Stakeholder Innovation Group

July 12, 2019

Maryland Hospital Association
Agenda

• Welcome and Introductions

• Update: Enhanced Episode Program

• Emergency Department Improvements in Care Transitions (EDICT) Payment Model

• CareFirst Value-Based Payment Strategy

• Post-Acute Care for Complex Adult Patients
STAKEHOLDER INNOVATION GROUP CHARGE

• Established Jan. 2018 at request of Maryland Health Secretary
• Stakeholder led, state supports staffing
• Initial focus areas:
  – Inventory transformation efforts
  – Identify high-opportunity strategies in support of population health and TCOC goals
  – Run stakeholder-driven process to propose payment model or population health improvement programs
The SIG is the primary forum to identify, discuss innovative ideas requiring State/Federal approval.

**Innovative Idea Process Flow:**

1. New Ideas

2A. SIG

2B. Operation Groups

State Staff (AID)

Key Points:
- Innovative ideas are brought to the SIG
- Ideas are enhanced through an iterative process
- When sufficient consensus is reached, ideas are sent for Secretary Vision Group (SVG) Review and Secretary approval

3. SVG Review

4. Secretary Approval
PROPOSED PAYMENT MODEL INTAKE FORM RECEIVING SUBMISSIONS

• SIG-approved submission form included on www.innovatehealthmd.org
• Submissions encouraged by Sept 2019 for Jan. 2021 performance period
• State offering technical assistance in advance of submission
• Upcoming SIG meetings will consider proposals

www.innovatehealthmd.org/payment
PAYMENT MODEL APPROVAL PROCESS

1. Submit payment model to Innovation website
2. State provides additional technical assistance
3. Considered by Stakeholder Innovation Group
4. Proposal shared with appropriate state agency or workgroup
5. Present proposal to Secretary’s Vision Group for approval
6. Concept approved for implementation/submission to CMS
Update on Enhanced Episode Program (EEP)

July 12, 2019
Enhanced Episode Program (EEP) Overview

- Maryland is developing a non-hospital convened episode-based payment program
- The State of Maryland will administer the program
- Program will be developed to have multiple tracks, each with specialty or clinical care specific grouped episodes
- Participants must accept downside-risk
- Examples of CMMI programs Maryland is considering for adaptation:
  - Bundled Payments for Care Improvement Advanced (BPCI-A)
  - Oncology Care Model (OCM)
  - Comprehensive ESRD Care (CEC) Model
Enhanced Episode Program (EEP), State-Administered New Model Program

- Conveners will aggregate risk across engaged providers/episode initiators:
  - Must take downside risk; risk pooling options available
  - Could be responsible for some administrative costs after a year or two
- Targeted start date of January 2021
- At the outset:
  - Physician Group Practices (PGPs) could partner with or be a convener
  - Would begin with 3 episodes triggered in Hospital Outpatient Department (HOPD) mirroring BPCI Advanced
- Provider-led reform: Working with SIG and provider groups to determine what additional track and episodes may be added
- Risk levels may be adjusted for providers who control larger/smaller portions of TCOC for the selected populations
- CMMI wants to change the name
EEP Builds on Prior Maryland Approaches

- Looks like hospital Care Redesign Program (CRP) and Medicare Performance Adjustment (MPA) in terms of waivers and payment flexibilities
  - Has some similarities to Maryland Primary Care Program (MDPCP) in terms of being a voluntary program for non-hospital providers who can opt for support from another organization (a Care Transformation Organization (CTO) in MDPCP)
- Amendment to TCOC Contract may make sense to clarify State-Federal roles, as with CRP, MPA, MDPCP
- Will require waivers from Medicare’s fee schedules to adjust non-hospital providers’ payments, as with hospital Global Budget Revenue (GBR) and CRP
- Provides new pathway to bring more non-hospital providers under risk- and value-based framework to:
  - Holding them accountable for Medicare TCOC and
  - Further align incentives across the care continuum
EEP’s Two 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
   - 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
2. **Episode Initiators**

- Do not sign PA with CMMI and State
- Medicare suppliers and providers 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
State is early in the design process, interested in talking with potential Conveners for 2021

- For potential follow-up, email tequila.terry1@maryland.gov (HSCRC Deputy Director for Payment Reform & Provider Alignment)
EMERGENCY DEPARTMENT IMPROVEMENTS IN CARE TRANSITIONS (EDICT) PAYMENT MODEL
PROPOSED PAYMENT MODEL
EVALUATION CRITERIA
Alignment models require different levels of effort to implement

- Innovative Ideas
  - Does not require federal flexibility (fund from GBR or other source)
  - National CMMI models (e.g., ACOs, BPCI-A)
  - Requires payment or waiver flexibility
    - Hospital based
    - Provider based
    - Care Redesign Program
    - New Model / Enhanced Episode Program

Level of Effort to Receive Approval
Reminder: Governance Summary for Consideration of Proposed Alignment Models

<table>
<thead>
<tr>
<th>Stakeholder Innovation Group</th>
<th>State Agencies</th>
</tr>
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<tbody>
<tr>
<td><strong>Purpose:</strong> Provide a forum for stakeholders to share input and assess innovative ideas that require State/Federal approval to implement</td>
<td><strong>Purpose:</strong> Evaluate innovative ideas that require State/Federal approval to implement to recommend to the Secretary and SVG</td>
</tr>
<tr>
<td><strong>Governance Model:</strong></td>
<td><strong>Governance Model:</strong></td>
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<tr>
<td>• Consensus-based</td>
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<tr>
<td><strong>Evaluation Criteria:</strong></td>
<td><strong>Evaluation Criteria:</strong></td>
</tr>
<tr>
<td>• Adapt from PTAC</td>
<td>• SWOT, TCOC, and Alignment Analysis</td>
</tr>
<tr>
<td><strong>Decision Points:</strong></td>
<td><strong>Decision Points:</strong></td>
</tr>
<tr>
<td>• SIG evaluates the extent to which proposed programs meet criteria:</td>
<td>• AID evaluates the extent to which the idea advances the goals of the State:</td>
</tr>
<tr>
<td>❑ Meets criteria and deserves priority consideration</td>
<td>❑ Advance to SVG</td>
</tr>
<tr>
<td>❑ Meets criteria</td>
<td>❑ Recommend for refinement</td>
</tr>
<tr>
<td>❑ Does not meet criteria</td>
<td>❑ Not recommended for implementation</td>
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Reminder: SIG Assessment Criteria for New Ideas Requiring State/Federal Approval

Assessment Criteria are modeled off of the federal Physician-focused Payment Model Technical Advisory Committee (PTAC)

<table>
<thead>
<tr>
<th>Assessment Criteria</th>
<th>Representative Assessment Points</th>
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</table>
| **Target Population**                | • Targets a patient population with high expenditures or high needs  
• Delivers care in way that reduces health disparities                                                                                                      |
| **Quality and Cost**                 | • Reasonable quality benchmark and goal(s)  
• Estimated ROI based on program administration costs and cost to conveners to participate                                                                     |
| **Value over Volume**                | • Strengthens accountability for a patient population  
• Incentives promote preventive care, population health, and/or public health                                                                                |
| **Payment Methodology and Flexibility** | • Builds upon existing payment mechanisms and/or attribution models  
• Provides flexibility to providers to delivery additional, high-value services  
• Feasibility of receiving requested waivers from CMS                                                                                                  |
Alignment, Implementation, and Design: Internal Assessment for State Agencies

The AID uses structured review tools to evaluate ideas and provide helpful feedback to the SIG and stakeholder groups as they refine the proposed ideas.

Part 1: SWOT Analysis

Part 2: Additional Analysis

| Alignment          | • TCOC Impact  
|                    | • State vision  
|                    | • Multi-payer expansion  
|                    | • State regulation or barriers that might need to be addressed for model to be most effective  
| Duplication        | • Other similar / competing programs  
| Unintended Consequences | • Negative cost, quality, or access impacts  
|                    | • Cost shifting  
|                    | • Impact on other payer’s rates or operations  
| Resource Requirements | • State investment  
|                    | • State ongoing maintenance  
|                    | • Additional state resources (or non-state resources) that might assist in model implementation  

AID: Feedback and Recommendation Decision

In order to effectively allocate state resources to models with the most potential, the AID will iterate with the SIG to evaluate and recommend which ideas move forward, which require additional work and where, and which models should not be pursued at this time.

AID Feedback and Recommendation

**Advance to SVG**
- Idea can be approved or approved conditionally with the expectation that certain design details would be updated.

**Recommend for Refinement**
- Idea is recommended to receive additional design refinements. State staff provide direction or pointed feedback to guide stakeholders.

**Not Recommended for Implementation**
- Idea is not recommended to receive additional state resources at this time due to serious design flaws or lack of legal authority, etc.
Emergency Department Improvements in Care Transitions (EDICT) Payment Model

Jesse Pines, MD
National Director of Clinical Innovation
US Acute Care Solutions
July 12, 2019
Objectives

• Broaden clinical scope of ED care
  • Post-acute care / coordination
• Provide ED physician incentives for value
• Focus: ED visits / admissions where pts can be cared for in outpatient settings
  • Care coordination may facilitate discharge / further ED visits
Two programs

• Efficient admission practices
  • Reduce variation in care/ dispo in conditions treatable as outpatients

• High-frequency ED use
  • Address social determinants via care plans
Program technology

• Hospital provides
  • Telehealth platform
  • Patient engagement program (i.e. technology platform for follow-up through email / text message)
Efficient admission practices

• Included diagnoses
  • Chest pain
  • Transient ischemic attack
  • Syncope
  • Congestive heart failure
  • Skin & soft tissue infections
  • Asthma/COPD
  • Deep vein thrombosis
  • Pneumonia
  • Atrial fibrillation
  • Hyperglycemia with diabetes mellitus
Efficient admission practices

- Patients eligible to receive
  - Telehealth follow-up call
  - In-home visit
Efficient admission practices

• Quality measurement / TCOC calculations
  • Narrower group where EDs have “control”
  • Exclude pts with ED visits within six months of index visit

• Exclusions for TCOC
  • ICU admissions
  • Direct OR transfers
  • Co-diagnoses that would necessitate hospital admission
    • E.g. sepsis, hypoxia, severe trauma
Efficient admission practices

• Post-discharge telehealth visit (@$100 per visit)

• In-home evaluation coordinated by ED (@$100/visit by ED physician; @$ 150/visit by home care provider)

• Information communicated with primary provider (@$1000 per year for any ED physician with >80% communication documented for eligible conditions)
Efficient admission practices

- Incentive payments from hospital’s global budget
- Additional shared savings (on top of global budget)
- Greater of the following two calculations:
  - The national 7-day risk adjusted TCOC for included populations (MINUS) the observed 7-day risk adjusted TCOC for included populations
  - A previous performance period’s 7-day risk-adjusted TCOC for included population (MINUS) the observed 7 risk adjusted TCOC for included populations
- Additional savings shared 50/50 by ED group/hospital
Efficient admission practices

- Quality / safety metrics
  - Utilization of evidence-based treatment protocols for conditions (>80% utilization)
  - Performing below risk-standardization 7-day return rates & mortality for each condition compared to national benchmark
Efficient admission practices

- Program monitoring
  - Case review of any 7-day returns and/or mortality and reporting of adverse events
  - Implementation of a patient engagement/experience program to identify early post-ED issues
    - (i.e. Unanticipated clinical decline, service issues)
Frequent ED users

• Identify / intervene where social determinants cause repeat ED use

• Included population:
  • Pt >= 4 ED visits at same facility within the previous 12 calendar months
Frequent ED users

• $300 incentive payment to ED physician for developing advanced care plan for eligible patients

  • In conjunction with primary care, case management

• Integrated into CRISP
Frequent ED users

• Post-discharge telehealth visit (@$100 per visit)

• In-home evaluation coordinated by ED (@$100/visit by ED physician; @$150/visit by home care provider)

• Information communicated with primary provider (@$1000 per year for any ED physician with >80% communication documented for eligible conditions)
Frequent ED users

• Incentive payments from the hospital’s global budget

• Additional savings available for bonus payment from the greater of the following two calculations:
  • The national 7-day risk adjusted TCOC for included populations (MINUS) the observed 7-day risk adjusted TCOC for included populations
  • A previous performance period’s 7-day risk-adjusted TCOC for included population (MINUS) the observed 7 risk adjusted TCOC for included populations

• Shared savings 50/50 for hospital / ED physician group
Frequent ED users

- Quality / safety metrics:
  - ED visit rates, hospitalization rates, and TCOC for individuals who eligible for this program over a 3-month period post-ED visits, compared the 3-months weighted average using the prior 12-months of data
  - 7-day hospitalization rates & mortality after the index visit
Program monitoring

• Case review of any 7-day hospitalization and/or mortality and reporting of adverse events

• Implementation of patient engagement program to identify post-ED issues and reporting of data
Payment Transformation Plan

Stakeholder Innovation Group Briefing

JULY 12, 2019
Agenda

A. CareFirst’s Five-Year Vision
B. Introduction of Value-Based Payment Models
C. Discussion
CareFirst’s Vision
CareFirst Five-Year Vision Statement

We want to fundamentally improve the healthcare system – by **leading thoughtful innovation** ourselves and **partnering with others** to drive change.

**Drive transformation** of the healthcare experience with and for our members and communities.

Our members and communities are our priority; we aspire to expand our impact to more **members and communities**.

We are dedicated to delivering a **distinctive experience** in ways that matter for our members and stakeholders, with a focus on **quality, equity, affordability, convenience, and access** to care.

We will be a **trusted partner** to our members, empowering them to lead their healthiest lives.
Introduction of Value-Based Payment Models
Multiple Models to Engage Major Provider Types

- **Primary Care Providers**
  - Patient-Centered Medical Home

- **Specialists**
  - Episode of Care Models

- **ACOs and Integrated Delivery Systems**
  - Total Cost of Care Model
Payment Transformation Model Design Principles

- **Build upon National experience**
  - HCP LAN
  - CMS
  - Other Blues

- **Enhance partnership between CareFirst and providers**
  - Collaborative design
  - Data exchange
  - Clinical care support programs

- **Reduce provider burden**
  - Align common measures wherever practical
  - Harmonious model design

- **Create meaningful incentives**
  - Performance recognition
  - Empowerment to change care processes
  - Incentives for Patient Experience and Outcomes
Payment Model Priority Areas

Initial efforts are focused on episodes of care for our most impactful specialties and an ACO population health model.

Percent of Cost by Specialty

- Orthopedic Surgery: 23%
- Obstetrics and Gynecology: 13%
- Gastroenterology: 8%
- General Surgery: 8%
- All Other: 48%
# Draft Model Episode Definition and Timeline

<table>
<thead>
<tr>
<th>Definition</th>
<th>ACO</th>
<th>Maternity*</th>
<th>Orthopedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total spend for all attributed members</td>
<td>Single birth maternity care including:</td>
<td>Select elective and appropriate orthopedic procedures</td>
<td></td>
</tr>
<tr>
<td>Antepartum</td>
<td>Delivery</td>
<td>Postpartum</td>
<td></td>
</tr>
</tbody>
</table>

| Timeline | Recurring annual cycle | 270 antepartum through 90 days postpartum | 30 days pre-op through 90 days post-op |

<table>
<thead>
<tr>
<th>Attribution</th>
<th>During previous 24 months:</th>
<th>Maternity episodes attributed provider who performs:</th>
<th>CareFirst members who experience a qualifying Episode of Care (EOC) during performance period will be included.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plurality of member claims attributable to an ACO PCP, specialist, or urgent care facility</td>
<td>Plurality of antepartum care</td>
<td>Delivery</td>
<td></td>
</tr>
<tr>
<td>Inpatient hospitalization at any ACO facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;1 visit to an ACO ED</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Member self-selected an ACO PCP</td>
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*Separate newborn model focused on first 30 days of life can run concurrently with maternity model*
Discussion
The Post-Acute Care for Complex Adults Program (PACCAP)

Proposed track addition to the Maryland Care Redesign Program (CRP) for 2020
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 and facilitate treatment in more appropriate settings
  - The cost of these interventions will come from the hospital’s global budgets

- 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
Executive Overview, cont.

- Level of hospital interest will determine final recommendation to Secretary Neall
  - July 12 meetings of SIG and CRP Steering Committee

- Pros
  - 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 Care Redesign 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
Potential Cons: Innovation Overload. Build it and hospitals don’t come. Effort

- Innovative Ideas
  - Does not require federal flexibility (fund from GBR or other source)
  - National CMMI models (e.g., ACOs, BPCI-A)
  - Requires payment or waiver flexibility
    - Hospital based
    - Provider based
      - Care Redesign Program
      - New Model / Enhanced Episode Program

Level of Effort to Receive Approval
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 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 lower 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
PACCAP Builds from the CMS INTERACT and other Clinical Care Models

- Hospital-SNF coordination models that allow hospital care management staff to round at SNFs have been shown to reduce unnecessary utilization
- Clinical staff and resources provide direct patient care and SNF support for patients with complex needs, e.g.:
  - When patients are admitted to the SNF, clinical staff may begin with an evaluation within 24 hours of arrival and continue with weekly clinical rounding
  - Resources can also be used meet specialized case management needs by providing support such as sitters or respiratory therapy
- Clinical staff perform tasks and build capacity of SNF/HHA-employed staff, e.g.:
  - Medication reconciliation, advanced care plans, SBRT, ADL screening
  - Hold weekly seminars on best practices on relevant topics
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
UPDATES AND NEXT STEPS
UPCOMING MEETINGS

• September 25, 9 - 11 a.m.
• October 22, 9 - 11 a.m.
• November 22, 9 - 11 a.m.
• December 16, 9 - 11 a.m.