

Stakeholder Innovation Group

February 25, 2019



Maryland Hospital Association

Agenda

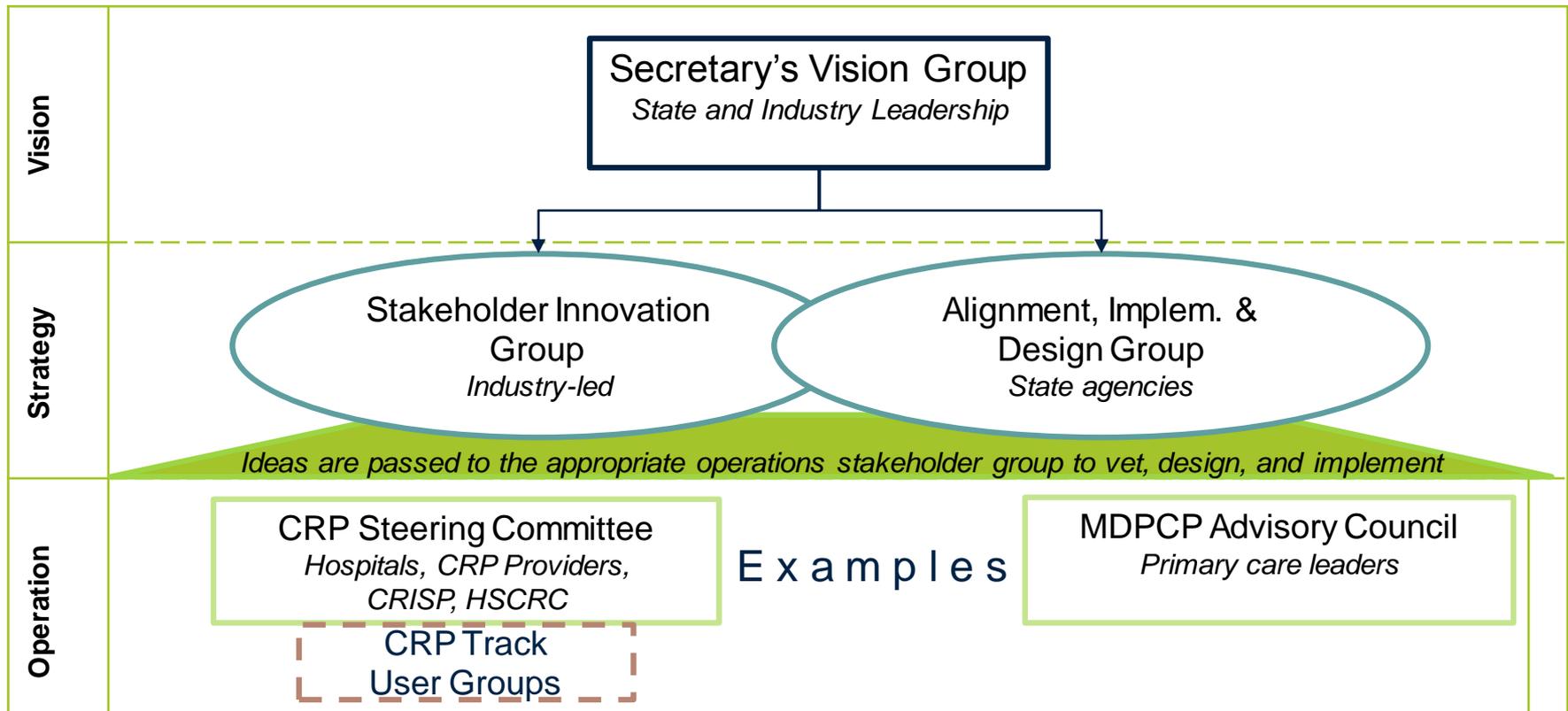
- Welcome and Introductions
- Stakeholder Engagement and Provider-Driven Innovation
- Requesting Waivers Under TCOC
- Opportunities to Participate in Federal Value-based Models vs. Building our Own
 - Federal Models Update
 - Timing and Considerations
- Next Steps

Welcome & Introductions

Stakeholder Engagement and Provider-Driven Innovation

Landscape of Stakeholder Groups

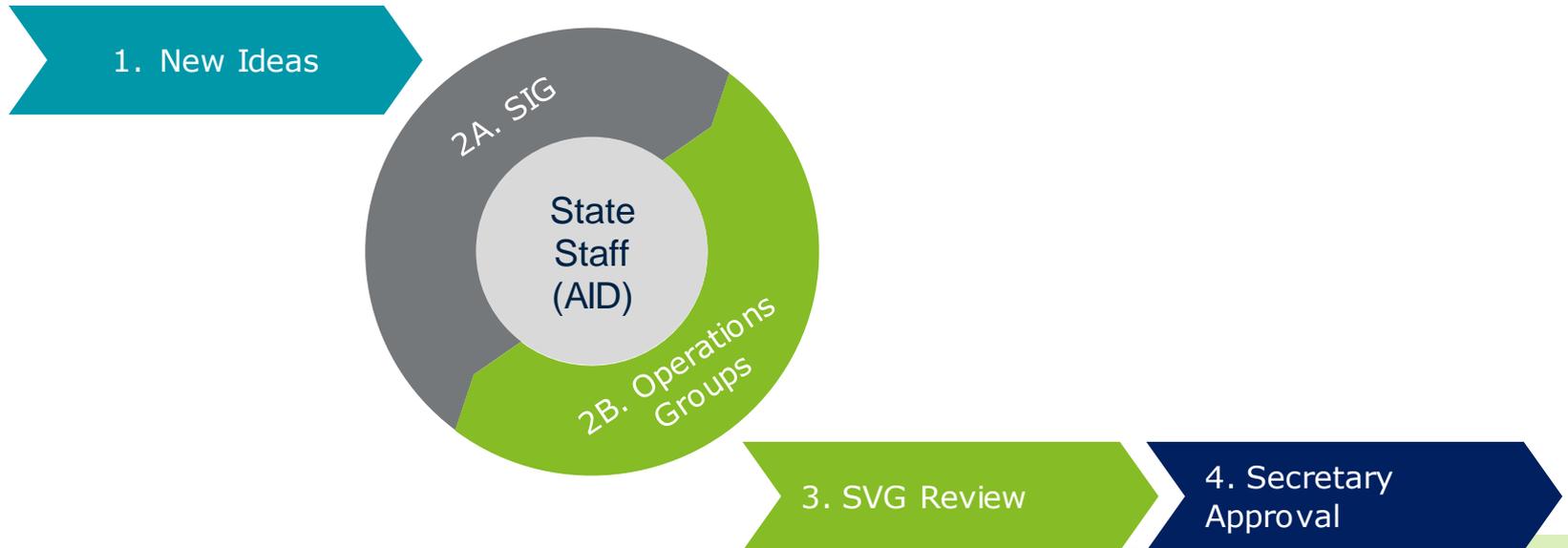
- Stakeholders play a key role in driving innovation
 - New ideas are introduced into the system through the SIG
 - Refinements can “bubble up” through Operations Groups



The SIG is the primary forum to identify, discuss, and disseminate innovative ideas

New ideas are...

1. Brought to the SIG for initial assessment and discussion,
2. Prioritized and potentially enhanced between the SIG, operations groups, and the State through an iterative process,
3. Moved to the Secretary's Vision Group when adequate consensus is reached, and
4. Reviewed by the Secretary for approval.



Ideas can be passed from the SIG to operations groups

Example

SIG Scope

Idea Generation /
Track Identification

Vet Idea and Track

Design CRP Track

Monitor and Refine
CRP Track

CRP Steering Committee Scope

- The SIG is the primary forum to discuss innovative ideas and potential new programs or tracks. It will:
 - Provide input on idea prioritization and initial vetting of provider interest
 - Assess how the idea may be categorized (e.g. CRP, New Model Program) and where an idea should be go (e.g. CRP Steering Committee or SVG)
- The CRP Steering Committee (or other operations groups) will continue to vet ideas, assist in design, and monitor and refine CRP Tracks over time
- CRP User Groups can provide operational feedback and refinements to the CRP Steering Committee
- HSCRC approves CRP Tracks and will notify the SIG and SVG

New Idea Intake Process



- New ideas submitted to the SIG through a standardized mechanism. SIG staff will:
 - Review submitted ideas for completeness
 - “Clinical conversations”: Engage with idea submitters and others to review and assess impact with TCOC Model and State policies
- Ideas supported by the SIG and State will be further designed, either by an operations group (e.g. CRP Steering Committee) or within the SIG
- If necessary, the care transformation idea is submitted to CMS for approval
- Approved care transformation ideas or successful existing programs are scaled to additional participants

Thoughts on Primary Collection Platform: Innovations for Better Health Website

- Information collected is specifically driven by the downstream analysis required by the SIG and the State
- Existing “Case Study Form” at www.innovatehealthmd.org could be rebranded as “Innovation Inventory”
 - Implemented and successful programs that need SIG support to be shared or scaled
- New Idea Intake Form for proposed Tracks, programs or episodes
 - New ideas that need SIG support for development
- For both forms,
 - Subscriber notifications or website call out for new or updated submissions
 - Specify the targeted population, interventions, convener, and partners
 - Describe potential Advanced APM applicability
 - Estimate TCOC savings vs. payments
 - Describe any new payments
 - Tag programs and interventions for alignment with State Bold Improvement Goals (BIGs)
 - Add Points of Contact (POCs) and links to program websites, and allow for the submission of additional evidence (papers, reports, etc.)

Waivers

State Waiver Request

- CMMI has flexibility to waive sections of the Social Security Act (especially Medicare)
 - CMMI can only use its waiver authority if it is necessary to test an alternative payment and care redesign model
 - CMMI generally requires that waivers be related to specific care redesign interventions in a Model Program
- The TCOC Model Agreement allows the State to request additional waivers to support programs under the Model
 - The waiver would only apply to Model programs with a demonstrable use case related to a care redesign intervention

Home Health Orders for NPs

- Medicare requires that a physician certify if a beneficiary needs home health services and establishes a plan of care as a condition of payment for home health care
 - Patients who lack access to a primary care physician must be under the care of a facility-based physician in order to receive home health services
 - This may result in higher costs and unnecessary facility utilization before patients receive home health services
- Nurse practitioners can independently practice medicine in Maryland and can oversee care for patients who do not have a primary care physician.

*CMMI is moving forward to approve this Medicare waiver request for statewide implementation (target date January 1, 2020):
For Nurse Practitioners located in Maryland with orders to Home Health Agencies operating in Maryland*

Types of Medicare Waivers that the State Can Request

1. Payment policy waivers that are available to providers in the Next Gen ACO and BCPI-A Models
2. Fraud and abuse waivers that are provided in the Next Gen ACO Model to encourage beneficiary alignment with an ACO
3. Other unique payment policy waivers that the State has designed in order to expand access to care and reduce the TCOC in the State

Requesting Medicare Waivers under the TCOOC Model Agreement

- In its Medicare waiver request, the State should specify to CMS:
 - Operational Requirements
 - Eligible providers
 - Eligible beneficiaries
 - Use case(s) in a program
 - Downside risk bearer
 - Any restrictions
 - Any State legal details
- Clearance and development timeline of at least 12 months

Discussion of Potential Waivers and Applicability

Waivers

- Telehealth Waiver
- Telehealth Benefit Extension
- Post-Discharge Home Visit Waiver
- SNF 3-Day Rule Waiver
- Beneficiary Incentives
- Beneficiary Coordinated Care Reward

Applications

- Hospital Payment Program
- Care Redesign Program
- New Model Program
- Maryland Primary Care Program
- Statewide

New Model Programs

Two Options for Non-Hospital Providers to Participate in New [Medicare] Models

- 1. Be permitted to join national CMMI models

and/or

- 2. Join New Model Program(s) designed and administered by Maryland

1. CMMI Models

- Discussions ongoing with CMMI about including MD in other federal models
 - Benefits
 - Speed
 - Leverage federal resources
 - Drawbacks or challenges
 - Accounting for GBR effects and savings
 - Feds determine all the rules about who/what is in (that is, little to no State flexibility)
- CMS's newly announced EMS Model
 - Maryland providers not excluded

Overview of the CMS Emergency Triage, Treat, and Transport (ET3) Model

- **Goals:**

- **Provide person-centered care**, such that beneficiaries receive the appropriate level of care delivered safely at the right time and place while having greater control of their healthcare through the availability of more options
- **Encourage appropriate utilization of services** to meet health care needs effectively (i.e. **Reduce avoidable transports** to the ED and unnecessary hospitalizations following those transports)
- **Increase efficiency in the EMS system** to more readily respond to and focus on high-acuity cases, such as heart attacks and strokes.

- **Permitted Medicare Payments**

- Participating ambulance suppliers and providers may receive Medicare funds for:
 - Transporting an individual to a ED, SNF, or dialysis centers (i.e. currently permitted locations);
 - Transporting to an alternative destination (such as a primary care doctor's office or an urgent care clinic); or
 - Providing treatment in place with a qualified health care practitioner, either on the scene or connected using telehealth.

ET3 Summary

- Estimated Medicare Savings of \$500M
- Program components include:

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

Source: CMS

Who can apply?

- The Model encourages local governments or other entities that operate or have authority over 911 dispatches to establishing a medical triage line for low-acuity 911 calls through two-year cooperative agreements.

Key Dates:

Summer 2019: RFA for Ambulance Suppliers and Providers

Fall 2019: Notice of Funding Opportunity for Local Governments

January 2020: Start Date of 5- Year Program

Who can apply?



Ambulance Suppliers and Providers

will support EMS innovation by transporting Medicare beneficiaries to currently covered destinations (e.g., ED) or alternative destinations, and by providing treatment in place with a qualified health care practitioner (on site or via telehealth).



Local Governments,

its designees, or other entities that operate or have authority over one or more 911 dispatches will promote successful model implementation by establishing a medical triage line for low-acuity calls received via their 911 dispatch system.

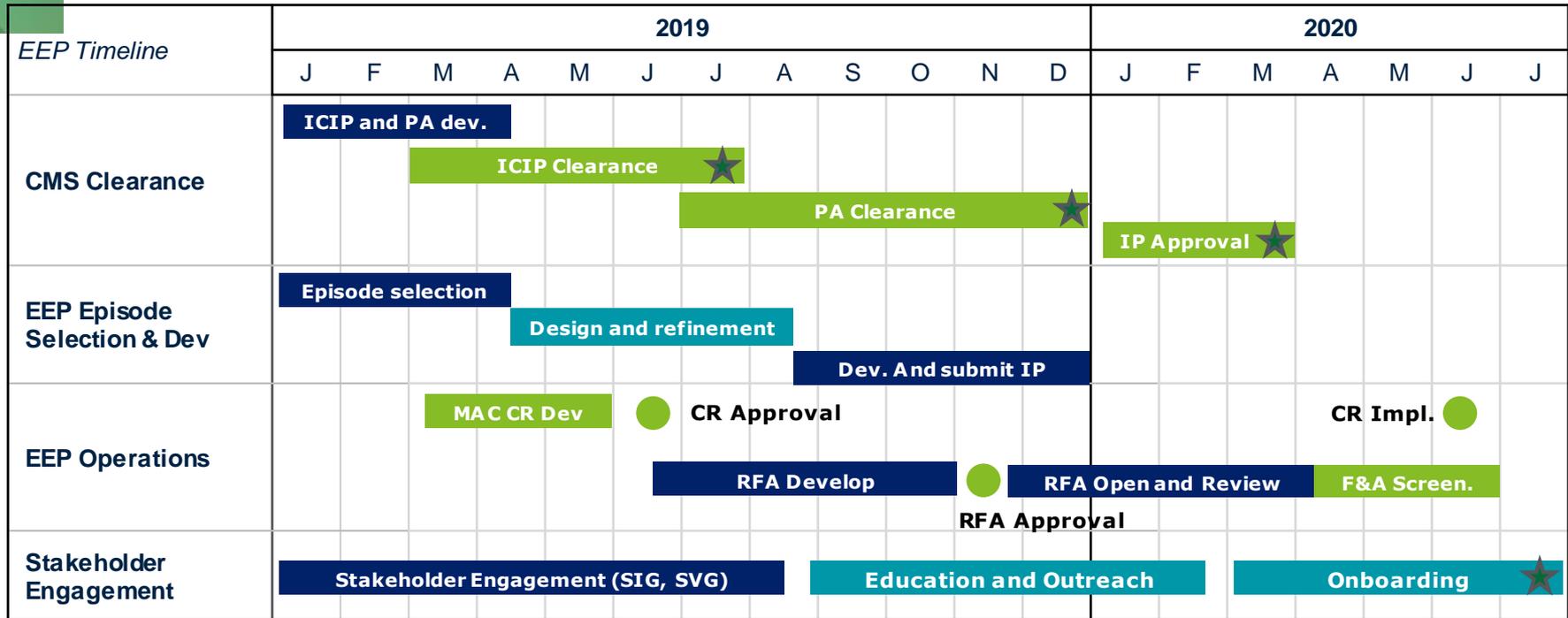
2. Update on Enhanced Episode Program (EEP), State-Administered New Model Program

- Convened by non-hospital providers
- Like hospitals under GBR and CRP, conveners:
 - Must take downside risk
 - Would be responsible for some administrative costs after a year or two
- Targeted start date of July 2020
- At the outset:
 - Physician Group Practices (PGPs) could be a convener
 - Would begin with 3 episodes triggered in Hospital Outpatient Department (HOPD) mirroring BPCI-Advanced:
 - Back and neck (except spinal fusion)
 - Defibrillator
 - Percutaneous coronary intervention (PCI)

2. Update on Enhanced Episode Program (EEP), cont.

- Other issues:
 - State will need to calculate hospital spending and savings accounting for Maryland's unique hospital system (that is, Maryland's unique Rate Centers and GBR interactions)
 - Moving forward, State will need to develop policies for inpatient bundles that addresses these issues plus does not conflict with the hospital-convened CRP Episode Care Improvement Program (ECIP) and Hospital Care Improvement Program (HCIP)
- The State recognizes “clinical conversations” (that is, conversations with potentially participating clinicians) will be necessary on an ongoing basis to appropriately design 3 outpatient episodes, incorporate new ones in the future, and gauge provider interest in participation

Enhanced Episode Program Development Timeline



Legend:

MD

CMS

EEP Adm.

Key Dependencies and Durations:

Legal Approvals

- ICIP and PA Approval 9 months
- IP Approval 3 months

MAC Change Request (CR)

- Quarterly cycle
- CR Approval 1Y in advance

CMS RFA

- Open for 90 days
- Review 30 days
- F&A screening 90 days

Discussion

- Pros/Cons for two options for Non-Hospital Providers to Participate in New Models
 1. Be permitted to join national CMMI models; and/or
 2. Join New Model Program(s) designed and administered by Maryland

Next Meeting

April 15, 2019

8:00 - 10:00 a.m.

Maryland Hospital Association