Care Transformation Steering Committee

March 6, 2020

Agenda

1. Administrative Updates
   i. Update on CTI User Guide, FAQ, and Intake Templates
   ii. Data Availability in the Care Transformation Profile
   iii. Fraud and Abuse Waivers for Approved CTIs
2. CTI Methodology
   i. Overlaps Policy
   ii. Risk Adjustment Methodology
3. Discussion of CTI Thematic Area #5: Emergency Care
4. Update on Remaining CTI Proposals
   i. Diabetes Management CTI
   ii. Miscellaneous CTI
5. Next CT-SC Meeting
   i. CTI Deadlines

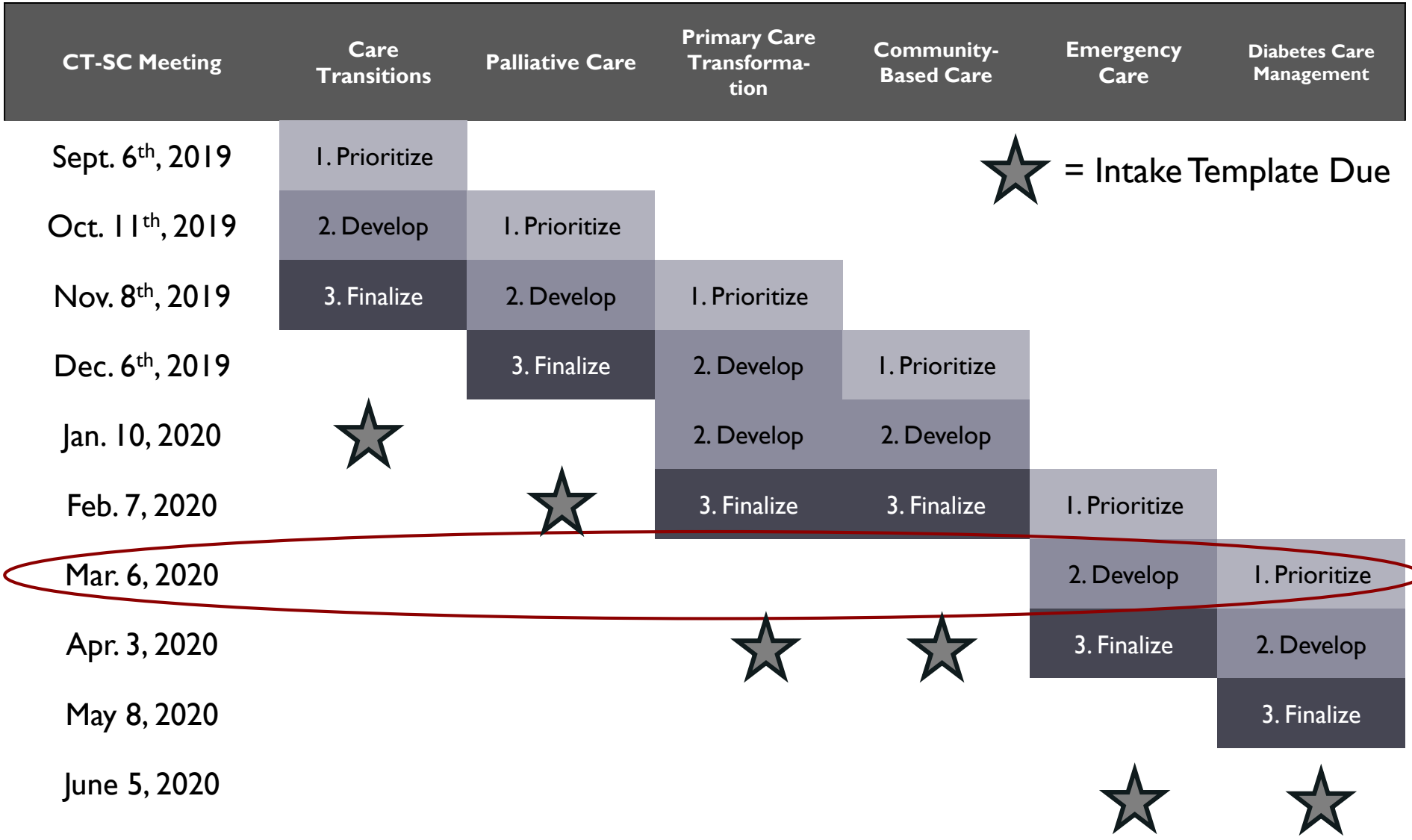
Administrative Updates

Update on CTI User Guide, FAQ, and Intake Templates

Data Availability in the Care Transformation Profile

Fraud and Abuse Waivers for Approved CTIs

Schedule for Rolling CTI Development



User Guide, CTI Report, and Intake Templates

- HSCRC staff has revised the CTI User Guide.
  - Updates primarily focused on overlap, risk adjustment, and other methodology.
  - These methodological changes are summarized here and will be discussed in detail at the next TCOC meeting.
- Staff are preparing a report on the initial CTI process for the April commission meeting.
- Reminder regarding upcoming CTI:
  - To participate in the Primary Care Transformation CTIs or Community-Based Care CTIs, please submit your Intake Template by April 3, 2020
  - NOTE: The 'Fragmented' Primary Care CTI is available and interested hospitals should contact hscrc.care-transformation@maryland.gov.

Key Dates by Thematic Area

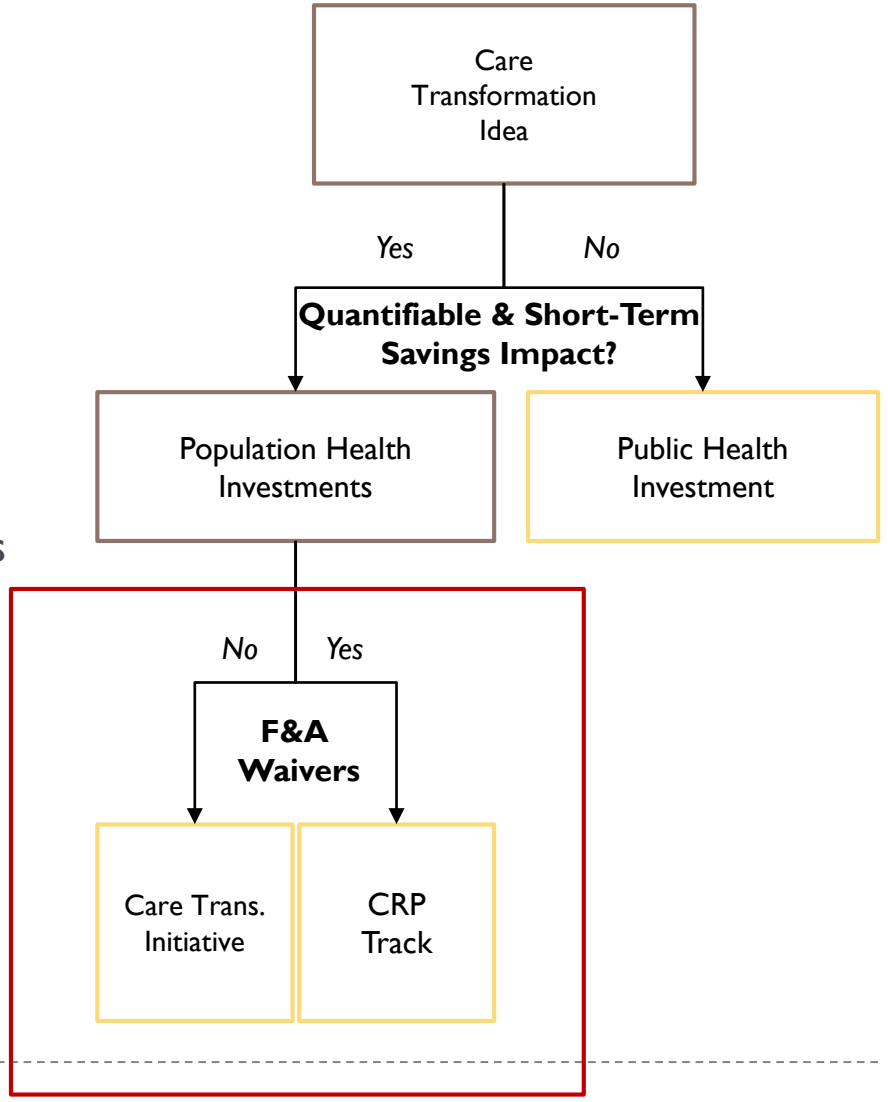
Thematic Area	Template Released	Template Webinar	Initial Template Due	Final Template Due
Care Transitions	Nov 18, 2019	Dec 5, 2019	Jan 10, 2020	May 8, 2020
Palliative Care	Dec 20, 2019	Jan 9, 2020	Feb 7, 2020	May 8, 2020
Primary Care	Feb 14, 2020	Mar 5, 2020	N/A	Apr 3, 2020
Community-Based Care	Feb 14,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

Data Availability in the CTP Tool

- HSCRC and CRISP are working to populate the CTP tool with the initial Care Transitions CTI.
  - We now expect the data to be available by late March.
  - We will be reaching out to credential hospital users to access to the tool next week.
- We expect to provide hospitals an opportunity to view data for their initial palliative care submissions.
  - Hospitals may submit a revised intake template for care transitions and palliative care.
  - Primary care and later CTI will not have enough time to turn around two submissions before July 1.

Fraud and Abuse Waivers

- Do hospitals think fraud and abuse waivers would be necessary and/or helpful to implement the Care Transitions, Palliative Care, Primary Care Transformation, or Community-Based Care CTIs?
- 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 Methodology

Overlaps Policy

Risk Adjustment Methodology

Overview of the CTI Overlaps Policy

Part 1: Overlaps that Occur on the Same Day

- Part 1.A: Prohibit hospitals from submitting two CTI with obvious definitional overlap
- Part 1.B: Provide a hierarchy of CTIs in the event that a beneficiary simultaneously meets the triggering criteria for multiple CTI

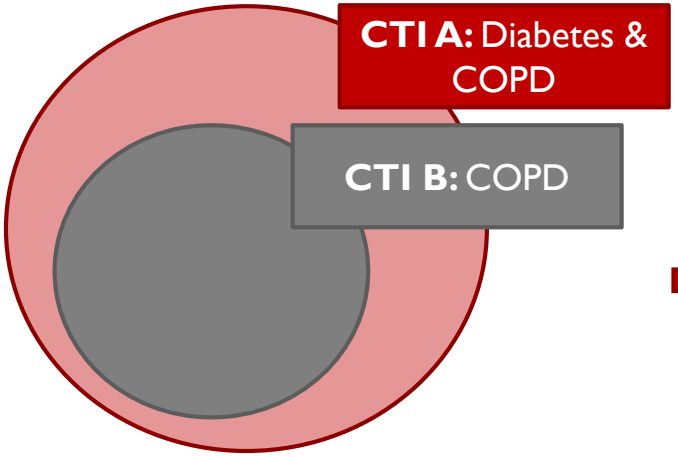
Part 2: Allowed Overlaps

- Allow CTI that have "acceptable" overlaps
- Panel-based CTI and episodic CTI will be allowed to overlap

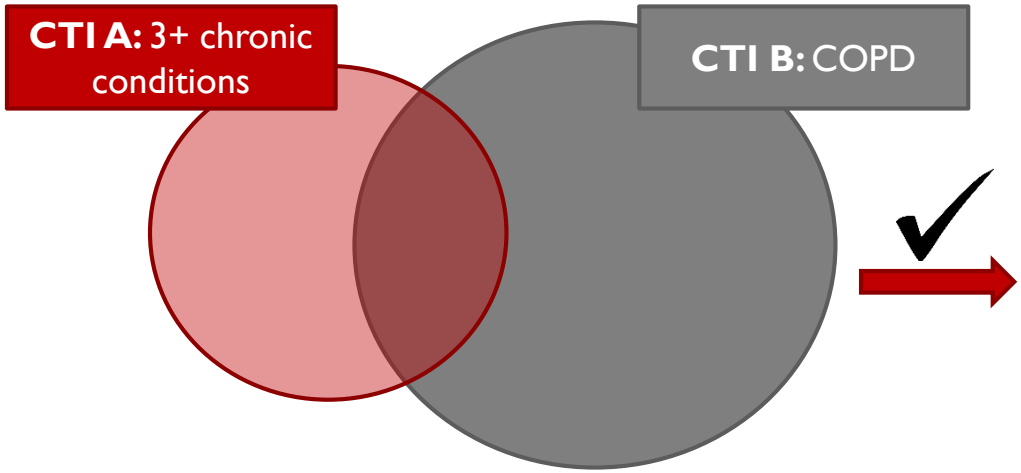
Part 3: Excluded Overlaps

- If a beneficiary appears in two or more CTI, then:
  - Arrange the episodes in trigger date order
  - Then drop the CTI episodes that occurred second

Part 1.A: Definitional Overlap



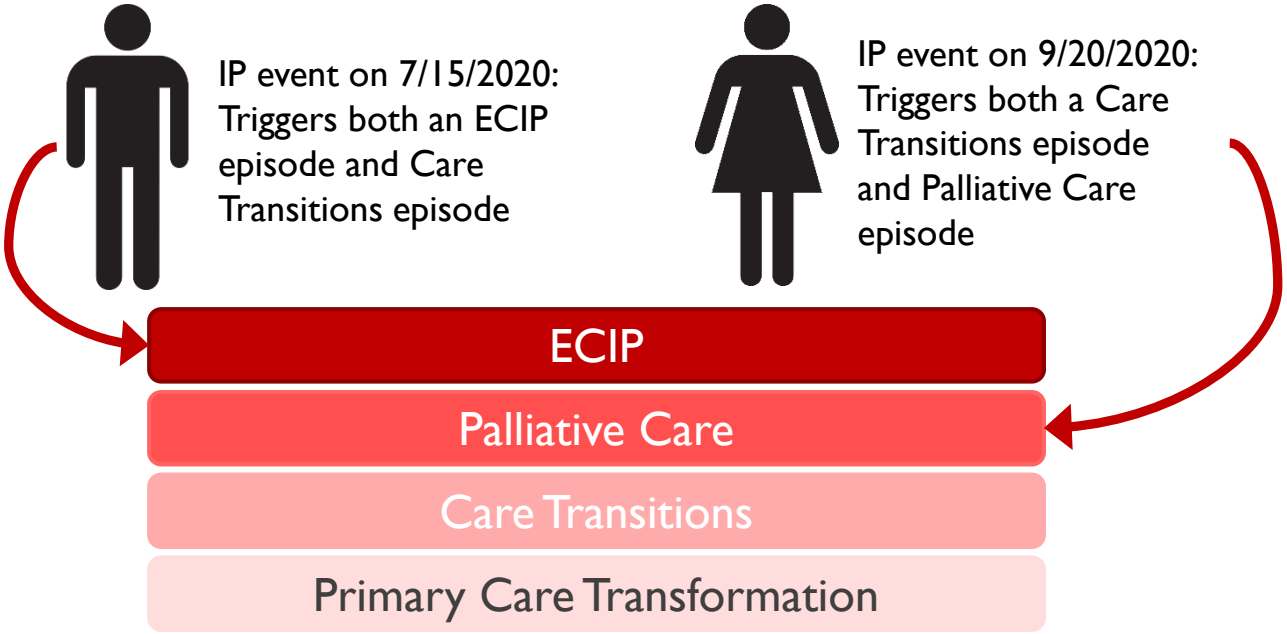
- Obvious definitional overlap will be revised.
- This is enforced within and across different CTI Thematic Area.



- Overlap that occurs organically between two CTIs with disparate definitional intentions will be allowed.
- A hierarchy will need to be developed to attribute beneficiaries to one of the CTI.

Part 1.B: Hierarchy Overlaps Policy

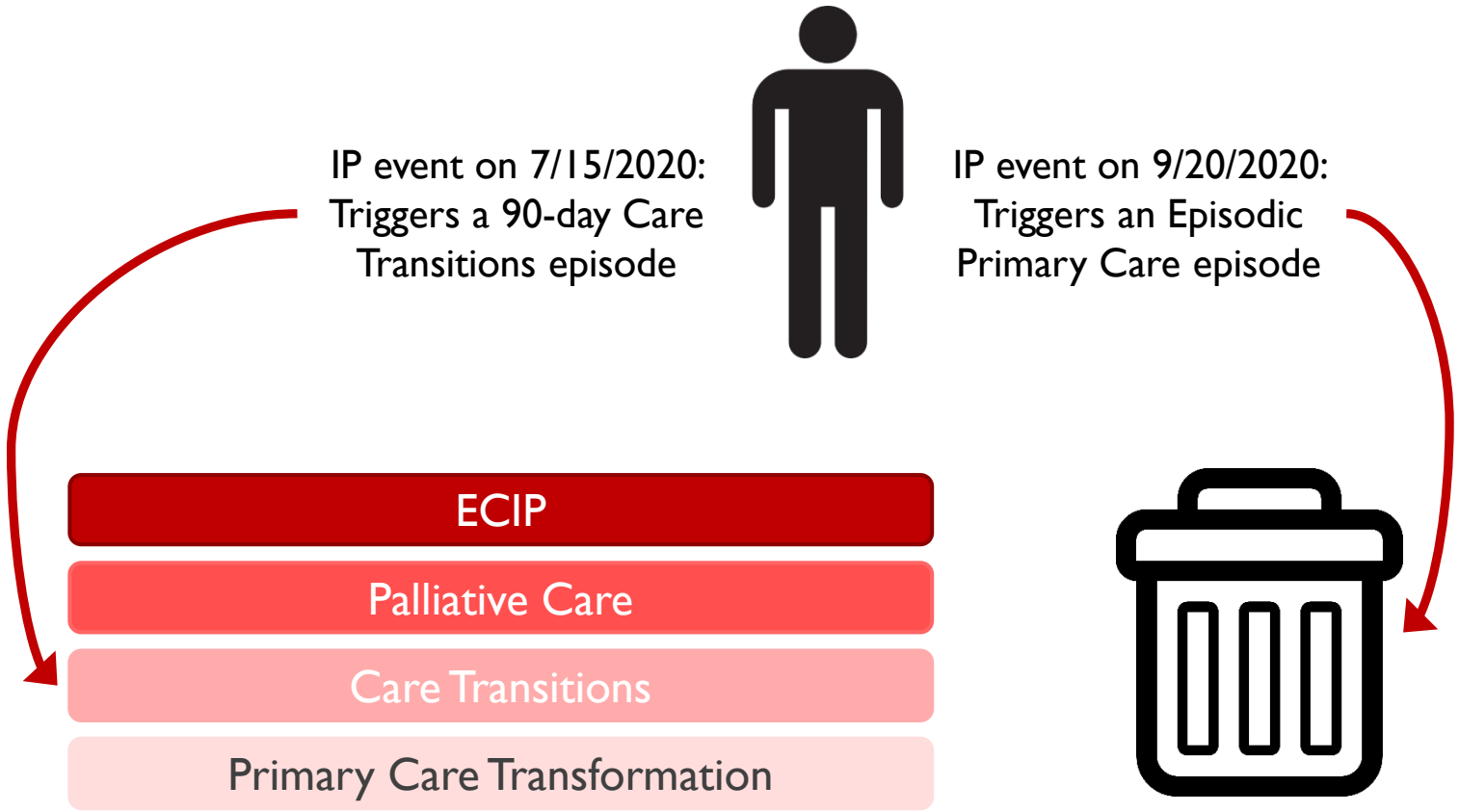
- In the case that a beneficiary triggers two different CTIs with the same event, the HSCRC is determining a hierarchy for which CTI Thematic Areas "wins" the beneficiary
- The CTI hierarchy will be determined during conversations between the hospital and the HSCRC. The suggested hierarchy is based on the "restrictiveness" of a CTI:
  - More restrictive CTIs should be higher in the hierarchy
  - Less restrictive CTIs should be later in the hierarchy



Part 2: Categorically Allowed Overlaps

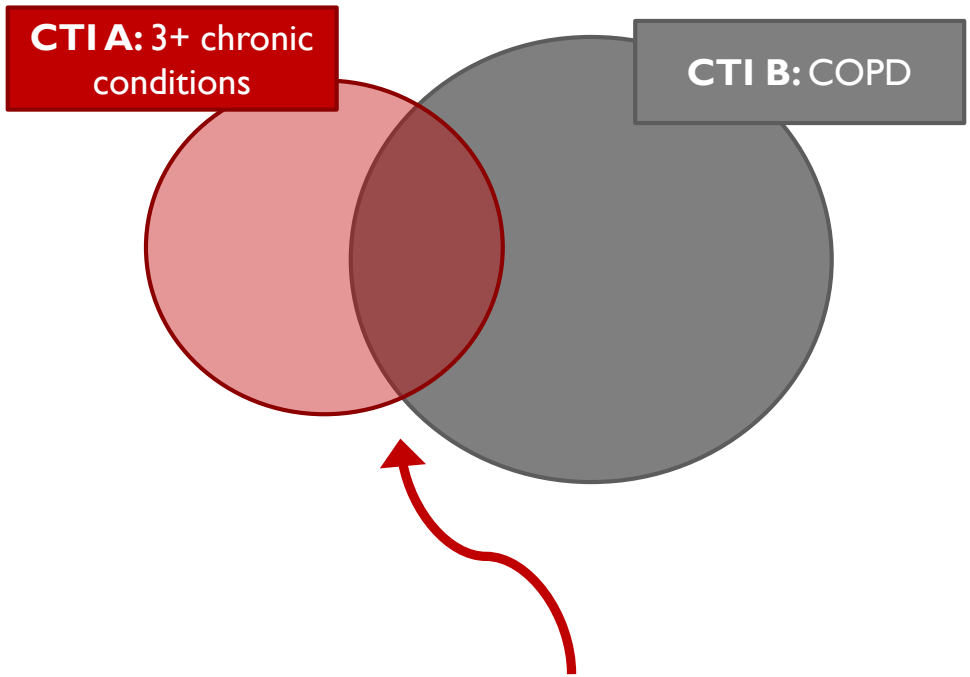
- Panel-based CTI make it difficult to determine which hospital should be held responsible when there are overlaps.
  - Panel-based CTI encourage longitudinal care management relationships with beneficiaries.
  - Episodic CTI encourage hospitals to manage acute events.
  - Neither type of relationship is more or less important than the other.
- Therefore, staff are proposing that panel-based CTI will be allowed to overlap with episodic CTI.
  - The panel-based CTI are the Panel-based Primary Care and Geographic Community Care CTIs.
  - This policy only applies when the episodic CTI is triggered at a different hospital than the panel based CTI.
- The hospitals will share credit for beneficiaries that are jointly attributed to a panel-based CTI and an episodic-based CTI.
  - Staff will analyze the magnitude of the overlap in terms of savings.
  - We will discuss potential modifications to the overlaps policy with the Care Transformation Steering Committee after the first performance year.
  - In future years, we may consider prorating or dividing the savings between hospitals.

Part 3: Standard Overlaps Policy In Action



Change to Overlaps Policy for Small Overlaps

- Staff's Initial Proposal: Allow CTI with a "small" overlap.
  - If fewer than 15% of a CTI's beneficiaries are in another CTI then that CTI would be allowed to overlap with another CTI.
  - Otherwise the normal overlaps rules will apply.
- Staff now recommend applying normal overlaps rules even when there is a small overlap.
  - Our rationale was that small overlaps did not matter much.
  - If it does not matter than we would prefer to simplify the methodology.

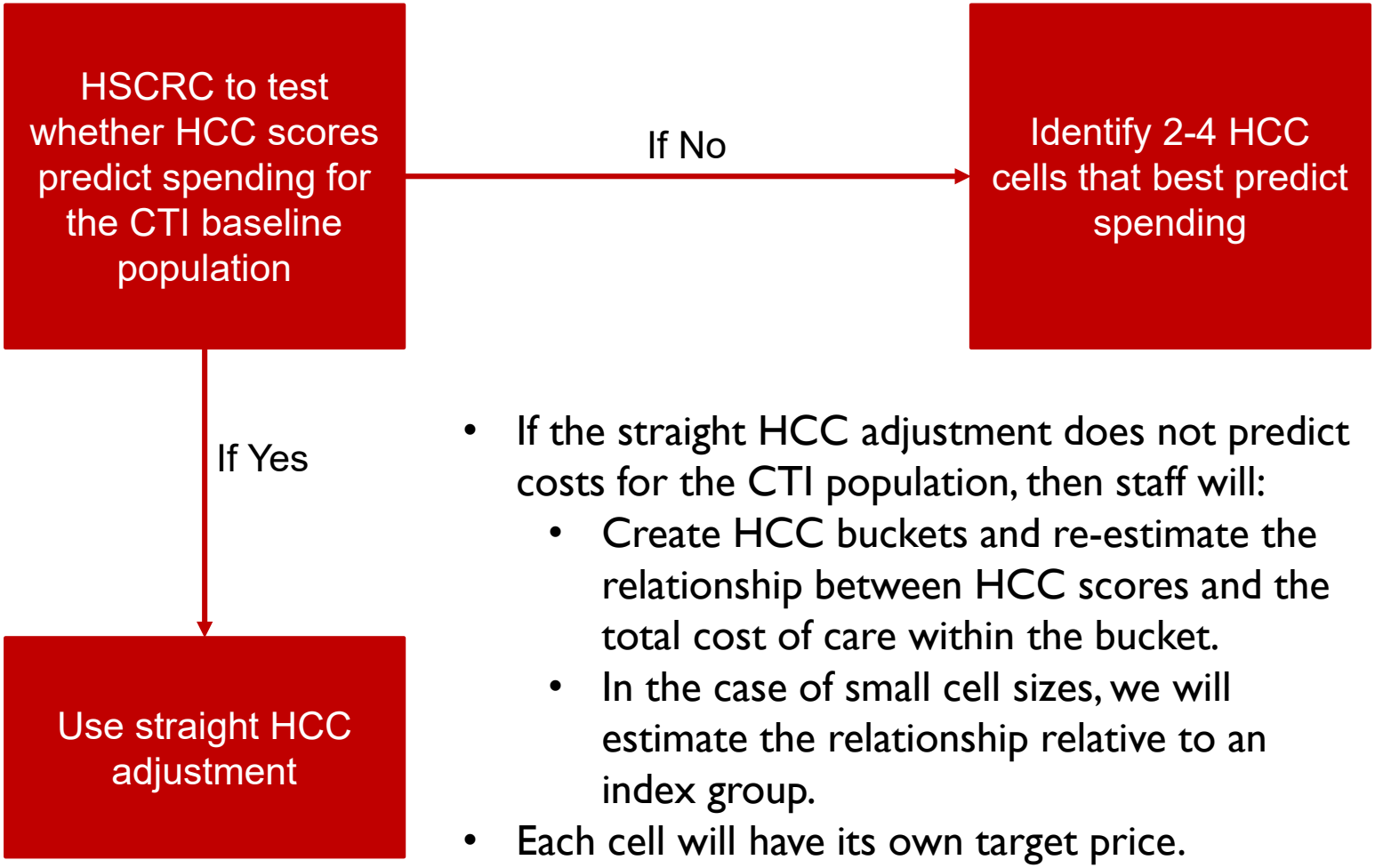


Overlaps would be allowed if the number of episodes that is in BOTH CTI is less than 15% of the number of episodes in the smallest CTI.

Risk Adjustment Methodology

- The initial CTI Methodology used an 'anchor factor' approach to risk adjustment based on CJR and other CMMI models.
  - Each HCC strata or APR-DRG would have a separate target price.
  - The anchor factor approach adjusts for small sample sizes at each individual cell.
- The anchor factor approach is complex and provides relatively few benefits relative to an HCC model. Therefore, Staff are proposing to simplify the risk adjustment approach to:
  - Use the HCC risk scores to set a target price.
  - The HCC model is designed to estimate the total cost of care for the average beneficiary.
  - This model may need a modification to adjust for differences between the CTI population and the 'average' beneficiary.

Simplification of the Risk-Adjustment Methodology



- If the straight HCC adjustment does not predict costs for the CTI population, then staff will:
  - Create HCC buckets and re-estimate the relationship between HCC scores and the total cost of care within the bucket.
  - In the case of small cell sizes, we will estimate the relationship relative to an index group.
- Each cell will have its own target price.

Three Step Process for the Risk Adjustment Process

1. Straight HCC risk-adjustment simply multiplies the hospitals' baseline costs by the HCC risk score.
   i. Suppose the hospital's CTI HCC risk score is 1.5 in the baseline period and 1.8 in the performance period.
   ii. In that case, the target price will be 1.2 (e.g. 1.8/1.5) times the hospitals baseline costs because the hospital's HCC scores are 120 percent higher in the performance period.
2. The HCC score may under or over predict costs for the CTI population. For example:
   i. Research has shown that adding a frailty adjustment can improve the accuracy of the HCC model.
   ii. The HCC model may under predict costs for a CTI that is targeted at the frail population.
3. If the HCC model under predicts for a given population, then the HSCRC will create HCC 'segments'.
   i. The segments will re-estimate the relationship between HCC and total cost of care for that population.
   ii. The current HCC model has different segments for the dually eligible beneficiaries, institutional beneficiaries, etc. We could add additional segments for the CTI population.
   iii. This will be discussed in greater detail at the March TCOC Workgroup Meeting.

Thematic Area #5: Emergency Care

Emergency Care – 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

Revision of the Mobile Integrated Health CTI to Emergency Care CTI

- Staff suggests revising the Mobile Integrated Health definition to include all Emergency Department initiated care transition CTI.
  - The Mobile Integrated Health interventions are triggered by frequent 911 calls or ambulance transports. This data does not consistently appear in claims data.
  - A number of hospitals had proposed care transitions CTI that are triggered by the Emergency Department.
- This CTI would be triggered by an Emergency Department visit and would allow the hospital to select the population based on ambulance transports or frequent emergency department utilization.
  - This will not perfectly overlap with the Mobile Integrated Health definitions but could identify a significant portion of the population.
  - Hospitals could also submit other interventions (such as care transitions) that are initiated in the Emergency Department.
- HSCRC is working with hospitals and EMS providers to create additional models for financing ambulance transport to alternative destinations of care. This would not need to be triggered based on claims.

Initial Population Definition for Emergency Care CTI

- This CTI will be trigger by an Emergency Department visit.
- Hospitals may use any combination of the following criteria to select a subset of the attributed beneficiaries.

	Age	Geographic Service Area	Diagnosis / DRG	Number of Chronic Conditions	Prior Hospitalization / ED utilization	Ambulance Transports	Episode Length
Criteria Options	Hospitals determine the age range their intervention targets	Hospitals may provide a list of 5-digit zip-codes	Hospitals may submit a list of: • ICD -10 primary diagnosis codes OR • APR-DRG / SOIs	• 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 can indicate a number of ambulance transports	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	Use all diagnosis and DRG codes	Any condition and no threshold of chronic conditions	No requirement on prior utilization	No threshold on ambulance transports	90 day episode window

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
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

Next Steps for the Emergency Care CTI

- Almost all populations can be picked up with our current population definition categories and proposed additional categories.
  - HSCRC staff will finalize the population definitions at the April CT-SC meeting.
  - 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.
- REMINDER: Once the population definitions have been finalized, hospitals will be given the opportunity to indicate whether they want to participate.
  - HSCRC will release the Intake Template and webinar date to hospitals on the Emergency Care CTI following the April CT Steering Committee Meeting

Update on Remaining CTI Proposals

Diabetes Care Management Proposals

- 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

Submitter	Eligible Population	Intervention Trigger	Duration
MedStar	Adults with uncontrolled type 2 diabetes	Type 2 diabetes A1C greater than or equal to 9%	TBD
GBMC	Encounter at GBMC HealthPartners or affiliated practices in past 18 months AND 1+ acute care hospitalization(s) with principal diagnosis of type 2 Diabetes	Diabetes education CPT within 30 days of acute care discharge	TBD
MedStar	2+ visits to a primary care doctor in FY2017 (from an NPI List to be provided) in the 12 months prior to the performance period	Discharge from a MedStar ED, inpatient, or observation status	365 days
Western Maryland Health System	All persons discharged from the inpatient BH unit with primary behavioral health diagnoses (mental health or substance abuse)	IP discharge	TBD
Western Maryland Health System	3 or more inpatient or observation visits prior to interacting with the CCR with the following primary diagnosis codes: COPD, CHF, and Diabetes	IP or Observation Encounter	TBD
Mercy Medical Center	All patients scheduled for hip/knee replacement at Mercy Medical Center	Date of operation	TBD

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

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 March 20th to be considered at the April 3rd CT Steering Committee Meeting
  - CTI proposals will be developed on a rolling basis, EARLIER submissions are better
- Future Meetings
  - Friday, April 3rd, 2020, from 1-3pm
  - Friday, May 8th, 2020 from 1-3pm
  - Friday, June 5th, 2020 from 1-3pm