STAKEHOLDER INNOVATION GROUP

Tuesday October 22, 2019

Maryland
Hospital Association

PROGRESS REPORT ON STATE PRIORITIES

Creating forums for collaboration at multiple levels with diverse stakeholder groups

Aligning financial incentives throughout the care continuum

Testing new models through pilots

Continue focus on hard to place patients

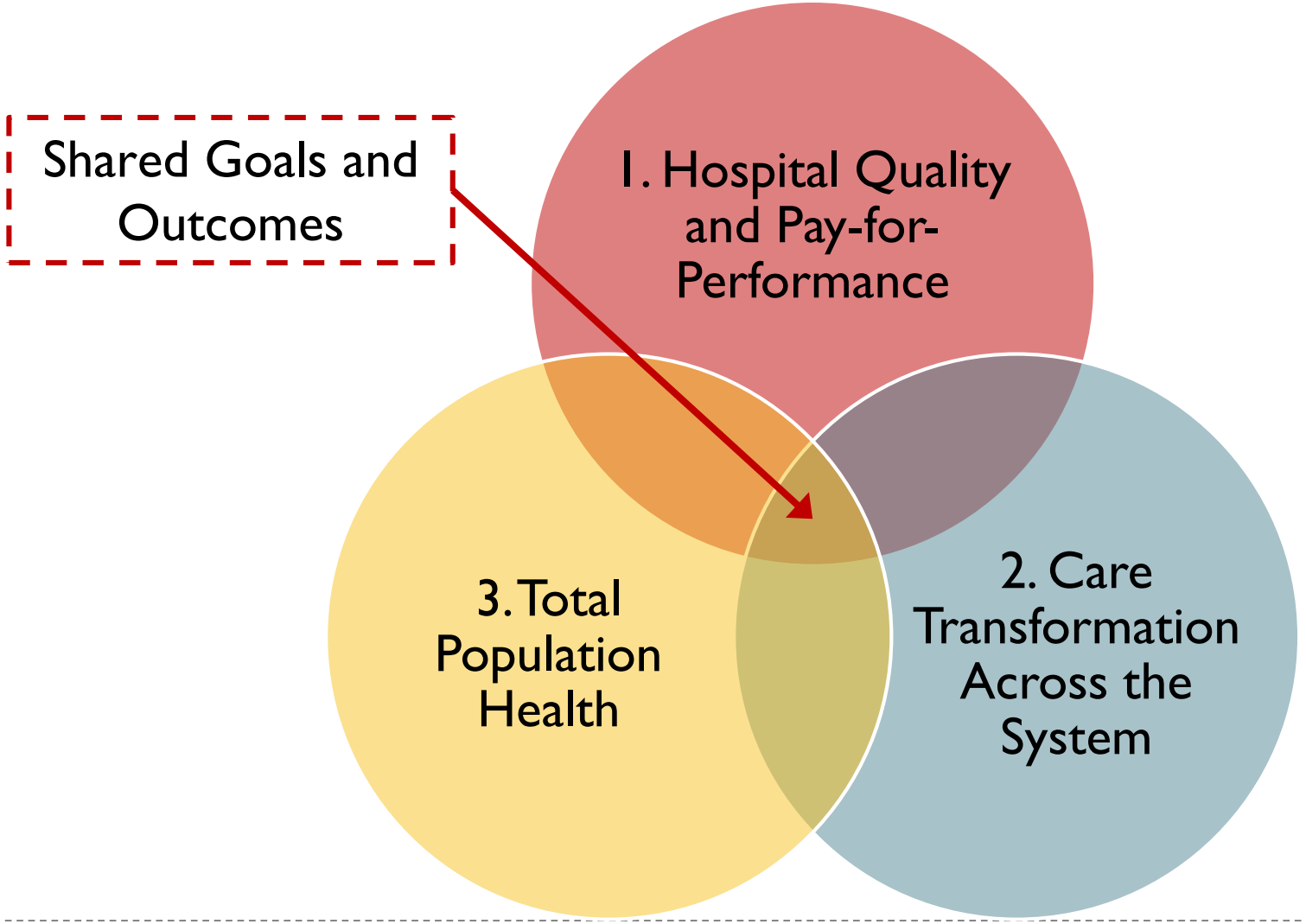
Informed by Data

October 22, 2019

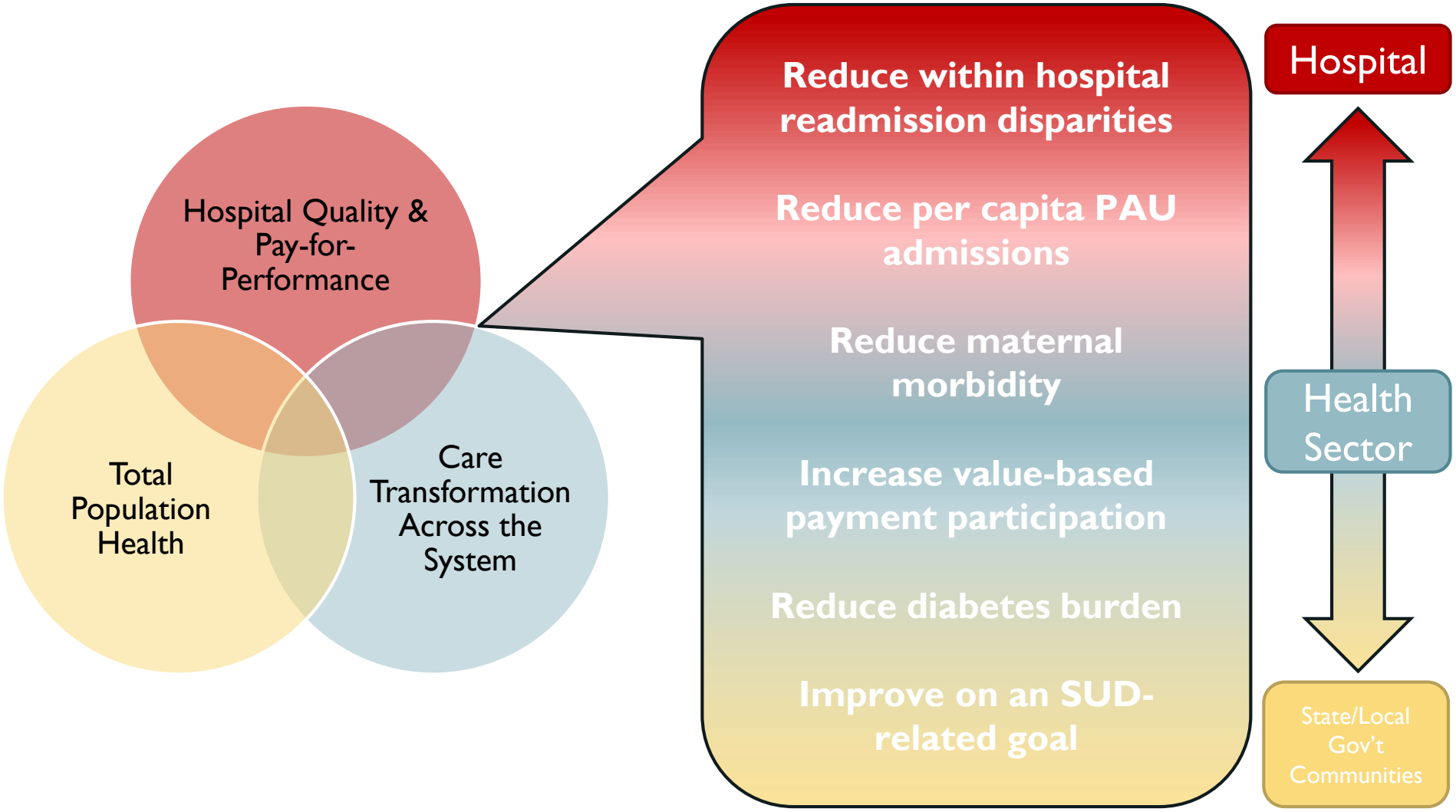
Statewide Integrated Health Improvement Strategy

Tequila Terry
Health Services Cost Review Commission

Statewide Integrated Health Improvement Strategy



Potential Examples of Shared Outcomes and Goals



Guiding Principles for Maryland's Integrated Health Improvement Strategy

- Maryland's strategy should fully maximize the population health improvement opportunities made possible by the Model
- Goals, measures, and targets should be specific to Maryland and established through a collaborative public process
- Goals, measures and targets should reflect an all-payer perspective
- Goals, measures and targets should capture statewide improvements, including improved health equity
- Goals for the three domains of the integrated strategy should be synergistic and mutually reinforcing
- Measures should be focused on outcomes whenever possible; milestones, including process measures, may be used to signal progress toward the targets
- Maryland's strategy must promote public and private partnerships with shared resources and infrastructure

1. Hospital Quality & Pay-for-Performance under the TCOC Model

Refine existing hospital pay-for-performance programs and quality reporting

- Maintain waivers from CMS
- Maximize all-payer opportunity
- Sustain and improve high quality care under capitated hospital model
- Monitor additional types of performance metrics for holistic evaluation of hospital quality

Develop paradigm for including population health metrics into pay-for-performance, monitoring, and various HSCRC financial methodology applications

- Align with outcomes-based credit
- Foster hospital accountability for population health
- Utilize HSCRC hospital pay-for-performance expertise to support and align with other state value based initiatives to achieve statewide population health goals

2. Care Transformation Across the System

- Objective: Create measure(s) of progress toward improved statewide outcomes and meaningful development of care transformation in Maryland
- Example: Structural measure of share of Medicare beneficiaries in Category 3

Category 1 No change in practice of care	**Category 2** Providers accept value-based payments for patients in their own setting of care	**Category 3** Providers financially accountable for value and care quality for a population regardless of setting*
E.g., FFS payments for providers Some link to value and quality of care may be included (e.g., MIPS) but do not fundamentally change the incentives	E.g., Hospitals under global budgets accountable for services in the hospital Moves to value within own setting but little/no financial accountability for outcomes or what happens in other settings	E.g., ACO, ECIP, EQIP This could be an attribution-based approach (e.g., ACO, ECIP, EQIP) or it could include self-defined populations (e.g., hospitals' Care Transformation Initiatives)

* For approaches beyond the Traditional MPA, which captures 100% of Medicare beneficiaries

3. Total Population Health

- Objective: Identify population health focus areas that the State will work to improve as part of the Total Cost of Care Model.

Priority Area 1: Diabetes

- Identified as a statewide priority by Maryland State Secretary of Health

Priority Area 2: Opioid Use Disorder

- Identified as a statewide priority by Lieutenant Governor through the Maryland Heroin and Opioid Emergency Task Force (2015-2018) and the Commission to Study Mental and Behavioral Health (2019)

Priority Area 3: TBD

- The State may choose a 3rd population health focus area by December 31, 2020.

What Has CMMI Said?

- CMMI insists that for the TCOC Model to be "expanded" (made permanent) based on data through 2021:
  - Targets must be set and progress shown in the 3 domains
    - Hospital quality
    - Care transformation
    - Population health
  - Would require the State to establish targets in all three domains as soon as possible in 2020
  - Although outcomes are preferred to show success, they are less likely to be obtained in 2021 data
  - Each goal /measure could have, for example, a 2021 milestone, a 2023 interim target, and a 2026 target

Statewide Integrated Health Improvement Strategy: Our Approach

Gather Data & Set the Goals

- Establish a collaborative process to select targets, measures and milestones
  - Hospital Quality and Pay-for-Performance (HSCRC Performance Measurement Workgroup)
  - Care Transformation Across the System (HSCRC TCOC Workgroup)
  - Total Population Health (MDH Diabetes Action Team)

Resource the Goals

- Develop multisector alignment of investments and accountability

Message the Goals

- Develop communications/outreach strategy for statewide engagement

Act on the Goals

- Launch and support a statewide network of effective change

Monitor the Progress

- Evaluate outcomes, reassess investments, adjust approaches accordingly

Structure of Statewide Integrated Health Improvement Strategy

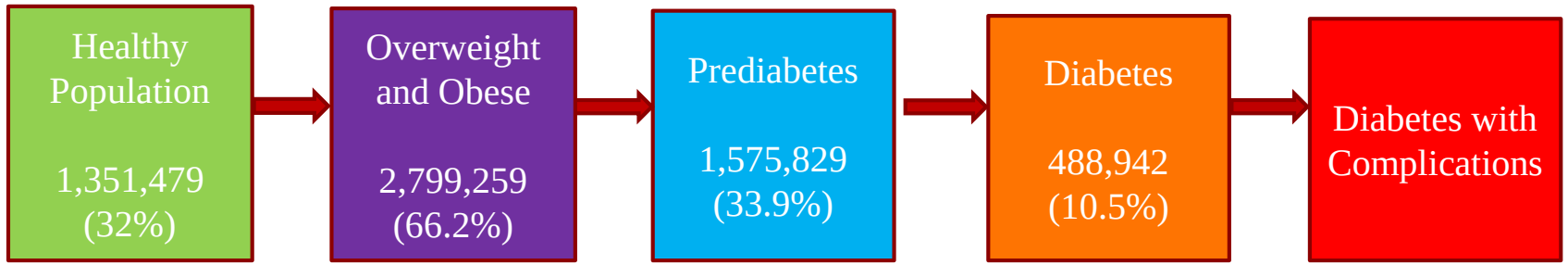
Domain	2021 Milestone	2023 Interim Target	2026 Target
1. Hospital Quality and Pay-for-Performance			
2. Care Transformation Across the System			
3. Total Population Health			

- As noted earlier, measures won't always fit solely into one domain – which is good, showing the complementary nature of statewide efforts under the Model.

Total Population Health: Activities Underway

Priority Area 1: Diabetes

- Leading cause of preventable death and disability
- Increasing prevalence reflecting significant racial, ethnic and economic disparities
- Evidence-based interventions (EBIs) can prevent or delay onset and improve outcomes
- Maryland Medicaid launching Diabetes Prevention Program (DPP) this Fall
- Diabetes/obesity cited as a priority by every jurisdiction's Local Health Improvement Coalition (LHIC) and every hospital's Community Health Needs Assessment (CHNA)
- Strong private sector support for a sustained statewide initiative
- Success provides credit in TCOC Agreement



Maryland Adult Population, 4,648,466

Data from: US Census; 2017 Maryland BRFSS, and for Prediabetes, CDC Fact Sheet for NHANES US prediabetes estimates applied to Maryland adult population.

MARYLAND

Diabetes Action Plan

- The Maryland Department of Health has released a draft **Diabetes Action Plan** to foster activity and enthusiasm to reduce the risk, consequences and cost of diabetes.

- The plan is comprised of 4 sections:
  - *Section I:* The Burden and Consequences of Diabetes
  - *Section II:* Determinants and Risk Factors for Diabetes
  - *Section III:* Intervention Strategies and Action Steps for Diabetes Prevention and Control
  - *Section IV:* Inventory of Diabetes-related Resources.

- Action is needed for:
  - People at a **healthy weight**, so they may prevent overweight and obesity
  - People who are **overweight and obese**, so they may achieve a healthy weight
  - People with **prediabetes and gestational diabetes**, so they may easily take part in prevention programs to halt disease progression
  - People with **diabetes**, so they may control their disease, get the proper medical care they need to manage their disease and enjoy their optimum health.

Diabetes Action Plan

- Maryland's draft **Diabetes Action Plan** is open for public comment https://phpa.health.maryland.gov/CCDPC/Pages/ccdpc_home.aspx
- Throughout the comments period, MDH will continue to refine the draft plan and will indicate the addition of any new material.
- The final plan will be released before the end of 2019.

Diabetes: Next Steps

ALIGN RESOURCES, MESSAGES AND ACTION

- Develop and Implement a Statewide Communication Plan
- Convene Local Health Improvement Coalitions
- Engage Providers Across the Care Spectrum
- Launch an Interactive Online Inventory of Diabetes Resources
- Engage Academia in Building Evidence around Effective Strategies
- Engage Payers Beyond CareFirst
- Engage Businesses and Residents in Why and How
- Report to CMMI on Progress

Regional Partnership Catalyst Grant Program

- The HSCRC staff is proposing a new **"Regional Partnership Catalyst Grant Program"** that would begin on July 1, 2020.
- The Regional Partnership Catalyst Grant Program will help support and align resources for the Statewide Integrated Health Improvement Strategy
- Widespread collaboration is a requirement for funding
  - Partnership models must include a variety of resources that influence health

Funding Stream I: Diabetes Prevention & Management Programs	Funding Stream II: Behavioral Health Crisis Services	Funding Stream III: Population Health Priority Area #3
• Support implementation of CDC approved diabetes prevention programs • Support diabetes management programs	• Support implementation or expansion of behavioral health models that improve access to crisis services	• To be defined by December 31, 2020

Funding Stream I: Diabetes Prevention & Management

- The diabetes funding stream will award grants to Regional Partnerships that choose to implement the Medicare Diabetes Prevention Program (MDPP)
- As an additional component of the diabetes funding stream, the HSCRC will also promote and track development of diabetes management services
  - Medicare Diabetes Self-Management Training (DSMT)
  - Medical Nutrition Therapy (MNT)
- Regional Partnerships will be tasked with expanding the number of MDPP suppliers across the State and getting Medicare beneficiaries enrolled with the long-term goal of losing weight.
- Proposed grant term: 5 years
- Rationale:
  - Promotion of an evidence-based program with demonstrated long-term results
  - Supports the statewide Diabetes Action Plan
  - Alignment with Medicaid and commercial payers
  - Funding mechanism exists beyond grant funds

Funding Stream II: Behavioral Health Crisis Services

- The behavioral health crisis services funding stream will award grants to develop and expand capacity for comprehensive crisis management services
- Grants would be used to support programs that align with the "Crisis Now: Transforming Services is Within Our Reach" action plan developed by the National Action Alliance for Suicide Prevention
  - Crisis Call Center & "Air Traffic Control" Services
  - Community-Based Mobile Crisis Teams
  - Short-term, "sub-acute" residential crisis stabilization programs
- The HSCRC staff would also consider other evidence-based crisis programs and services that may be appropriate to address region specific needs
- Proposed grant term: 5 years
- Rationale:
  - Promotion of interventions to assist in reducing unnecessary ED and hospital utilization
  - Intended to help address the gaps in capacity that exist

Regional Partnership Catalyst Grant Program: Next Steps

- If program is approved, HSCRC would launch an RFA to consider applications for funding effective for July 1, 2020
- The HSCRC staff will form an unbiased evaluation committee that will include subject matter experts on Diabetes and Behavioral Health crisis management
- Public comments are being accepted on the design of the Regional Partnership Catalyst Grant Program
  - Comments period ends October 23, 2019
  - Comments should be emailed to hscrc.rfp-implement@maryland.gov

For more information on the current Regional Partnership activities, please visit HSCRC website at: https://hscrc.maryland.gov/Pages/regional-partnerships.aspx

Thank You

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Episode Quality Improvement Program (EQIP)*

* Formerly known as EEP (Enhanced Episode Program)

10/22/19 SIG

HSCRC
Health Services Cost Review Commission

Bad News: For years, CMMI has excluded Maryland from many models or limited take-up

- Bundled Payments for Care Improvement Advanced (BPCI Advanced)
- Oncology Care Model (OCM)
- New Radiation Oncology (RO) Model
- Comprehensive ESRD Care Model (CEC)
- Comprehensive Primary Care Plus (CPC+)

Good News: Maryland Model now permits developing our own versions

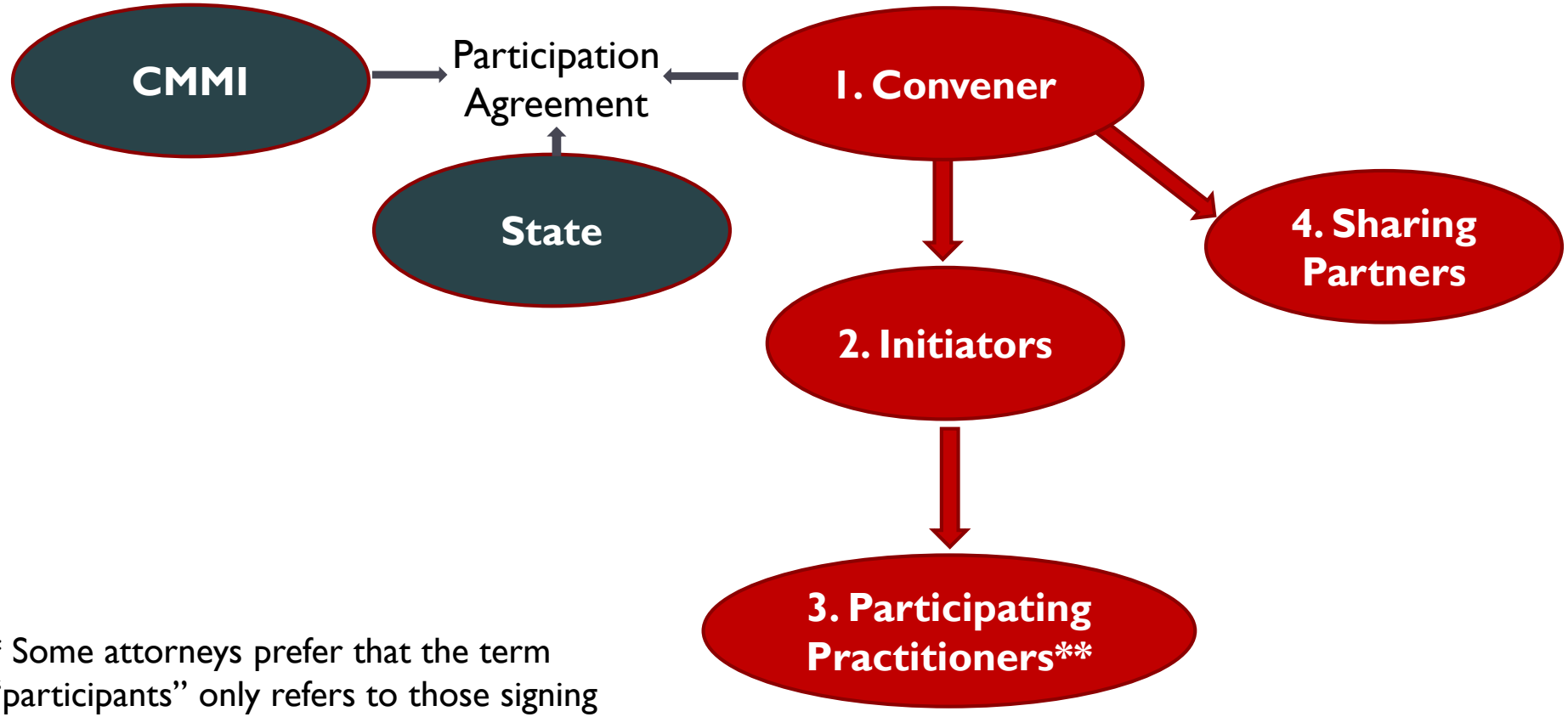
- Episode Quality Improvement Program (expected start date January 2021):
  - Which clinical categories of episodes?
- Maryland Primary Care Program (MDPCP started January 2019)

- Also, CMMI permitting Maryland providers into newest proposed kidney models (ETC, KCF, CKCC)

Episode Quality Improvement Program (EQIP): Overview and goals

- EQIP is episode-based payment program designed for non-hospital providers to:
  - Include more providers in a value-based payment framework
  - Include more episodes than in CMMI models
  - Broaden access to Medicare's 5% Advanced APM opportunity
  - Encourage multi-payer alignment
- As with all TCOC Model programs (except for MDPCP), participants (Conveners in EQIP context) must accept more-than-nominal downside risk
  - Episode Initiators (e.g., physician participants) can participate through a Convener and agree on risk/reward arrangement
- Targeted start date of January 2021, with RFA Spring 2020

EQIP's Types of "Participants"*



* Some attorneys prefer that the term "participants" only refers to those signing the Participation Agreement (PA). In EQIP, that would be only Conveners, plus CMMI and the State.

** Only needed if (1) the Initiator is a PGP or Facility, and (2) that Initiator wants to share payments with their practitioners.

EQIP's Types of Participants: 1. Conveners

1. **Episode Conveners**
   - APM Entity that bears the risk
   - Legal entity like an ACO, CTO, or a Participant in BPCI-A
   - Respond to Request for Applications (RFA), sign Participation Agreement (PA), and submit Implementation Protocol (IP)
   - Expecting no more than a couple dozen Episode Conveners (but no State/Federal restriction on number)
   - Enter into agreement with Episode Initiators
   - Provide their Episode Initiators with resources and support, for example:
     - Technical assistance, outreach and education, enrollment support
     - Care management resources
     - Episode management and analytics

EQIP's Types of "Participants": 2. Initiators

2. Episode Initiators

- Do not sign PA with CMMI and State
- Medicare suppliers and providers (e.g., doctors) that:
  - Initiate clinical episodes,
  - Implement care intervention plans,
  - Treat patients
- Enter into agreement with Convener
  - CMMI and State not a party
- NPIs like those on:
  - ACO list,
  - MDPCP practice roster, or
  - CRP Certified Care Partner list

EQIP's Types of "Participants": 3. Participating Practitioners 4. Sharing Partners

3. **Participating Practitioners**
   - If the Initiator is a PGP or a facility, they may want to share payments with their individual downstream practitioners

4. **Sharing Partners**
   - The Convener may want to share incentive payments with non-Initiator organizations (e.g., with a PAC facility that is helping reduce readmissions and TCOC but is not an Initiator)

EQIP Track Components

1. Episode(s) description, including:
   - Triggering Service identifiable through claims
   - Duration of Episode
   - Qualifications: Eligible Medicare providers
   - Medicare spending included/excluded (e.g., above 99th percentile)
   - Care interventions, as specified in EQIP Track Template
2. Reconciliation Payment Methodology (target prices & quality adjustments)
3. Risk Component (e.g., 3% discount factor before upside payment)

EQIP: Simplified hypothetical example
Actual details TBD

- Convener elects to take responsibility for Medicare TCOC for:
  - Triggered by _[CPT code(s)]
  - For spending over _[90]__ days
- The Convener's average Medicare TCOC is $10,000 per beneficiary
  - CMS wants its 3% savings – Discount Factor → $9,700 target
  - Across the Convener's patients, if the Convener's average per beneficiary spending falls below $9,700 (assuming certain quality metrics are met), Convener receives payment from Medicare
  - On the other hand, average Medicare TCOC above $_____ will require a payment from the Convener
- Because Maryland hospitals operate under a global budget, reductions in Medicare hospital utilization do not produce a one-for-one savings to Medicare
  - Performance on hospital spending will be discounted by ~50%

ORTHOPEDIC BUNDLED PAYMENT MODEL

Section 1: Submitter Information	
Name	Dr. Nicholas Grosso
Title	President
Organization or Affiliation	The Centers for Advanced Orthopaedics
Email	ngrosso@cfaortho.com
Phone Number	443-520-5770
Date of submission	September 2019
Section 2: Payment Model Idea Overview	
Name	Orthopedic Bundled Payment Model
Description of Idea	Establishes an episode of care payment model for patients receiving certain orthopedic services. Payment structure incentivizes evidence-based practices that can lead to better care quality and reduced costs. Would fit in State's proposed Episode Quality Improvement Program (EQIP).
Objective	☐ Reduction of disease burden ☐ Provision of alternative clinical services ☒ Streamlining of available services (i.e. improved patient choice) ☒ Reduce per capita cost ☒ Reduce total cost of care (TCOC) ☐ Other:
Section 3: Payment Model Idea Details	
Target Population	Medicare beneficiaries that receive certain orthopedic services. Patient attributed to provider when select CPT and/or ICD-10 codes are triggered in Medicare Part B claims for participating physician or physician practice.
Description of Intervention(s)	Using claims-based trigger codes to identify Medicare beneficiaries, an episode payment model will be created to pay providers treating patients receiving certain orthopedic services. Consistent with SIG and CMMI requirements, the model would have two-sided risk, would qualify as an Advanced APM, and would make payments retrospectively based on performance. The specific orthopedic services are: 1. Hip Replacement & Hip Revision 2. Knee Arthroscopy 3. Knee Replacement & Knee Revision 4. Low Back Pain 5. Lumbar Laminectomy 6. Lumbar Spine Fusion 7. Osteoarthritis 8. Shoulder Replacement 9. Anterior cervical discectomy and fusion (ACDF)
Duration of Performance Period	Consistent with EQIP, performance period will be annual, beginning January 2021.

	Within that performance period, the episode begins with the operation and extends to a 90 day post-discharge period.

Quality Impact	Measures that apply, consistent with CMMI's BPCI-Advanced:
	• **Process**: Advanced Care Plan (NQF #0326)
	• **Patient outcome**:
	  ○ THA/TKA complication rate (NQF #1550);
	  ○ All-cause Hospital Readmission Measure (NQF #1789);
	  ○ Perioperative Care: Selection of Prophylactic Antibiotic: 1st or 2nd Generation Cephalosporin (NQF #0268)
	• **Patient experience or satisfaction**: CMS Patient Safety Indicators (PSI 90)
	These measures are currently calculated by the State/CRISP in the hospital-convened Episode Care Improvement Program (ECIP). We recommend that the quality adjustment be applied similar to ECIP and BPCI-Advanced: The Episode Initiator-specific Composite Quality Score (CQS) for the above measures would be applied to reconciliation payments (capped at ±10%). Performance is determined by ranking Initiators relative to their peers, and observing their improvement relative to peers over the baseline period.

Downside Risk Requirement for TCOC Accountability	**Entity bearing risk**: In EQIP, Episode Conveners bear the risk. Physician group practices (PGPs) can be an Episode Convener. Or, PGPs and individual Medicare providers and/or suppliers (Episode Initiators and/or Participating Practitioners) could sign up under another organizational Episode Convener (e.g., Fusion 5). Arrangements for incentive/risk sharing between the Convener and downstream partners will be decided in advance of the performance year. Consistent with BPCI-Advanced, a 3% discount/savings threshold (Target Price) must be met before payments are made to conveners. Medicare Total Cost of Care (TCOC) spending in the episode above the Target Price must be repaid by the Convener (and potentially by downstream partners, depending on their risk arrangement). These TCOC and Quality requirements ensure Conveners can be considered Advanced Alternative Payment Models (Advanced APMs) participants by CMMI, under the MACRA law.
Financial Methodology	Methods for calculating ROI for these areas: • **Program sustainability**: Participants will follow the State's approach for EQIP. • **Total cost of care impact**: The episode savings will be calculated with a pre/post analysis that compares the actual episode costs with the baseline costs, trended forward by an inflation factor, providing Medicare with TCOC savings based on the 3% discount factor. Inclusions and exclusions in Medicare TCOC would generally follow BPCI-Advanced (e.g., exclusions for an admission for organ transplants, major trauma, cancer-related care, ventricular shunts).
Anticipated Resource Requirements	
Funding Requirements	Source of funding for development, implementation, and operations:

EMERGENCY DEPARTMENT UTILIZATION

Maryland
Hospital Association

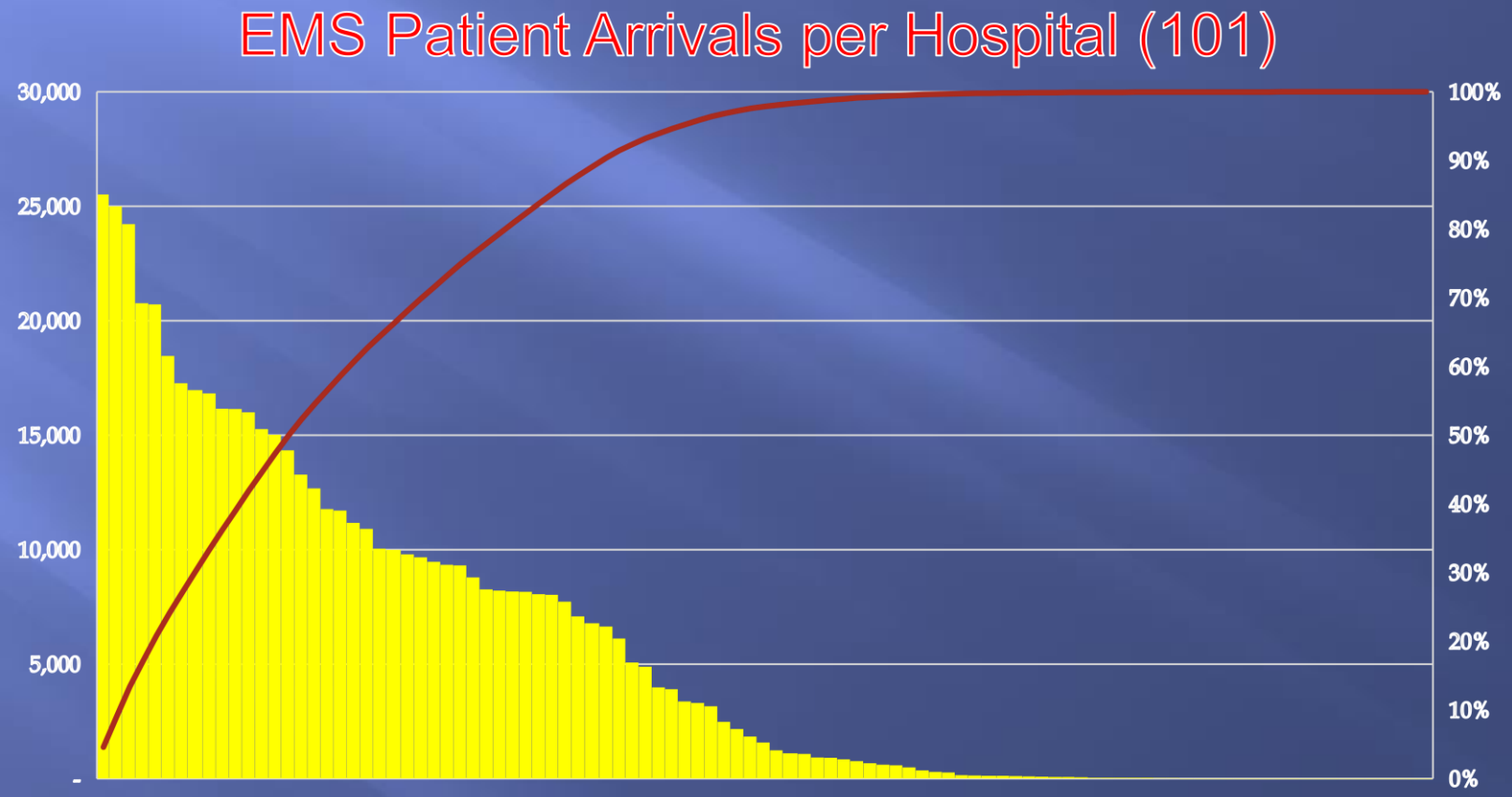
Maryland
Emergency Medical Services
Opportunity for Innovation

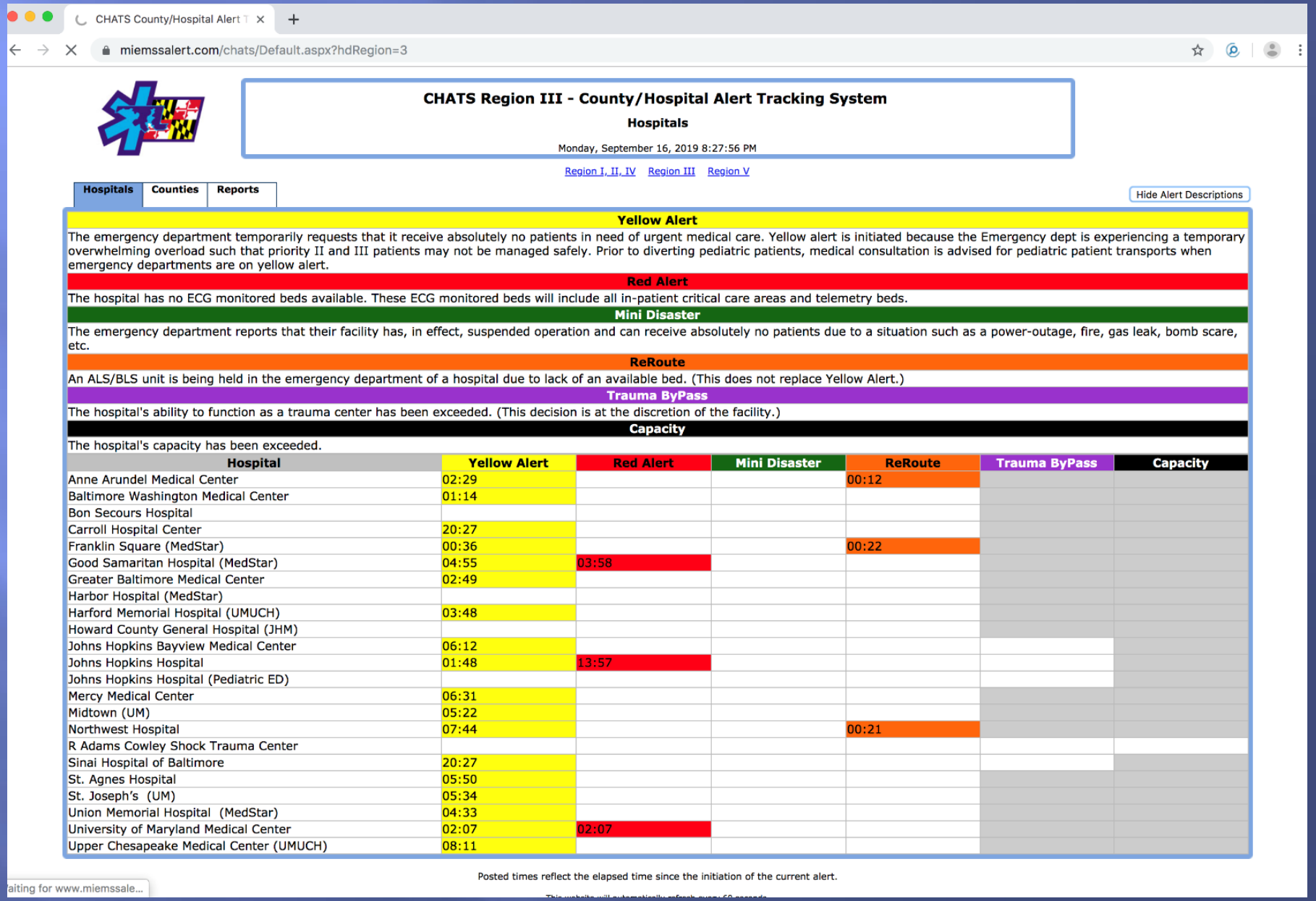
Stakeholder's Innovation Group

October 22, 2019

2018 EMS Patient Transports

1.2 million EMS responses; 583,000 patient transports




CHATS County/Hospital Alert T
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CHATS Region III - County/Hospital Alert Tracking System
Hospitals
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Region I, II, IV
Region III
Region V
Hospitals
Counties
Reports
Hide Alert Descriptions
Yellow Alert
The emergency department temporarily requests that it receive absolutely no patients in need of urgent medical care. Yellow alert is initiated because the Emergency dept is experiencing a temporary overwhelming overload such that priority II and III patients may not be managed safely. Prior to diverting pediatric patients, medical consultation is advised for pediatric patient transports when emergency departments are on yellow alert.
Red Alert
The hospital has no ECG monitored beds available. These ECG monitored beds will include all in-patient critical care areas and telemetry beds.
Mini Disaster
The emergency department reports that their facility has, in effect, suspended operation and can receive absolutely no patients due to a situation such as a power-outage, fire, gas leak, bomb scare, etc.
ReRoute
An ALS/BLS unit is being held in the emergency department of a hospital due to lack of an available bed. (This does not replace Yellow Alert.)
Trauma ByPass
The hospital's ability to function as a trauma center has been exceeded. (This decision is at the discretion of the facility.)
Capacity
The hospital's capacity has been exceeded.
Hospital | Yellow Alert | Red Alert | Mini Disaster | ReRoute | Trauma ByPass | Capacity
Anne Arundel Medical Center | 02:29 | | | 00:12 | | |
Baltimore Washington Medical Center | 01:14 | | | | | |
Bon Secours Hospital | | | | | | |
Carroll Hospital Center | 20:27 | | | | | |
Franklin Square (MedStar) | 00:36 | | | 00:22 | | |
Good Samaritan Hospital (MedStar) | 04:55 | 03:58 | | | | |
Greater Baltimore Medical Center | 02:49 | | | | | |
Harbor Hospital (MedStar) | | | | | | |
Harford Memorial Hospital (UMUCH) | 03:48 | | | | | |
Howard County General Hospital (JHM) | | | | | | |
Johns Hopkins Bayview Medical Center | 06:12 | | | | | |
Johns Hopkins Hospital | 01:48 | 13:57 | | | | |
Johns Hopkins Hospital (Pediatric ED) | | | | | | |
Mercy Medical Center | 06:31 | | | | | |
Midtown (UM) | 05:22 | | | | | |
Northwest Hospital | 07:44 | | | 00:21 | | |
R Adams Cowley Shock Trauma Center | | | | | | |
Sinai Hospital of Baltimore | 20:27 | | | | | |
St. Agnes Hospital | 05:50 | | | | | |
St. Joseph's (UM) | 05:34 | | | | | |
Union Memorial Hospital (MedStar) | 04:33 | | | | | |
University of Maryland Medical Center | 02:07 | 02:07 | | | | |
Upper Chesapeake Medical Center (UMUCH) | 08:11 | | | | | |
Posted times reflect the elapsed time since the initiation of the current alert.
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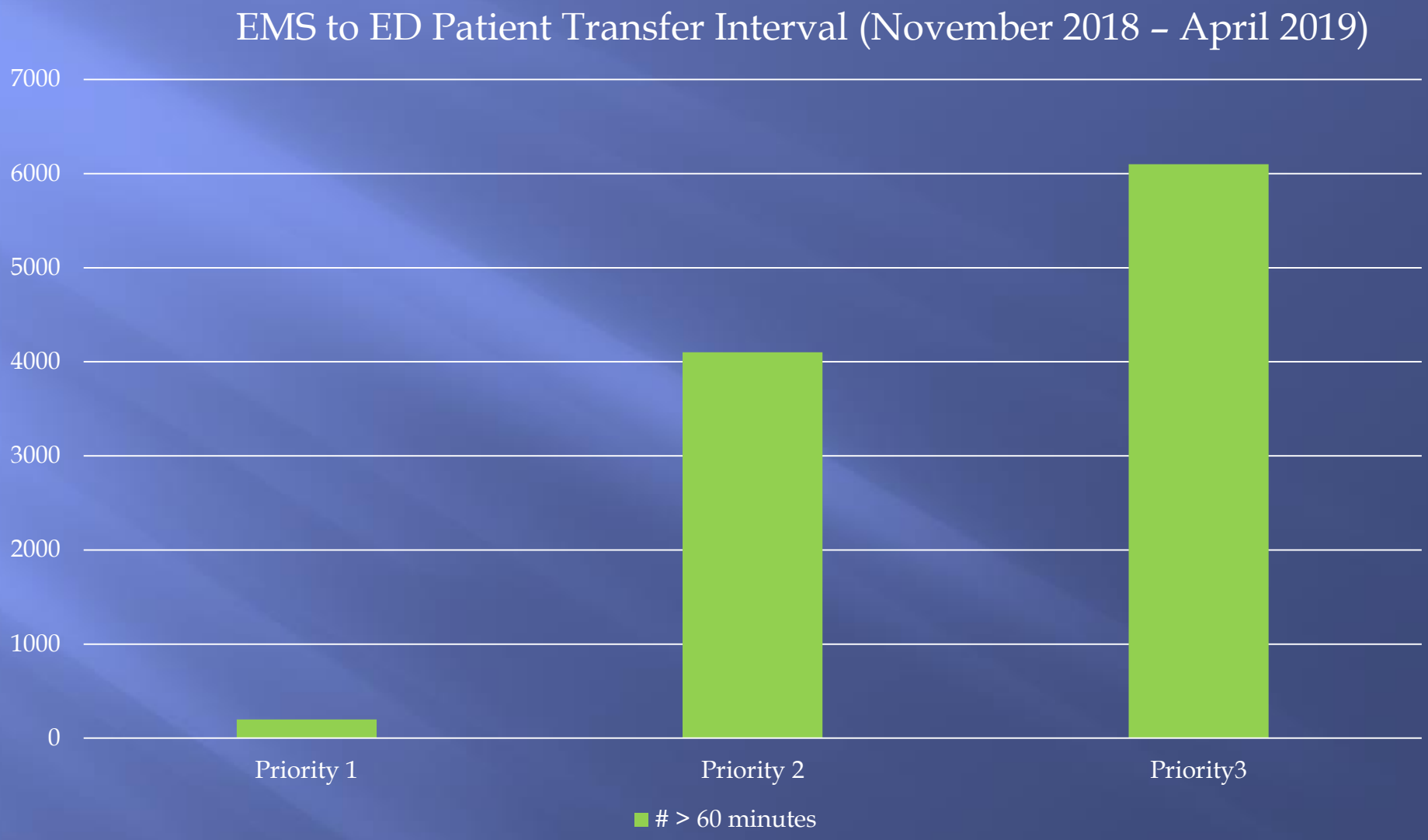
EMS to ED Patient Transfer Interval (November 2018 – April 2019)
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6000
5000
4000
3000
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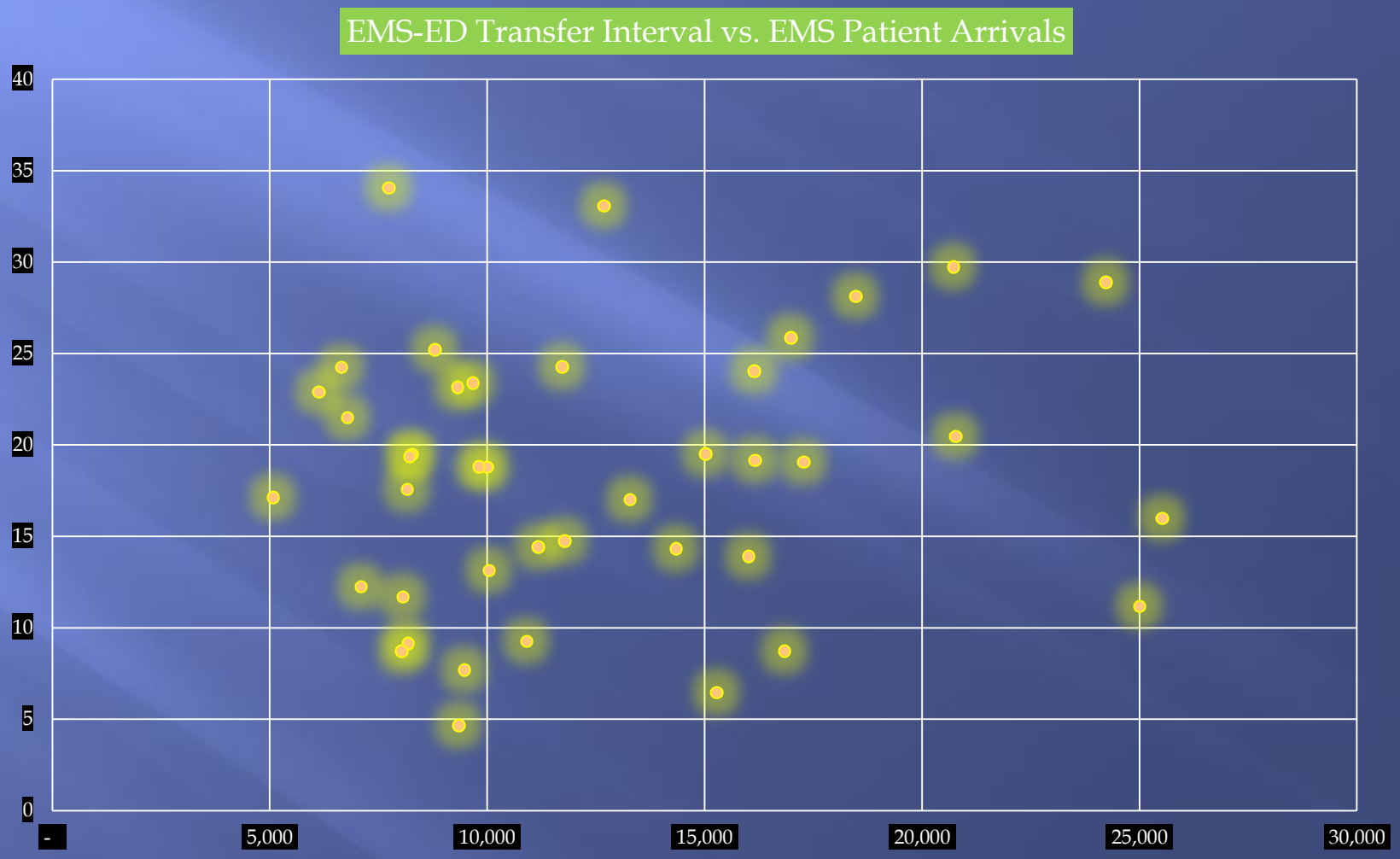
Priority 1
Priority 2
Priority3
> 60 minutes

EMS – ED Transfer Variability



Maryland Hospitals / Emergency Departments Struggle

- Far under-perform as indicated by CMS efficiency metrics
  - ED_1b: Median Time from ED Arrival to ED Departure for Admitted ED Patients
  - ED_2b: Admit Decision Time to ED Departure Time for Admitted Patients
  - OP_18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients

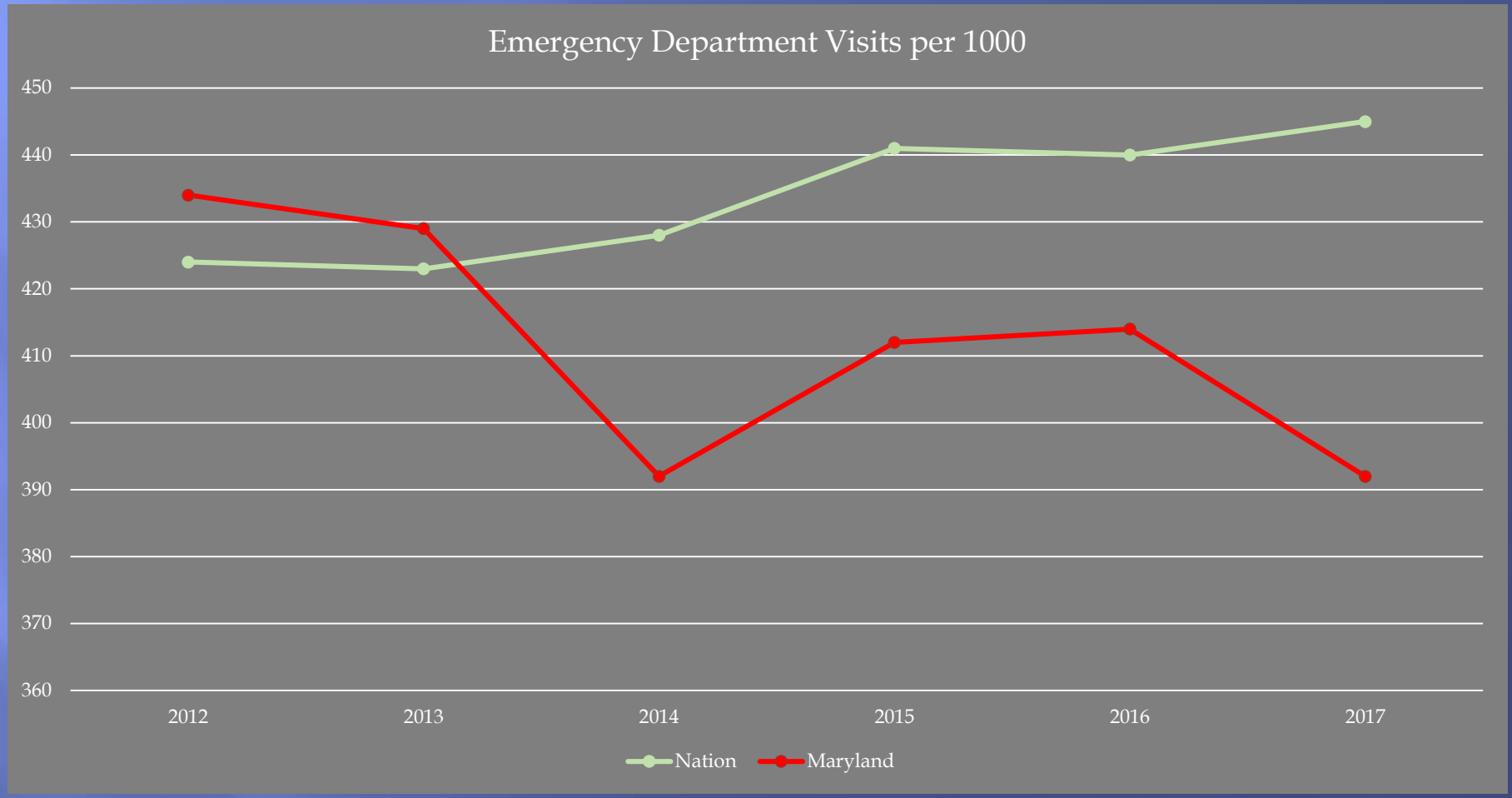
Trends in Maryland Hospital Emergency Department Utilization:

An Analysis of Issues and Recommended Strategies to Address Crowding

Report of the Joint Work Group on Emergency Department Utilization

Maryland Health Care Commission
Health Services Cost Review Commission

April 2002



EMS Transports to ED: 5% increase past 4 years

Emergency Department

Imagine…

What we know:

- Some callers to 9-1-1 don't really need EMS at all.
- Some EMS patients could be treated right there.
- Some EMS patients are best treated not at the ED.
- Some proactive effort could avert the 9-1-1 call.

ET3
Evaluation, Triage, Treatment & Transport

- Five-year program through CMMI to expand Medicare EMS reimbursement for FFS patients
  - EMS transportation to a non-ED destination
  - Treatment (by a qualified practitioner) and no EMS transport
- Two-year agreements for 9-1-1 centers to establish triage capabilities

ET3 Goals

- Provide person-centered care so beneficiaries receive appropriate level care at the right time and place while having greater control of healthcare.
- Encourage appropriate utilization of services to meet healthcare needs (e.g., avoid unnecessary transports to EDs)
- Increase efficiency in EMS system to more readily respond to and focus on high-acuity cases (e.g., heart attacks and strokes)

Estimated Medicare Savings - $500M

1. Quality-adjusted payments for EMS innovations

- Provide new payment options for transport and treatment in place following a 911 call
- Tie payment to performance milestones to hold participants accountable for quality

2. Support for aligned regional markets

- Make cooperative agreements available to local governments, its designees, or other entities that operate or have authority over one or more 911 dispatches acting on their behalf in regions where selected model participants operate
- Focus funding on the establishment of medical triage lines to ensure appropriate use of EMS resources and advance multi-payer adoption to support overall success and sustainability

3. Enhanced monitoring and enforcement

- Build accountability through the monitoring of specific quality metrics and adverse events
- Include robust enforcement to ensure patient safety and program integrity

Maryland EMS Innovation Models

- #1: Treat and Release!
- #2: Alternative [to ED] Destinations!
- #3: Mobile Integrated Health!

EMS Treat & Release

- EMS clinicians identify potential patient
- Obtain consent
- Establish audio/video connection with qualified healthcare practitioner
- Facilitate definitive care without transport
- Current state: HCP paid; not EMS
- Goal: HCP and EMS compensated

Alternative Destinations

- Not every EMS patient needs an ED
- May not even be ideal or desirable

Alternative Destination (AD) Protocol

- Low Acuity / Priority 3 Patient
- Patient is 18 years of age or older
- Able to Communicate with EMS
- Understands Consent Form/Process
- Agrees to be transported to AD

Yes

Vital Signs Acceptable?

Yes

ACCEPTABLE VITAL SIGNS

- **Respirations:** 10-20
- **Pulse:** 50-120
- **Pulse Ox:** >92%
- **Temperature:** 96-102 F
- **Blood Glucose:** 70-300

ACCEPTABLE BLOOD PRESSURES:

- **Urgent Care/PCP:**
  Systolic 100-160 & Diastolic 60-100
- **Stabilization/Crisis Center:**
  Systolic 80-220 & Diastolic 50-120

High Risk Conditions Absent?

Yes

High Risk Conditions

- Abdominal Pain, Unexplained
- Altered Mental Status
- Back Pain, Unexplained
- Chest Pain
- Dyspnea/Shortness of Breath
- Focal Neurological Deficits (Acute)
- Seizures
- Sepsis, Suspected
- Syncope
- **Requires more than minimal assistance to walk**
- **Unable to Cooperate with History and Exam**

Physical Exam without Time Dependent Needs

Yes

Physical Exam/Time Dependent Needs

- Airway
- Breathing
- Circulation (Including to Extremity)
- Disability (Deficit) or Deformity
- Severe Tenderness with Palpation/Exam
- Significant Head or Truncal Trauma
- Uncontrolled Bleeding
- **Require ALS Monitoring or Interventions**
- **Concern for Potential Deterioration in Condition**

Yes

Obtain Consent & Insurance Info from Patient

Contact & Obtain Acceptance of Patient from AD

Transport to AD

IF ANY HIGH RISK CONDITIONS OR PHYSICAL EXAM/TIME DEPENDENT NEEDS, EMS SHALL TRANSPORT TO CLOSEST APPROPRIATE ED/FEMF

IF PATIENT IS EXCLUDED BASED ON VITALS ALONE, TRANSPORT TO CLOSEST APPROPRIATE ED/FEMF UNLESS MEDICAL DIRECTION FROM APPROVED BASE STATION AUTHORIZES TRANSPORT TO ALT DESTINATION

Rev. 06/06/2019

ETHAN

<Emergency Telehealth and Navigation>

- Houston
  - 2.3 million people
  - 250,000 EMS calls per year
- ETHAN
  - 4 years
  - Diverted 20,000 patients from ED
  - Savings: >$20million

Alternative Destinations

- Current state: EMS not compensated
  - Financial incentive to go to ED
- Goal: EMS compensated for transport to appropriate non-ED destinations

Mobile Integrated Health (MIH)

- EMS collaborates with healthcare partners
  - Proactive
  - Decrease 9-1-1 calls
  - Decrease hospital re-admissions
  - Improve overall health
- Focus
  - Frequent 9-1-1 callers
  - High ED utilizers
  - High risk hospital discharges
- Facilitate access to available services/resources

Mobile Integrated Health (MIH)

- Current state
  - No dedicated funding
  - Grant supported
- Goal
  - Sustainable funding
  - Long-term
  - Performance-based

Future of New EMS Models
(Senate Bill 682 Report, 2019)

- New EMS models of care need long-term sustainable funding solutions to continue …
- Reimbursement for the three EMS care models must be financially and practically viable for all system participants, including payers.

Future of New EMS Models
(Senate Bill 682 Report, 2019)

- Reimbursement for the three EMS care models should include all private and public payers to avoid cost-shifting between payer types and to ensure equitable treatment of consumers, regardless of insurance source.

- EMS reimbursement changes must dovetail with Total Cost of Care Model.

Recommendations
(Senate Bill 682 Report, 2019)

#7 HSCRC and the Stakeholders Innovation Group should consider these models of EMS care in the process of developing proposals for CMS for new tracks for the Care Redesign program for Medicare funding under the TCOC model.

#10 HSCRC should continue to identify and consider EMS care delivery financing models that occur outside of Maryland for possible proposals to CMMI at CMS for approval under the TCOC Model, including any future EMS-focused models developed by CMMI.

Facilitating EMS Innovation Models in Maryland

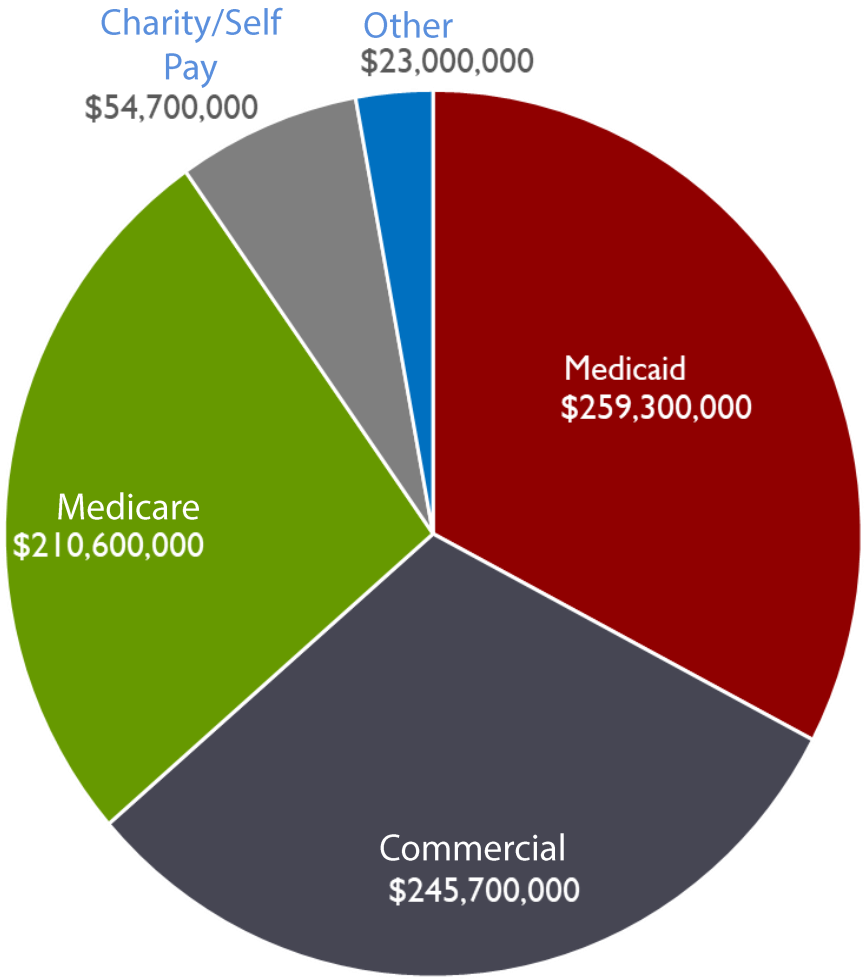
- Acknowledge: The ED is not always needed.
- Recognize: EMS can be part of a solution.
- Develop: Hospital & EMS collaborations to create innovative approaches.
- Adopt: Statewide goal of implementation of innovative EMS care models (i.e., not dependent upon ET3 participation).
- Identify: Sustainable long-term funding strategies.


WHAT'S THAT NUMBER FOR 911 AGAIN?

ED UTILIZATION OPPORTUNITY ANALYSIS

- HSCRC staff analyzed the statewide Emergency Department (ED) utilization in response to previous SIG discussions/Submissions
  - Emergency Department Improvements in Care Transitions (EDICT)
  - CMMI ET3 Model and Emergency Medical Services (EMS) Opportunities to implement mobile-integrated health and alternative destination
- Avoidable ED utilization was identified using the NYU algorithm which identifies non-admitted patients who fall into two categories:
  - Primary Care Treatable, and
  - Non-emergent conditions that could be treated in Urgent Care or other community settings
- Overall ED spending and episode spending initiated at the ED was also assessed

POTENTIAL SAVINGS IN UNNECESSARY ED UTILIZATION

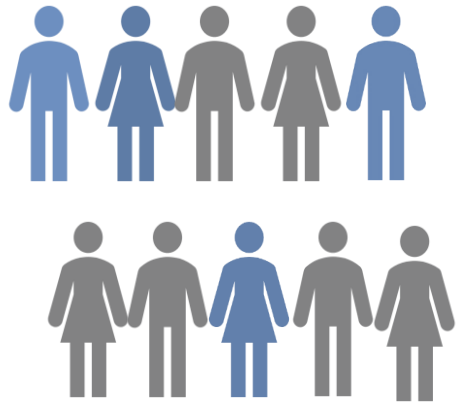


$793,300,000 was spent on Emergency Department Utilization that could have been treated at a **primary care setting** or **was not emergent**

33.8% of total ED utilization

4% of total hospital revenues

27% attributable to Medicare



37.5% of ED utilization across all payers can be attributable to patients who have **3+** visits annually.

$42 Million

In **avoidable costs statewide** from frequent utilizers that could have been treated at a primary care or non-emergent setting

Source: HSCRC Analysis of 2017 ED visits Statewide in Casemix

MEDICARE EMERGENCY DEPARTMENT EPISODE SPENDING IS CONCENTRATED IN OUTPATIENT AND PHYSICIAN SERVICES

326,305 Episodes of Care* Started in the ED in 2018

Average Episode Total Cost: $2,477*

- Outpatient: $1,454
- Physician: $696
- Inpatient: $286
- SNF, Hospice, ESRD: $40

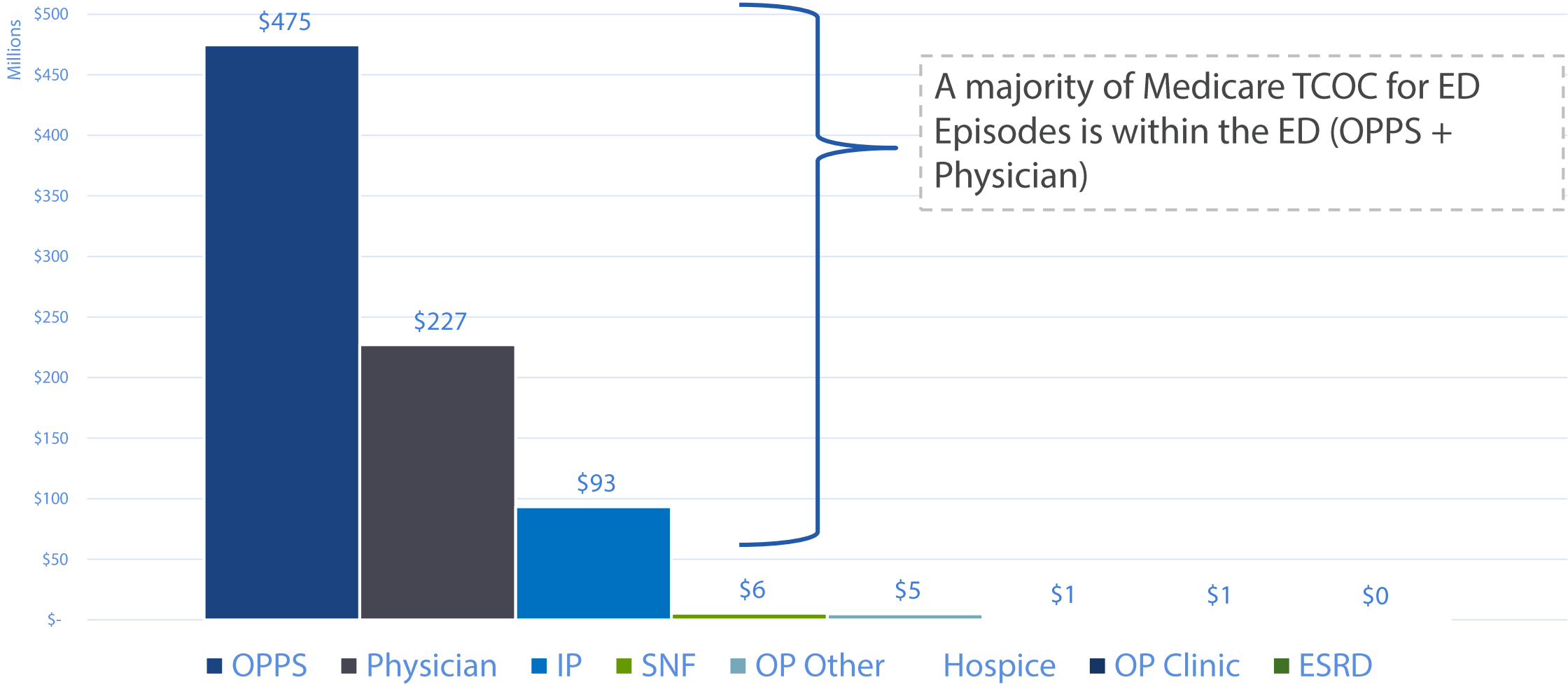
100% had Outpatient Spending
99.2% had Physician Spending

Outpatient Spending Ranges:
$768 - $3,657 (1st-9th decile)
Physician Spending Ranges:
$466 - $1,467 (1st-9th decile)

- 3% had Inpatient Spending
- 0.7% had Skilled Nursing Spending
- 0.4% had Hospice Spending
- 0.2% had ESRD Spending

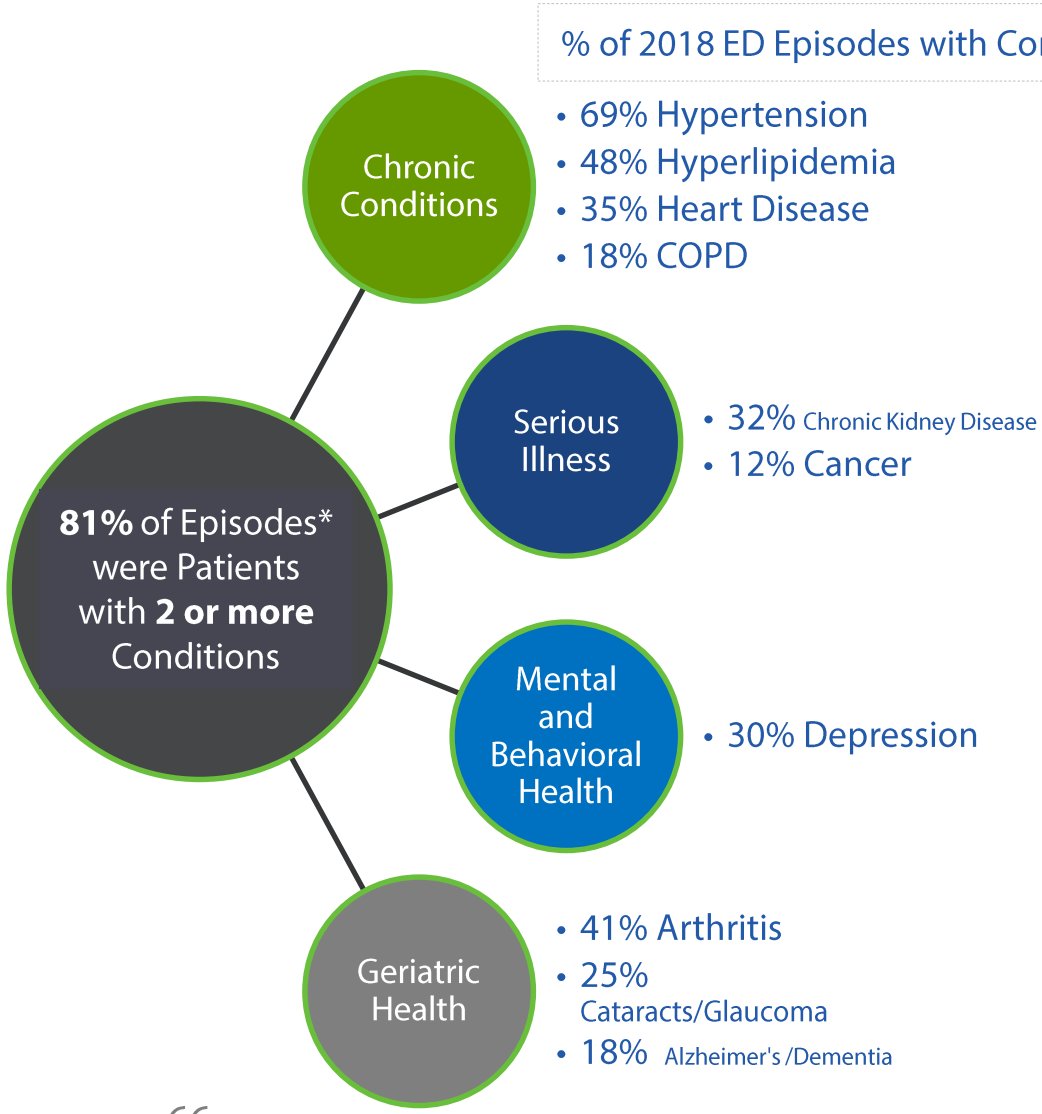
* Based on 15-day episodes in 2018 that included some form of utilization

COSTS OF ALL MEDICARE ED EPISODES*



* Based on 15-day episodes in 2018

MULTIPLE COMORBIDITIES DOMINATE ED EPISODE CONDITIONS



Interventions that could help to reduce avoidable utilization for Medicare beneficiaries with these conditions:

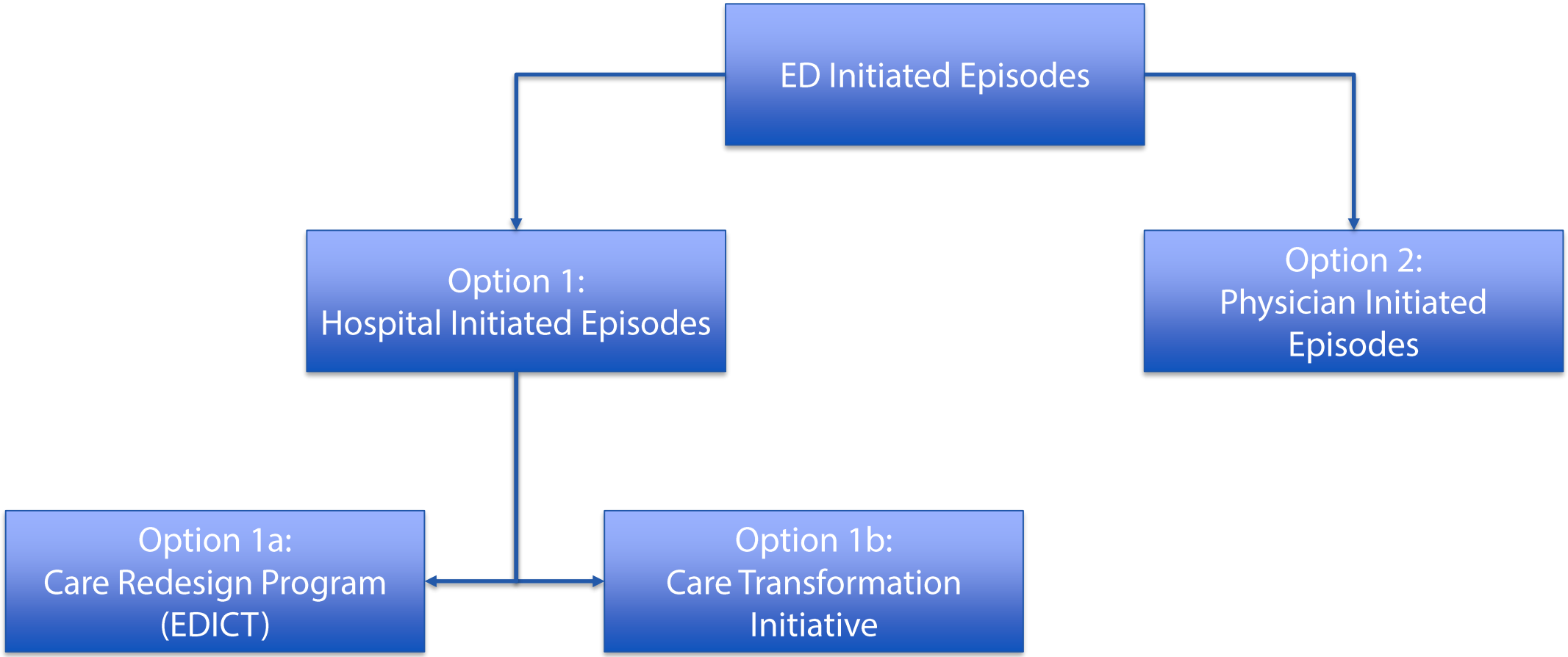
- Care Management and Coordination
- Community-based access to unscheduled care
- Disease-specific interventions and care protocols

* Based on 15-day episodes in 2018, Medicare beneficiaries only.

OPPORTUNITIES IN EDICT

- Emergency Department Improvements in Care Transitions (EDICT) provides a model to address unnecessary ED use and reduce TCOC
  - Interventions: telehealth visit, in-home evaluation, communication with primary provider
  - TCOC Savings calculation: 7-day spending in observed vs. previous performance period
  - ED Physicians receive care management payments for managing payments
- Next steps for EDICT:
  1. **Hospitals**: build a CTI or CRP (enable incentive and resource sharing) for the opportunity to build an ED bundle
  2. **Physicians**: build a track in EQIP for the opportunity to build an ED bundle

POTENTIAL OPTIONS FOR ED EPISODES



COMPARISON OF OPTIONS FOR ED BUNDLES AND EDICT

- **Option 1a:** EDICT under a Care Redesign Program
  - Hospitals would receive reconciliation payments for savings in ED Episodes.
  - Hospitals would pay the care management fees to ED physicians (and other care partners) out of their global budgets or reconciliation payments.
- **Option 1b:** ED Episode under a Care Transformation Initiative
  - Hospitals would receive reconciliation payments for savings in ED Episodes
  - Not care management payments to ED physicians would be made
- **Option 2:** ED Episodes included in EQIP
  - Physicians would receive reconciliation payments for savings in ED Episodes
  - Physicians would receive care management fees from CMS
  - Physicians would have downside risk.
- Options 1 and 2 are <u>not</u> mutually exclusive.

ED SAVINGS ARE AN OPPORTUNITY FOR EMS MODELS

- EMS Models and protocols may help to improve ED throughput and utilization for non-emergent needs. Some examples include:

Emergency Triage, Treat, and Transport Model (ET3)

Medicare only EMS billing for additional services

- **Treatment in place** for beneficiaries who does not meet medical necessity requirements for ambulance transport may still meet medically need healthcare services
- **Transport to an alternative setting** of care for beneficiaries who do not need ED services but does need some healthcare service and could be transported to a location equipped to serve their acuity.

Medical Triage Line ("Houston Model")

- **911 line staffed with nurses/appropriate clinical personnel** who help to triage EMS needs and direct low-acuity patients to alternative settings, address needs over the phone or deploy mobile-integrated health teams
- Develops partnership with health **information exchange** (CRISP) so that patient records and correct community providers can be connected to the patient

Mobile Integrated Health (MIH)

- EMS providers have access via telehealth or a mobile clinician team to clinicians and social services for low-acuity emergency services
- MIH assists EMS personnel in **treating low-acuity needs in place** and determining referral or transport to community-based care