Care Transformation Steering Committee

July 12, 2019

Agenda

- New CRP Track: Post Acute Care for Complex Adults Program (PACCAP)
- Update on Possible Alignment with Other Payers
- Other Episode Updates
- Care Transformation Initiatives

New CRP Track: Post Acute Care for Complex Adults Program (PACCAP)

Executive Overview

- PACCAP: New CRP track could start January 1, 2020
  - CRP tracks are convened by hospitals; participation is voluntary
  - Hospital determines potential care partners and if/how to share resources
  - PACCAP is designed to allow hospitals to share resources with Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs)
- Hospital proposed concept under auspices of Secretary Neall's workgroup on Hard to Place Patients
  - PACCAP can help to address barriers to timely discharge, reduce avoidable utilization and facilitate treatment in more appropriate settings
  - The cost of these interventions will come from the hospital's GBR
- CRP calendar required State to submit draft Implementation Protocol to CMS by June 30 for consideration of January 2020 start
  - ✓ Draft PACCAP Implementation Protocol submitted to CMMI June 28
  - Level of hospital interest will determine final recommendation

Executive Overview, cont.

- To the extent this flexibility is needed before some hospitals move forward with such hospital-PAC collaboration, we want to provide that flexibility using Medicare waivers under CRP
- Even if some hospitals currently do this, then getting credit and putting these activities on CMMI's radar screen will provide evidence of collaboration
- As with other CRP tracks, could promote further opportunities and conversations around cross-continuum collaboration to improve quality and reduce costs, which is the true intent of the Maryland Model

Problem

- Patients with complex conditions or who need additional care supports for discharge to occur often remain in the hospital beyond when it is still medically necessary.
  - SNFs and HHAs do not accept these patients since it is uneconomical for them to provide care management staff or additional resources for these patients.
  - This does not count as a readmission but is still an unnecessary hospitalization, since they could be treated in another setting.
- These untimely discharges can lead to extreme lengths of stay, potential quality detriments and deteriorating patient satisfaction.
- This problem is particularly acute for beneficiaries with, e.g.,:
  - Exacerbated dementia/delirium
  - Bariatric conditions
  - Advanced wound care needs

PACCAP Objectives

- **Resource Sharing:** Create an opportunity for hospitals to share resources with SNFs/HHAs to facilitate complex patient discharge
- **Care Redesign:** Share care protocols and enhance care management amongst SNFs/HHAs and hospitals
- **Data Analysis and Feedback:** Identify patients with complex clinical needs or extraordinary lengths of stay to appropriately facilitate post-acute care setting discharge
- **Health Care Provider Engagement:** Promote hospital and SNF/HHA collaboration and care pathway development
- **Patient and Caregiver Engagement:** Increase patient satisfaction and communication throughout the care continuum

Care Redesign Interventions

- Hospitals will choose which interventions to implement as part of their program under PACCAP
- Initially, PACCAP will focus on the Hospital-SNF/HHA relationship, but may expand to other post-acute care settings as appropriate
- The interventions may include:
  - Deploying nurses and other care management supports in order to round with patients
  - Creating clinical care pathways with the SNF/HHA staff
  - Coordinating discharge planning and care management with hospital based care teams
  - Provision of therapy services, as appropriate, in SNFs/HHAs
  - Provision of resources, such as bariatric equipment, to SNFs

Intervention Resources

- The hospital may provide intervention resources to help the SNF/HHAs implement their care redesign interventions
- Intervention resources will take one of two forms:
  - Nursing & support staff (FTEs) – Hospitals will provide clinical staff to the SNFs/HHAs to both help implement the clinical care model and create care coordination linkages
  - Infrastructure support – Hospitals will provide physical resources to help implement their care pathways. For example, the hospital may provide a bed that is low to the ground for a patient identified as a fall risk
- Per CRP requirements, hospitals will be required to record the type of resources and the time that those resources are made available to the SNFs/HHAs

Design and Regulatory Details

- PACCAP would begin January 1, 2020
- Existing CRP Fraud & Abuse waivers are adequate to allow sharing of resources (e.g., clinical staff, infrastructure)
  - No additional waivers requested for CY 2020
- No incentive payments for CY 2020
- SNFs and Home Health Agencies (HHAs) are the only potential Care Partners for CY 2020

Letter of Intent to assess hospitals' interest

- HSCRC and MHA will organize a webinar in late July.
  - The webinar will provide an overview of the PACCAP Implementation Protocol and address any questions that hospitals might have
- Staff would like hospitals to indicate whether they would participate in PACCAP.
  - Hospitals that are interested in participating in PACCAP should submit a letter of intent to HSCRC in the first week of August
  - HSCRC will make a decision about whether to pursue PACCAP with CMMI based on the level of interest from hospitals

Update on Possible Alignment with Other Payers

Payment Transformation Plan

Care Redesign Steering Committee

JULY 12, 2019

Agenda

A. CareFirst's Five-Year Vision

B. Introduction of Value-Based Payment Models

C. Discussion

CareFirst's Vision

CareFirst Five-Year Vision Statement

We want to fundamentally improve the healthcare system – by **leading thoughtful innovation** ourselves and **partnering with others** to drive change

We will be a **trusted partner** to our members, empowering them to lead their **healthiest lives**

Drive transformation of the **healthcare experience** **with and for** our **members and communities**

We are dedicated to delivering a **distinctive experience** in ways that matter for our members and stakeholders, with a focus on **quality, equity, affordability, convenience, and access** to care

Our members and communities are our priority; we aspire to expand our impact to more **members and communities**

Introduction of Value-Based Payment Models

Multiple Models to Engage Major Provider Types

CareFirst

Primary Care Providers

- Patient-Centered Medical Home

Specialists

- Episode of Care Models

ACOs and Integrated Delivery Systems

- Total Cost of Care Model

Payment Transformation Model Design Principles

Build upon National experience

- HCP LAN
- CMS
- Other Blues

Enhance partnership between CareFirst and providers

- Collaborative design
- Data exchange
- Clinical care support programs

Reduce provider burden

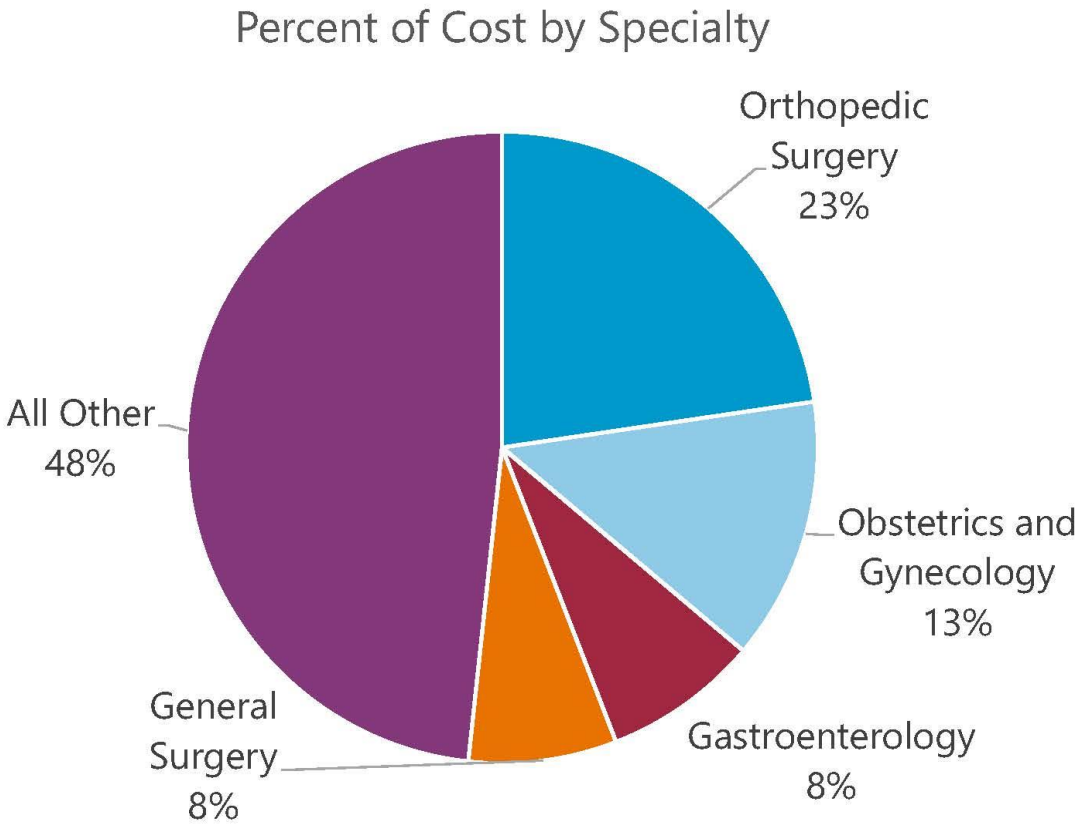
- Align common measures wherever practical
- Harmonious model design

Create meaningful incentives

- Performance recognition
- Empowerment to change care processes
- Incentives for Patient Experience and Outcomes

Payment Model Priority Areas

Initial efforts are focused on episodes of care for our most impactful specialties and an ACO population health model.



Draft Model Episode Definition and Timeline

	ACO	Maternity*	Orthopedic
Definition	Total spend for all attributed members	Single birth maternity care including: • Antepartum • Delivery • Postpartum	Select elective and appropriate orthopedic procedures
Timeline	Recurring annual cycle	270 antepartum through 90 days postpartum	30 days pre-op through 90 days post-op
Attribution	During previous 24 months: • Plurality of member claims attributable to an ACO PCP, specialist, or urgent care facility • Inpatient hospitalization at any ACO facility • >1 visit to an ACO ED • Member self-selected an ACO PCP	Maternity episodes attributed provider who performs: • Plurality of antepartum care • Delivery	CareFirst members who experience a qualifying Episode of Care (EOC) during performance period will be included.

*Separate newborn model focused on first 30 days of life can run concurrently with maternity model

Discussion

Other Episode Updates

Additional ECIP Episodes

- The hospitals that choose not to participate in ECIP have indicated that the current selection of episodes does not cover enough cost and/or volume.
- Staff are considering expanding the scope of ECIP by:
  - Considering alignment with other payers – CareFirst has developed their own bundles. Staff are working to align programs so there are common episodes, where appropriate.
  - Specialist initiated bundles – ECIP bundles are triggered with a hospital discharge. Staff are considering episodes that could be triggered by physician procedures.
- Staff would like hospitals to suggest new episodes that would cover additional cases to increase ECIP impact.

Care Transformation Initiatives

Care Transformation Initiatives Independent of CRP Tracks

- Under the GBR, hospitals have been engaging in care transformation. But…
  - Hospitals efforts have not been systematically assessed
  - Identifying care transformation efforts is important to ensure alignment between HSCRC policies, justify infrastructure grants, and demonstrate value to CMMI
- Staff are considering two policies to encourage participation in care transformation:
  - Reward Care Transformation Initiatives (CTIs) that will earn a return on investment through the Medicare Performance Adjustment Efficiency Component (MPA-EC)
  - Link a portion of the update factor to participation in care transformation

MPA Efficiency Component

- The MPA-EC is necessary to reward hospitals for their successful CTIs.
  - Similarly to ECIP, hospital can earn reconciliation payments if they reduce the TCOC for the beneficiaries in their CTIs.
  - Savings will be paid through a 'bonus' MPA adjustment to the hospitals' Medicare payments in the following year.
- The MPA-EC recommendation will return to the TCOC Workgroup on July 27th, 2019.
  - Commission Final Recommendation will be put forth at the September 11th, 2019 meeting.
- Given the current TCOC run-rate, staff do not intend to use the MPA-EC to meet savings targets.
  - However, staff do intend to issue an adjustment to reward CTI participation and prevent 'backsliding' on the savings targets.

Incentivizing participation in Care Redesign

- Staff are considering recommending that a portion of the update factor be linked to participation in care transformation programs (CRP, CTIs, etc.).
  - For example, 0.25% of the UF could be withheld from hospitals who do not meaningfully participate in ECIP.
    - Year 1: Hospital Participates in ECIP
    - Year 2: Hospital is in X episodes
    - Year 3: Hospitals earns savings in Y episodes
  - Staff do not have a preference for ECIP over other programs. Hospitals that submit CTI could also meet the requirement.
- Details of this policy will be shared and vetted with this group as developed.

Required components for a CTI

Categories	Components for Quantification
Defined Care Transformation Interventions – Hospital Submission	• A standardized pathway to address unmet clinical or social needs • Identifiable 'partners' at the hospital or in the community who will implement the intervention
Identifiable Intervention Population/Period – Hospital Submission	• A 'trigger' to identify when an intervention is provided • Must be identifiable in Medicare claims based on clinical condition, patient history and/or other criteria; cannot be identified with an EHR or clinical data point
Measurable Impact on TCOC – HSCRC calculation	• A bound on the measurement period will be determined after which the intervention effects should be observable • Measurable costs for the intervention population will be compared to a counterfactual for if the intervention did not occur to calculate a reconciliation payment

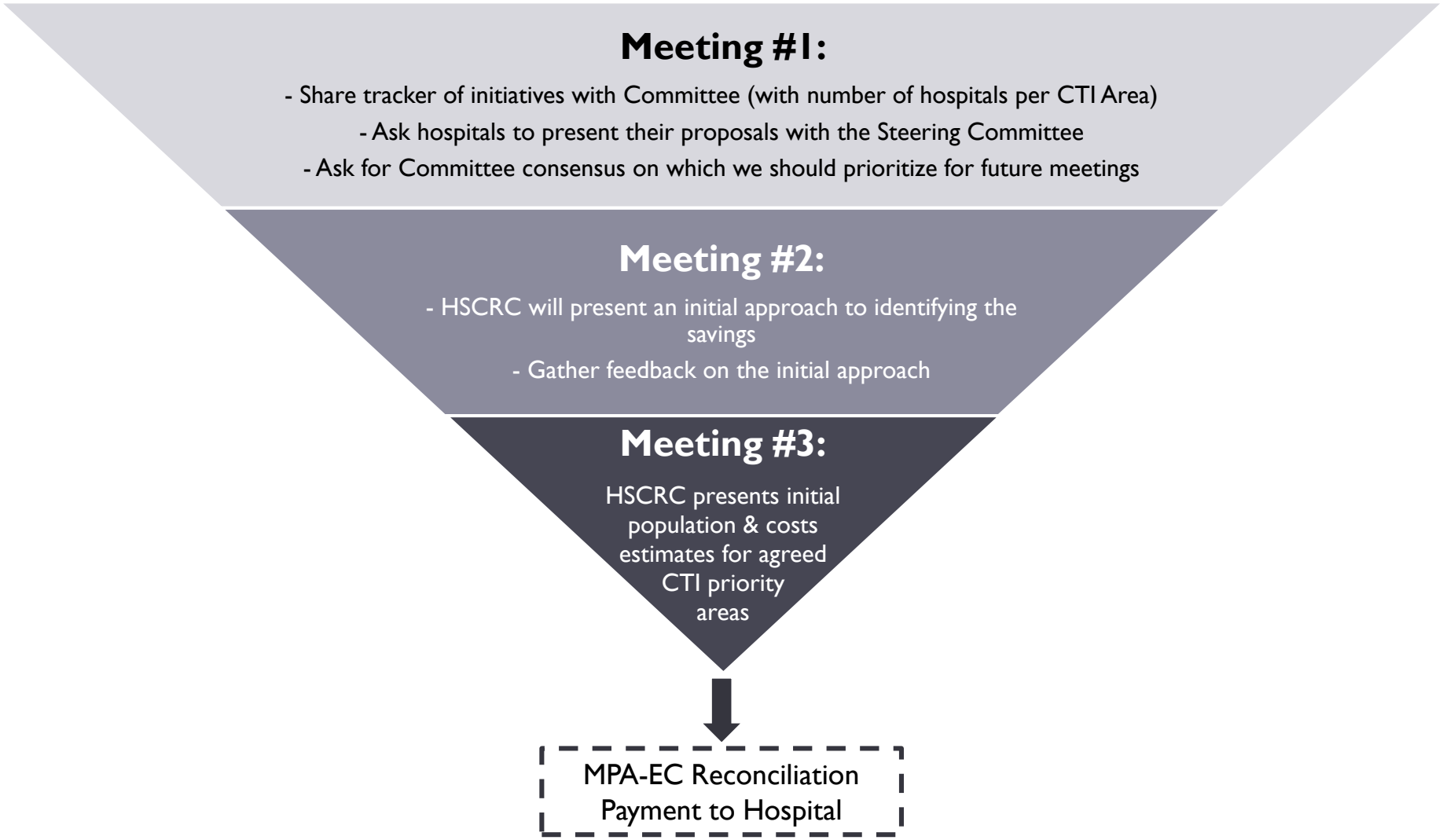
Initial CTI Proposals

Proposal	Description
OPAT	Episode triggered for patients with IV antibiotics discharged to SNFs
MESH: Ambulatory ICU	Interdisciplinary care teams that target high-utilizer patients
ALF Rotations	Clinical staff that round at assisted living facilities
Pathways of Care	Episode triggered for patients with a any of ten chronic conditions visiting a PCMH
Palliative Care	Care mangers screen patients and, where appropriate, refer to a palliative care team
Care Clinic	Multidisciplinary clinic setting to provide care management to high-utilizer patients
Palliative Care Program	Patients with a high SOI are referred to a palliative care team
Diabetes Boot Camp	Patients with uncontrolled diabetes are referred to a "boot camp" with care team
Rehab at Home (PaCC)	Patients with joint surgery receive targeted education to prepare for discharge home
PCMH	All primary care practices built to NCQA level 3 standards
Elder Care in the Home	Physicians provide home visits for physically frail patients who cannot travel
Palliative Care Referrals	All cancer and patients over 85 years old are referred to a palliative care team

Example: Palliative Care

- Several hospitals have submitted proposals for a palliative care CTI
  - Hospitals would present their palliative care CTI
  - The Steering Committee will discuss how the proposals should be prioritized and grouped, if applicable
- HSCRC will proposal options for identifying the eligible population and assessing the ROI
  - For example: All patients with a cancer diagnosis or an SOI of 3&4 and a LOS > 4 days
- The CT Steering Committee will discuss where palliative care should be prioritized. Based on:
  - Potential savings
  - Interest from hospitals
  - Etc.

CTI Review Process



Note: each CTI must complete all three meeting steps to receive approval.

Submission Process

- HSCRC Staff have developed a form for hospitals to submit their CTI proposals to HSCRC.
  - HSCRC staff will meet with hospital staff and provide technical assistance to hospitals submitting a proposal.
  - Questions and submissions to: hscrc.care-transformation@maryland.gov
- Hospitals should submit their proposals to HSCRC by August 23rd to be considered at the next Steering Committee meeting.
  - Hospitals that have submitted a CTI may present their proposal at the September 6th, 2019 meeting.
  - Staff intend CTI proposals to be an ongoing process. Proposals submitted after August 23rd will be considered in November.

Future Meetings at HSCRC Offices

- Friday, Sept 6, 2019 - 1 to 3pm
- Friday, Nov 8, 2019 - 1 to 3pm