maryland
health services
cost review commission

Post-Acute and Long-Term Care
Model Progression Stakeholder Engagement Workgroup

Agenda

March 20, 2023
1 pm – 3 pm
4160 Patterson Avenue
Baltimore, MD 21215

The meeting may be attended in person at the above address, Room 100, or via Zoom. Please register for the Zoom meeting using the mailing sent earlier this month.

1. Example of Hospital/Skilled Nursing Facility Collaboration

LifeBridge Health
Andrea Horton
Executive Director
Clinical Post-Acute Operations

2. Discussion of WG Recommendations

See skeleton draft

3. Next steps

The following link provides information on HSCRC's TCOC Model Progression Stakeholder Workgroups,
https://hscrc.maryland.gov/Pages/TCOCModelProgression.aspx

Maryland
Hospital Association

March 10, 2023

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen:

On behalf of MHA's 60 member hospitals and health systems, I am writing to express the field's concern about the process and scope of the Post-Acute & Long-Term Care Workgroup.

During the initial meeting, which only included the Health Services Cost Review Commission (HSCRC), MHCC, Medicaid, SNF advocates, and individuals with a business interest in a SNF quality tool, the scope was narrowly defined to skilled nursing facilities (SNF). There has been a singular focus to create a SNF quality incentive program funded by hospital GBR and/or Medicaid. To date there has not been a transparent examination of utilization, quality, or cost data for SNFs and other post-acute settings. MHA asks that the process and scope for post-acute progression planning be reevaluated to include representation from stakeholders from home health and hospice.

Misaligned financial incentives between hospital and post-acute providers has been a barrier to success under the Total Cost of Care Model. MHA fundamentally supports incentives and penalties based on performance for the post-acute sector. Policy recommendations should be informed by data, build on programs supported by current policy, and support voluntary risk sharing relationships or receive funding independent of hospital GBR. MHA urges MHCC and HSCRC to consider action to:

- Revise the SNF Medicaid pay for performance program that focuses on patient care and support inclusion of additional measures to the SNF VBP program as proposed by CMS
- Explore Medicaid funding for SNF quality incentive program
- Evaluate and encourage SNF participation in ISNP
- Evaluate whether to extend the Medicare three-day stay waiver
- Encourage a Medicare demonstration or pilot for SNFs with incentives that align with the Model
- Explore new shared saving programs among hospitals, home health, and hospice to support home-based care

Additionally, in 2019 a Post-Acute Discharge Work Group convened as part of the Secretary of Health's Vision Group. This group was comprised of health care leaders and subject matter experts across the spectrum of health care, government, and regulatory agencies. The Group was commissioned to address post-acute discharge challenges for patients in acute care and meet the needs of patients with complex medical and behavior health needs. Little progress has been made to implement the recommendations made for the post-acute sector, largely due to the COVID19 public health emergency. MHA urges MHCC and HSCRC to incorporate and build on the Post-Acute Discharge Work Group's recommendations to address the impact of long-stay patients with complex needs.

We appreciate the opportunity to add our voice to the Post-Acute & Long-Term Care Work Group for Model progression planning and look forward to continuing to work with you to craft recommendations to enhance patient care across the continuum.

I would be happy to discuss these ideas in advance of the next meeting.

Sincerely,

Erin Davis
Director, Quality & Health Improvement

CC: Adam Kane, Esq., Chairman
Joseph Antos, PhD, Vice Chairman
Victoria W. Bayless
James Elliott, M.D.
Maulik Joshi, DrPH
Stacia Cohen, RN, MPA
Sam Malhotra
Allan Pack
Geoff Dougherty
Alyson Schuster
Dianne Feeney

Email of Feb 28

Folks,

The facilities we discussed on Friday are running lovely programs but the state is not seeing significant results. In fact we are exactly at the expected risk adjusted numbers for Maryland and nationally. The only improvement seen is in the six hospitals that participated in the HSCRC funded program in Montgomery and Anne Arundel. The CRISP Partnership model in the data includes the HSCRC program and the subsequent CRISP continuation of that model as funded by the Department of Health.

Lowering hospitalizations not only reduces cost but it also transforms care for the better. Lower hospitalizations correlate with better care and happier families. Part of the presentation to CMS at the time of the waiver renewal negotiation, as per my understanding, is to include evidence of care transformation. The hospital programs simply aren't achieving care transformation. The new CRISP program does.

To achieve statewide care transformation, we need to change the incentives of the SNFs. Hospitals have incentives, as Willem has pointed out, but we are still seeing average results.

Please also keep in mind that not only readmissions lead to higher cost of care. There are two other components involved in regard to SNFs. Maryland is also running too high in SNF length of stay as well as primary admissions from the long term care population. LOS should be approximately 16 - 19 days. The primary admissions are reducible by 40% as well. Total decreased cost in Maryland would be $250 - 300 million.

One other point, if patients aren't admitted to the hospital then they do not return to the SNF as Medicare patients. This reduces Medicare costs significantly. I will ask BRG to run that number for us.

If bringing SNFs under the HSCRC is too unwieldy and would take too long then My updated simple proposal is:
1) We agree it is necessary to incent SNFs to reduce readmits, admits, and LOS.
2) The incentives can come any of the following; a) reduction of admission costs - maybe 10% b) elimination of hospital based SNF collaboration programs that are not showing results. This might save at least $25 million per year. c) Direct funding from Medicaid (see below.)
3) We look at Medicaid incentives as well. These are federal government matched funds which amplifies the effect as borne by the state. I would tie significant portions (25%?) of funding to outcomes. The outcome data is available from CRISP and is up to date by month. I would suggest a $25 million dollar addition to SNF funding matched with $25 million from the feds.

I truly believe the SNF industry is willing to look at models that incent SNFs, increase total funding, but also put poor performers at peril.

Thanks

Scott Rifkin

Post Acute and Long-Term Care Work Group – skeleton draft of WG recommendations

Significance of Post Acute Care (PAC) and Long-Term Care (LTC) within the Maryland Care Continuum – *Year (see note below)*

Setting / Service		Estimated Annual Expenditure	Proportion of Total Health Care Expenditure	Proportion of Total Expenditure Borne by Medicare
Nursing Home (Comprehensive Care Facility or CCF)	Skilled Nursing Facility (SNF) Services			100%
	Custodial Care Services			0%
Home Health Agency (HHA) Services				
Acute Rehabilitation				
Outpatient Rehabilitation				

Source: _____

Note: When considering reporting of this type of information, the impact of COVID-19 needs to be addressed. Based on a KFF analysis of NHC data, CCF census in Maryland in FY2022 (21,336) was about 3,000 patients below the average census for the five pre-pandemic years of FY2015-FY2019.

Differences Observed in Use of Inpatient PAC and LTC Services: Maryland vs. United States – *Year (see note above)*

Setting / Service		Admissions Rate from General Acute Care Hospital		Length of Stay (Days)		Readmission Rate (to General Acute Care Hospital following Discharge)	
		Maryland	U.S.	Maryland	U.S.	Maryland	U.S.
Nursing Home (CCF)	SNF Services						
	Custodial Care Services						
Acute Rehabilitation							

Source: _____

Differences Observed in Use of Outpatient PAC and LTC Services: Maryland vs. United States – *Year (see note above)*

Setting / Service		Use Rate following Discharge from General Acute Care Hospital		Average Number of HHA Visits or Rehab Visits		Readmission Rate (to General Acute Care Hospital following Discharge)	
		Maryland	U.S.	Maryland	U.S.	Maryland	U.S.
HHA Services							
Outpatient Rehabilitation							

Source: _____

Beyond the basic facts identified above that should be assembled as a supplement to the recommendations of the WG, the group's discussion has included estimates of savings that can be achieved by implementing proposed changes in how hospitals and SNFs manage the [hospital inpatient stay/discharge to SNF/SNF inpatient stay] episode of care, based on evidence produced by pilot or other types of projects that have been tried and tested. (You know who you are.) We need to back up these savings estimates with documentation.

Additionally, we have heard about two models of hospital/SNF collaboration and will hear about a third on March 20. What I believe is lacking is some specific information on the positive outcomes of these collaborations. How much was use of hospitals, readmissions to hospitals from SNFs, and hospital or SNF ALOS affected? If actual change information is not available, can we document, based on experience, the potential for change in these voluntary collaborations?

Opportunities and challenges facing LTC industry

Staffing – While not systematically quantifiable at this time, reports from the field indicate that, currently, SNFs are unable to staff a sufficient number of beds to fulfill demand on a timely basis, leading to substantial backup of patients in hospitals awaiting discharge to a SNF.

Changes in ownership and operation of SNFs – Discussions have noted that the pace of CCF ownership changes accelerated in recent years (a third of CCFs changing hands was the highest proportion mentioned; MHCC records indicate slightly less than 30% of the total facilities in Maryland over the last two years). MHCC has been concerned with the high number of new operators with mediocre quality-ratings track records, as measured by NHC composite star ratings and with the potential negative impact of the private equity business model becoming a larger element of CCF services in Maryland. MHCC does not regulated health care facility changes of ownership.

Workgroup composition

The WG includes representatives of:

Three long-term care/aging services associations; Health Facilities Association of Maryland, LeadingAge, and LifeSpan Network;

Three state agencies; MDH (Medicaid), HSCRC, and MHCC;

Five consultants; Burton Policy Consulting, Schwartz, Metz, Wise & Kauffman, P.A., Real Time Medical Systems, Nelson Sabatini, M.D., and Berkeley Research Group;

Service Employees International Union, Local 1199;

The Maryland Hospital Association; and

Egle Nursing Home Management, Inc. (Jeffrey Metz, who is also a Maryland Health Care Commissioner.

Policy Recommendations

The problems:

Too many Maryland SNF patients are readmitted to the hospital during their SNF stay and the ALOS of SNF patients is too long. (Hopefully, we can provide documentation backing up this problem statement.)

Too many Maryland patients discharged from hospitals are admitted to SNFs whose rehabilitative care needs could be appropriately handled by a course of home health care visits or outpatient rehabilitation visits. (Data supporting this problem statement?)

The solution:

Improving the quality of SNF care while reducing costs can be achieved by improving the management of care provided to patients determined to need post-acute care rehabilitation upon discharge from a hospital (or a hospital emergency department visit). Improving care management in the SNF setting can reduce the number of SNF patients readmitted to the hospital during their rehabilitative stay by more closely monitoring illness conditions and injuries that tend to result in transfer of SNF patients to the hospital so that the correct early intervention by the SNF care team can be implemented and admission to the hospital avoided. Better case management should also result in an ability to discharge SNF patients more quickly, reducing SNF ALOS. Better case management and discharge planning should improve the appropriateness of post-discharge disposition of patients, substituting home health or outpatient care, as appropriate, as an alternative to SNF services.

The key questions:

How can the incentives for better management of care by SNFs be enhanced to a level at which substantial numbers of SNFs are effectively reducing readmissions and LOS?

How can hospitals be incentivized to reduce referral of patients to SNFs and, as an alternative, increase referral of patients to home health care and outpatient rehabilitation?

Recommendation One – **one sentence**

Explanatory paragraph

context/vision/etc.

relevant tools/flexibilities needed to implement

Recommendation Two

Recommendation Three