publicly.)
- Mary Puckett (The Coordinating Center): Were there any comments around family caregivers? (Mr. Loughran: There was a lot of conversation around person-centeredness). Which care managers are referenced? (Mr. Loughran: They could be nurses, other clinicians, perhaps non-clinical community advocates.) (Mr. Atlas: There is not one specific provider type that should lead care coordination as people may have various provider specialties depending on their condition.) Are there any comparable surveys that bring in consumer feedback? (The Department is open to this.)
- Adrienne Ellis (Director of Healthcare Reform and Community Engagement, Mental Health Association of Maryland): We did send our survey out to our network of consumers—our response included their input. We did not focus on risk, etc., but on person-centered care and other consumer-focused issues. Emerging from the responses was the adverse effect of having too many care management entities; consumers should be involved in care planning. I would like to hear about the state’s definition of care coordination.
- Scott Rifkin (CEO, Mid-Atlantic HealthCare): There is a lot of talk about bundles and risk, which makes sense in both the Medicare and Medicaid sense. There are people who do not have to be there and could safely be at home—should explore that going down the road.
- Donna Kinzer (Executive Director, HSCRC): One of the points of reluctance at the HSCRC level has been due to not wanting to confuse care intervention with care management—facility level/broad scale would not be able to be implemented by payers. There is a reluctance to use fixed terms. It depends on the needs of the patient and also because the payment method for services could be very different for each service provider typed based on a definition. HSCRC will not be capable of overseeing care management.) (Ms. Ellis: Maybe not HSCRC but there needs to be one agency coordinating this across the state.)
- Mr. Atlas: I agree that we need to define care coordination, care management, case management, etc. Having multiple care coordinators is the antithesis of person-centered care.
- Danna Kaufmann (Schwartz, Metz & Wise): Would it be possible to get an overview of the programs mentioned? (Mr. Atlas: We can provide this. We certainly do not want to wash these programs away and start over. Perhaps we could fold individual waivers under one large demonstration waiver.) (Ms. Kaufmann: Could you also pull together the percentage of duals in each of these programs?) (Ms. Doyle: Use PACE as an example of a longstanding program that works) (Teja Rau, Chief, Maryland Department of Aging: It would be good to see what the options are for a specific disease condition.) (Ms. Roddy: What we are laying out is high-level. There will always be interventions within every model that may be replicated. There will be a second level of discussion after the high-level structure is set.) Ms. Roddy wants the group to really think about looking at total cost of care and not just one disease condition for these models to operate

Guiding Principles

- Mr. Atlas reviewed the guiding principles.
- Ms. Grant: There are parallel discussions going on about the second phase of the All-Payer Model. How is this going to be informed by those discussions? Also, what is the timeline? (Mr. Atlas: Between these meetings, our team, the HSCRC, and their consultants are meeting to ensure compatibility; stakeholder meetings go for three months till the end of June, and we have until the end of August for SIM).
- Ms. Doyle: What are the outcomes that providers will be measured against? Social determinants are incredibly important—the value-based payment will be critical so that we can provide services outside the benefit package. Capitation would allow for this.
- Maansi Raswant (Director, Policy and Data Analytics, Maryland Hospital Association): This should not be applied across the board. When we look at these models, is it right to look at the models first and the population later? Should it not be the other way around? We should identify diagnoses, then design. (Mr. Atlas: We are trying to do that. The lack of time does not allow us to not think of elaborate models.) What about starting with a pilot? There had been initial talk about Baltimore City. (Ms. Roddy: We said that under the CIMH model with previous administrations. We need to work with HSCRC on statewide program—they have to integrate. Once we figure that out, maybe we can pilot. You can talk about the high-level structure before going into specific conditions.) These models have lots of carve-outs. (Ms. Roddy: What we have put on the table is total cost of care for Medicare and Medicaid. We are looking at comprehensive care and integration across the full continuum.)
- Nicki McCann (Johns Hopkins Governmental Affairs, sitting in for Laura Herrera Scott): Maybe we do not need to define care coordination but focus on person-centered care, helping the person to achieve their own goals.
- Medicare Access and CHIP Reauthorization Act (MACRA)
 - Debi Kuchka-Craig (Corporate Vice President, Managed Care, MedStar Health): Regarding the last bullet on MACRA—I am not sure it should be a guiding principle, just a nice unintended consequence. (Mr. Atlas: A lot of physicians are not really appreciating MACRA yet, but CMS is developing a final rule for the end of this year. If we can help, it is a win. You are correct that as a guiding principle, it is not the same as the person-centered care, etc.) Many physicians are in ACOs and already working on that.
 - Niharika Khanna (Maryland Learning Collaborative): I appreciate that MACRA is there—CMS is considering Maryland to be unique and if the model will qualify for MACRA.)
 - Ms. Grant: It is hard to use MACRA as a guiding principle when we do not know what it will look like. (Mr. Atlas: The whole point of MACRA is to pay for value, so if anything, it is redundant given there will be other quality measures.)
- Ms. Rau: We should be making sure community resources are sustainable.
- Ms. Ellis: I would suggest that, if you are not talking to the consumer, you are not doing patient-centered care. I agree with the need for flexibility.

- Ms. Kaufmann: When we start talking about integrated data, we need to make sure the forms are uniform.

All-Payer Model Amendment

Ms. Donna Kinzer presented that the state is working on trying to get some amendment from CMS about getting more flexibility in payment for coordinating care. The current amendments requested are to have more flexibility so that physicians can work closer together in care coordination. Ms. Kinzer's team is hoping for approval of these amendments over mid-summer from the federal government. It is important to note that approval is never guaranteed and if approval is given over the summer she would hope to have a January 2017 start date.

- Ms. Kinzer reviewed Internal Cost Savings (ICS) and Pay for Outcomes (P4O) programs, with emphasis on P4O.
- Dr. Rifkin: This is spot-on with how you interact with SNFs and other parts of the system.
- Ms. Doyle: What has been done with the HSCRC and hospital-centric system has been a good start, but I am hoping that bringing in the duals and Medicaid will bring this to a community-focused setting, even outside of the walls of primary care. (Ms. Kinzer: This is a hybrid—the CCM fee is inbound, if supported with other resources, this could be an important alignment activity—hospitals, nursing homes and community providers. As hospitals get into the 'how do we be successful mode,' they will find they need this. For example, a patient lives on the third floor and calls an ambulance to go to the ER because they cannot otherwise get to the doctor. We need to get that person on the first floor so that they can use public transportation.) Ms. Kinzer thinks this is a very important factor to think about but also have to keep in mind how payments for services are made. Also it is important to think about the downstream effects for patients.
- Dr. Khanna: Good to include SNFs. There are a lot of downstream factors before getting to hospital and SNF. Will be difficult to pin a P4O on a community provider—great idea but with a lot of challenges. (Ms. Kinzer: Lots of work on how to call community providers—future iterations will use PDP—patient-designated provider—instead of PCP. Providers can bill under CCM code.)
- Ms. Grant: What is the role of any risk to providers? There is no risk on the hospital beyond what is already in the waiver, no risk to the provider because they will receive incentives, but there's no risk down the road? (Ms. Kinzer: The P4O does not place risk on non-hospital providers. There is a provision that says the total cost of care cannot go up. If it does, the hospital will not be able to pay out shared savings, though community providers will have earned their CCM fee).
- Ms. Raswant: From a hospital standpoint, there is risk in sharing out monies—one way to look at it. (Ms. Kinzer: This is not a new responsibility for hospitals; about 75 percent of Medicare beneficiaries are not under any care coordination right now. We also think some ACOs might participate as well.)

Straw Models: Managed Fee-for-Service

- Mr. Atlas reviewed Managed Fee-for-Service model
- David Horrocks (President and CEO, CRISP): Do we have good data about where beneficiary ACOs are, i.e. which practices? (Ms. Roddy: CMMI will be providing us with that.)
- Ms. Doyle: Which states could we look at? (Mr. Atlas: Colorado and Washington State. North Carolina does this for regular Medicaid beneficiaries but not duals.)
- Ms. Kaufmann: Why did they leave the duals out? (Mr. Atlas: They are actually moving away from this to a capitated model but still leaving the duals out.)
- Ms. Rau: Going back to Donna's example, how would this model address the need for social services and community resources? (Mr. Atlas: This person would be known to the RCCE; the consumer or caregiver would have the number and contact them for to arrange, or the doctor's office could call RCCE to arrange.) This should be spelled out more specifically in here—not just transportation but heat turned off, etc. (Ms. Roddy: Point well-taken.) (Ms. Shannon McMahon reiterated that some of these details should be discussed as this process is meant to be a true stakeholder engagement process. The department has not developed any specific plan so these questions and factors need to be brought up and addressed deliberately as possible at these meetings.) (Mr. Atlas: We need to be considerate of what is fundable in a Medicare/Medicaid context. We might get waivers from CMS to allow us to pay for some social supports; we should push the envelope as much as possible.)
- Judy Lapinski (COO, Mid-Atlantic Association of Community Health Centers): I am one of the ones pushing for state definition of care coordination. We still don't know what we are really talking about. Let's define the terms. What are the things we can feasibly put in there, at least in big general categories? (Mr. Atlas: We can form a sub-group to look at defining care coordination. (Ms. Grant, Ms. Lapinski, Dr. Khanna, Ms. Raswant, Ms. Doyle, Ms. Rau and Mr. Rose volunteered.)
- Ms. Doyle: The capitated plan we had was at the provider level. (Mr. Atlas: We are not currently contemplating any condition-specific capitation models—we could talk later.)
- Ms. Grant: The care coordination necessity is going to be very resource-intensive. To do it well, it is going to have to touch social determinants and will need more. (Mr. Atlas: CCM is not meant to touch social determinants. We will have to stratify the population and allocate other resources. One of our goals today is to choose which of the three big categories where we want to throw our energies.)
- Scott Rose (CEO, Way Station): PCMH can be a specialized provider—is there openness for the strategy of a behavioral health provider being a medical home? (Mr. Atlas: We need to come up with some clinical rules-setting, but if a behavioral provider is a person's main provider, one could imagine they could serve as PDP.) (Ms. Kinzer: Alternatively, if the behavioral provider arranges all their primary care.) (Ms. Roddy: We have a Chronic Health Home (CHH), we are paying \$98 PMPM, and it is very specific what they have to do...we have to make sure to leverage what's already in place.) I'm concerned about duplication. (Ms. Roddy: CHH was never meant to be primary provider.) Yes but if there's an enhanced ability to fulfill this role, could look at that. (Ms. Roddy: Maybe at a future meeting could talk about the challenges of working with the duals population in terms of dealing with Medicare.) The difficulty is not in dealing with

a Medicare-funded PCP. It is when there is care management with different entities. With the SMI population, it is developing the motivation to follow through with treatment. It is grounded in relationships. We do not want to lose that. Then there is skill development, as well as creativity in determining a care management solution.

- Ms. Raswant: Back to the guiding principles, could we include under beneficiaries to promote more engagement? Some beneficiaries may require to be engaged than other or at least have increase accountability of their healthcare. It may be helpful to consider concepts that would allow the person to follow the self-determination model so that the consumer really feels involved in making choices in their healthcare. (Echoed by Ms. Krupke-Craig and Ms. Ellis.)

Duals ACO

- Mr. Atlas reviewed Duals ACO model
- Ms. Kaufmann: Does a provider have to be able to receive payment from both Medicare and Medicaid? (Mr. Atlas: It does not have to be that way, but the provider should be able to accept payment from at least one of those sources.)
- Ms. Grant: [Asked about novelty.] (Mr. Atlas: CMS has been hinting at this. In Minnesota, they have been working on a model that requires MCOs to work with ACOs.) What evidence is there that this model will work for this complex population, given the mixed experience with ACOs? (Mr. Atlas: The ACOs were poorly-planned to begin with. We will declare up front that ours will be a workable design.) (Ms. Kinzer: PCMHs have not worked in a lot of states either, but they did in Maryland—aligned interests between hospitals, PCPs and LTC providers.)
- Dr. Rifkin: Do they still require a minimum of 5000 covered lives? (Mr. Atlas: That is still the case with CMS, except in rural areas.) This would have worked well with SNFs but CMS would not waive it. This would work great within a company. (Mr. Atlas: We could put this on a list of desired waivers.) (Ms. Roddy: Keep in mind what makes sense for total cost of care, etc., i.e. the size of the risk pool.)
- Ms. Kuchka-Craig: Would this model manage the Medicare or Medicaid side? (Ms. Roddy: We would be managing the whole person.) (Ms. Kinzer: The Homes and Community Based Services (HBCS) have expenditures in the millions with a series of other pieces, such as the co-insurance for the other side—perhaps we need a pie chart—but about half the cost is Medicaid.) (Mr. Atlas: Medicare will only cover through a skilled nursing facility (SNF) stay; would fall off once off the Medicare radar.)
- Ms. Lapinski: Other than a lack of readmissions and ED, we are really just looking at cost and not outcomes. (Mr. Atlas: We will be looking at quality during the next meeting. Both those elements will be part of the incentive.)
- Ms. Doyle: You could have a network of providers that form an ACO, or a network of providers that form a RCCE, with the difference being the risk? (Mr. Atlas: RCCE is for care coordination, not care delivery. ACO would include care delivery—more hands-on.)
- Ms. Lapinski: Provider entities could apply to be RCCEs, so that there would be one less entity arranging care? Such as an FQHC? (Mr. Atlas: It could be anybody per the current design, so long as they demonstrate that they could perform the scope of work—QIO, HMO, etc.) (Ms. Roddy:

the RCCE will be dispersing payment. I am not sure if a federally qualified health center (FQHC) could do this beyond its own patients.)

- Ms. Ellis: You suggested they would do pre-authorization—it would not make sense to have providers doing their own authorization. (Mr. Atlas: It would have to be a neutral body. In North Carolina, they employ nurse coordinators in primary care offices.)
- Ms. Kuchka-Craig: Because of GBR and where we are going, how long before this would start? Does timeline of Yr3 downside risk align with Phase 2.0? (Ms. Roddy: We are working to develop a model for the duals that is integrated with HSCRC. If we need permission to share Medicare dollars with providers or limit number of ACOs, we will need waivers. We will have an application ready to CMS by end of summer. Depending on type of waiver, CMS might take six months to approve the waiver. After that, we have to implement. 2019 is when Phase 2 when starts.) This project could have a begin date of 2020. (Mr. Atlas: There could be a glide path on risk variable.) (Ms. Kinzer: In terms of savings opportunities for Medicare, which is the current focus, the extension says we have to focus on Medicare total cost of care and outcomes. If you look at Medicare cost, it is about 700-800 million dollars in admissions to hospitals, then there is some outbound to post-acute, so those comprise the edges of what could produce opportunities for care improvement and savings. One of the things within P4O is to put our arms around as much of that as possible within the existing model—position us without having Medicaid piece nailed down. There are good opportunities to work together within the amendment. There is a different timeline for Medicare piece; we will work in Medicaid later.)
- Ms. Lapinski: When getting closer to downside risk, patient attribution will be a bigger concern. Is there a line of thinking on that? (Mr. Atlas: Will need to use Medicaid level but firm it up. CMS has a NextGen ACO model with prospective attribution approach—we might look at that.)

Capitated Plan

- Mr. Atlas summarized capitated plan.
- Dr. Rifkin: How about an I-SNP instead of D-SNP? They are doing that in Pennsylvania.
- Comment from the workgroup: Interdisciplinary Care Team concept could be applied in MFFS or ACO concept as well.

Next Steps

- Workgroup homework: Think of additional questions—please do not wait until next meeting but send them in via email as the come.
- The conclusion of a committal poll shows the group is leaning more towards the ACO model.
Non-committal poll:
 - MFFS: 3
 - ACO: 4
 - Capitated: 1
- Ms. Grant: We need to talk about the models in light of the guiding principles.

- Ms. Raswant: I would like to see high-level, key takeaways from other states (Mr. Atlas: We would like to lay out a preferred model at the next meeting—hoping for influx of input after this meeting.)
- Comment from the workgroup: The workgroup needs to vet each model before narrowing it down. (Ms. Roddy: Let us do it via email—try to figure out where to focus our efforts.)
- Mr. Atlas: We are willing to have conversations with people over phone or in-person. We need to confine that, but we can do individual conversations.
- Ms. Ellis: Could we set up an email group? (Ms. Roddy: Yes.) (Ms. Kinzer: Other workgroups have used Basecamp.)
- Ms. Grant: I would like to be cognizant of the Open Meetings Act.
- Ms. Rau: It would be helpful to know what we're thinking about how to integrate community resources into each model. (Ms. Roddy: It would be useful to hear how the hospitals will be using P4O to incorporate community resources.)

Public comments:

There were no comments from the public.

Meeting was adjourned at 4:10 pm.