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