Care Transformation Steering Committee

September 6, 2019

Agenda

1. Administrative Updates
   i. Update on Post Acute Care for Complex Adults Program (PACCAP)
   ii. Update on Episode-based Payment Development
   iii. Update on CTI Target Pricing Methodology
2. CTI Development Process
   i. Requirements to Identify CTI Population
   ii. Groupings within Thematic Areas
   iii. Hospital at Home Example
3. Discussion of CTI #1
   i. Transitions of Care
   ii. Next Steps
4. Next CT Steering Committee Agenda
   i. Review of Upcoming Thematic Areas
   ii. Reminder of the CTI Submission Process

Administrative Updates

Administrative Updates

- Quick update
  - Name changed from "Care Redesign Steering Committee" to "Care Transformation Steering Committee"
  - HSCRC Staff have updated the group's name to encompass the growing work outside of formal Care Redesign Programs
- Meeting schedule
  - Moving to meeting monthly instead of every other month
    - Friday October 11, 2019, from 8-10am
    - Friday November 8, 2019, from 8-10am
    - Friday December 6, 2019, from 8-10am

Update on Post Acute Care for Complex Adults Program (PACCAP)

- The State is planning on submitting a revised PACCAP submission to CMMI in July of 2020 for a January 2021 start date
  - The State received some letters of intent to participate in PACCAP, however, other stakeholders expressed interest in additional use cases
  - The revised submission will include a broader use case (sharing of high-cost drugs and medical supplies, etc.)
- In the interim, the HSCRC Staff will convene a subgroup of the CT Steering Committee beginning in November to discuss regulatory barriers between hospitals and SNF/HHA
- Those interested in participating should email HSCRC.care-transformation@Maryland.gov

Subgroup to discuss Episode Alignment

- HSCRC staff will hold a subgroup meeting in late September/October to discuss the evolution of ECIP
  - At the previous CT Steering Committee Meeting, CareFirst outlined their approach to episode based payments
  - The subgroup will compare the design of other payer episodes with ECIP and identify ways to align with other payers
- HSCRC staff will invite representatives of other payers (Medicaid, commercial, etc.) to participate
- If CT Steering Committee members are interested in participating, please email:

  HSCRC.care-transformation@Maryland.gov

Methodological Workgroup Meeting

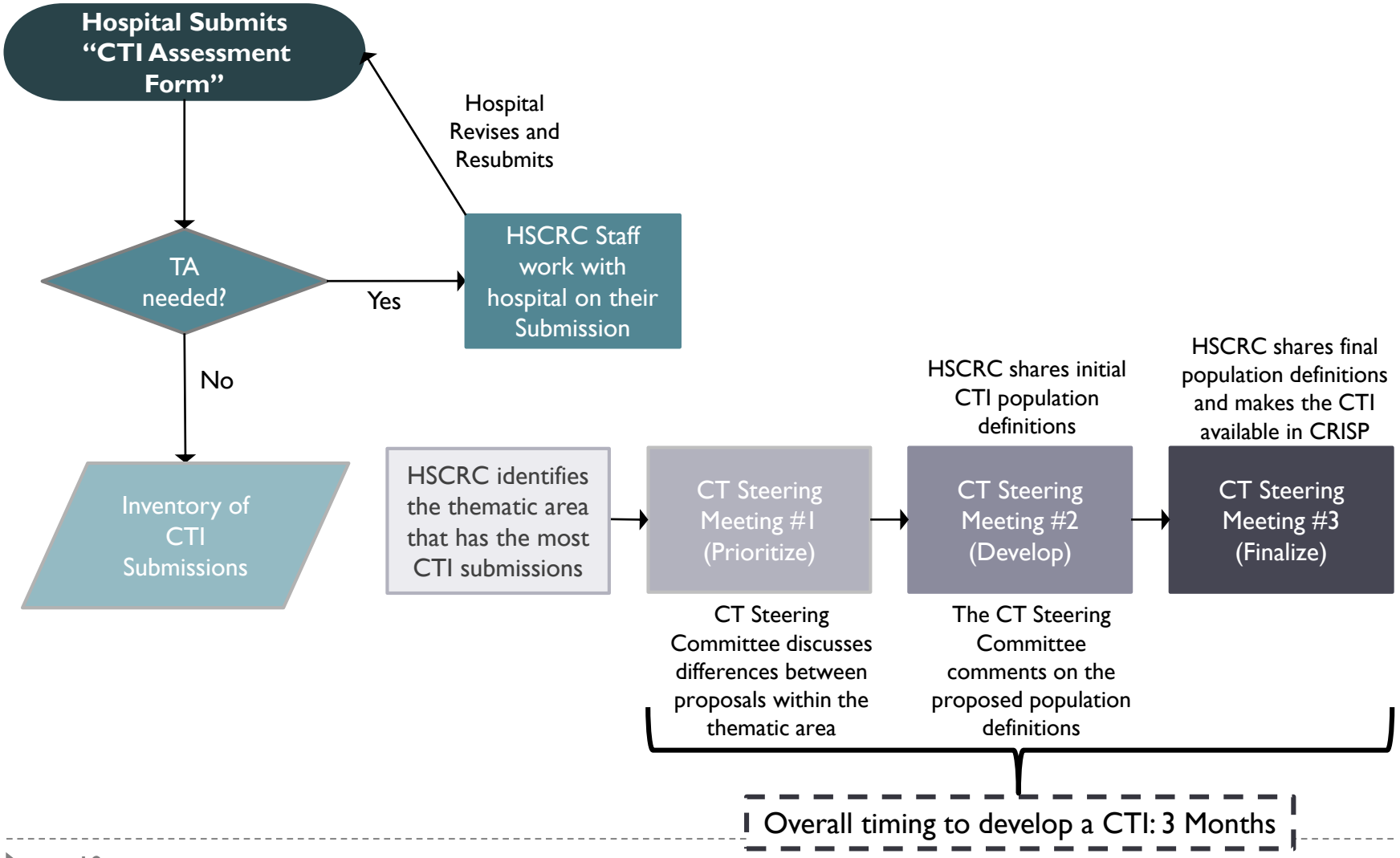
- HSCRC staff will present a walkthrough of the target price and reconciliation calculations at the September TCOC workgroup meeting
  - Calculation of inflation factors (both hospital and nonhospital)
  - Risk adjustment
  - Small sample-size threshold
  - Overlap between multiple CTIs
  - Outlier exclusions
- HSCRC staff will also share User Guide and FAQ documents to stakeholders
- Please provide additional questions and suggested topics by email to HSCRC.care-transformation@Maryland.gov.

Review CTI Process

Overall Timing

- First CTIs will be implemented July 1st, 2020 and NOT January 1st, 2020
  - HSCRC staff are allowing more time for industry development and feedback
  - The first performance period will run from July 1st 2020 to June 30th 2021. The first payments will be made on July 1st 2022
- Hospitals may submit their CTI proposals at anytime
  - We anticipate 5-7 CTIs by July 1st, 2020, selected monthly
  - To be considered for selection, hospitals should submit their CTI proposal two weeks prior to the next CTI Steering Committee Meeting
  - Hospitals should submit their CTIs to HSCRC.care-transformation@maryland.gov

CTI Approval Process



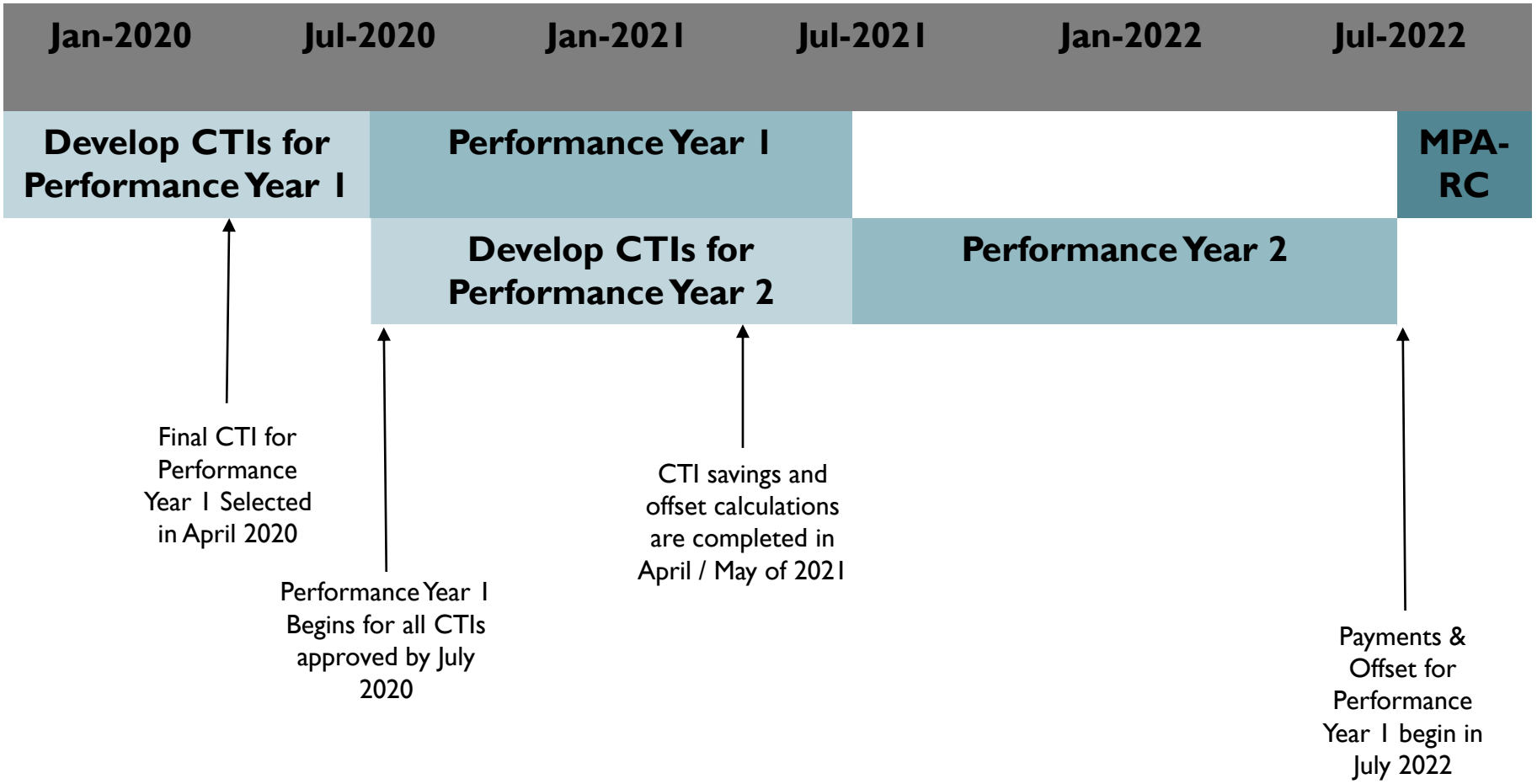
Schedule for Rolling CTI Development

CT-SC Meeting	CTI Area #1	CTI Area #2	CTI Area #3	CTI Area #4	CTI Area #5	CTI Area #6	CTI Area #7	CTI Area #8
Sept. 6th, 2019	1. Prioritize							
Oct. 10th, 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			3. Finalize	2. Develop	1. Prioritize			
Feb. 7, 2020				3. Finalize	2. Develop	1. Prioritize		
Mar. 6, 2020					3. Finalize	2. Develop	1. Prioritize	
Apr. 3, 2020						3. Finalize	2. Develop	1. Prioritize
May 1, 2020							3. Finalize	2. Develop
June 5, 2020								3. Finalize
July 10, 2020								

Final month to select CTI that will begin in July

PERFORMANCE PERIOD STARTS FOR CTIs 1-8

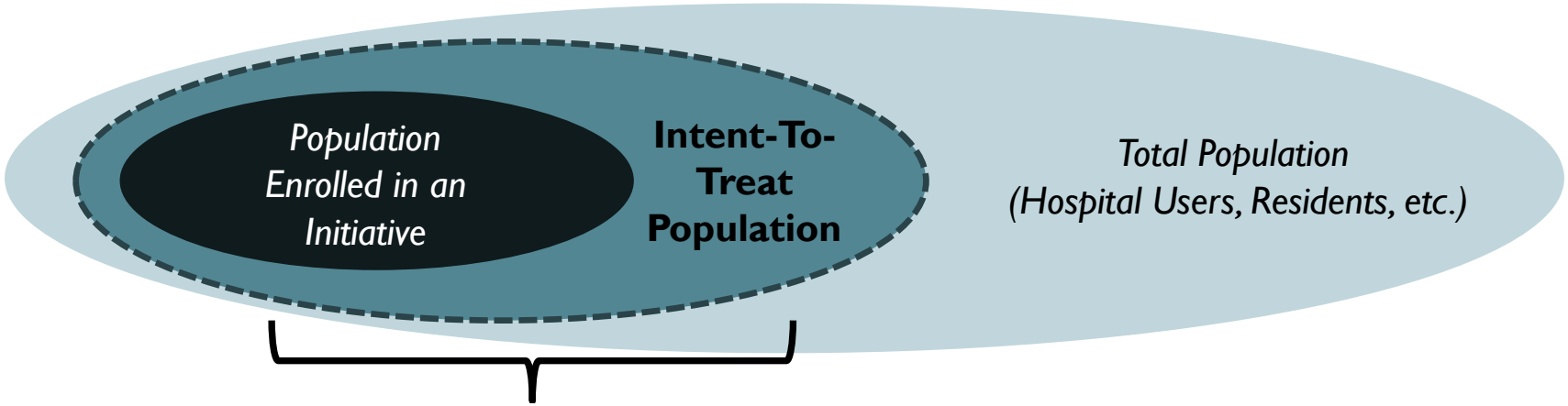
Timeline of the CTI Process and Payments



Identifying the CTI Population

Identifying the Population

- The trigger must be identifiable in claims data but may include **any** combination of:
  - Receipt of procedure(s) (e.g. hospitalization or count of ED visits)
  - Condition (chronic condition, primary diagnosis code, or DRG)
  - Geographic residency (by zip code or county)
  - Receipt of services from an indicated provider (CCN, TIN, NPI, or type of provider/specialty of supplier)
  - Other claims-based data as necessary
- The parameters should represent the Intent-To-Treat population



Goal: Ensure the intent-to-treat population parameters are specific enough to capture the enrolled population with minimal extraneous inclusion

Creating the Eligible Population Cohort

- Step 1: Choose the eligible population
  - Identify beneficiaries who could benefit from the intervention (e.g. diabetic beneficiaries for a diabetes intervention)
  - Trigger based on the diagnosis of a condition (ICD principal diagnosis, chronic condition flag, etc.) or if beneficiary receives a certain procedure (IV-antibiotics, etc.)
- Step 2: Restrict the population to those **most likely** to be impacted by the intervention
  - Identify which eligible beneficiaries could have received the intervention from the hospital
  - Trigger based on a touch with the hospital or an associated provider
- Step 3: Choose the intervention window
  - The window could be 15, 30, 60, 90, 180, etc. days
  - All costs during the window (regardless of setting of care) are included
- The **final trigger** is a combination of the eligible population and those who may have been impacted by the intervention

Example: Mobile Integrated Health

- A hospital deploys a community-based team to provide home visits for patients that have called 911 six or more times
- Step 1: Identify the eligible population
  - 911 calls are not identifiable in the claims data
  - BUT ambulance transport is identifiable
  - For example: Find the overlap between six or more 911 calls and three or more ambulance transports
- Step 2: Restrict the population
  - Anyone living in the service area of the hospital's EMS program
- Step 3: The intervention window is 180 days from the third ambulance transport
- **The Trigger** is anyone who has three or more ambulance transports and lives in the hospital's EMS service area

CT Steering Committee
Discussion of CTI Proposals

Discuss CTI Proposals

1. CT Steering Committee will discuss the grouping of CTIs into thematic area(s) based on the number of submissions

2. CT Steering Committee will assess the clinical differences between the submitted interventions and populations

Groupings of CTIs in a Thematic Area

	Are the proposed interventions clinically similar?		
Are the proposed populations clinically similar?		Yes	No
	Yes	1 CTI	1 CTIs
	No	2 CTIs*	2 CTIs

*The HSCRC may combine/unify populations in the future so everyone has an incentive to expand the CTIs' intervention and impact

Hypothetical Hospital at Home Interventions

- Physician completes daily visits to patient's home and available 24 hours a day for urgent or emergent visits
- Nurse or care manager provided to each patient to supervise the case management, support adherence to treatment, monitor patient's needs, and ensures that the team elements are in place
- Diagnostic studies provided in home
- Home-based telemedicine protocols and access are set up with the patient prior to discharge to allow physician communication and monitoring services
- Individualized patient centered plan created from comprehensive assessment to identify needs
- Referral to additional health, community, social support services

Hypothetical Hospital at Home Proposals

Proposal	Eligible Population	Intervention Trigger	Duration
CTI Proposal I	CHF, COPD, community-acquired pneumonia, and cellulitis	ED Visit	25 days
CTI Proposal II	CHF, COPD, community-acquired pneumonia, and cellulitis	ED Visit	30 days
CTI Proposal III	CHF, COPD, community-acquired pneumonia, cellulitis, deep venous thrombosis, pulmonary embolism, urinary tract infection, nausea, and dehydration	ED Visit	30 days
CTI Proposal IV	Patients recovering from a hip or knee replacement, hysterectomy	Hospital Discharge	15 Days

Hypothetical Discussion Questions

- Are the proposed CTI interventions clinically similar? Or are there substantive clinical differences between the interventions?
  - Is it necessary for a physician to performance a daily visits to patient's home? Or is it enough for the physicians to be available for telehealth while a nurse performs a home visit?
- Do the differences between the patient population reflect a clinically different population or a program design?
  - Is the difference between a 25-day and a 30-day period post-ED visit clinically meaningful?
  - Is it clinically different to provide home care after an ED visit versus providing home care after a hospitalization?
- Is the hospital at home intervention meaningfully different than other interventions that target CHF, COPD, pneumonia, and cellulitis (e.g. PCMH)?

Hypothetical CTI Combinations

1. CTI Proposals I and II could be combined into a CTI because:
   - The Eligible Population shares a common definition across CTI proposals
   - The difference between a 30-day window and a 35-day window is not clinically meaningful
2. CTI Proposal III could be split into two CTIs because:
   - The population with deep venous thrombosis, pulmonary embolism, urinary tract infection, nausea, and dehydration is meaningfully different than the population with CHF, COPD, community-acquired pneumonia, and cellulitis
   - Hospitals would have the option of participating in one or both of the populations
3. CTI Proposal IV could be developed into a separate CTI because:
   - The population is substantially different
   - The intervention beginning at hospital discharge (rehab) is different than hospital at home beginning in the ED (acute care)

CTI Thematic Area #1: Transitions of Care

Care Transitions– Proposed Interventions

- Discharge planning in physician's office prior to surgery
- Hospital screening and assessment
- Home assessment or step-down level of care planning
- Home and Skilled-nursing visits
- Initiation of home-based medication reconciliation for patients with 5 or more medications
- Addition of mobility technician staff in hospital to decrease deconditioning during hospitalization
- Improved discharge coordination with hospitalist support
- Telehealth transition services
- Disease management education
- Referral to community care management and resources

Submitter	Eligible Population	Intervention Trigger	Duration
MedStar System Hospitals	All surgeries on joints.	IP Discharge	TBD
Holy Cross	Patients admitted to the hospital with a medical DRG and an SOI of 2 or 3 EXCLUDING those previously admitted to the hospital within the prior 30 days.	IP Discharge	60 Days
Holy Cross Germantown	Patients admitted to the hospital with a medical DRG and an SOI of 2 or 3 EXCLUDING those previously admitted to the hospital within the prior 30 days.	IP Discharge	60 Days
Howard County General	Patients discharged to home OR to home with home care AFTER the second hospitalization or ED visit within the previous 12 months.	IP Discharge or ED Encounter	180 Days
Capital Region Health	Patients admitted to the hospital with a primary diagnosis of CHF, COPD, Diabetes, or Sepsis AND more than one inpatient admission within the past 30 days.	IP Admission	30 Days
Charles Regional MC	Patients admitted to the hospital with a primary diagnosis of CHF, COPD, Diabetes, Sepsis, ESRD or sickle cell anemia AND more than one inpatient visit in the past 30 days or more than 3 inpatient stays within the past 6 months.	IP Admission	30 Days
Shore Regional Health	Patients admitted to the hospital with a primary diagnosis of CHF, COPD, Diabetes, or Sepsis AND more than one inpatient visit in the past 30 days.	IP Admission	30 Days
St. Joseph's MC	Patients admitted to the hospital with a primary diagnosis of CHF, COPD, Diabetes, or Sepsis AND more than one inpatient admission in the past 12 months.	IP Admission	30 Days
University of Maryland MC	Patients admitted to the hospital excluding pregnancy or mental health as primary reason for admission; new active chemotherapy patient; and/or organ transplant within the past 12 months.	IP Admission or ED Encounter	90 Days
Baltimore Washington MC	Patients admitted to the hospital with a primary diagnosis of CHF, COPD, Diabetes, or Sepsis AND more than three inpatient admissions or ED visits in the past 12 months.	IP Admission or ED Encounter	180 Days

Care Transitions Submissions: Discussion Questions

- Are these interventions sufficiently close to one another?
  - Is the clinical intervention substantially different if the intervention is initiated after a hospital admission versus initiated after a hospital discharge?
  - Is the clinical intervention different if it includes those episodes initiated based on ED visits as well as hospital admissions?
  - 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 180 days)?
- Are these substantially different populations?
  - How targeted towards disease states are these interventions? Is it clinically different to trigger based on a set of diseases vs. all admissions?
  - What threshold of utilization (if any) should denote patients necessitating enhanced discharge planning?
  - Are the interventions clinically different if a patient has one IP hospitalization within the previous 12 months instead of 1 month?
- How different are these interventions compared to others (High Risk Clinics, etc.) that target the same population?

Next Steps for Transitions of Care CTI

- HSCRC staff will create CTI population definitions based on the CT Steering Committee's feedback
  - The initial population definitions will be shared at the October CT Steering Committee Meeting
  - The final population definitions will be shared at the November CT Steering Committee Meeting
- Once the population definitions have been finalized, hospitals will be given the opportunity to indicate whether they want to participate
  - Hospitals may participate in the CTI regardless of whether they were the ones to propose the CTI
  - The TCOC Workgroup will begin discussing methods to ensure that a hospital is "meaningfully" participating in the CTI that they indicated

Discuss Upcoming CTI Thematic Groupings

Upcoming CTI Thematic Areas

- HSCRC Staff reviewed the CTI Submissions and grouped them based on the similarities between the proposed interventions
  - CTI Thematic Areas will be rank ordered based on the number of hospitals submitting proposals in that area
  - The order of CTI Thematic Areas could change based on the submissions that come in prior to the October meeting
- Feedback on the grouping of the CTI Thematic Areas is welcome
  - Hospitals that have programs in that thematic area but have not yet submitted a proposal are encouraged to do so
  - In the future, submissions will be publicly available prior to the meeting

Initial CTI Proposals – Thematic Areas

CTI Thematic Area	Overview of Proposed Interventions
Home Visits by Community Care Teams (8 Submissions)	Community care teams visit patients in their homes to perform the following interventions: • They conduct standardized assessments including a social, behavioral, and home safety evaluation • They help to address advanced care planning, behavioral health, caregiver burden, grief counseling, etc. • They help to address unmet clinical and social needs by linking residents to community services • They provide scheduled preventative care and chronic disease management Community-care teams where either deployed from the hospital directly following a hospitalization or through a partnership with a local EMS provider, but the interventions appear similar.
Primary Care Transformation (7 Submissions)	Multi-disciplinary teams provide comprehensive care coordination including: • Execution of individualized plan of care and weekly care planning huddles • Development of care improvement initiatives for patient experience and clinical outcomes • Extended hours of operations to expand access to primary care services Primary care interventions took two forms: 1) community-based care teams embed at primary care practices; and 2) High Risk Clinics that are located on hospital grounds. Both sets of clinical interventions aim to provide comprehensive clinical and psychosocial support to improve health outcomes and reduce utilization.
Palliative and End of Life Care (6 Submissions)	Hospital based palliative care teams provide medical care and social supports including: • Providing advanced care planning and education • Creating standardized care pathways • Referrals for all hospitalized patients • Coordinating services between the hospital attending physician and community primary care

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 Sept 27th to be considered at the Oct 11th CT Steering Committee Meeting
  - CTI proposals will be developed on a rolling basis so EARLIER submissions are better
- Future Meetings
  - Friday, October 11, 2019, from 8 to 10am
  - Friday, Nov 8, 2019, from 8 to 10am
  - Friday December 6, 2019, from 8-10am