Interim Term Quality Improvement and Cost Savings Strategy Recommendations to the MaineCare Redesign Task Force (PL. 657-1746)

October 17, 2013

Background:

The following public policy recommendations to the MaineCare Redesign Task Force are fundamentally based on:

- A comprehensive analysis of the aggregate data prepared by MaineCare staff, the recommendations of the MaineCare Redesign Task Force consultant (SVM), and additional data analysis submitted as Appendix A.
- The goal of Maine DHHS/MaineCare and the Redesign Task Force to consider and recommend to the Maine Legislature short term (3-6 months) and interim term (6-12 months) cost savings and potential quality improvement strategies with attention to minimizing unintended negative outcomes over the long term.
- Compatibility with the MaineCare Value Based Purchasing Strategies: Accountable Communities, PCMH pilots, and 2703 related health home initiatives by augmentation of multiple systems care coordination based on medical necessity, data sharing, and quality standards.
- Focus on high cost chronic care conditions across the spectrum of MaineCare services and home and community based waiver(s) eligibility categories as recommended by SVM Consulting:
  - High Risk/High Cost populations
    - Complex case management program for adults with multiple co-morbidities
    - Care management program for adults with disabilities
  - Managing Long Term Care
    - Shifting Long Term Care to community based settings
  - Managing High Cost Enrollees – Mental Health

- ❖ Behavioral Health Organizations as integrated entities responsible for comprehensive care

- Managing High Cost enrollees – Individuals with Developmental Disabilities

- Source: SVM, "Medicaid Cost Containment Strategies," 9/25/2012 presentation to the MaineCare Redesign Task Force.

- Recommended solutions are based on proven evidence based strategies.

- **NOTE on Cost Savings:** for the purpose of illustrating an expected level of cost savings based on the implementation of one or more of the Quality Model Initiatives recommended to Maine DHHS and the MaineCare Redesign Task Force we have included a relatively conservative analysis of a 5% incremental decrease in the ID/DD Home and Community Based Waiver costs over a three year period reasonably expected to yield $43.747 million in aggregate savings with no caseload reduction and all factors being equal. As we know, all factors are not equal over time so we point out the importance of the need for a more detailed analysis that minimally takes into account:

  - Annual medical inflation

  - Changes in provider rates

  - Changes in projected number of designated beneficiaries engaged with each Quality Model Initiative

  - Changes in the number of individual Home and Community Based Waiver funded "slots"

  - The ability of the state to enlarge the number of community based residential options for targeted populations that are less expensive in the aggregate than the current distribution of individualized and group living options.

- Unanticipated events

☒ Given the scope, size, and cost of the aggregate number of MaineCare beneficiaries who experience multiple chronic care conditions and/or receive services from MaineCare's current delivery systems for Long Term Care and Intellectual and Developmental Disabilities home and community based waivers an estimate of aggregate savings over a three year period from the point of implementation and adjustment for "ramp up" time could yield savings between 5% and 15% cumulative and a dollar savings between $75 million and $125 million cumulate if not higher.

A more detailed analysis of actual MaineCare claims paid, services patterns for medical and non-medical services, and individual practice/provider utilization trends would provide a more refined estimate. Cost savings estimate for all three models would be refined by cross-analysis to the CIMM projected savings model for Medicaid savings included in the SIM application to CMS.

1. Integrated Chronic Care Management Initiative for High Cost Cases

☒ Provides comprehensive chronic care management action strategies for individuals with multiple chronic care conditions in unison with HCBS 1915 (c) waiver services, rehabilitation option mental health services, and EPSDT related services.

☒ Based on a partnership focused on the individual person/recipient that is actively guided by independent RNs and medical social workers in unison with the individual's primary care provider (PCP), specialists, medication plan, and home and community based services.

☒ Targets chronic conditions improvements tracked by care connecting Health Information Technology (HIT).

☒ Assists/educates/empowers the individual to take control over their own health care with a goal of independent self-management to the maximum extent possible.

☒ Actively promotes and encourages personal responsibility.

- ☒ Supports relationships with PCP, specialists, related service needs.
- ☒ Coordinates transportation at the individual person level.
- ☒ Assures/participates in follow-up care after hospitalizations of Medicaid/Medicare paid nursing facility rehabilitation stays.
- ☒ Assists with other community providers across the range of Medicaid paid services, including HCBS waivers, food, clothing, support groups, and housing.
- ☒ Model is designed on designated cost savings based on integrating medical care, to achieve cross systems active communication, and data analytics.

2. Independent HCBS DD/LTC Waiver Management Initiative

The goal of this initiative is to implement a partnership strategy for the independent administration of home and community based services on behalf of MaineCare's distinct populations of vulnerable adults and children with Intellectual/Developmental Disabilities (DD) and adults with Long Term Care (LTC) Needs.

The independent waiver management model is compatible with, and complimentary to, the development of Accountable Communities medical services and patient centered medical home (PCMH) primary care/Section 2703 health homes-based on current MaineCare policy and a focused Chronic Care Management initiative. Effective implementation strategies for each vulnerable population (SPMI/SED; people with ID/DD; LTC) require specialized solutions within a comprehensive care coordinated Medicaid program framework.

The fundamental principles of the Integrated Home and Community Based Services Waiver Quality Model are:

- ☒ Independent medical necessity based assessment for eligibility for services.
- ☒ Independent individualized case services planning (with attention to multiple diagnoses).
- ☒ Individualized services budget.
- ☒ Facilitate recipient provider choices.
- ☒ Independent annual/change in condition re-assessments.
- ☒ Independent utilization review.
- ☒ Independent provider quality assurance and improvement measurement.
- ☒ Independent institutional diversion and transition action strategies

- ☒ Assurance of HCBS provider coordination with the medical services needed and provided by Accountable Communities/PCMH/2703 health homes.
- ☒ Technical assistance for provider remediation and improvement.
- ☒ Participant experience survey.
- ☒ Aggregate budget adherence by categorical population/funding source.
- ☒ Assurance of participant rights, appeals, and complaints.

The anticipated outcomes are:

- ☒ Standards based assessment, services planning, and individualized budgeting of cases specialized to each population.
- ☒ Appropriate utilization based on medical necessity and medically assessed strengths and needs.
- ☒ Increased home and community based services access.
- ☒ Improved health status based on HCBS assured provider(s) coordination with AC/PCMH/2703 health homes.
- ☒ Cost savings, given current costs of MaineCare's ID/DD and LTC waivers.
  *High Cost medical services care coordination for HCBS services recipients to be determined when MaineCare policy is known and clarification of the Accountable Communities, PCMH/2703 health homes, and community care teams and any assignment of risk.
- ☒ Requires a targeted Medicaid purchasing strategy to achieve systemic objectives, improve quality, and save costs.

➢ Why the Independent DD/LTC HCBS Waiver Management Initiative Makes Sense

- ☒ Compatible with the MaineCare Accountable Communities and PCMH/Health Homes initiatives by not creating another layer of government bureaucracy and bridging the gap on medical services coordination with the current decentralized case management and DD/LTC provider systems.
- ☒ Successful implementation improves quality and results in savings
- ☒ Can be implemented through market based RFP competition within 60 to 90 days.
- ☒ Can be implemented on a "pay for performance" or risk basis to assure MaineCare gets what it pays for.

- MaineCare can articulate how consumers and families will be involved, what the measures of transparency should be, and how protection, appeals, and complaints will be managed based on a contract.

How the Independent DD/LTC Waiver Management Initiative Will Improve Quality

- Access is equitably distributed and consistently determined.
- Objective, standardized, independent assessment process assures rater non-bias reliability.
- Service authorization process is efficient, transparent, assures recipient/family choice.
- Independent services authorizations assure documented individual needs, strengths, and goals in all recipients' services plans that can be measured.
- Independent waiver management assures that services are delivered according to the authorized services plan and adjusted upon reauthorization
- Independent retrospective provider review according to specified waiver and state quality requirements.

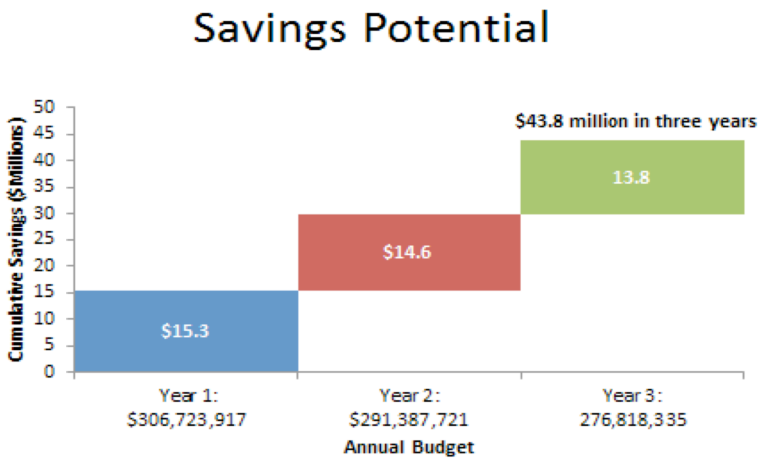
How the Independent DD/LTC Waiver Management Initiative Will Result in Savings

- **What the Numbers tell us:**

  - In 2009 MaineCare expended $306,723,917 on the DD HCBS waiver (Source: Thompson Reuters)
  - Based on similar waiver management solutions in other states, a reasonable quality based cost reduction strategy would yield significant savings at an incremental approach of 5% annual cumulative cost savings over a three year period, unadjusted for medical inflation and possible program growth:

Total Budget	Year 1: 5%	Year 2: 5%	Year 3: 5%	Total Estimated Savings
$306,723,917: Year 1	$15,336,196			$15,336,196

$291,387,721: Year 2		$14,569,386		$29,905,582
$276,818,335: Year 3			$13,840,917	$43,746,499



- ☒ Savings could be used to address program expansion needs, if any, or base budget reductions.
- ☒ Savings could also be achieved in the Long Term Care program by evolving the reliance on nursing homes and increasing home and community based services options for Maine's seniors.

3. Population Based Integrated Services Model for Medicaid Eligible Individuals with a Serious Mental Illness and Chronic Co-Morbid Medical Conditions

- ☒ Target Program Users: State operated community mental health centers (CMHC) and other agencies designated by the Department of Mental Health
- ☒ Target Population: Medicaid eligible members with behavioral health disorders who have a diagnosis established by the Department and at least 1 co-occurring chronic medical condition

- ☒ **S**ervices provided by an integrated behavioral health organization:
  - ☒ Technical assistance, training of providers and support staff and information tools for agencies and providers
  - ☒ HIPAA-compliant technology that links agencies and provider systems
  - ☒ State of the art predictive modeling, risk assessment, analytics and reporting supports
  - ☒ Communication and Coordination Between Providers
  - ☒ Coaching Mental Health Providers to Meet Physical Health Needs *and* PCPs to Meet Co-occurring SPMI needs
  - ☒ Integrated Primary Care Case Management
  - ☒ Intensive Case Management: Identification/ICM of the highest risk/highest cost individuals
  - ☒ Provider Engagement
- ☒ Department Support
  - ☒ Develops a State Medicaid Plan amendment for approval of a 2703 Health Home project (Missouri model is a best practice example)
  - ☒ Comprehensive Care Management: Data driven stratification to prioritizing members most in need of intervention and identification of the intervention
  - ☒ Monitoring patient outcomes and provider specific behaviors
  - ☒ Quality improvement recommendations and processes
  - ☒ Outcomes measurement and reporting
- ☒ Department establishes BHO requirements, sets rates, utilizes performance and outcomes based contracting design utilizing incentives and risk based on pre-established clinical, health status, compliance, and quality metrics.

Appendices

A. Maine's Data Frames the Need

- ☒ **5%** of all Medicaid recipients expend 58**%** of total MaineCare's budget**. (**Source**:** MaineCare presentation**,** 8/28/12).
- ☒ Long term care expenditures represent **55%** of the total expenditures of the 5% high users (Source: MaineCare presentation, 8/28/12).
- ☒ Expenses by Clinical Conditions: All members (Source: MaineCare presentation, 9/25/20102)
  - Mental Health: 28%

- Developmental Disabilities: 20%

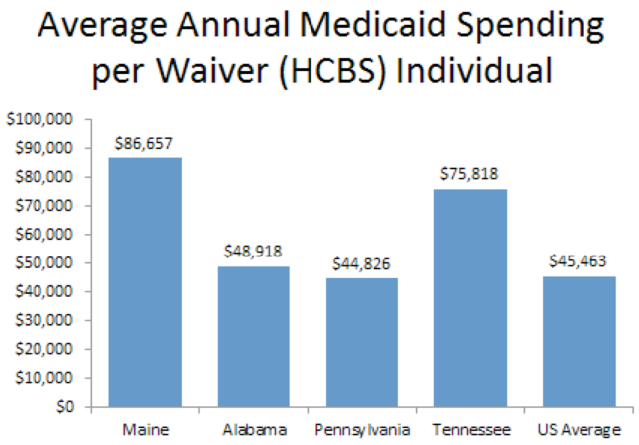
☒ Total MaineCare Long Term Services and Supports Expenditures - 2009:

- Total Nursing Facilities: $252 million
- Total HCBS: $82 million
- Source: AARP: "Across the States: Profiles of LTSS," 2012 edition

☒ MaineCare estimates that the Accountable Communities (AC) model will not have a significant impact in reducing costs of long term care. (Source: MaineCare presentation, 8/18/12).

☒ MaineCare's 1915 (c) waiver for Home and Community Based Services (HCBS) for people with Intellectual Disabilities/Developmental Disabilities (ID/DD) ranks as the **third** most expensive state in the US:

- ☒ National average: $45,463 per person
- ☒ Maine average: $86,657 per person
- ☒ Source: Coleman Institute/University of Colorado, 2011/2009 CMS data



☒ Maine spends **51.5%** more per person on ID/DD HCBS waiver per $1,000 personal income (PI) than US average:

- ☒ National average: $4.12 per $1,000 PI
- ☒ Maine: $8.00 per $1,000 PI
- ☒ Source: Coleman Institute/University of Colorado, 2011/2009 data

- Maine spends **49.5%** more per capita on ID/DD HCBS waiver than the national average:
  - National average: $180 per capita
  - Maine: $363 per capita
  - Source: Coleman Institute/University of Colorado, 2011/2009 data
- **71%** of Maine Care's high cost members (5%) use long term care services (Source: MaineCare 2010 Fact Sheet).

B. Action Steps Needed to Make This Happen in Six to Twelve Months:

- Communicate with CMS to frame the State's intention.
- Identify what waiver terms may need to be modified, request CMS technical assistance as needed, discuss CMS financial grant options that may be available to invest in the state's objective that do not require state match.
- Create a Medicaid Purchasing Strategy RFP Development Team or empower existing MaineCare RFP development resources.
- Target the population to be served, such as ID/DD HCBS waiver eligible adults and children.
- Target the services to be managed by the vendor, including ID/DD HCBS waiver services, independent case management services.
- Establish vendor requirements.
- Target an identified method that is compatible with the Accountable Communities and PCMH/Health Home models that assures high cost case care management either within the scope of the procurement, within the scope of the Accountable Communities/PCMH/Health Home models including articulated coordination requirements with HCBS consumers and waiver providers, or an identified method such as the Vermont Chronic Care Initiative tiered care coordination model.
- Clearly identify waiver management vendor requirements:
  - Operate a HCBS ID/DD comprehensive waiver management organization that includes independent assessment; individual consumer services budgeting; aggregate waiver budget responsibilities and performance requirements based on outcomes, and measures of gainshare, and risk; individual services plan and budget approval and review process, and services monitoring and consumer satisfaction.

- ☒ Waiver management process must include at a minimum:
  - Initial, annual, change in condition independent assessment.
  - Assessment process including consumer, family/significant others, guardians, potential service providers as needed, and vendor professional assessment staff.
  - Ensuring vendor sets individual waiver budget based on medical necessity and assessment findings.
  - Working with consumer and family/significant others/guardians review budget and choose services.
  - Vendor reviews and prior authorizes services.
  - Consumer receives services; vendor audits delivery of services.
  - Annual/bi-annual re-assessment is scheduled and the cycle begins again.
  - Vendor performs periodic quality, utilization, and consumer satisfaction reviews that meet CMS Quality Assurance and state requirements.
- ☒ State identifies regular (monthly, quarterly, etc.) vendor meeting and reporting requirements.
- ☒ State clearly identifies consumer protection, rights, appeals, and complaint procedures.
- ☒ Identify public input process.
- ☒ Engage competitive RFP process

C. States that have implemented successful Initiative strategies:

State	Independent Quality Model
California	Aged/Disabled LTC Waiver Program Management
West Virginia	Aged/Disabled LTC Waiver Program Management
West Virginia	ID/DD Waiver Program Management
Maryland	ID/DD Waiver Program Management

Florida	ID/DD Waiver Program Management
Hawaii	Behavioral Health Medicaid Integrated Services
Georgia	Behavioral Health Medicaid Integrated Services
Maine	Behavioral Health Medicaid Services
Maryland	Behavioral Health Integrated Services: state employees
Commonwealth of Puerto Rico	Behavioral Health/Medical Services Integrated Services
Washington, DC	High Risk Individuals Care Management
Iowa	High Risk Individuals Care Management
Ohio	High Risk Individuals Care Management
Oregon	High Risk Individuals Care Management
Pennsylvania	High Risk Individuals Care Management
Vermont	High Risk Individuals Care Management
California	High Risk Individuals Care Management
Hawaii	High Risk Individuals Care Management
FL, GA, ME, WV, WY: Critical assessment in determining individual mental illness and developmental disabilities related needs in institutional and/or community settings.	Level 1 and/or level 2 PASRR screening

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