# Care Transformation Steering Committee

January 10, 2020

# Agenda

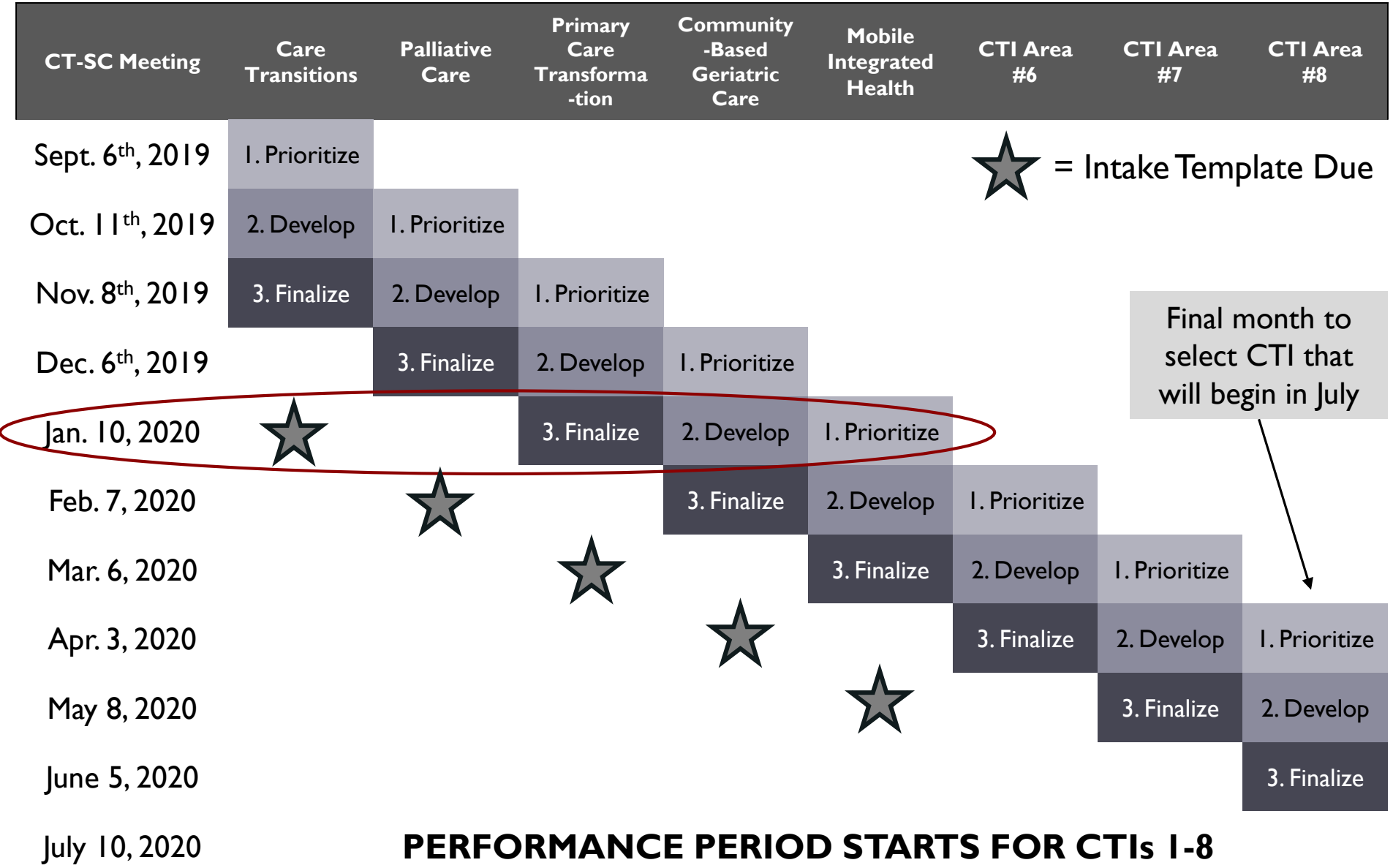
1. Administrative Updates
   i. Update on CTI User Guide, FAQ, and Palliative Care Intake Template
   ii. Fraud and Abuse Waivers for the Care Transitions CTI
   iii. CRISP Analytic Support Services
2. Discussion Topics
   i. Modifications of Existing CTI
   ii. Single vs. Multiple CTI
   iii. Intervention Effectiveness vs. Scale
3. Discussion of CTI Thematic Area #3: Primary Care Transformation
   i. Final Population Definition
   ii. Operationalizing the CTI
4. Discussion of CTI Thematic Area #4: Community-Based Geriatric Care
   i. Proposal for Initial Population Definitions
   ii. Next Steps
5. Discussion of Miscellaneous CTI
6. Next CT-SC Meeting
   i. Upcoming CTI Thematic Groups
   ii. CTI form deadline

# Administrative Updates

# User Guide, FAQ, and Intake Templates

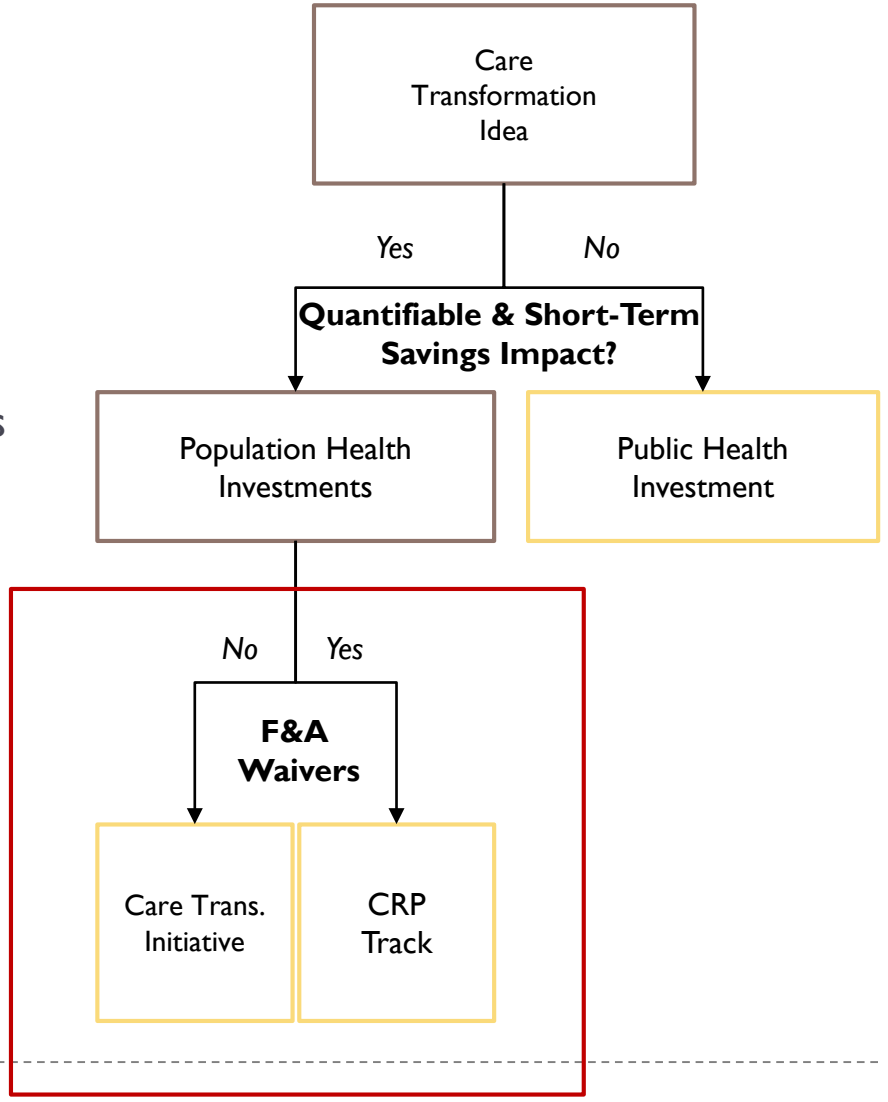
- HSCRC staff has shared the CTI User Guide.
  - Please provide additional questions and suggested topics by email to HSCRC.care-transformation@Maryland.gov.
  - Comments on the CTI User Guide are due January 15, 2020.
  - Methodological questions will be addressed at the next TCOC Workgroup meeting.
- We are still in the process of developing the CTI FAQ.
- HSCRC staff has also shared the Palliative Care Intake Template and held a webinar going over the form on 1/9.
  - Hospitals need to submit this form by February 7, 2020 to qualify to participate. Hospitals will then be invited to submit a final Palliative Care CTI by May 8th, 2020.
- REMINDER: to participate in the Care Transitions CTI, please submit your initial Intake Template by January 10, 2020 (*today*)
- Hospital submitted CTI Assessment Forms are now available on the HSCRC website by Thematic Area, along with the items mentioned above: https://hscrc.maryland.gov/Pages/Care-Transformation-Steering-Committee.aspx

# Schedule for Rolling CTI Development



# 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



# Analytics Support as Hospitals Evaluate CTIs

- The HSCRC and CRISP are committed to supporting the hospitals with analytics to assist them in refining their CTI submissions prior to May 8, 2020.
- The HSCRC has set aside funding for CRISP to provide analytics support to hospitals prior to May 8th.
  - CRISP can assist hospitals in analyzing their CTI populations for CTI that have been approved and have an Intake Template.
  - Analytic requests that exceed the scope of the Intake Template will be delayed until a new CTI Assessment Form is submitted.
- While CRISP and the HSCRC will endeavor to support all requests, funding and time is not unlimited.
  - HSCRC will prioritize analytic requests to ensure that all hospitals have equal access to analytics.
  - Not all analytic requests (particularly multiple requests) will be addressed prior to May 8th.
- Requests for analytics support should go to CRISP's CRS team.

# Longer Term Analytic Support

- In early 2020, the HSCRC and CRISP will be discussing with CRISP's RAC an approach to support Fiscal Year 2021 Care Transformation Analytics and longer-term broader population health analytics.
- Some options include:
  - Maintaining a CRISP focus on new report delivery and allowing hospitals and their consultants to develop capabilities organically;
  - Establishing a formal program to enhance consultant access and familiarity with CRISP tools and TCOC analytics;
  - Funding a population health analytics capability through the State using money withheld from hospital rates.

# Discussion Topic: Modifications to Existing CTI Intake Templates

# Changes to Currently Approved CTI Intake Templates

- As hospitals have been filling out the Intake Templates, some requests for additional changes have come up. For example:
  - Add procedure codes to the triggering conditions tab
  - Include psychiatric facilities in the look forward / look back tab
- We can make minor modifications for existing CTIs, so we are including a new tab in the Intake Templates that allows for 'requested modifications.'
  - However, adding modifications and additional features will take resources and adding those features cannot be guaranteed.
  - Therefore, hospitals should fill out the remainder of their CTI Intake Templates using the default that they would prefer assuming that the requested modification is not made in time.
  - To guarantee that features are included in the CTI they should be brought up during the CT Committee meetings when the CTI is being discussed.

# Example: Modification Tab for CTI Intake Templates

## Care Transformation Initiatives

Intake Template

Thematic Area: Care Transitions

**Requested Modifications**

**Instructions:** If the criteria you are seeking to modify is not available within the current tabs and tables, please use this tab to provide an example of the criteria you would like to use. In the space below, create and complete the table with the modification you are suggesting for the HSCRC's review. Upon submission of your Template, we will review your requests and follow up on its feasibility. As you complete the rest of this Template, please fill out the tabs as if this modification is not available. If we approve the modification, your change will be incorporated in the Template and sent back for you to finalize by

| Code Type (ICD-10-CM or APR-DRG) | DX, APR-DRG, or CPT Code | SOI (optional with DRG only) |
|---|---|---|
| *APR-DRG* | *230 OR 231* | |
| APR DRG | OR 260 for prin proc | |
| CPT | OFB00ZZ | |
| CTP | OFB10ZZ | |
| CTP | OFB20ZX | |
| CTP | OFB20ZZ | |
| CTP | OFBG4ZZ | |
| CTP | OFBG0ZZ | |
| CTP | OFT10ZZ | |

# Discussion Topic: Single vs. Multiple CTI

# Reminder about multiple CTIs

| | 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.

# Suggestions for Filling Out Intake Templates

- Use a single Intake Template if you can identify your population by using two or more criteria with an 'AND' statement.
  - Example: A care transitions program that targets both COPD and CHF
  - Solution: A single Intake Template should be submitted because the Intake Template can identify those patients by including COPD and CHF on the chronic conditions tab
- Use two Intake Templates if you can only identify your population by using two or more criteria with an 'OR' statement.
  - Example: A care transitions program that targets both COPD and patients that have 3+ hospital visits in the prior 12 months
  - Solution: Two Intake Templates should be used because the population can only be identified by using two different tabs (the Chronic Conditions tab and the Prior Utilization tab) combined by an 'OR' statement.
- In some cases, two different populations might use very different clinical interventions (e.g. MIH and post-discharge clinics) for the same or similar population.
  - These should still be combined into a single CTI.
  - Hospitals will receive credit for both populations (e.g. COPD and CHF).
  - Hospitals cannot separate out their population to protect success in one part of their intervention from failure in another part of their intervention.

# Discussion Topic: Effectiveness vs. Scale of Interventions

# Incidence Approach vs. Population Approach

- The Palliative Care and Primary Care CTIs allow hospitals to select beneficiaries who receive a service from a particular NPI.
  - If a hospital uses an NPI to select beneficiaries who receive the intervention (such as palliative care consults), the baseline cohort will include beneficiaries who received a service from that NPI in the baseline period.
  - This is an Incidence Approach, which measures the effectiveness of the intervention on the average TCOC of the beneficiaries receiving the intervention.
- The Palliative Care and Primary Care CTIs also allow hospital to identify the population who **could** receive an intervention.
  - A hospital that does not use an NPI to select beneficiaries can indicate anyone eligible to receive the intervention. The baseline cohort includes those beneficiaries who are eligible to receive the intervention.
  - This is a Population Approach, which measures both the effectiveness of the intervention and the number of beneficiaries that receive the intervention.

# Savings Examples for Alternative Approaches

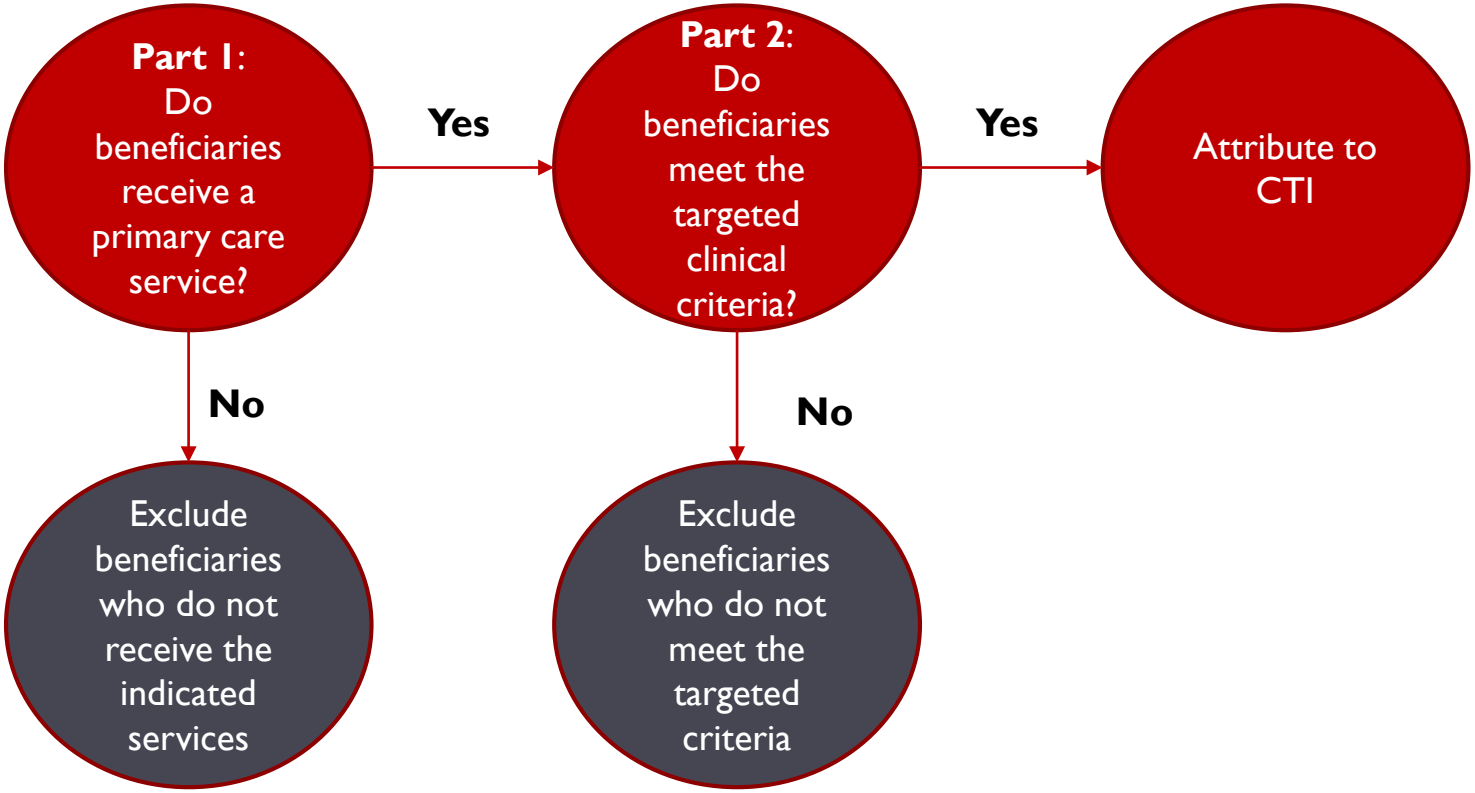
| | | Baseline | Performance Period (No Improvement) | Performance Period (Improvement) |
|---|---|---|---|---|
| Population Approach | Total Population | 1,000 | 1,000 | 1,000 |
| | Avg Total Cost of Care | $9,800 | $9,600 | $9,600 |
| | Total Savings | - | $20k | $20k |
| Incidence Approach | Population Receiving Intervention | 200 | 400 | 200 |
| | Avg Cost of Benes Receiving Intervention | $9,000 | $9,000 | $8,000 |
| | Total Savings | - | $0 | $20k |
| | Population Not Receiving Intervention | 800 | 600 | 800 |
| | Avg Cost of Benes Not Receiving Intervention | $10,000 | $10,000 | $10,000 |

# 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

# Overview: Triggering a Primary Care Transformation CTI



# Part 1, Option 1: Panel Approach

**Part 1**: Do beneficiaries receive a primary care service?

- Option 1a: 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.
  - Beneficiaries will be attributed to practices beginning on July 1 and will be retained in the panel until June 30.
  - The Baseline Period will be July 2018 – June 2019 using 2016 & 2017 data to run the attribution. The Performance Period will start July 2020 using 2018 & 2019 data to run attribution.
  - The hospital must provide a list of primary care NPIs
- Option 1b: Fragmented Primary Care
  - The hospital will be attributed any beneficiary that does not have a primary care provider (identified by TIN) who provides more than 50% of their office-based E&M visits.
  - The Baseline Period can go back to July 2017 – June 2018 using July 2016 – June 2017
  - Requires that the hospital provide a list of zip-codes

# Different Approaches to Choosing Panels

- Both the MDPCP and the Fragmented Care populations are examples of population-based approaches.
  - Hospitals will get credit both for scaling interventions (completing care plans, wrap around supportive service, etc.) across their attributed populations and also for increasing the effectiveness of those interventions.
  - The two approaches have different approaches to the primary intervention:
    - The primary intervention in the MDPCP approach is providing patient-centered medical care activities to beneficiaries that currently have an established relationship with a primary care provider.
    - The primary intervention in the fragmented care approach is providing primary care to beneficiaries that do not currently have an established primary care provider.
- For the Fragmented Care approach, the HSCRC will allow for longer attribution lengths to ensure that the hospital has enough time to establish a longitudinal relationship with beneficiaries.

# Part 1, Option 2: PCP-Triggered Episode

**Part 1**: Do beneficiaries receive a primary care service?

## Option 2a: Qualifying NPI Taxonomies

The Hospital is attributed a beneficiary when one of their NPIs provides an E&M claim and has one of the following taxonomies:

- Family Medicine
- Adolescent Medicine
- Addiction Medicine
- Adult Medicine/Health
- Geriatric Medicine
- Hospice & Palliative Medicine
- Internal Medicine
- Obstetrics
- Gynecology
- Maternal & Fetal Medicine
- Pediatrics
- Psychiatry & Neurology
- General Practice
- Physician Assistant
- Medical
- Nurse Practitioner
- Acute Care
- Community Health

## Option 2b: Qualifying E&M Codes

The Hospital is attributed a beneficiary when one of their NPIs provides a 'qualifying primary care' claim. This includes:

- Prolonged E&M
- Transitional Care Management Services
- Home Care E&M
- Advance Care Planning
- Welcome to Medicare
- Annual Wellness Visits
- Chronic Care Management Services

# Part 2: Do patients meet the clinical criteria?

**Part 2:** Do beneficiaries meet the targeted 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

| | 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<br>• Hospital may provide a list of chronic conditions | • Prior hospitalization OR ED utilization threshold, AND/OR<br>• Time window for how recent that utilization was | • E&M touch by provider type pre-admission<br>• First setting of care post discharge (MADE logic) | 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 | Any condition and no threshold of chronic conditions | No requirement on prior utilization | No look back or look forward | 90 day episode window |

| 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 |

# Operationalizing the Primary Care Transformation CTI

- Hospitals will be required to submit the following details confirming their desired specifications:
  - Part 1:
    - Selection of a panel based approached (Option 1a or Option 1b) or a touch-based approach (Option 2a or Option 2b)
    - The hospital will provide a list of their NPIs or their Zip Codes
  - Part 2:
    - Age
    - Zip codes
    - Chronic conditions threshold
    - Prior utilization qualifications
    - Look back/look forward
    - Episode length
    - Base period
- HSCRC will release the Intake Template to hospitals for the Primary Care Transformation CTI within a week following this meeting.
- Deadline for this submission: March 6, 2020

# Home-Based Primary Care

- Several hospitals submitted proposals for 'Home-Based Primary Care' based on interventions such as:
  - Independence at Home
  - Hospital at Home
  - Direct Primary Care – Serious Illness Model
- Given the nature of the eligible population for these interventions, hospitals indicated that the standard risk adjustment / target pricing methodology may be insufficient.
- Staff will release the Primary Care CTI Intake Template and continue discussing additional approaches for Home-Based Primary Care.
  - Hospitals that are interested in Home-Based Primary Care should indicate their interest to HSCRC staff (email: hscrc.care-transformation@maryland.gov)
  - Home-Based Primary Care will be discussed with the CT Steering Committee and available to all hospitals.

# Thematic Area #4: Community-Based Geriatric Care

# Community-Based Geriatric 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

# Options for the Triggering Conditions

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

| Touch with a Post-Acute Provider | Geographic Address |
|---|---|
| The hospital can provide a list of NPIs that correspond to SNFs or a Home Health Agency.<br>• The CTI will include any beneficiary who has a claim with the post-acute care provider.<br>• The baseline cohort will be any beneficiaries seen by that PAC provider in the baseline year.<br>• 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 9-digit zip code or street addresses.<br>• The CTI will include any beneficiary that resides within the address.<br>• This will be a panel approach, attributing beneficiaries on the first day of the fiscal year.<br>• The baseline cohort will be any resident of that geographic area during the baseline year. |

# Initial Population Definition for Community-Based Geriatric Care

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

| | NPI or Addresses | Chronic Conditions | Number of Medications | Episode Length |
|---|---|---|---|---|
| *Criteria Options* | • The hospital may provide a list of NPIs corresponding to PAC providers, OR<br>• The hospital may provide a list of physical addresses, including either 9-digit zip codes or street addresses. | • Indicate a number of chronic conditions, AND/OR<br>• Hospital may provide a list of chronic conditions | • 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* | The hospital is required to submit one of the two options. | Any condition and no threshold of chronic conditions | 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 |

# Next Steps for Community-Based Geriatric Care

- 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 February 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.
- In 2019, several hospitals proposed a Care Redesign Program (PACCAP) that would allow hospitals to share resources with SNFs.
  - HSCRC delayed a decision about whether to submit PACCAP to CMS until the spring of 2020.
  - MHA convened a workgroup to discuss regulatory changes to support partnerships between hospitals and SNFs.
  - HSCRC requests that MHA also discuss whether the Community-Based Geriatric Care CTI should be combined with PACCAP to allow hospitals to share incentive payments, as well as intervention resources, with SNFs.
- REMINDER: Once the population definitions have been finalized, hospitals will be given the opportunity to indicate whether they want to participate.

# Miscellaneous CTI

# Miscellaneous Modifications to Existing CTI Proposals

- We will use the next month 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

# Additional CTI Proposals – Future Thematic Areas

| TA # | CTI Thematic Area | Overview of Proposed Interventions |
|---|---|---|
| 5 | Mobile Integrated Health (6) | • Medical teams collaborate with EMS partners<br>• Deploys community-based teams to provide home visits for high utilizer patients<br>• Home visits can include assessments, education, connection to community resources, and connection to primary care or specialty providers<br>• Assessment of medical condition, environment, and social determinants affecting patient's stability that may include medication affordability, transportation, environment, mental health, and drug screening |
| 6 | Diabetes Care Management (2) | • 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<br>• Care Manager and PCP provide medical care, care planning, behavioral change, social support, and referral to diabetic educator for nutritional education |

# Categorization for Remaining CTI Proposals

| Submitter | Eligible Population | Intervention Trigger | Duration |
|---|---|---|---|
| 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 |
| Western Maryland | All adult patients in an employed primary care practice who screen positive for depression | Service provided by Integrated Behavioral Health Professional | TBD |

- HSCRC staff believe the remaining CTI proposals will fit into two broad Thematic Areas
  1. Medication reconciliation programs ("Thematic Area 7")
  2. Behavioral health case management ("Thematic Area 8")
- With the current timeline, the HSCRC should be able to implement more than 95% of all CTIs we have today for the first Performance Period (beginning July 2020)

# 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 Jan 24th to be considered at the Feb 7th CT Steering Committee Meeting
  - CTI proposals will be developed on a rolling basis, EARLIER submissions are better
- Future Meetings
  - Friday, February 7th, 2020, from 1-3 pm
  - Friday, March 6th, 2020, from 1-3pm
  - Friday, April 3rd, 2020, from 1-3pm