Care Transformation Steering Committee

December 6, 2019

Agenda

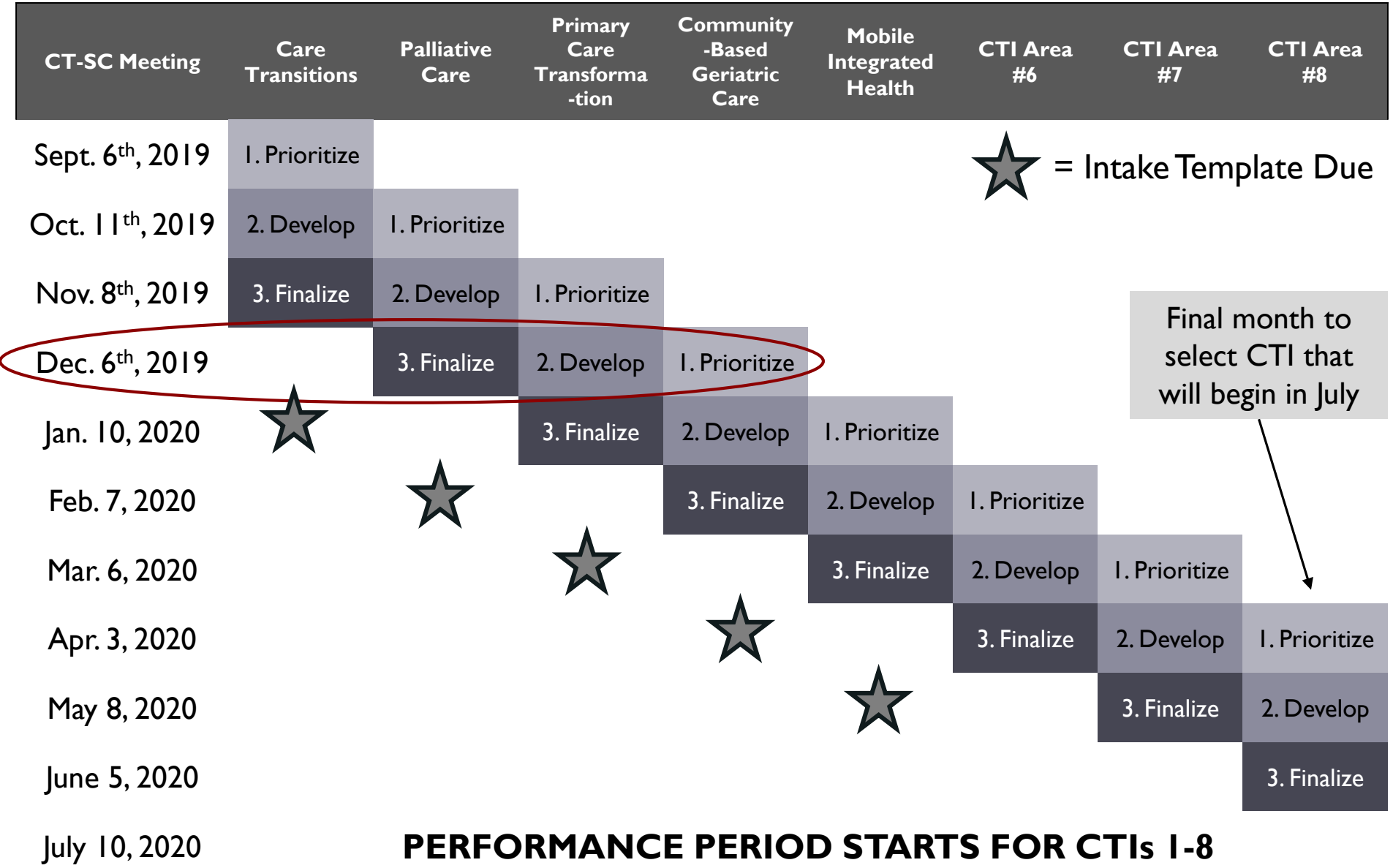
1. Administrative Updates
   i. Update on CTI User Guide, FAQ, and Care Transitions Intake Template
   ii. CTI development timing
   iii. Data Tool User Testing
2. Discussion of CTI Thematic Area #2: Palliative Care
   i. Final population definition
   ii. Operationalizing the CTI
3. Discussion of CTI Thematic Area #3: Primary Care Transformation
   i. Proposal for initial population definitions
   ii. Next steps
4. Discussion: High Risk Clinics
5. Discussion of CTI Thematic Area #4: Community-Based Geriatric Care
   i. Review proposed interventions and populations
   ii. Discuss clinical similarities of proposals
   iii. Next steps
6. Next CT-SC Meeting
   i. Upcoming CTI Thematic Groups
   ii. CTI form deadline

Administrative Updates

User Guide, FAQ, and Intake Template

- HSCRC staff has shared the CTI User Guide. We plan to publish the accompanying FAQ in December.
  - Please provide additional questions and suggested topics by email to HSCRC.care-transformation@Maryland.gov.
  - Comments on the CTI User Guide are due January 15, 2020.
  - Methodological questions will be addressed at the next TCOC Workgroup meeting.
- HSCRC staff has also shared the Care Transitions Intake Template and held a webinar going over the form on 12/5.
  - Hospitals need to submit this form by January 10, 2020 to qualify to participate. Hospitals will then be invited to submit a final Care Transition CTI by May 8th, 2020.
- All are available on the HSCRC website here: https://hscrc.maryland.gov/Pages/Care-Transformation-Steering-Committee.aspx

Schedule for Rolling CTI Development

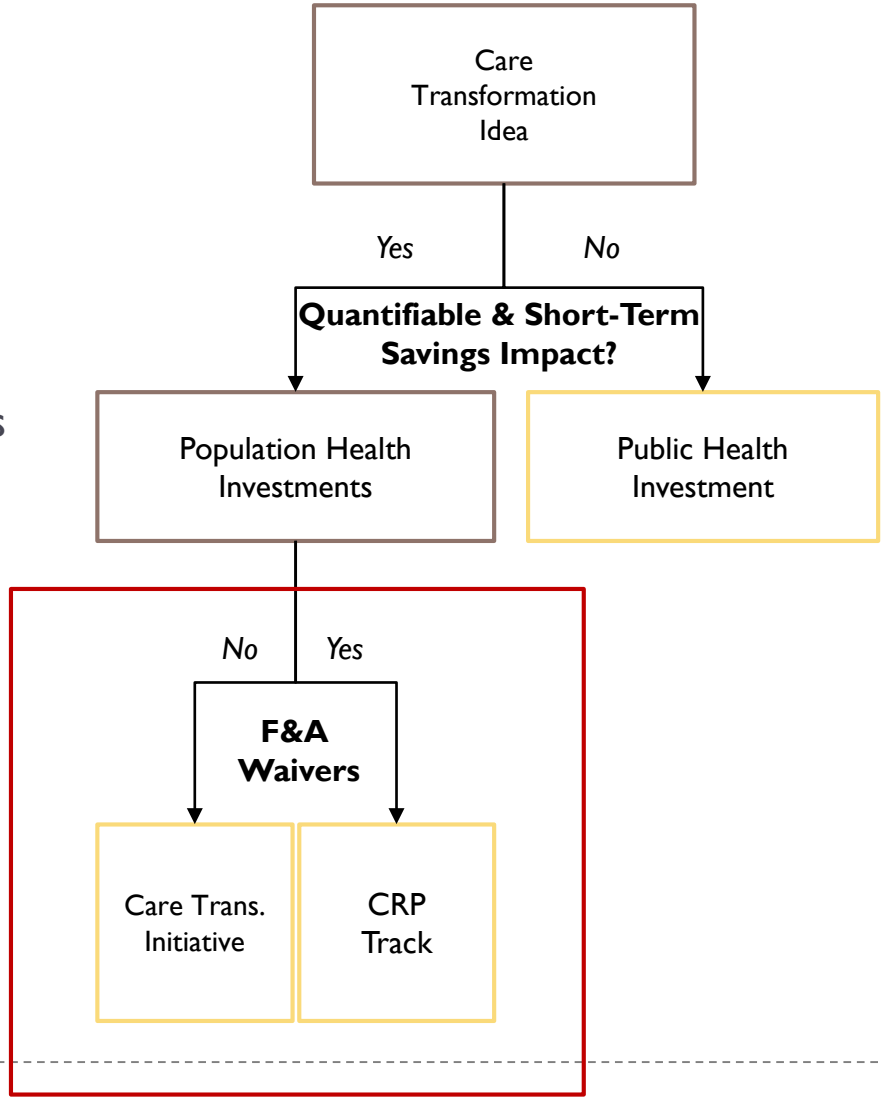


CTP User Testing

- Hospitals will be invited to test the Care Transformation Profiler (CTP) this month.
- This will ensure the views in CTP provide the most useful information for hospital implementing CTIs.
- The testing will elicit feedback on the following:
  - If information is clearly displayed
  - If information is relevant and useful
  - What information could be added

Fraud and Abuse Waivers

- Do hospitals think fraud and abuse waivers would be necessary and/or helpful to implement the Care Transitions or Palliative Care CTI?
- Potential reasons to seek fraud and abuse waivers:
  - To make incentive payments to clinicians
  - For additional flexibility when discharging to a SNF



CTI Thematic Area #2: Palliative Care

Initial Population Definition for Palliative Care

- The Palliative Care CTI will be triggered by an Inpatient Admission at the hospital
  - HSCRC staff expect the Palliative Care CTI to encompass 9 of the initial CTI proposals
  - Hospitals will then be allowed to submit a population definition that includes any combination of the following criteria:

	Age	Geographic Service Area	Number of Chronic Conditions	Prior Hospitalization / ED utilization	IP Events	Episode Length
Criteria Options	Hospitals determine the age range their intervention targets	Hospitals may provide a list of 5-digit zip-codes	• Indicate a number of chronic conditions, AND/OR • Hospital may provide a list of chronic conditions	• Prior hospitalization OR ED utilization threshold, AND/OR • Time window for how recent that utilization was	Hospitals may submit: • A list of ICD-10 primary dx codes OR • A list of APR-DRG / SOIs OR • Preferred ROM designations OR • Length of stay qualifications	Hospitals may submit an episode length of: 30, 60, 90, 120, 150, 180, or 365 days
Default if Criteria is not Specified	All Medicare beneficiaries (65+)	Use no geographic restriction	Any condition and no threshold of chronic conditions	No requirement on prior utilization	Use all diagnosis and DRG codes	90 day episode window

"Touch" with a Palliative Care Team

	NPI Attribution
Criteria Options	The hospital may provide a list of NPIs. Beneficiaries will be included if they receive a physician service from that provider during the course of their hospitalization stay.
Default if Criteria is not Specified	Use no NPI restriction.

- The NPI used for the palliative care CTI must include a Physician/Hospice and Palliative Care taxonomy from Medicare to be eligible.
  - The hospital must select a base year during which all of the submitted NPIs were practicing at the hospital.
  - In future years, an NPI may be added to the list. But they must have been practicing at the hospital for 1 year before they are eligible.

Submitter	Eligible Population	Intervention Trigger	Duration
Frederick	Diagnosis of a chronic condition (CHF, COPD, Cancer, Dementia, ESRD, End Stage Liver Disease, Stroke)	IP Admission	TBD
JH Bayview	80+ years old AND diagnoses of sepsis, malignancy, or respiratory failure AND hospice care post discharge AND NPI of at least 1/3 palliative physicians	Discharge	90 Days
MedStar Hospitals	SOI/ROM of 3-4 AND LOS >= 4	Discharge	TBD
GBMC	85+ years old OR stage 3 or 4 cancer diagnosis OR dementia diagnosis OR hip fracture diagnosis	IP/ED Admission AND Palliative care consult billed by GBMC palliative care provider	TBD
Holy Cross Hospital	All medical DRGs with ROM = 4	IP Admission	180 Days
Holy Cross - Germantown	All medical DRGs with ROM = 4	IP Admission	180 Days
Howard County General	80+ years old AND 3+ chronic conditions AND Howard county resident	Discharge AND - dx code of Palliative care OR - NPI linked to Palliative consult	TBD
Johns Hopkins Hospital	75+ years old AND APR-DRG 720 (sepsis), 133(respiratory failure), and/or dx of cancer	IP Admission	TBD
Doctors Community Hospital	65+ years old AND high risk with 2+ Admissions, ED visits, or Obs visits during past 90 days AND inpatient oncology claim	IP/ED Discharge AND List of 6 Palliative NPIs	120 Days

Operationalizing the Palliative Care CTI

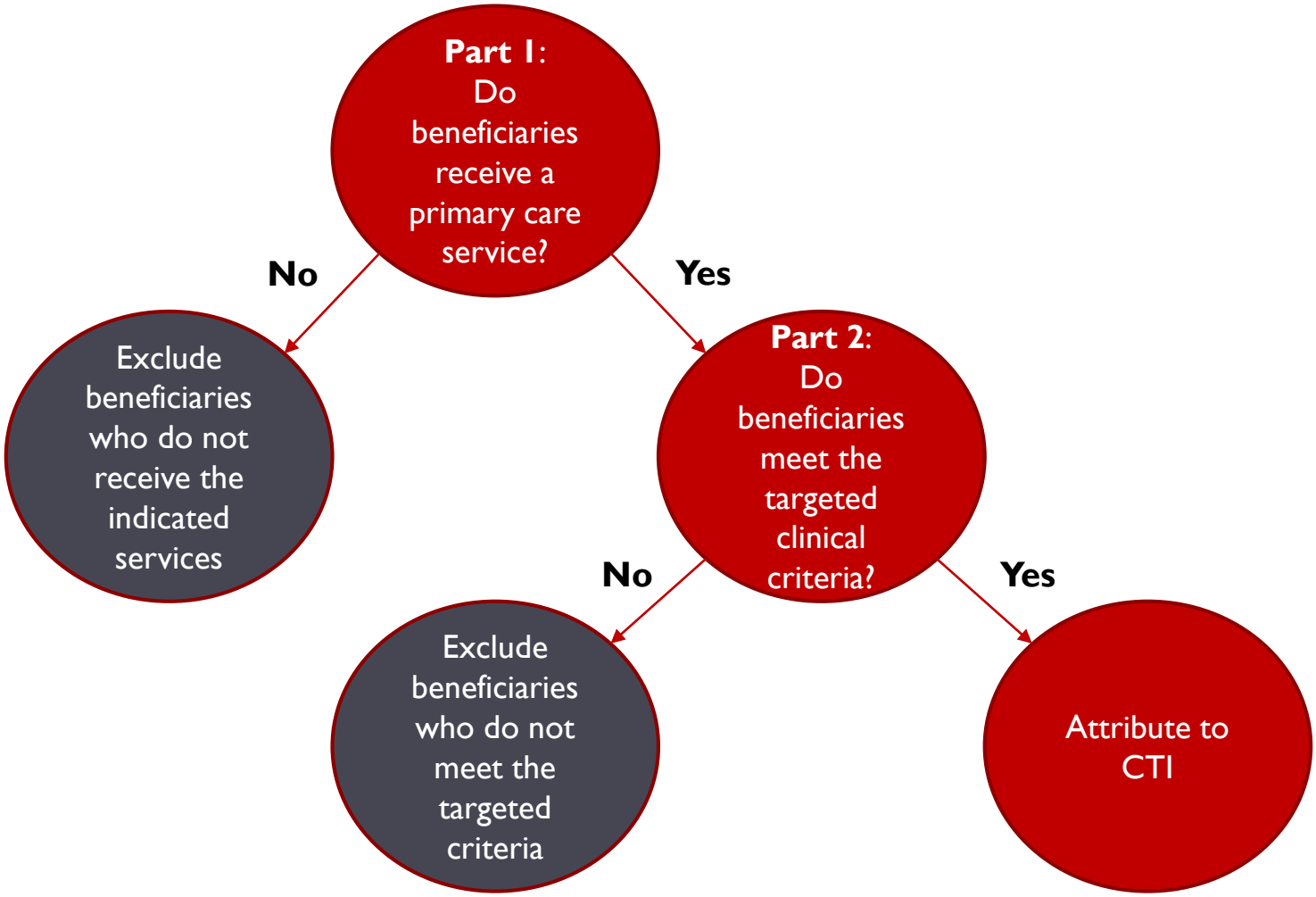
- Hospitals will be required to submit the following details confirming their desired specifications:
  - Age
  - Zip codes
  - Chronic conditions threshold
  - Prior utilization qualifications
  - IP Events
  - NPI Lists
  - Episode length
  - Base period
- HSCRC will release the Intake Template to hospitals on the Palliative Care CTI within a week following this meeting.
  - Deadline for this submission: February 7, 2020

CTI Thematic Area #3: Primary Care Transformation

Primary Care Transformation – Proposed Interventions

- Clinic established a primary care practice to deliver medical and wrap around supportive services from a MD, NP, Nurse, Case Manager, Social Worker, CHW, Pharmacist, Pastoral Care, and Health Behavioral Specialist
- Complete comprehensive assessments (e.g. social, behavioral, and home safety), develop plans of care, make office visits and house calls, conduct weekly interdisciplinary care planning rounds, and referrals to community resources (e.g. transportation services, in home personal assistance, prescription assistance)
- Care teams (NP, LCSW, CHW) help to address advanced care planning, behavioral health, caregiver burden, grief counseling, etc.
- Mobile teams provide home-based primary care, mobile labs and radiology, transportation services, care coordination, and a large array of social services (e.g. guardianship legal counsel)
- Care manager contacts patients 2 days after hospitalization to assist with medication reconciliation, assess risk, schedule PCP appointments, and other social services (e.g. transportation)
- Development of care improvement initiatives at primary care practices (e.g. extending hours of operation, hiring care coordinators/managers, contacting patients with hospital visit) for improving patient experience and clinical outcomes through PCMH

Overview: Triggering a Primary Care Transformation CTI



Part 1: Do patients receive a primary care service?

Part 1: Do beneficiaries receive a primary care service?

- Two options are available to qualify as a primary care service:
  1. Option 1: Use of MDPCP Attribution
     i. Hospital provides list of NPIs
     ii. Will use HSCRC's "MDPCP-like" attribution
  2. Option 2: Professional Fee with Place of Service Codes 11, 12, 13, 14, and/or 15
     i. Hospital provides list of NPIs
     ii. Option to ensure NPIs provide primary care services:
        a) Check NPI's taxonomy
        b) Check NPI's primary care claims

Code	Place of Service
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit

- Hospitals may select between these options, but will be required to select one for the Primary Care Transformation CTI.

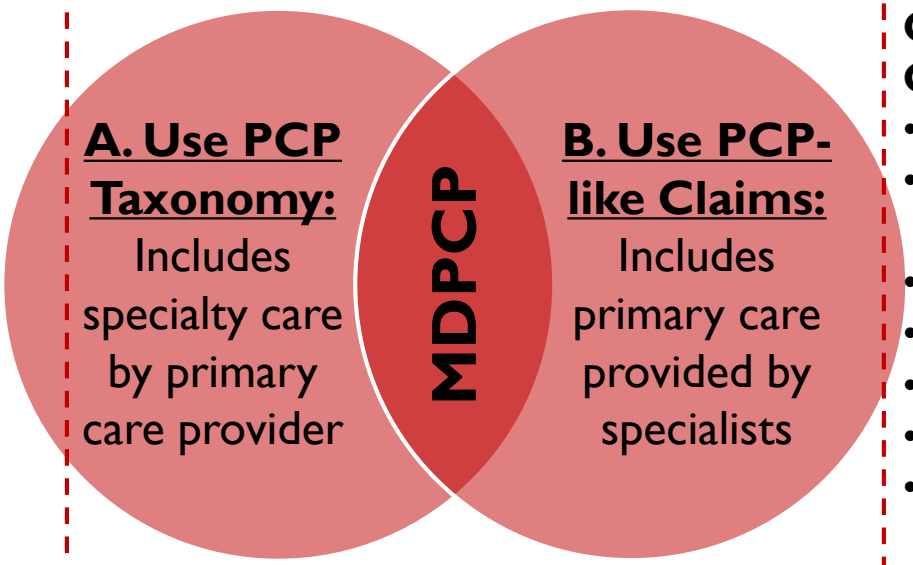
Part 1: Difference Between Options 2a & 2b

Part 1: Do beneficiaries receive a primary care service?

- Hospitals considering using the professional fee with a POS code (Option 2) have to also select one of the following to ensure NPIs provide primary care services:
  a) Check NPI's taxonomy
  b) Check NPI's primary care claims

Qualifying PCP Taxonomies:

- Family Medicine
- Adolescent Medicine
- Addiction Medicine
- Adult Medicine/Health
- Geriatric Medicine
- Hospice & Palliative Medicine
- Internal Medicine
- Obstetrics
- Gynecology
- Maternal & Fetal Medicine
- Pediatrics
- Psychiatry & Neurology
- General Practice
- Physician Assistant
- Medical
- Nurse Practitioner
- Acute Care
- Community Health



Qualifying PCP-like Claims:

- Prolonged E&M
- Transitional Care Management Services
- Home Care E&M
- Advance Care Planning
- Welcome to Medicare
- Annual Wellness Visits
- Chronic Care Management Services

Part 2: Do patients meet the targeted clinical criteria?

Part 2: Do beneficiaries meet the targeted clinical criteria?

- The Primary Care Transformation CTI will be triggered by Option 1 or Option 2
  - HSCRC staff expect the PC Transformation CTI to encompass 8 of the initial CTI proposals
- Hospitals will then be allowed to submit a population definition that includes any combination of the following criteria:

	Age	Geographic Service Area	Number of Chronic Conditions	Prior Hospitalization / ED utilization	Look back/ Look forward	Episode Length
Criteria Options	Hospitals determine the age range their intervention targets	Hospitals may provide a list of 5-digit zip-codes	• Indicate a number of chronic conditions, AND/OR • Hospital may provide a list of chronic conditions	• Prior hospitalization OR ED utilization threshold, AND/OR • Time window for how recent that utilization was	• E&M touch by provider type pre-admission • First setting of care post discharge (MADE logic)	Hospitals may submit an episode length of: 30, 60, 90, 120, 150, 180, or 365 days
Default if Criteria is not Specified	All Medicare beneficiaries (65+)	Use no geographic restriction	Any condition and no threshold of chronic conditions	No requirement on prior utilization	No look back or look forward	90 day episode window

Submitter	Eligible Population	Intervention Trigger	Duration
Frederick	Individuals with 3 or more hospitalizations or 6 or more ED visits within the previous year	Receives service from Fredrick's PCPs as identified by NPI list	TBD
Howard County General	Howard County Resident aged 65+ discharged to home or to home with home care	Bill for services provided at home (POS = 12 or 15)	TBD
JH Bayview	Baltimore City Resident aged 65+ discharged to home or to home with home care from JHBMC	Bill for services provided at home (POS = 12 or 15)	90 Days
MedStar	Discharge from any acute care hospital or ED that reports ADT info to CRISP data exchange	Patient attributed to MedStar Health PCP under MDPCP; "MDPCP-like" MPA attribution	30 days
JH Bayview	3+ hospital encounters (IP, Observation, or ED) in 365 days	Receives service from MESH provider as identified by NPI list	120 Days
GBMC	All Medicare FFS patients with a GBMC clinic visit in the preceding 18 months	E&M Office Visit CPT codes (99201-99215)	TBD

Future Criteria in Development

- CMMI's Seriously Ill Population (SIP) Definitions
  - Significant chronic or other serious illness determined by:
    - HCC score of 3.0+ ; OR
    - HCC score of 2.0+ combined with 2+ unplanned hospitalizations in the previous 12 months; OR
    - DME claims for either transfer equipment or a hospital bed (as indicators of frailty).
  - Fragmentation determined by:
    - No single practice (identified by the Tax ID Number or "TIN") accounts for more than 50% of the beneficiary's total evaluation and management visits; OR
    - The beneficiary had 2+ ED visits or observation stays in the previous 12 months.

- CMMI's Independence At Home Shared Savings Demonstration
  - Add variations on look forward/look back:
    - **Look back**: add a category for "subacute rehab" AND episodic "skilled nursing services"
    - **Look forward:** two home visits in 90 days

Primary Care Transformation CTIs using Additional Criteria

Submitter	Eligible Population	Intervention Trigger	Duration
GBMC	3 or more chronic conditions AND serious illness diagnosis (aligned with CMMI Seriously Ill Population Payment Model)	Initial E&M home visit from provider in the program (NPI list)	TBD
MedStar Hospitals	Reside in zip code catchment (21210, 21211, 21212, 21213, 21214, 21218, 21239, 21206) AND two or more chronic conditions (CMS CCW ICD-10 list) AND hospitalization in the past 12 months AND received subacute rehab services or episodic skilled nursing services in past 12 months AND ADL/IADL impairment (Claims Frailty Index (CFI)) AND patient is enrolled in program for primary care AND 2 home visits within 90 days	First visit claim (E&M code for a home visit) under clinicians' NPIs and/or TIN	365 Days

Next Steps for Primary Care Transformation

- All populations can be picked up with our current population definition categories and proposed additional categories.
  - HSCRC staff will work on identifying SIP populations and extending the look forward/look back analysis
  - HSCRC staff will finalize the population definitions at the January CT-SC meeting
- REMINDER: Once the population definitions have been finalized, hospitals will be given the opportunity to indicate whether they want to participate.
  - A hospital that cannot fit their population into this framework should submit a separate CTI form to the HSCRC for future consideration in another thematic area

Discussion: High Risk Clinics

High Risk Clinic CTIs

- CTIs originally categorized as "High Risk Clinics" were deemed to fit into either the Primary Care Transformation or Care Transitions CTIs:
  - CTIs in red font moved to Primary Care Transformation
  - CTIs in grey font moved to Care Transitions
- A full listing of all CTIs within each Thematic Area will be published on the HSCRC website in the coming weeks.
- This will allow us to move on to a new Thematic Area and get to more submitted CTIs

Submitter	Eligible Population	Intervention Trigger	Duration
Frederick	Individuals with 3 or more hospitalizations or 6 or more ED visits within the previous year	Receives a service from one of Fredrick's PCP as identified by an NPI	TBD
Johns Hopkins Hospital	Diagnosis of CHF	Discharge to home	TBD
Baltimore Washington MC	Diagnosis of CHF, COPD, Diabetes, or Sepsis AND >3 IP or ED visits in 365 days	IP or ED Encounter	90 Days
Upper Chesapeake Health	Diagnosis of HTN, Diabetes, CHF, CAD, Sepsis AND >1 IP admission in 30 days	IP admission	90 Days
St. Joseph's MC	No PCP listed AND >=2 IP admissions in 365 days	IP admission	30 Days
UMMC	No PCP listed OR uncontrolled chronic condition diagnosis (ICD) OR new diagnosis of HTN, diabetes, COPD or CHF	IP or ED Encounter	90 Days

Thematic Area #4: Community-Based Geriatric Care

Community-Based Geriatric Care – Proposed Interventions

- Patients requiring long term IV antibiotics have plans of care determined by infectious disease specialists, care coordinated by interdisciplinary pharmacy team, and are discharged to SNF partners that have implemented best practices (e.g. telemedicine)
- Care team (Nurse, Care Manager, etc.) follows up with patients over telephone and in-person, post-discharge from a SNF sub-acute stay
- Chronic Care Management Team (RNs, LPNs, etc.) uses tele-monitoring technology to engage high risk chronic disease populations to increase self-management and provides oversight of medication management/pill box fills
- Health Coaches are assigned to senior living buildings to conduct standardized assessments for referred residents and address unmet clinical (supported by RN) and social needs for residents with elevated risk
- Improve care quality and care coordination for patients transitioning to ALF by coordinating care transitions from hospital/SNF to ALF and collecting patient/family experience and utilization data for ALF

Submitter	Eligible Population	Intervention Trigger	Duration
JH Bayview	IP discharge to a list of SNFs AND reside in zip codes 21222 or 21224 AND receive IV antibiotic on day of hospital discharge AND NPI of at least 1 infectious disease attending during hospitalization	IP Discharge	60 Days
JH Bayview	JHBMC and HCGH patients discharged from hospital or SNF post hospital, prior to ALF care	Hospital or SNF Discharge	90 Days
AAMC	All Medicare FFS patients discharged from SNF sub-acute stay	SNF Discharge	30 Days
Nexus Montgomery Hospitals	Medicare FFS patients aged 65+ who are residents of target buildings based on their address	Patient address	TBD
Frederick	All patients receiving home health services through FMH Home Health	Currently enrolled or discharged from a home care episode with FMH Home Health	TBD

Community-Based Geriatric Care: Discussion Questions

- Are these interventions sufficiently close to one another?
  - Is the intervention substantially different if the intervention is initiated after a hospital discharge versus initiated by residing at a particular address?
  - Is the intervention different if it is triggered based on enrollment or discharge from a hospital home health program?
  - Does a shorter or longer post-discharge window indicate that the intervention is clinically different (e.g. 30 days versus 60 days; 30 days versus 90 days)?
- Are these substantially different populations?
  - Is it problematic to combine a CTI that targets IV antibiotic populations with a CTI that takes all patients discharged from a hospital/SNF?
- If we are unable to get geographic data beyond the zip code level, what other ways could we identify residents of targeted senior living buildings? NPI lists?
- Would hospitals be able to indicate which SNFs they are targeting if the CTI triggers on SNF discharge?
- Will fraud and abuse waivers be particularly useful for these CTIs as hospitals work with SNF and ALF care partners?

Next Steps for Community-Based Geriatric Care

- HSCRC Staff will create CTI population definitions based on the CT Steering Committee's feedback.
  - The initial population definitions will be shared at the January CT Steering Committee Meeting
  - The final population definitions will be shared at the February CT Steering Committee Meeting
- REMINDER: Hospitals may participate in the CTI regardless of whether they were the ones to propose the CTI
  - In February, an Intake Template will be distributed for hospital to indicate their intent to participate

Discussion of Upcoming CTI Thematic Groupings

Additional CTI Proposals – Future Thematic Areas

TA #	CTI Thematic Area	Overview of Proposed Interventions
5	Mobile Integrated Health (6)	• Medical teams collaborate with EMS partners • Deploys community-based teams to provide home visits for high utilizer patients • Home visits can include assessments, education, connection to community resources, and connection to primary care or specialty providers • Assessment of medical condition, environment, and social determinants affecting patient's stability that may include medication affordability, transportation, environment, mental health, and drug screening
6	Diabetes Care Management (2)	• Technology-enabled diabetes care management with real-time blood glucose monitoring, virtual clinic visits over the telephone or text, medication management, and discharge to primary care • Care Manager and PCP provide medical care, care planning, behavioral change, social support, and referral to diabetic educator for nutritional education

Categorization for Remaining CTI Proposals

- HSCRC staff believe the remaining CTI proposals will fit into two broad Thematic Areas
  1. Behavioral health case management ("Thematic Area 7")
  2. Medication reconciliation programs ("Thematic Area 8")
- Some of the remaining CTIs will also qualify under Thematic Areas in development if the definition criteria is expanded
  - Ex: allowing NPI touch as a restriction for Care Transitions
- With the current timeline, the HSCRC should be able to implement more than 95% of all CTIs we have today for the first Performance Period (beginning July 2020)

Remaining CTI Proposals

Submitter	Eligible Population	Intervention Trigger	Duration
AAMC	Medicare FFS patients with 5 or more current medications AND a diagnosis of CHF, COPD, or diabetes	TBD	TBD
MedStar Hospital	Medicare beneficiaries with 2 or more visits to a primary care doctor (from NPI list) in the 12 months prior to the performance period	Discharge from a MedStar ED/IP/ Observation	365 Days
Western Maryland	All persons discharged from the inpatient BH unit with primary behavioral health diagnoses (mental health or substance abuse)	IP BH discharge	TBD
Western Maryland	All adult patients in an employed primary care practice who screen positive for depression	Service provided by Integrated Behavioral Health Professional	TBD
Western Maryland	3 or more inpatient or observation visits prior to interacting with the Center for Clinical Resources AND the following primary diagnosis codes: COPD, CHF, or Diabetes	CCR Interaction	TBD

Next Steps

Next Steps and Further Submissions

- Send questions and CTI Assessment form submissions to: hscrc.care-transformation@maryland.gov
- Staff intend an ongoing CTI proposals process
  - CTI proposals must be submitted by Dec 27th to be considered at the Jan 10th CT Steering Committee Meeting
  - CTI proposals will be developed on a rolling basis, EARLIER submissions are better
- Future Meetings
  - Friday, January 10th, 2020, from 1-3 pm
  - Friday, February 7th, 2020, from 1-3 pm
  - Friday, March 6th, 2020, from 1-3pm