Care Transformation Steering Committee

February 7, 2020

Agenda

1. Administrative Updates
   i. Update on CTI User Guide and Intake Templates
   ii. Fraud and Abuse Waivers for Approved CTIs
2. Discussion of CTI Thematic Area #3: Primary Care Transformation
   i. Final Population Definition
   ii. Operationalizing the CTI
3. Discussion of CTI Thematic Area #4: Community-Based Care
   i. Final Population Definition
   ii. Operationalizing the CTI
4. Discussion of CTI Thematic Area #5: Mobile Integrated Health
   i. Review proposed interventions and populations
   ii. Discuss clinical similarities of proposals
   iii. Next steps
5. Update on Miscellaneous CTI
6. Next CT-SC Meeting
   i. Upcoming CTI Thematic Groups
   ii. CTI deadlines

Administrative Updates

User Guide and Intake Templates

- HSCRC staff is revising the CTI User Guide.
  - Additional details on overlap, risk adjustment, and other methodology will be available by February 26, 2020 and discussed at the next TCOC Workgroup meeting.
- REMINDER: to participate in the Palliative Care CTI, please submit your Intake Template by February 7, 2020 (*today*)

Schedule for Rolling CTI Development

CT-SC Meeting	Care Transitions	Palliative Care	Primary Care Transforma-tion	Community-Based Care	Mobile Integrated Health	Diabetes Care Management
Sept. 6th, 2019	1. Prioritize					
Oct. 11th, 2019	2. Develop	1. Prioritize				
Nov. 8th, 2019	3. Finalize	2. Develop	1. Prioritize			
Dec. 6th, 2019		3. Finalize	2. Develop	1. Prioritize		
Jan. 10, 2020	★		2. Develop	2. Develop		
Feb. 7, 2020		★	3. Finalize	3. Finalize	1. Prioritize	
Mar. 6, 2020					2. Develop	1. Prioritize
Apr. 3, 2020			★	★	3. Finalize	2. Develop
May 8, 2020						3. Finalize
June 5, 2020					★	★
July 10, 2020						

★ = Intake Template Due

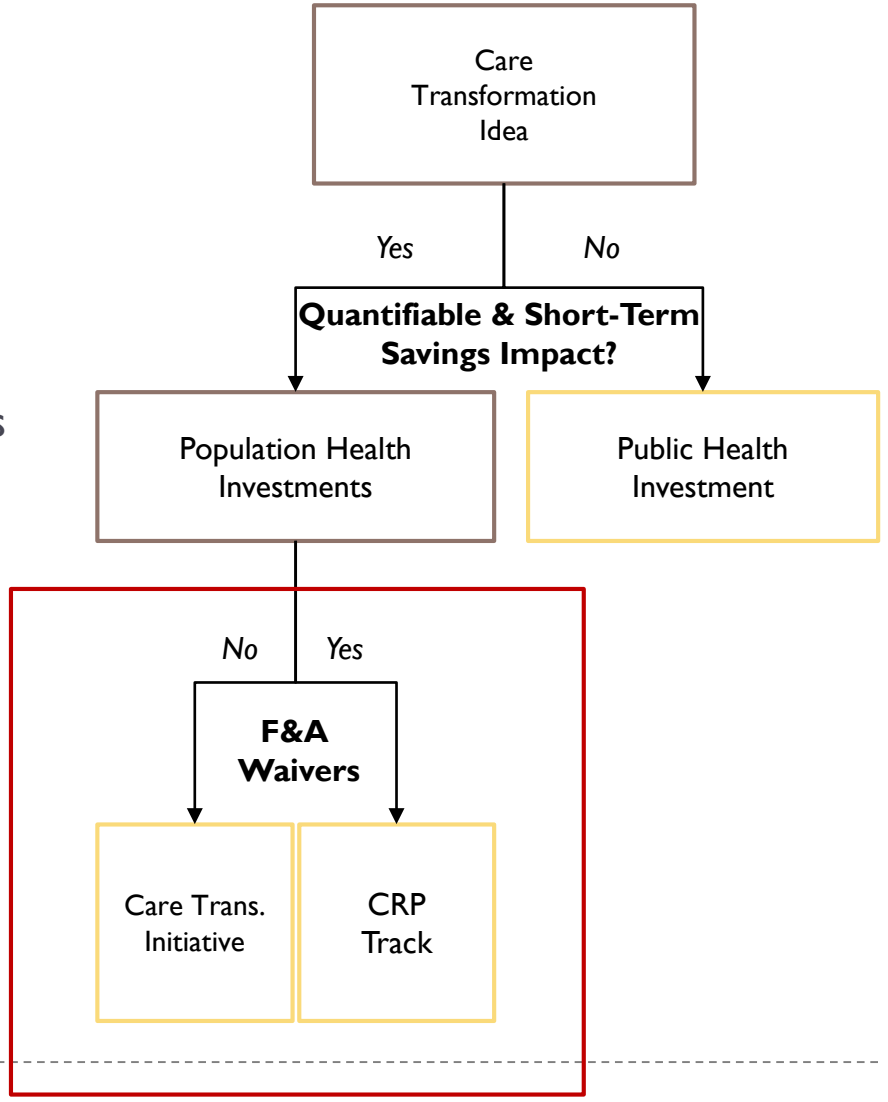
PERFORMANCE PERIOD STARTS FOR CTIs 1-6

Intake Template Deadlines

Thematic Area	Template Released	Template Webinar	Initial Template Due	Final Template Due
Care Transitions	Nov 18, 2019	Dec 5, 2019	Jan 10, 2020	May 8, 2020
Palliative Care	Dec 20, 2019	Jan 9, 2020	Feb 7, 2020	May 8, 2020
Primary Care	Feb 14, 2020	Mar 5, 2020	N/A	Apr 3, 2020
Community-Based Care	Feb 14, 2020	Mar 5, 2020	N/A	Apr 3, 2020
Mobile Integrated Health	Apr 10, 2020	May 7, 2020	N/A	June 5, 2020
Diabetes Care Management	May 15, 2020	May 21, 2020	N/A	June 5, 2020

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
  - Allows providers to be MACRA-tized



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

Splitting Primary Care Based CTI into Two Options

- The primary care CTI will be split into two options:
  - Option 1: Episodic Primary Care will allow hospitals to trigger a CTI when a beneficiaries receives a listed service from one of the listed NPIs.
  - Option 2: Panel-Based Primary Care will allow a hospital to trigger a CTI at the beginning of the year and follow those beneficiaries for the performance period.
- HSCRC will release the Intake Template to for both the Episodic Primary Care and the Panel-Based CTI within a week following this meeting.
  - Hospital may participate in one or both of the CTIs.
  - Deadline for this submission: April 3, 2020

CTI Thematic Area #3: Primary Care Episodes

Overview of Primary Care Episodes

- The episode based CTI will allow the hospital to identify physician initiated episodes based on them providing an E&M service to beneficiaries.
  - Beneficiaries will be attributed to the hospital on the day that they receive one of the listed services from the NPIs selected by the hospitals.
  - The hospital will be accountable for the costs that occur during a fixed episode window following the initiating claim.
- This is similar to the Care Transitions and the SNF-based Community Care CTI in that episodes are triggered by the receipt of a service by the indicated provider type.
- For example:
  - The hospital could chose 'transitional care management' service as the trigger.
  - The hospital would be attributed any beneficiary who receives transitional care management services from their NPIs.
  - The savings will be calculated by comparing beneficiaries that receive transitional care management from the NPI in the performance period and baseline periods.
- This could function similarly to the Care Transitions CTI but initiated by a NPI at a post-discharge clinic or the initiation of a chronic event (such as first dialysis service).

Operationalizing Primary Care Episodes

- Hospitals will be required to submit the following details confirming their desired specifications:
  - Part 1: The hospital will provide a list of their NPIs and select a list of E&M codes that will be used to trigger the episode.
  - Part 2: The hospitals will select a set of beneficiary criteria who will be included in their CTI. Options include:
    - Age
    - Zip codes
    - Chronic conditions threshold
    - Prior utilization qualifications
    - Look back/look forward
    - Episode length
    - Base period
- Reminder: NPIs must be included in the baseline period and the performance period

Default Primary Care Based E&M Services

- The Hospital is attributed a beneficiary when one of their NPIs provides a 'qualifying' claim.
  - The hospital may submit a list of E&M claims that will be used to trigger the primary care service.
  - If the hospital does not provide a list of codes, the default will be to use the following:
    - Prolonged E&M (99354-99355)
    - Transitional Care Management Services (99495-99496)
    - Home Care E&M (99324-99328, 99334-99337, 99339-99345, 99347-99350)
    - Advance Care Planning (99497- 99498)
    - Welcome to Medicare (G0402)
    - Annual Wellness Visits (G0438, G0439)
    - Chronic Care Management Services (99487, 99489-99491)
- Staff removed the NPI taxonomy restriction. Hospitals should be careful to provide NPIs that actually assist with the intended intervention.

Part 2: Do patients meet the clinical criteria?

- Hospitals may use the following criteria to select a subset of the attributed beneficiaries.
- For example: A hospital could select only those beneficiaries who are attributed to them under the primary care attribution and have CHF

	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)	For Option 2, hospitals may submit an episode length of: 30, 60, 90, 120, 150, 180, or 365 days For Option 1, episode length is automatically 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 for Option 2

CTI Thematic Area #3: Panel-Based Primary Care

Overview of Panel-Based CTI

- The panel-based CTI will function similarly to other CTIs with the exception that attribution will occur on the first day of the performance period.
  - A hospital will be attributed a list of beneficiaries on July 1 and retain that population for the entire performance period.
  - The panel will have a target price that is equal to the costs of a baseline panel that would have been attributed to the hospital in the baseline period.
  - The hospital will receive any savings if the costs of the panel in the performance period are less than the costs of the target price.
- For example:
  - A hospital that submits their MDPCP NPIs will be attributed a panel of beneficiaries beginning on July 1, 2020.
  - The target price will be based on the costs of the panel of beneficiaries attributed to the hospital in the baseline period.
  - The savings will be calculated by comparing the July 2020 – June 2021 (performance period) panel to the July 2019 – June 2020 (baseline period) panel.
- The baseline period will be held constant so that hospitals receive credit for improvement in the population.

Operationalizing Panel-Based Primary Care

- Hospitals will be required to submit the following details confirming their desired specifications:
  - Part 1: The hospital will provide a list of their NPIs OR a list of the zip codes where they operate.
    - Option A: Select patients with a PCP who provides the plurality of a beneficiaries' care.
    - Option B: Select patients with care fragmented across multiple PCPs.
  - Part 2: The hospitals will select a set of beneficiary criteria who will be included in their CTI. Options include:
    - Chronic conditions threshold
    - Prior utilization qualifications
    - HCC range
    - Frailty flag
    - Base period

Part 1: Panel Approach

- Option A: MDPCP-Like Attribution
  - HSCRC will run the "MDPCP-Like" attribution using the previous two years worth of data.
  - The hospital will be attributed any beneficiary to whom their NPIs provided a plurality of office-based E&M services.
  - The baseline period is July 2019 – June 2020 and the performance period is July 2020 – June 2021.
- Option B: Fragmented Primary Care
  - HSCRC will run a "Fragmented Primary Care" attribution using the previous two years worth of data.
  - The hospital will be attributed any beneficiary who resides with the listed zip-codes and does not have a primary care provider that provides more than 50% of their office-based E&M visits.
  - The baseline period is July 2019 – June 2020 and the performance period is July 2020 – June 2021.
- Reminder: All beneficiaries attributed based on a panel approach will be attributed for the entire performance year.

Part 2: Do patients meet the clinical criteria?

- Hospitals may use the following criteria to select a subset of the attributed beneficiaries.
- For example: A hospital could select only those beneficiaries who have fragmented primary care and CHF

	Number of Chronic Conditions	Prior Hospitalization / ED utilization	HCC Range	Frailty Flag
Criteria Options	• 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	• A lower bound on the HCCs score • An upper bound on the HCC score	• A frailty flag is evidenced by a DME claim for a hospital bed or transfer equipment.
Default if Criteria is not Specified	Any condition and no threshold of chronic conditions	No requirement on prior utilization	No look back or look forward	No frailty flag

Future Methodological Adjustments

- Over the next year (July 2020 – June 2021) the CT Steering Committee will discuss:
  - Methodologies to add NPIs to the attribution for panels (e.g. do not require the NPI to be in both the baseline period and performance period)
  - Desirability of allowing hospitals to retain panels for longer than a single year
  - Potential modifications to the target price methodology to use an actuarial approach rather than a pre/post methodology for certain types of panels

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 via NPI list	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
Western Maryland	All adult patients in an employed primary care practice who screen positive for depression	Service provided by Integrated Behavioral Health Professional	TBD
Doctors	Age 65+ AND 2+ Admissions, ED visits, or Obs visits during past 90 days AND diagnosis of CHF, COPD, or diabetes	Receives service from mobile clinic or PCP office identified by NPI list	90 Days
Doctors	Age 65+ AND 2+ Admissions, ED visits, or Obs visits during past 90 days AND diagnosis of CHF, COPD, or diabetes	Receives service from wound, sleep, or discharge clinic/referral program	90 Days

Thematic Area #4: Community-Based Care

Community-Based 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

Operationalizing the Community-Based Care CTI

- Hospitals will be required to submit the following details confirming their desired specifications:
  - Part 1:
    - Selection of touch with a post-acute provider OR geographic address
    - The hospital will provide a list of their NPIs OR their Zip Codes
  - Part 2: The hospitals will select a set of beneficiary criteria who will be included in their CTI. Options include:
    - Chronic conditions threshold
    - Number of medications
    - Episode length
    - Base period
- HSCRC will release the Intake Template to hospitals for the Community-Based Care CTI within a week following this meeting.
- Deadline for this submission: April 3, 2020

Selecting the Triggering Condition

- Community-Based Care is targeted to patients that reside in the community, either touching a post-acute care provider or in a geographic area.
- Hospitals will have two options for attributing patients to the CTI:

1a. Touch with a Post-Acute Provider	1b. Geographic Address
The hospital can provide a list of NPIs that correspond to SNFs or a Home Health Agency. • The CTI will include any beneficiary who has a claim with the post-acute care provider. • The baseline cohort will be any beneficiaries seen by that PAC provider in the baseline year. • The hospital may choose whether the initial post-acute stay is included in the episode.	The hospital can provide a list of geographic addresses, either 5-digit zip code, 9-digit zip code, or street addresses. • The CTI will include any beneficiary that resides within the address on the first month of the period. • This will be a panel approach, attributing beneficiaries on the first day of the fiscal year. • The baseline cohort will be any resident of that geographic area during the baseline year.

Final Population Definition for Community-Based Care

- The Community-Based Care CTI will be triggered by one of the options (1a or 1b) on the prior slide.
- Hospitals will then be allowed to submit a population definition that includes any combination of the following criteria:

	Chronic Conditions	Prior Hospitalization / ED utilization	Number of Medications	Episode Length
Criteria Options	• 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	• The hospital may set a threshold on the number of medications that the beneficiary receives.	Hospitals may submit an episode length of: 30, 60, 90, 120, 150, 180, or 365 days
Default if Criteria is not Specified	Any condition and no threshold of chronic conditions	No requirement on prior utilization	Use no restriction on the number of medications	90 day episode window

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
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
Doctors	Age 65+ AND 2 or more Admissions, ED visits, or Obs visits during past 90 days AND diagnosis of CHF, COPD, or diabetes AND 5 or more current medications	TBD	90 Days
Doctors	Age 65+ AND 2 or more Admissions, ED visits, or Obs visits during past 90 days	SNF Discharge	90 Days

Thematic Area #5: Mobile Integrated Health

Mobile Integrated Health – Proposed Interventions

- Collaborate with Fire and Rescue and County Health Department to deploy a community-based team (NP, Community Social Worker, CHW, and paramedic) to provide home visits for high-utilizer/frequent flyer patients
- Emergency Medical Service (EMS) personnel, nurses, and CHWs focus on maintaining high risk individuals' health at their homes while also providing convenient care access in the community
- MIH Team Care Partners evaluate patient, and arrange follow up as necessary, which includes: home visits and assessments, heath education, connection to community resources, connection to primary care or specialty providers
- Paramedic and Nurse Practitioner visit to provide an assessment of medical condition, environment, and social determinants affecting patient's stability that may include medication affordability, transportation, environment, mental health and drug screening

Submitter	Eligible Population	Intervention Trigger	Duration
Howard County General	18 + years AND Howard County Resident AND 2 or more ambulance transports to HCGH in 365 days	TBD	TBD
Capital Region Health	Beneficiaries with greater than 1 IP or ED admission within the past 30 days	IP or ED admission	30 days
Charles Regional MC	Beneficiaries with 6 or more ED admissions in a 3 month period	ED admission	90 days
Shore Regional Health	Beneficiaries with 3 ED, observation, or IP visits within the past 6 months	IP admission	12 months
UMMC	Beneficiaries with a primary diagnosis of respiratory system diseases OR circulatory system diseases OR endocrine, nutritional, metabolic, and immunity disorders OR digestive system diseases OR genitourinary system diseases OR nervous system and sense organs diseases AND exclude pregnancy	Hospital admission or ED evaluation	90 days
Peninsula Regional	Beneficiary with 3 or more EMS calls within zip codes 21801 or 21804 with transport to the ED in the previous 6 months for non-life threatening medical issues	5th EMS call with billed transport to Medicare for a non-life threatening condition	6 months
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

MIH: 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 after an ED discharge?
  - Does a shorter or longer post-discharge window indicate that the intervention is clinically different (e.g. 30 days versus 180 days; 30 days versus 365 days)?
- Are these substantially different populations?
  - Is it problematic to combine a CTI that targets based on diagnosis codes versus a CTI targeting a threshold of ambulance transports?
- Are ambulance transport claims a reliable source of information to use as a trigger for CTIs?
  - Is a particular threshold of ambulance transports agreed upon by the industry as necessitating MIH intervention (e.g. 2 vs. 3 transports)?
- How would this CTI interact with other developing EMS models at HSCRC?

Next Steps for MIH

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

Miscellaneous CTI

Miscellaneous Modifications to Existing CTI Proposals

- We are continuing to develop additional modifications to existing CTIs. These will include:
  - Modifications to Care Transitions CTI:
    A. Care Transitions for MDPCP attributed beneficiaries
    B. Care Transitions initiated by an ED visit
    C. Care Transitions for patients that have a touch with a particular NPI
    D. Care Transitions for patients that are discharged to a particular SNF
  - Modification to the Primary Care CTI:
    A. Medicare beneficiaries with 2 or more visits to a primary care doctor (from NPI list) in the 12 months prior to the performance period

Discussion of Upcoming CTI Thematic Groupings

Future Thematic Areas

- Thematic Area 6 is likely to be diabetes care management
- We received two CTIs with the following proposed interventions:
  - 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

Next Steps

Next Steps and Further Submissions

- Send questions, CTI assessment form submissions, and CTI Intake Templates to: hscrc.care-transformation@maryland.gov
- Staff intend an ongoing CTI proposals process
  - CTI proposals must be submitted by Feb 21st to be considered at the Mar 6th CT Steering Committee Meeting
  - CTI proposals will be developed on a rolling basis, EARLIER submissions are better
- A revised CTI User Guide will be published prior to the next CT Steering Committee Meeting.
- Staff are preparing a report on the initial CTI process for the March or April commission meeting. A draft will be circulated prior to the next CT Steering Committee Meeting.
- Future Meetings
  - Friday, March 6th, 2020, from 1-3pm
  - Friday, April 3rd, 2020, from 1-3pm
  - Friday, May 8th, 2020 from 1-3pm