STAKEHOLDER INNOVATION GROUP

November 22, 2019

Maryland Hospital Association
# MEETING AGENDA

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| Welcome, Introductions & Meeting Goals                     | Nicole Stallings  
Senior Vice President, Government Affairs and Policy, MHA |
| Updates                                                    | Chris Peterson  
Principal Deputy Director, Payment Reform and Provider Alignment, HSCRC  
Gene Ransom, CEO MedChi  
Nicole Stallings, MHA |
| -Episode Quality Improvement Program (EQIP) Subgroup        |                                                |
| -EMS Payment Model Subgroup                                 |                                                |
| Post-Acute Care Workgroup- Recommendations for SIG Engagement | Jinlene Chan, MD,  
Assistant Secretary, Department of Health  
Uma Ahluwalia, Principal, Health Management Associates |
| SIG Annual Progress Report to the Secretary’s Vision Group | Erin Dorrien  
Director, Policy, MHA |
EPISODE QUALITY IMPROVEMENT PROGRAM SUBGROUP

Chris Peterson, HSCRC
Gene Ransom, MedChi

Maryland Hospital Association
EMS PAYMENT MODEL
SUBGROUP

Nicole Stallings, MHA
PAC Workgroup Goals

**Issue:** Adults and youth in acute care settings (inpatient acute care or hospital emergency departments) with complex health conditions that make it challenging to be able to place in a lower level of care.

1. **To identify barriers** for appropriate and least restrictive placements for individuals with complex acute and sub-acute health and behavioral health needs within acute care settings.

2. **Develop protocols for discharging patients** with complex health and behavioral health needs as demonstrated by successful post-acute discharges to appropriate and least restrictive placements in the community.

3. **Identify resource needs** and take an innovative approach about how to build out an appropriate multi-disciplinary system of care and continuum of placement options for people in acute care settings needing to be discharged.
Overview of Workgroup Process

Needs and resource assessment
- Data gathering
- Identify significant barriers and gaps

Develop potential solutions
- Short, medium and long-term
- Financial, regulatory/policy, practice, infrastructure, partnerships
- Look at other care models

Prioritize solutions
- Impact and feasibility

Focused development and implementation of high priority solutions
System Schematic

Prevention & Diversion

- Improved management in lower levels of care
- More community placement options

Transition/Discharge

- Fewer readmissions
  - Improved discharge planning & care coordination
  - More community placement options
- Shorter lengths of stay
  - Higher acuity and complexity needs additional supports

Locations:
- Home
- Nursing Homes
- Assisted Living
- Residential Treatment
- Group Homes
## Barriers and Gaps

### Payers/Financing
- Payment and incentive structure
  - LTCF
  - BH services continuum
- Uninsured

### Providers
- Capacity, particularly specialized care
- Clinical Practice
  - Lack of coordination
  - More trained staff

### Patients
- Complex medical & behavioral needs
- Financial hardship
- Caregiver limitations
- Decision-making competency
Barriers & Gaps: Payer/Financing

Adults
- No payer for undocumented, uninsured after acute care
- Parity in benefits (esp. BH related) between public and private payers
- Medicaid:
  - Delays in AERS or PASRR evaluations and pre-authorizations for LTC
- Medicare:
  - Nursing home bundled payment structure is a disincentive to take high-cost patients (ex. With high-cost medications or BH diagnoses)
  - Little to no BH coverage in Medicare

Children & Transitional Age Youth
- Parity in benefits (esp. BH) between public and private payers.
  - Parents take children off their plan or use Voluntary Placement Agreements (VPA’s) to access public services
- Multiple funding sources for children’s services.
- Medicaid:
  - Need a more robust menu of effective evidence-based and evidence informed practices
  - Medical necessity criteria for transition age youth and young adults needs to be changed for better access.
Barriers & Gaps: Providers

Adults

- No coordinated discharge protocols for patients already known to state/local agencies
- Need for confidential sharing of patient information among community providers and key agency staff.
- Need for crisis or mobile crisis 24/7
- Need for increased specialized bed capacity, both residential and community-based.
- Shortage of BH workforce

Children & Transitional Age Youth

- Referral protocols needed for patients already known to state/local agencies and may need more services.
- Need for confidential sharing of patient information among community providers and key agency staff.
- Need for crisis or mobile crisis 24/7 for youth.
- Need for increased specialized bed capacity, both residential and community-based.
Barriers & Gaps: Patient Population

Adults

- Need for guardianship or decision-making
- Dialysis patients with complex health or medical issues are turned away (esp. bariatric and those with behavioral issues)
- Behavioral health patients in need of nursing facility level of care are denied admission.
  - Aging population, with dementia
- Autism Spectrum Disorder (ASD)
- Brain Injury—associated behaviors present challenges for rehabilitation
- Homeless individuals with medical needs do can cycle back to hospitals.

Children & Transitional Age Youth

- Autism Spectrum Disorder (ASD)
- Youth (+/- state custody) with a history of:
  - Highly aggressive behaviors
  - Victims of human trafficking
  - Sex offenders, fire-starters
PAC Workgroup Priority Strategies/Service Types

• Tier 1 & 2 strategies identified (handout)
• Many different types of services identified to strengthen the state’s continuum of care:

**Adults**
- Brain Injury rehabilitation
- Skilled nursing with:
  - Greater behavioral health capacity
  - Greater Alzheimer’s/dementia care capacity
- ACT teams
- Mobile integrated health services with EMS, hospitals, primary care
- Certified Community Behavioral Health Clinic (CCBHC)
- Behavioral health urgent care clinics
- Dialysis services for complex patients
- Medical beds in homeless shelters

**Children & Transitional Age Youth**
- Residential Treatment Centers with service specialization
- High-intensity Therapeutic Group Homes
- Community-based outpatient services for children
- Respite services
- Early childhood mental health services

**BOTH**
- Neurobehavioral inpatient psychiatric units
- Residential Rehabilitation Programs (RRPs)
- Mobile crisis teams
Current Work/Initiatives (known)

- Behavioral Health system needs
  - Lt. Governor’s Behavioral and Mental Health Commission
  - HGO Behavioral Health Solutions workgroup
  - Medicaid ‘System of Care’ financing discussion

- PAC Workgroup discussions
  - Initial coordination protocol development
  - PACCAP model development (HSCRC/SIG)
  - Dialysis conversation (assisted by Kidney Disease Commission)

- Brain injury (on-going conversation with UM-ROI, WMHC, BIA, others)
- Quality Services Reform Initiative (QSRI—DHS, UMD-SSW)
- Others?
Highest Priority Strategies/Service Types

Of all Tier 1 and 2 strategies, the SVG identified the following priorities:

- **Guardianship**: Streamline adult guardianship process (Aging, DHS, Courts)
- **Referral protocol**: Build out a patient referral protocol with timeframes & accountability across the care continuum
- **BH Capacity**: Address the need for greater capacity along the behavioral health continuum
  - Focus on youth-specific services (crisis, therapeutic group homes, RTCs, etc.)
- Specialized care for people with brain injury
- Non-emergent care for bariatric patients
Discussion

- What strategies would you prioritize?
- What scope could the SIG take on within this strategy?
Next Steps

For the high priority area(s), SIG sub-committee would convene to further develop strategies:

1) Identify specific data needs and sources (HSCRC, CRISP, others)

2) Key strategy development within these areas:
   - Policy/regulatory changes
   - Financial models (ex. use of public-private partnerships/funding)
   - Clinical practice models
   - Infrastructure needs (ex. capital or IT)
   - Key partnerships
ANNUAL SIG PROGRESS REPORT TO THE SECRETARY’S VISION GROUP

Erin Dorrien, MHA
STAKEHOLDER INNOVATION GROUP

• Industry led, state supports staffing
• Initial charge:
  – 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
• Submit annual report to Secretary’s Vision Group outlining progress and recommendations
SIG ACCOMPLISHMENTS SINCE 2018 REPORT

- Created platform to capture innovations
- Reviewed models and waivers to determine alignment with model goals
- Expanding tools available to align payment incentives
- Increasing opportunities for a new payment models with non-hospital conveners

Stakeholder Innovation Group

Progress Report

This progress report of the State of Maryland Health Secretary, highlights recommendations for all stakeholders.

Three overarching themes emerge:
- Innovation is happening more than 200 subcommittee initiatives and promote.
- Additional tools will be insufficient to achieve model.
- New tools will be required.

Success requires a wide utilization as much as critical. While health care and well-being is a commitment from non-partisan providers.

Carrying out the initial recommendations, the group proposed to further support the final goal.

Stakeholder Innovations

From February 2019 to April 2019

- Creating an inventory
- Developing work
- Analysing the risks
- Identifying high-impact
- Selecting data and factors to be considered
- Developing initial test
- Current implementation

Next Steps

Based on these recommendations, the key requests the following actions:

- The Secretaries’ Vision Group should endorse an effort to create a third track under the Care definition metamodel after the federal IMI-advanced program
- The health services cost review commission should work with stakeholders and CMS to gain approval of IMI-Alliance with hospital convenors, with a January 2020 launch

Next Steps for the Stakeholder Innovation Group

The big recommendations have been contained in the final draft and should not be seen as definitive or complete.

The work of provider alignment will need to continue beyond the scope of the SIG and should be focused on flexibility and innovation. In the coming months, the group will continue to promote submissions to the innovation inventory and support the planning for the innovation summit.
CREATED PLATFORM TO CAPTURE EXISTING INNOVATIONS

INNOVATIONS FOR BETTER HEALTH

Spreading Innovations in Health Care Delivery

This website, endorsed by Maryland's Stakeholder Innovation Group, offers a glimpse at how many of Maryland's health care providers and community organizations are working together to improve care delivery.

We urge you to use this site to share innovative programs and practices that improve the health of Maryland's communities.

Learn More

County Served
Target Population
REVIEWED MODELS AND WAIVERS TO DETERMINE ALIGNMENT WITH MODEL GOALS

STATE AND FEDERAL INITIATIVES

• Maryland Primary Care Program
• EMS models
  – Treat in place
  – Alternative destination
  – Mobile integrate health
• Statewide Integrated Health Improvement Strategy
  – Regional Partnerships
  – Diabetes Action Plan
  – Behavioral Health
• Federal Kidney Disease Models

PAYER-LED INITIATIVES

• Medicaid Diabetes Prevention Program
• CareFirst Value-Based Payment Model Priorities
  – Total Cost of Care: ACO
  – Bundles: Orthopedic, Maternity, GI and General Surgery
EXPANDING TOOLS AVAILABLE TO ALIGN PAYMENT INCENTIVES

• Developed and launched Episode Care Improvement Program
  – 16 hospitals participating
  – Multiple surgical and medical episode, increasing in 2020
  – Diverse care partners, increasing in 2020
• Secured waiver to allow nurse practitioners to write home health orders
• Approved framework for Post Acute Care for Complex Adult Patients (PACCAP) for Jan. 2021 launch
• HSCRC continues to encourage Maryland participation in national models
• CRISP developed standard data reports for skilled nursing facilities
• MIEMSS and MHCC supported applicants for CMS’ EMS payment model
INCREASED OPPORTUNITIES FOR NEW PAYMENT MODELS WITH A NON-HOSPITAL CONVENER

- Informed Episode Quality Improvement Program (EQIP) framework
- Established process for submission of stakeholder payment proposals and received proposals from:
  - Physicians
  - Behavioral health providers
  - Post-acute care providers
DISCUSSION: OPPORTUNITIES TO REFOCUS TO SUPPORT MODEL SUCCESS

- Continue EQIP and EMS Model subgroups
- Continue to capture new ideas for payment models, innovative partnerships
- Assign progress on “Post-Acute Care Workgroup” recommendations; develop subgroups
- Consider changes to meeting timing, membership aligned with 2020 focus