DRAFT Complex and Chronic Care Improvement Program Template

Performance Year 2017

(Not approved by CMS – subject to continuing review process)

A. Introduction

The Complex and Chronic Care Improvement Program (CCIP) is designed to allow Participant Hospitals to support eligible physicians and practitioners (Care Partners) in the care management of High Need and Rising Need Patients (defined in Section D) with complex and chronic conditions. The CCIP provides necessary waivers that allow Participant Hospitals to share resources and financial incentives with participating Care Partners. Participant Hospitals will also receive comprehensive Medicare data to be used for care redesign. The resources and data provided by the Participant Hospital will help eligible Care Partners to access the Centers for Medicare & Medicaid Services (CMS) Chronic Care Management (CCM) fee for Medicare patients and are intended to align with the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) requirements.

Each year, the Participant Hospital will submit an Implementation Protocol which describes the hospital's CCIP program. The program must meet certain requirements which are outlined in this Program Template.

In the CCIP, participating Care Partners are defined as Patient Designated Providers (PDPs) and must meet the following criteria (see section D.ii for further details) to be eligible as the Patient Designated Provider:

- Designated by a patient as the patient's primary provider of care
- A family practice, general or specialist physician, clinical nurse specialist, or a nurse practitioner
- Provide services to beneficiaries who are within the service area of the Participant Hospital
- Have a National Provider Identifier (NPI); and
- Participate in the Medicare Program

The CCIP is designed to:

- Enable Participant Hospitals to provide care management resources and other Care Redesign Interventions to PDPs that provide care for patients with chronic and complex conditions.
- Allow Participant Hospitals to offer incentive payments to PDPs that provide care for patients with chronic and complex conditions.
- Promote and support collaboration and cooperation among hospitals and physicians/practitioners on behalf of patients.
- Promote data-driven, ongoing improvement in care delivery over time.
- Facilitate overall practice transformation towards patient-centered care that produces improved outcomes and meets or exceeds quality measures.
- Leverage common tools and technology including those developed by CRISP, such as the electronic notification system and analytics capabilities.

B. Components of the Program: Required and Optional

The CCIP consists of two major components: 1) Care Redesign Interventions and 2) Incentive Payments paid to PDPs. In order to participate in the program and thereby gain access to the associated waivers and Medicare data, the Participant Hospital must develop and deploy meaningful Care Redesign

Interventions. Care Redesign Interventions include (i) resources and services the Participant Hospital will provide or make available to PDPs and (ii) activities performed by a PDP designed to improve the quality of care and reduce the need for admissions ("Care Intervention Activities"). Starting in Performance Year 2018, Participant Hospitals will have the option of offering cash Incentive Payments to PDPs, as described in Appendix A.

Care Redesign Interventions (Required Component of the CCIP Program)

Care Redesign Interventions funded by the Participant Hospital will provide support to PDPs that serve patients with chronic and complex conditions. Care Redesign Interventions are offered at the outset of the program and continue throughout the duration of the program.

The Participant Hospital will deploy resources, such as risk stratification processes, health information technology for use in the creation of Care Plans and sharing information with providers, reports that provide meaningful and actionable data to PDPs for use in the care of patients, and care management staff and 24/7 telephone lines staffed by Care Managers to support the care of the PDP's CCIP patients (see Section C for details). Care coordination resources will assist PDPs in managing the care of patients, improving the quality of care, and reducing potentially avoidable admissions and readmissions. The program will improve the care of chronically ill and medically complex patients by working with the patient, family, and all care providers to achieve the patient's stated health goals. The program will educate patients, coordinate care, assist patients in managing their conditions, and work to remove barriers to achieving the best possible health result. The care management program begins with a health risk assessment which is the starting point for the individualized Care Plan.

The PDP is responsible for directing the overall care of patients with chronic and complex conditions, actively working with the patient's Care Manager, and participating in or overseeing required Care Intervention Activities, including;

- Completion of a Health Risk Assessment
- Completion and maintenance of a Care Plan
- Medication management and reconciliation
- Ensure that appointments are available for a patient within 7 days after a hospitalization discharge

Ideally PDPs will also employ best practices, including:

- Administering of pneumonia vaccines
- Monitoring and managing disease status indicators such as:
    - ACE inhibitor and beta blocker therapy when LVEF is <40
    - Set goals and monitor HgB A1C levels at least quarterly
    - Develop hypertension plan and monitor goals

The PDP will use technology, tracking systems and communications processes that are agreed upon by the hospital and PDP to support the coordination of care.

Incentive Payments Paid to PDPs (Optional Component of the CCIP Program)

Incentive payments will begin in 2018, if the hospital chooses to use them.

Incentive payments are designed to promote alignment between the hospital and PDPs. To assist PDPs with financial support for care redesign, Participant Hospitals may share positive financial results with PDPs who are completing the required Care Intervention Activities of the program. Payouts are contingent upon certain requirements, including performing the defined activities at the provider level, reduced utilization, and total cost of care targets at hospital level (see Appendix A for details).

C. Care Redesign Interventions (Required)

Participant Hospitals are required to provide the following:

Staffing
• Care management staff for High Need and Rising Need patients in the CCIP program working in conjunction with the patient's PDP • Twenty four/seven (24/7) phone access to a Care Manager accessible by all patients in the CCIP • Training for care management teams and PDP staff regarding Health Risk Assessment (HRA) completions, development of Care Plans, and care management interventions appropriate to identified risks
Care Management
• Care management staff (centrally located and assigned to PDPs or co-located within PDP practices) • Risk stratification methodology that identifies High Need and Rising Need Patients (hospital can use HSCRC Update Factor Definition, CCIP Best Practice definition or create their own) • Completion of an HRA as the beginning of the Care Plan, in coordination with the PDP • Completion of a Care Plan, in coordination with the PDP, including goal setting, goal progress reviewed and noted, and the identification of care management needs • A standardized Care Plan template to be used by the hospital-funded care management team with PDP oversight and accessible to the PDP • Care plans to be kept current with CRISP and within the available care management platform and accessible to the Care Manager and PDP 24/7 (please note if the care plan cannot be uploaded a care alert may be entered in CRISP) • Standardized communication protocols between care management team members and PDPs • Processes, technology and procedures for coordination and sharing of pertinent information as needed between the PDP and other health professionals • Coordinating patient's treatments as directed by the Care Plan, and documenting coordination of care , barriers and resolutions in the Care Plan • Documented work flows and role definitions for patient hand-offs between care management team, PDP, specialty care, and other needed supports • Referral and linkage of patients to community resources • Patient education on self-care and self-management of chronic diseases • Review of planned hospital admissions, procedures, and expectations with the patient and family members • Care Manager is in continuous contact with the patient as needed or to satisfy the CCM requirement (20 minutes of care management activity) for the program's duration

- A follow-up contact by the care management team within 24 hours of discharge to review discharge summary, any barriers to care, and document transition plans regarding:
    - Reason for hospitalization
    - Medications to be taken (purpose, dosage, when, how, where to obtain)
    - Self-care activities
    - Crisis management
    - Coordination and planning for follow-up appointments
    - Issues to be addressed at time of outpatient follow-up, including any pending results
- Care management team to alert PDP prior to follow-up outpatient appointment of discharge plan
- Ensure there is a system in place for tracking and managing:
    - Care management outreach and timely follow-up
    - Referrals
    - Care transitions
    - Test results
    - Preventive and social service needs
- Care management team supports medication reconciliation with PDP oversight
    - Review of the medication list to ensure safety, accuracy, and appropriate usage of medication
    - Assess barriers to medication adherence

Health Information Technology

- CEHRT accessible and available to PDPs (if PDP currently does not have CEHRT)
- Capability within the CEHRT to document the Care Plan and care management activities and CCM requirements
- Access to the Care Plan 24 hours/7 days per week by the Care Manager and PDP

Data

- Provide periodic performance reports to PDPs for the purpose of self-monitoring and performance improvement

Best Practice Care Redesign Interventions (Optional)

Below are activities known to improve quality of care, and reduce avoidable admissions and readmissions for people with complex and chronic conditions. Although not required, hospitals are encouraged to begin incorporating these activities in the program.

Staffing

- Care management teams and/or clinical care staff that complete home visits as directed by the Care Plan
- Standardized training modules, tools, protocols, and processes across care coordinators/managers
- Learning collaborative across PDP staff and care management teams

Care Management

- Standardized care management protocols and work flows tailored to High Need and Rising Need Patients
- Transportation of patient for medical appointments or upon hospital discharge to community, home, or discharge setting, if needed
- A home visit by the care management team within 24 hours of discharge and review of discharge plan and any barriers encountered, under certain/specific conditions

• Additional health literacy and health promotion activities and programming, e.g., cooking and nutrition classes, fitness classes, nutrition counseling, walking groups, chronic care peer support groups • Resources, tools, and data to assist community providers in tracking and providing clinical care management activities such as using ACE inhibitor and beta blocker therapy when left ventricular ejection fraction (LVEF) is <40, setting goals and monitoring HgB A1C levels appropriately, attaining adequate blood pressure control, and administering annual flu shots • Periodic systematic case review • Periodic updates to HRAs as defined by hospital program guidelines or when clinically indicated
Health Information Technology
• Additional data analytics and evidenced-based tools • Registries to input, track, and monitor results • Interface(s) between a PDPs CEHRT, care management platform, the hospital platform, and CRISP (hospital funds and ensures functioning interface)

D. Additional Hospital Requirements

i. Participant Hospital Responsibility - Patient Identification

Participant Hospitals will identify two categories of patients eligible for the CCIP program: "High Need Patients" and "Rising Need Patients." Participant Hospitals must include both categories of patients in their program.

For the Risk Stratification methodology, the Participant Hospital may use the recommendation below, or propose its own definition to be submitted in the Implementation Protocol.

Risk Stratification recommendation for the CCIP program:

High Need Definition: At least 3 inpatient discharges or observation visits > 23 hours in past 12 months, plus at least two chronic conditions, one of which is COPD, Diabetes, Heart Failure or Hypertension.

Rising Need Definition: At least 2 inpatient discharges or observation visits >23 hours or an emergency department outpatient visit in the past 12 months, plus at least two chronic conditions, one of which is COPD, Diabetes, Heart Failure or Hypertension.

ii. Participant Hospital Responsibility — PDP Identification and Contracts

The Participant Hospital will identify Care Partners who may be eligible to participate as a PDP in the CCIP program through patient identification, CRISP data, hospital records, or other methods. Participant Hospitals will invite these providers to participate in the CCIP program by sharing program information, expectations, and a potential patient list. Patients must positively affirm that the selected provider is their primary care provider. The Participant Hospital will provide PDPs with discussion materials to be used with the patient.

The Hospital signs a standardized Care Partner Agreement with each PDP in their program. The agreement will include a description of the program, criteria for participation, and roles and

responsibilities of the Participant Hospital and PDP, including specific care management requirements. Annual updates will become an appendix to the Care Partner Agreement.

iii. Participant Hospital Responsibility — Monitoring and Program Status Reporting

Participant Hospitals are responsible for the operation of their CCIP program.

A "Hospital Annual Report" (outlined in the Participation Agreement) must be submitted by the Participant Hospital to the Health Services Cost Review Commission (HSCRC) at the end of each Performance Year. Data for the report will be obtained by the hospital from its internal systems, CRISP, and a third party administrator. Participant Hospitals will be provided a template to use for submission of the Hospital Annual Report.

The Hospital Annual Report should include the following information:

	Required Metrics	**Data Source**
Eligible Patients	Number of Eligible High Need Patients as defined by hospital risk stratification method	Hospital
	Number of Eligible Rising Need Patients as defined by hospital risk stratification method	Hospital
Enrolled Patients	Number of Enrolled High Need Patients as defined by hospital risk stratification method	Hospital
	Number of Enrolled Rising Need Patients as defined by hospital risk stratification method	Hospital
Staffing and Other Resources	The ratio of Care Managers to enrolled patients	Hospital
	Number of PDPs participating in the program	Hospital
Estimate of Care Intervention Activities with Patient	Number of High Need patients with a completed Care Plan	Hospital
	Number of Rising Need patients with a completed Care Plan	Hospital
	Number of enrolled patients with a documented care alert in CRISP	CRISP
	Percent of High Need patients in the program with a completed Care Plan	Hospital
	Percent of Rising Need patients in the program with a completed Care Plan	Hospital
	Number of patients that received medication reconciliation as documented in the Care Plan	Hospital
	Number of patients that completed a provider visit within 7 days of acute discharge	CRISP/Administrator
	Number of patients with more than one care management phone conversation	Hospital
	Average number of patients/day that accessed 24/7 patient phone access to a Care Manager	Hospital

	Required Metrics	Data Source
	Total Number of Care Interventions received by enrolled patients (total number of activities reported in this section)	Hospital
Overall Financial Performance	Funds available in the incentive pool based on the incentive pool calculation	Administrator
	Total amount of investment in CCIP program and description of care management resources provided to PDPs.	Hospital

E. PDP Requirements

i. Patient Designated Provider (PDP) Requirements —Eligibility to Participate

Physicians and practitioners eligible for the CCIP program are family practice, general or specialist physicians, clinical nurse specialists, and nurse practitioners who are willing to take responsibility for the overall management and coordination of patients with chronic and complex conditions, and meet the following requirements:

- Designated by a patient as the patient's primary provider of care
- Provide services to beneficiaries who are within the service area of the Participant Hospital
- Have a National Provider Identifier (NPI); and
- Participate in the Medicare Program

A PDP must enter into a Care Partner Agreement with a Participant Hospital and agree to perform Care Intervention Activities described in this Program Template.

A PDP may participate in multiple Participant Hospitals' Complex and Chronic Care Improvement Programs.

ii. PDP Responsibility —Care Intervention Activities

The PDP is responsible for directing the overall care of patients with chronic and complex conditions. The PDP is responsible for actively working with the patient's Care Manager and participating in or overseeing required activities, including;

- Completion of a Health Risk Assessment
- Completion and maintenance of a Care Plan
- Medication management and reconciliation
- Ensure that appointments are available for a patient within 7 days after a hospitalization discharge

Ideally, PDPs will also employ best practices, including:

- Administering of pneumonia vaccines
- Monitoring and managing diseases status indicators such as:
    - ACE inhibitor and beta blocker therapy when LVEF is <40, if patient is eligible

- Set goals and monitor HgB A1C levels at least quarterly, if patient is eligible
- Develop hypertension plan and monitor goals, if patient is eligible

The PDP will use technology, tracking systems and communications processes that is agreed upon by the hospital and PDP to support the coordination of care.

iii. PDP Responsibility - Patient Enrollment

The PDP will deploy processes to invite patient participation in the CCIP, describe the patient's cost sharing to them (if billing CCM), and explain care management services to be provided, and how to revoke participation in the program, and obtain a written agreement for participation in the program that includes a consent to electronic communication of medical information to medical partners. The Participant Hospital will provide PDPs with a template for the discussion and materials to be used with the patient.

iv. PDP Responsibility — Program Technology

The CCIP program requires the use of Certified Electronic Health Record Technology (CEHRT). PDPs must:

- Upload CCIP participating patient panels into CRISP, including additions and deletions monthly.
- Use a structured record for maintaining patient health information and for providing regular updates to the Care Plan. The PDP may use their own software if hospital compatibility and CEHRT requirements are met.

Appendix A

DRAFT CCIP Incentive Payment Program (Beginning in 2018)

Three interacting goals must be accomplished for Incentive Payments to be paid:

1. To qualify for an Incentive Payment, PDPs must complete 80% of required Care Intervention Activities for at least 80% of the patients enrolled in the program with the PDP
2. Funding must be available in the incentive pool
3. Total Cost of Care Guardrails must be met

i. Methodology for PDP Incentive Payments

Activities required by the PDP for each patient in the CCIP program (anticipated for 2018):

Completed Care Plan
PDP visit within 7 days of discharge from a hospitalization
Pneumonia Vaccine
Medication management and reconciliation
Chronic disease management as measured by disease-specific indicators

Eighty percent of all of the PDP's enrolled patients must have received at least 80% of the required Care Intervention Activities in order for the PDP to qualify for an Incentive Payment.

PDPs must complete a minimum of 80% of the required Care Intervention Activities for a particular patient to qualify for an incentive for that patient.

EXAMPLE of Incentive Payment

Metrics	**Patient 1**	**Patient 2**	**Patient 3**	**Patient 4**
Complete Care Plan	Yes	Yes	Yes	Yes
PDP visit w/in 7dys inpatient stay	Yes	No	Yes	N/A
Pneumonia Vaccine	Yes	Yes	Yes	N/A
Medication Reconciliation	Yes	No	No	Yes
Disease Specific Activity	Yes	Yes	Yes	Yes
Totals	6/6 = 100%	4/6 = 67%	5/6 = 83%	4/4 = 100%
Do patient metrics meet Incentive Payment thresholds?	Yes	No	Yes	Yes
Risk Adjustment HCC score 0.6–1.25 = 1, HCC score 1.26+ = 1.5	1*1 = 1	0*1.5 = 0	1*1.5 = 1.5	1*1.5 = 1.5
Quality Incentive >85% to 90% = 1.05 multiplier >90% to 95% = 1.10 multiplier >95% = 1.15 multiplier	1.15	N/A	N/A	1.15
Total Points per Patient	1.15	0	1.5	1.725

Metrics	Patient 1	Patient 2	Patient 3	Patient 4
Total Score for Patient Designated Provider = 4.375				

*Assumes that PDP has completed 80% of the Care Intervention Activities on 80% of the PDP enrolled patients

An HCC risk adjustment factor is then applied to the patient's score to compensate the PDP for the intensity of care needed by some patients. This compensates the PDP for additional work while ensuring that the amount paid is not disproportionate to the work performed.

If a patient's score is 1.26 or higher, the payment per patient is increased by 50%. A quality incentive is then applied for Care Intervention Activity-completion rates over 85%. Scores of 85% to 90% are multiplied by 1.05, 90% to 95% are multiplied by 1.10, and scores over 95% are multiplied by 1.15.

For High Need patients, the maximum annual Incentive Payment is $655 per patient without the risk adjustment or quality incentive. The PDP is eligible to earn up to $1,146.55 per patient including the risk adjustment and highest quality incentive.

Assuming the chart calculation above is the scores of a high needs pool, the scoring would pay $2,865.63. ($655 x 4.375)

For Rising Need patients, the maximum annual Incentive Payment is $100 before risk adjustment or quality incentive. For each patient, the PDP is eligible to earn a maximum annual Incentive Payment of $172.50 including the risk adjustment and highest quality incentive. -

Assuming the chart calculation above is scores of a rising risk patient pool, it would pay $437.50. ($100 x 4.375)

(Note: Under some circumstances, a PDP may qualify for a monthly CCM fee ($42) from Medicare. CCIP requires that CEHRT provided to PDPs include CCM documentation fields that substantiate PDP billing of CCM fees.

ii. Methodology for Incentive Pool Development

The incentive pool is derived solely from the Participant Hospital's budget and is driven by reductions in potentially avoidable utilization. The calculation of the incentive pool is based on changes in utilization for a cohort of patients that align with the types of patients that are in the CCIP. The population is not the same but its attributes are similar.

The Incentive Pool Methodology is still being developed and will be finalized by the TCOC Workgroup. TCOC Workgroup meetings start in December 2016 and are open to the public.

iii. Methodology for Total Cost of Care Guardrails

Total Cost of Care Guardrails must be met in order for incentives to be paid. Participant Hospitals will be limited or precluded from paying Incentive to PDPs if the actual Total Cost of Care calculated at the hospital level does not meet the hospital-level Total Cost of Care target. Total Cost of Care Guardrails are calculated at the hospital level.

Calculating Hospital-specific TCOC

Assume for Hospital A, the primary service area is PSA1. The methodology will use the same area assumptions as the State GBR calculations.

1. Part A Calculation
    a. Determine Medicare Part-A FFS beneficiaries that reside in PSA1 = BenesA
    b. Determine Part A spending for BenesA
    c. Calculate Part A Medicare spending per beneficiary = b/a
2. Part B Calculation
    a. Determine Medicare Part-B FFS beneficiaries that reside in PSA1 = BenesB
    b. Determine Part B spending for BenesB
    c. Calculate Part B Medicare spending per Beneficiary = b/a
3. Calculate Hospital TCOC for PSA1 = Part A Calculation + Part B Calculation =1+2
4. Repeat for each performance year
5. National medical trend will be used as a guardrail for increases in total medical costs. An increase in expenses over the national medical trend number for the defined measurement period will result in no incentive payments.

Excluded from total spending and total beneficiaries pool – costs associated with patients receiving tertiary services such as transplants, research cases, burn cases and trauma cases.

The TCOC Guardrail methodology is still under development and will be finalized by the TCOC Workgroup. TCOC Workgroup meetings start in December 2016 and are open to the public.