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Care Transformation Steering Committee

March 18, 2022

Agenda

- Future of CRP
- Review of CTI Program
- Application Process for CTI

CRP Survey

CRP Survey Background

CMS has pressed the State to explain the utility of the CRP for hospitals. We believe this reflects:

- A concern about the administrative burden of administering the CRP
- A concern that physicians that receive QPP status are meaningful engaged in partnerships with hospitals.

The State asked hospitals to participate in the CRP survey, in order to better inform our conversations with CMS.

- The objective of this survey was to explore the extent to which hospitals support care partners in ECIP and HCIP.
- Survey questions focused on supports hospitals are currently providing or plan to provide to care partners (aside from sharing incentives).
- The results of this survey will be used to inform decision making on the continuation of ECIP and HCIP and CRP waivers.
- A total of 15 health systems completed the survey.

Key Insights

- All responsive hospitals offer a variety of care transformation resources to providers. Hospitals began sharing resources with providers as early as 2011, with most resource sharing beginning in 2019.
- The top provider types hospitals offer resources to include: Physicians, Clinical Nurse Specialists or NPs, Physician Assistants, Hospitals, and SNFs.
- **Most providers do not offer resources only to ECIP certified care partners.**
- Most providers offer resources regardless of provider/patient participation in ECIP and providers' employment status with the hospital/health system.
- **Most hospitals find the waivers to be critical to offer care transformation resources.**

Question 7

Do you offer the resource regardless of providers' employment status with your hospital or health system (Yes/No)?

Answer Choices	Responses	
Yes	92.86%	13
No	7.14%	1

*One hospital skipped this question

Question 9

Are the CRP waivers critical, incidental, or unnecessary for you to offer this resource?

Answer Choices	Responses	
Critical	57.14%	8
Incidental	35.71%	5
Unnecessary	7.14%	1

*One hospital skipped this question

Conclusion

Based on the results of the survey:

- We believe hospitals do not require waivers to support the majority of care transformation supports.
- However, a select few hospitals' resource sharing is supported by federal waivers.

Therefore, we are considering:

- Requiring that all participants in ECIP share either a) Incentive Payments to physicians; OR 2) more than a nominal amount of care management staff, etc.
- Ending HCIP, giving limited participation by hospitals.

Stakeholder Comments Welcome…

We do not understand what resources sharing would be prohibited by the absence of the waiver. We would benefit from additional information on:

- Examples of resources are provided under ECIP that could not be provided without the Waiver.
- We need specifics. The hospital providers W to X partners for Y hours a week at a cost of $Z.
- Please send examples to willem.daniel@maryland.gov.

HSCRC Remains Committed to CRP

The HSCRC worked with CMS to create CRP so that hospitals would have the flexibility to make incentive payments to physicians similar to the ACOs. We remain committed to supporting CRP.

- CRP has been a valuable tool for hospitals beginning their transformation efforts.
- CRP is necessary to support EQIP.

We will continue to work with hospitals to create CRP Tracks. We will create CRP Tracks covering any patient population that the hospital is interested in. But before we submit a CRP Track to CMS, we need:

- Hospitals that are willing to make incentive payments to their care partners OR share a more than nominal amount of resources with their Care Partners.
- Between 6 – 8 hospitals that are willing to participate.

Overview of CTI Process Methodology

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Overview of the CTI Process

The CTI Application process for Year 2 is now open.

- Hospitals will need to use the CRISP tool to create a CTI process.
- We credentialled hospital users as a point of contact. These users can create new CTI.
- Please reach out to us or CRISP if you have questions creating a CTI.

During the application process, it is now possible to estimate the number of beneficiaries prior to submitting their CTI.

- We **highly** recommend that hospitals use that feature.
- The majority of questions come from hospitals that expected to have more beneficiaries attributed to them.
- If hospitals have questions we will work with them to better understand their population.

It is not required to create and/or change a CTI. Existing CTI will be rolled over to the next year unless it is changed.

Step 1. Determining Baseline Period Costs

Step 1.A. Determining the CTI Eligible Population

In order to be included in a CTI, the beneficiary must be enrolled in both Medicare Parts A and B during the year AND the beneficiary must have a Medicare as a primary payer.

Additionally, beneficiaries will be removed if:

- The beneficiary is receiving services for End-Stage Renal Disease
- The beneficiary dies during the CTI episode
- The beneficiary is diagnosed with COVID

These criteria are optional. Hospitals may request to include those beneficiaries in their CTI population.

Step 1.B. Identifying Selected CTI Beneficiaries

CTI Eligible Population

- CTI eligible beneficiaries must be in Medicare parts A and B.
- Beneficiaries with ESRD, COVID, or death are excluded.

Apply CTI Trigger

- Each thematic area has a claims-based “triggering condition.”
- Any beneficiary that has a service meeting the triggering condition is eligible to be included in the CTI.

Hospital Selected Criteria

- The hospital may select beneficiary criteria that are included in the CTI.
- Beneficiaries that do not meet the hospital-selected criteria will be excluded.

Example of Exclusion Criteria

Description	Potential CTI Episodes	Percent of Potential
July 2017 through June 2018 - Short Term Claims	7,232	100%
Satisfying Continuous Enrollment	6,589	91%
After overlap exclusions(within episode)	5,128	71%
After ESRD and Death exclusions	4,666	65%
After excluding First PAC (SNF and Home Health)	3,112	43%
After Other Payer exclusions - (PRPAYAMT > 0)	2,955	41%
After Event Run-out exclusions	2,907	40%
After Overlap Restriction	2,907	40%

Step 1.B. Identifying Selected CTI Beneficiaries

Each CTI “Thematic Area” has a claims-based triggering condition. Any beneficiary meeting the triggering conditions may be included in the CTI.

The triggering conditions are:

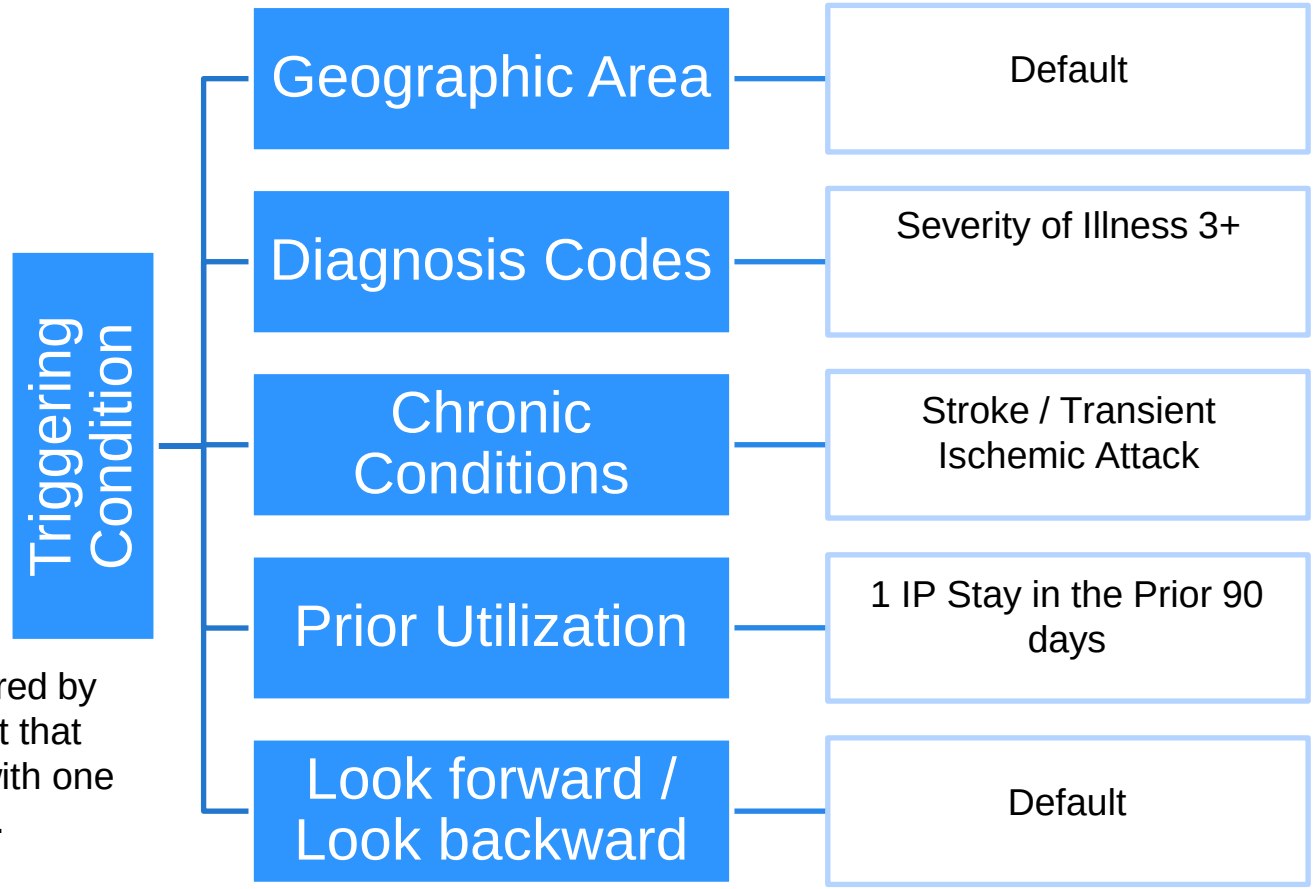
Care Transitions	Emergency Care CTI	Palliative Care CTI	Episodic Primary Care	Panel-Based Primary Care	SNF Based Primary Care	Geographic Primary Care
• Triggered when a beneficiary is discharged from an Acute Care Hospital.	• Triggered with a beneficiary is admitted to the ED. • Hospitals can choose: A) only ED events leading to a hospitalization; B) only ED events leading to an Inpatient Stay; C) any inpatient visit.	• Triggered when a beneficiary is discharged from an Acute Care Hospital **AND** the beneficiary had a claim submitted by the listed NPIs. • Requires the hospital to identify the NPIs.	• Triggered when the beneficiary has a claim with the primary care NPI. • Requires the hospital to identify the NPIs.	• Triggered when the beneficiary received the plurality of their primary care services **over the prior two years** from the listed NPIs. • Requires the hospital to identify the NPIs.	• Triggered when the beneficiary receives a service with the facility NPI. • Requires the hospital to identify the NPIs.	• Triggered **at the start of the year** when the beneficiary resides in the zip codes. • Requires the hospital to identify the zip codes.

Step 1.B. Identifying Selected CTI Beneficiaries

Hospitals can select a subset of the eligible population by choosing the CTI selection parameters. A beneficiary will be included in the CTI if they meet **both** the triggering condition and the selection parameters.

Age	Service Area	Diagnosis	Chronic Conditions	Prior Utilization	Look Forward / Look Backward
• The hospital may indicate an age range for the included beneficiaries. All beneficiaries outside of this range will be excluded.	• The hospital may submit zip codes as a residency requirement. Only beneficiaries that reside in these zip codes are included.	• The hospital may submit DRGs or ICD diagnosis codes. Only beneficiaries with one of those codes are included.	• The hospital may submit a list of chronic conditions. Only beneficiaries with those conditions will be included.	• The hospital may specify a number of prior hospitalizations. Only beneficiaries that have received that number of hospitalizations will be included.	• The hospital may specify events that happen before or after the triggering event (such as being discharge to a SNF). Only beneficiaries that have those events will be included.

Step 1.B. Identifying Selected CTI Beneficiaries



The CTI is triggered by an Inpatient Visit that includes a claim with one of the NPIs.

This CTI is triggered by an inpatient stay with a SOI of 3 or 4 and a claim with one of the NPIs.

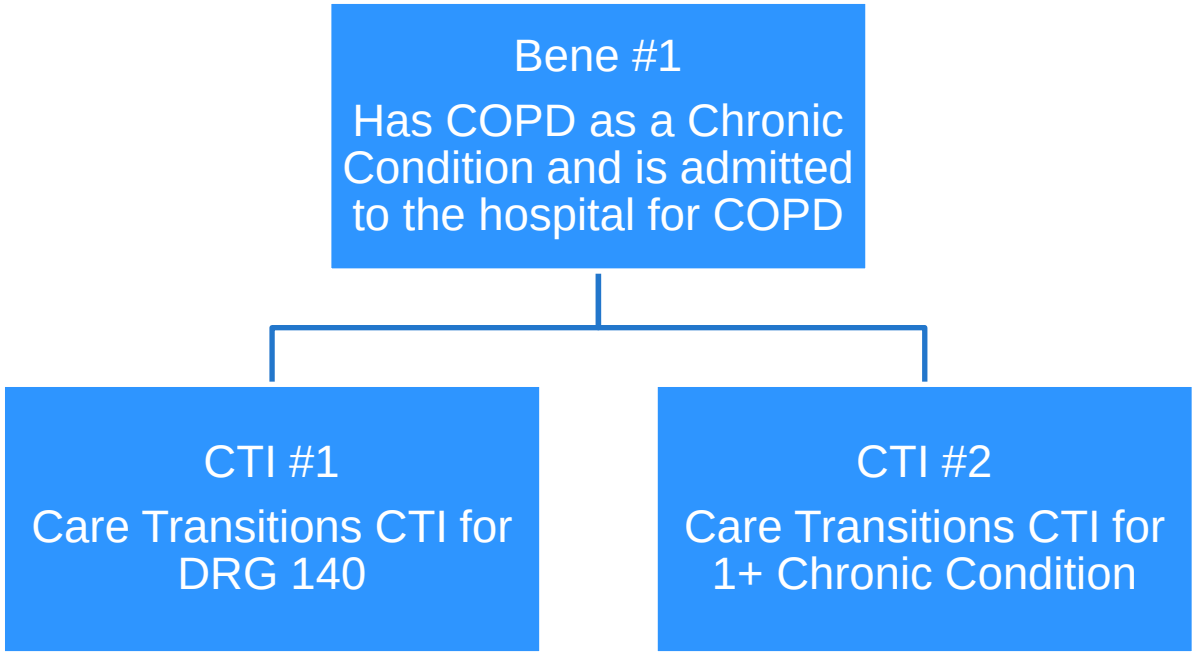
Only beneficiaries with chronic conditions flag for Stroke / Transient Ischemic Attack, and at least one hospitalization in the prior 90 days.

Step 1.C. Exclude Overlaps

Certain CTI episodes that overlap with another CTI will be excluded. The treatment of the overlaps depends on where and when the CTI is triggered.

- Definitional Overlaps – CTI episodes that meet two different triggering conditions **at the same hospital & on the same day** will be assigned to only one of the CTI, depending on the hospital's preferences.
- Episodic Overlaps – CTI episodes that meet two different triggering conditions **at the same hospital on different days** will be assigned to the CTI that occurred first.
- Inter-hospital Overlaps – **Any CTI that overlaps between two different hospitals will be allowed.** The CTI will be counted towards both hospital's CTI.

Step 1.C. Exclude Overlaps



This is a case of definitional overlap.

- Both CTI #1 and CTI #2 are triggered by an inpatient stay and the beneficiary meets the selection criteria for both CTI.
- The beneficiary will be attributed to one of the two CTI based on the hospital's preference.
- Hospitals can set a hierarchy for which CTI will be prioritized. E.g. if CTI #1 is prioritized then it will receive the bene and CTI #2 will not.

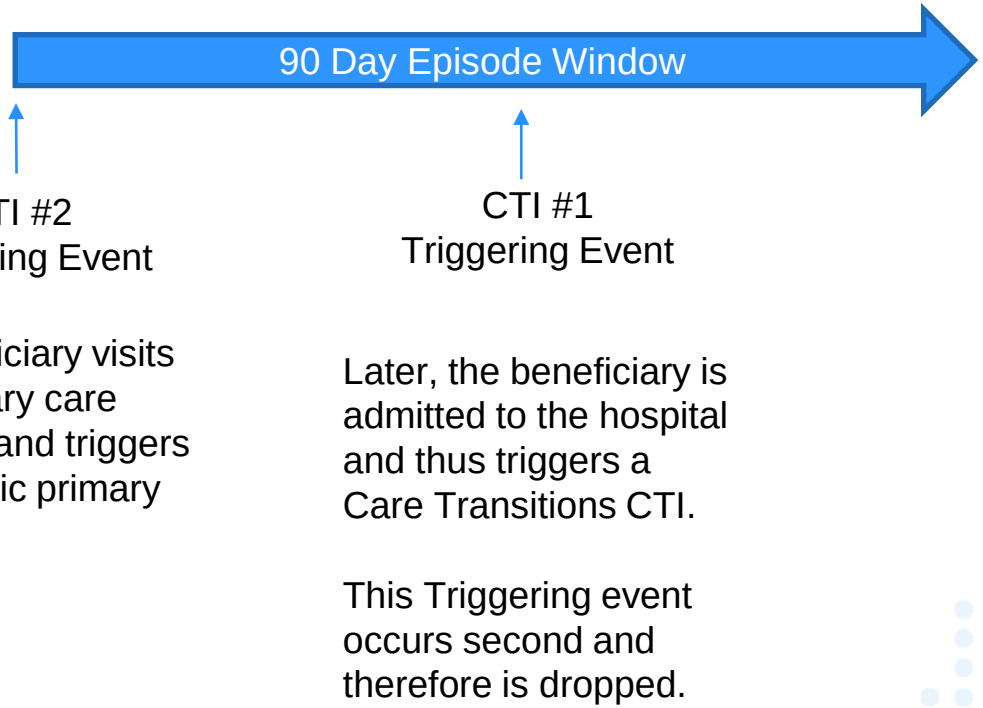
Step 1.C. Exclude Overlaps

The hospital is participating in two CTIs.

- CTI #1: Care Transitions for any beneficiary with COPD.
- CTI #2: Episodic Primary Care for any beneficiary with COPD.

A beneficiary with a COPD who has both an IP stay and an PCP visit would be eligible for both CTI.

The beneficiary will be attributed to the first CTI that occurs.

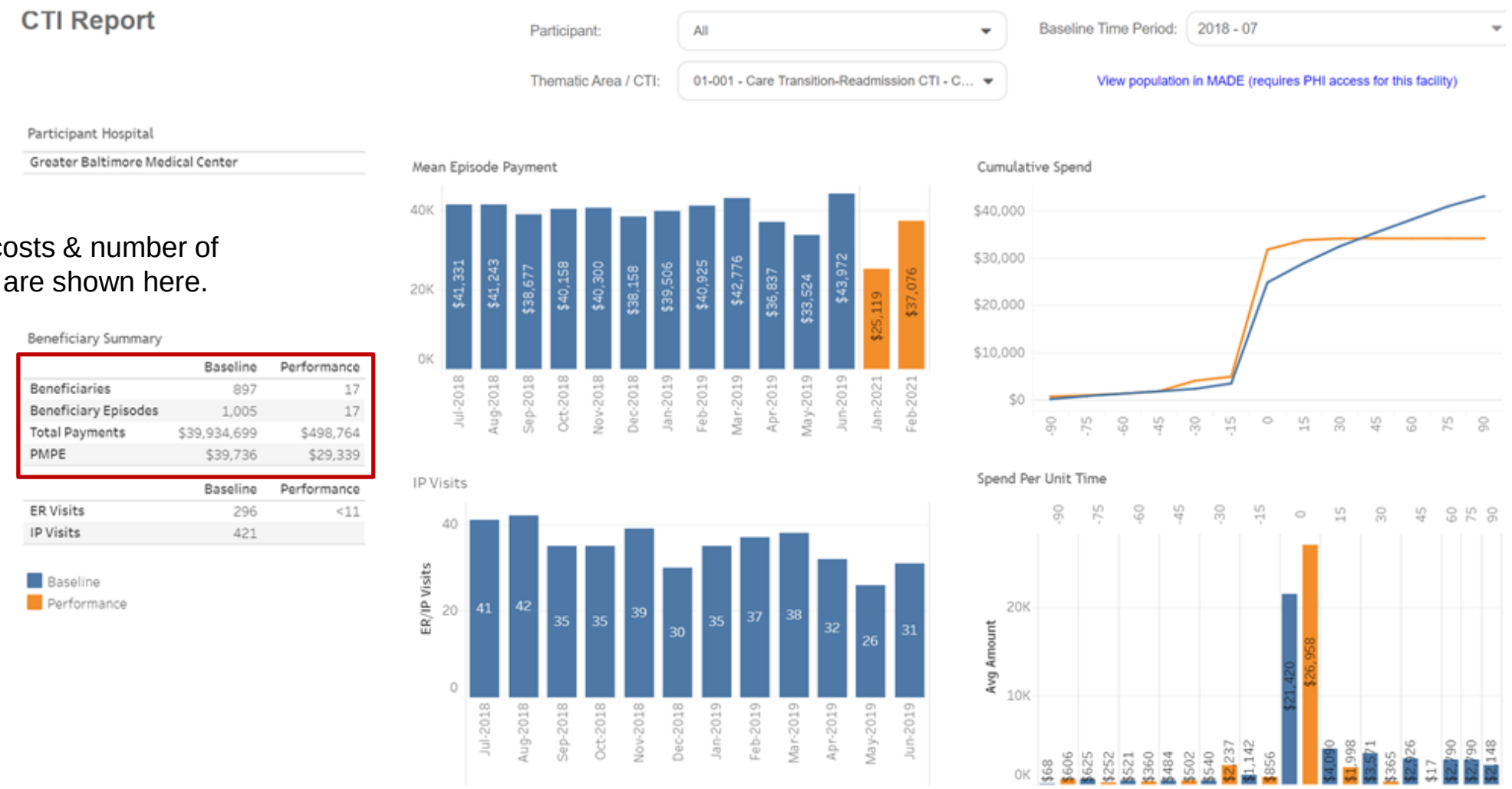


Step 1.D. Determining Baseline Costs

Each beneficiary that is included in the CTI triggers an episode lasting for some number of days after the triggering event. The length of the episode is determined by the hospital.

- All Parts A and B costs that occur within the episode are included in the CTI, except for the noted exclusions.
- Any claim that meets the following condition will be excluded:
  - Part B payments for drugs on the average sales price (ASP) list
  - Blood clotting factor, identified by HCPCS J7199
  - Inpatient claims for hemophilia and clotting factors
  - Pass-through payments for medical devices in OPPS hospital claims
  - Claims that represent per-beneficiary-per-month (PBPM) payments for hospice claims
- Some claims have service dates that last for multiple days.
  - These claims are prorated based the proportion of the claim that falls inside of the episode window.
  - For example, a 60-day SNF claim where 20 of the days fall within the episode window would contribute 33% of the cost to the episode.

Step 1.D. Determining Baseline Costs



Baseline costs & number of episodes are shown here.

* Note that costs are shown in current year dollars after inflation (described in the next step) is applied.

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Step 2. Setting a Target Price

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Step 2.A. Inflation

The baseline costs will be inflated to make them comparable to current year costs. All data in the CTP are shown in current year dollars. The inflation process takes one of two forms:

- Unregulated costs are inflated using the CMS update factors for the appropriate settings. For example, physician costs are increased by the growth rate in the Physician Fee Schedule between the baseline costs and the performance year.
- Regulated costs are inflated using a three-step process:
  - Regulated charges are standardized using standard CMS methodology
  - Standardized charges increased by the HSCRC Annual Update Factors between the baseline and performance period.
  - The updated charges are translated back into actual dollars using the original ratio of actual charges to standardized charges.

The inflation process for the regulated costs is designed to hold hospitals harmless for any price fluctuations caused by utilization changes under the GBR.

*Note: The inflation update for regulated costs is in progress and note reflected in the CTP. The regular inflation process was used that includes the GBR price effect.

Step 2.B. Risk Adjustment

All costs in the CTI are adjusted based on the risk of the population. The risk adjustment process involves two steps:

- Regression Analysis
- Risk Adjustment

In the regression analysis, we determine the relationship between the CTI episode costs and the risk score.

- This is necessary because the CTI population tends to cluster towards the tails of the risk distribution.
- The regression analysis uses the statewide population that meet the selection criteria applied by the hospital for that CTI.

The risk adjustment regression is used to set a preliminary target price for the hospitals CTI:

- The average risk score for the CTI population is multiplied by the coefficient from the regression analysis.
- The preliminary target price is thus equal to hospitals baseline costs restated using the statewide relationship between the CTI episode costs and the risk score.

Step 2.B. Risk Adjustment

The preliminary target price **will change** by the end of the performance period.

- The final target price will be updated based on the final risk score of the CTI population in the performance period.
- The risk score of the population in early months of the performance period may have different risk profiles. Hospitals are encouraged to be cautious about comparing early performance data to the target price.

			Baseline				Performance			
Convening Entity	Thematic Area	CTI Name	Episodes Initiated	Total Payments	Preliminary Target Price	Preliminary Aggregate Target Price	Episodes Initiated	Total Payments	Preliminary Target Price	Preliminary Aggregate Target Price
Greater Baltimore Medical Center	Care Transitions	01-001:Care Transition-Readmission CTI - Chronic Conditions	1,005	$39,934,699	$39,555	$39,753,133	17	$498,764	$39,555	$672,441
Grand Total			1,005	$39,934,699	$39,555	$39,753,133	17	$498,764	$39,555	$672,441

Note: Early performance data will have incomplete claims runout.

Step 3. Calculating CTI Savings

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Step 3.A. Comparing the Target Price with Performance Costs

CTI savings will be calculated by comparing the target price with the performance period costs.

- The savings can be calculated by simple subtraction (see the example below).
- Note that the final target price will be restated using the risk score in the performance period population.
- The final target price will not be known until after the performance period is over.

			Baseline				Performance			
Convening Entity	Thematic Area	CTI Name	Episodes Initiated	Total Payments	Preliminary Target Price	Preliminary Aggregate Target Price	Episodes Initiated	Total Payments	Preliminary Target Price	Preliminary Aggregate Target Price
Greater Baltimore Medical Center	Care Transitions	01-001:Care Transition-Readmission CTI - Chronic Conditions	1,005	$39,934,699	$39,555	$39,753,133	17	$498,764	$39,555	$672,441
Grand Total			1,005	$39,934,699	$39,555	$39,753,133	17	$498,764	$39,555	$672,441

Note: Early performance data will have incomplete claims runout.

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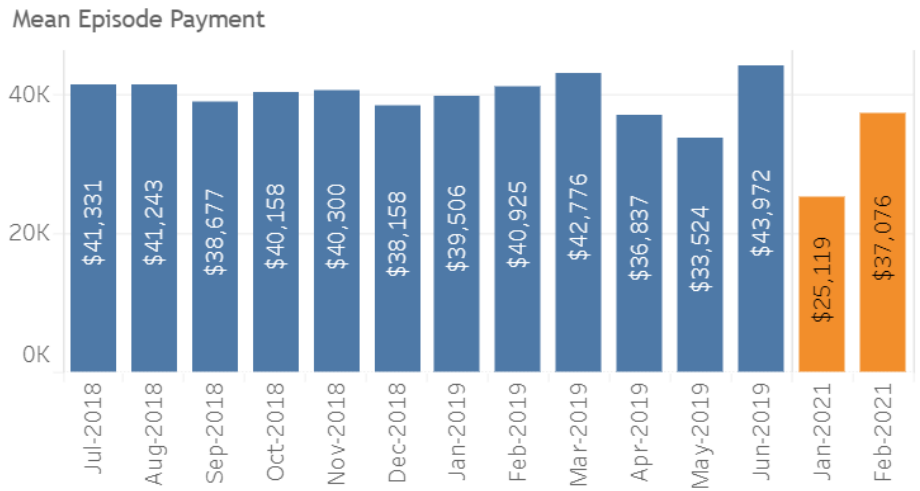
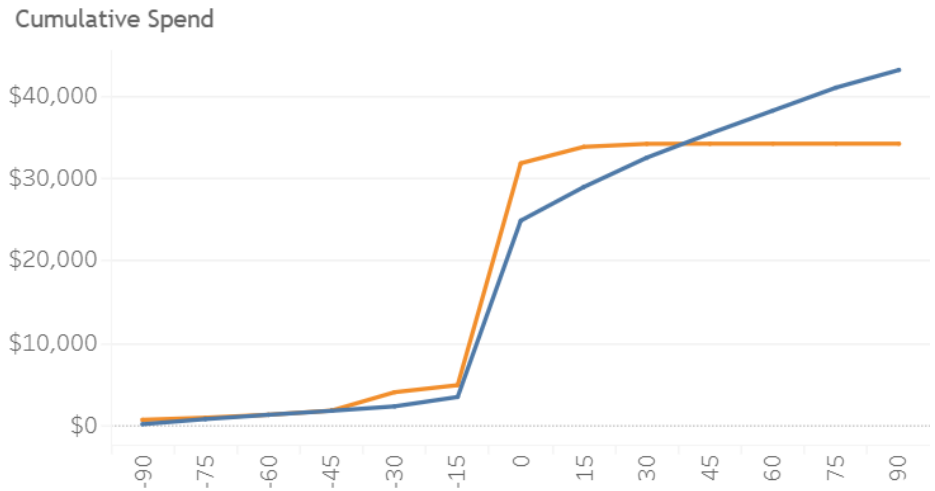
Step 3.A. Comparing the Target Price with Performance Costs

The data hospitals receive is “real time.” This means that the data hospitals receive is affected by two types of runout:

- Episode runout – Hospitals begin receiving data before the episode is over so costs will increase as the episode completes.
- Claims runout – Claims take some time to be submitted and processed. Costs will increase over time as a result.

The CTP will include the option to view only completed episodes / view all episodes. This will be added once there are completed episodes.





This chart shows time since the episode triggering event. The line is flat there is no data that far beyond the triggering event.

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Step 3.B. Minimum Savings Rate

In order to receive a CTI payment, the hospital's CTI savings must be greater than the minimum savings rate.

- The CTI savings percentage are equal to the performance period costs / final target price.
- The minimum savings rate is based on the number of episodes in the CTI.
- The CTI savings differ based for hospital-based CTI versus all other CTI.

Minimum Savings Rate	Setting Specific CTI	Community Triggered CTI
1.0	> 8977	> 19655
1.5	3991 - 8977	8736 - 19655
2.0	2246 - 3990	4916 - 8735
2.5	1441 - 2245	3146 - 4915
3.0	1001 - 1440	1286 - 3145
3.5	731 - 1000	1606 - 2185
4.0	561 - 730	1231 - 1605
4.5	441 - 560	971 - 1230
5.0	361 - 440	791 - 970
5.5	301 - 360	651 - 790
6.0	251 - 300	551 - 650
6.5	210 - 250	466 - 550
7.0	181 - 210	401 - 465
7.5	161 - 180	351 - 400
8.0	141 - 160	311 - 350
8.5	126 - 140	270 - 310
9.0	111 - 125	246 - 270
9.5	101 - 110	221 - 245
10.0	91 - 100	201 - 220
15.0	< 90	< 200

Step 3.B. Minimum Savings Rate

The minimum savings rate for the CTIs will be evaluated sequentially using the following algorithm:

1. CTI will be ranked according to how much they exceeded the required savings
2. Starting from the highest saving CTI:
    1. The total savings will be added together and compared to the sum of the required savings
    2. If the total savings exceeds the total required savings, then another CTI will be added
    3. If not, the hospital earns the total savings from all the combined CTI

This allows the savings from one CTI to roll over to another CTI. In other words, a CTI that ‘saved big’ can boast a CTI that barely missed the minimum savings rate.

Step 3.B. Minimum Savings Rate

CTI	# Episodes	TCOC	MSR	Required Savings	Actual Savings	Difference	Cumulative TCOC	Required Savings	Cumulative Savings
CTI #3	275	$6,300,000	6.0%	$378,000	$485,000	$107,000	$6,300,000	$378,000	$485,000
CTI #6	315	$600,000	5.5%	$33,000	$35,000	$2,000	$6,900,000	$411,000	$520,000
CTI #1	260	$5,000,000	6.0%	$300,000	$292,000	-$8,000	$11,900,000	$711,000	$812,000
CTI #4	500	$10,500,000	4.5%	$472,500	$375,000	-$97,500	$22,400,000	$1,183,500	$1,187,000
CTI #5	260	$3,000,000	6.0%	$180,000	$50,000	-$130,000	$25,400,000	$1,363,500	$1,237,000
CTI #2	400	$9,800,000	5.0%	$490,000	-$200,000	-$690,000			

Step 3.C. Determining the Statewide Offset

Hospitals will earn an adjustment to their MPA based on their performance relative to their peers.

- Hospitals earn savings equal to the amount by which their CTI performance exceeds the MSR.
- The sum of statewide CTI savings will be multiplied by the hospital's share of statewide hospital revenue.
- Hospitals earn the net of the two adjustments.

Example: Hospital A is 10% of the overall hospital revenue. It earns $12 million in CTI savings. Statewide savings are $100 million. Hospital A earns an MPA adjustment equal to $12 million - $10 million = $2 million.

Step 3.C. Determining the Statewide Offset

All performance data is released in real time through the CTP.

- Hospitals can track how each other are doing in order to assess the excepted magnitude of the statewide offset.
- Caveats about the claims runout and final target prices apply.

Hospital that want to estimate the magnitude of the their savings **MUST** look at completed episodes.

- For example, including incomplete episodes suggests that the savings offset will be $1.2 billion.
- Looking at completed episodes suggests that the savings will be $1.6 million.

A retrospective analysis of the observation period suggests that the total offset would have been about $26 million, if effectuated.

Reminder: CTI Application Process is now Open

Hospitals may submit new CTIs.

- Please use the CRISP portal to do so.
- Please reach out to CRISP with any question.

Hospitals are not required to submit a new CTI. Existing CTI will roll over to the next period.

Appendix: CRP Survey Questions and Responses

Question 1

Do you offer any of the following care transformation resources to providers (Yes/No)?

- Care management services.
- Community health worker or navigator services.
- 24/7 provider support to coordinate/direct patient care.
- Standardized protocols or care pathways.
- Coordination/communication with post-acute care providers.
- Interdisciplinary team meetings or rounds.
- Patient/family education.
- Medication reconciliation or medication therapy management.
- Remote patient monitoring.
- Other

Answer Choices	Responses
Yes	100.00%
No	0.00%

Question 2 Cont'd

If Yes, please briefly describe.

Care Transformation Resource Type	Hospital Specific Examples
Care management services	○ Post-Acute Care Team SNF program ○ Patient Care Management team which includes Social Workers, Discharge Planners, Nurse Navigators and Community Health Workers that meet with the Interdisciplinary team daily for discharge planning ○ Contracted care management services (includes CHWs) to practices that participate in the Maryland Primary Care Program ○ Diabetes Prevention Program
Community health worker or navigator services	○ Community health workers who support patients after admission to establish care in their community ○ Addressing social determinants of health ○ Mobile integrated community health program ○ Community health mobile van to support vaccinations, cancer screenings, etc.
24/7 provider support to coordinate/direct patient care	○ Access to RN, Social Workers, and Respiratory Therapy
Standardized protocols or care pathways	○ Collaboration with ECIP Care Partners to utilize standard care protocols and care pathways to ensure highly reliable care ○ HF pathways, disease specific Epic order sets, ED standing orders/protocols, standardized interventions, COPD pathways
Coordination/communication with post-acute care providers.	○ Supports facilitation of programmatic meetings on a defined schedule for transparency regarding performance among facility Care Partners ○ CRISP ENS TCM calls, system efforts(Harmony, Point Right), Post-Acute Collaborative, Automated systems for post-acute care coordination

Question 2

If Yes, please briefly describe.

Care Transformation Resource Type	Hospital Specific Examples
Interdisciplinary team meetings or round	○ Introduction of interdisciplinary care team in advance of the elective surgical procedure rather than post-surgery for purposes of discharge planning ○ Daily Care Transition Rounds
Patient/family education.	○ Virtual pre-operative teaching class ○ PFAC support ○ Diabetes education center
Medication reconciliation or medication therapy management.	○ Follow up with all patients discharged to home for a minimum of 30 days for case management, medication reconciliation, chronic disease management. ○ Unit based clinical pharmacists, Pharmacist assigned to both HF Bridge and Transitional CareClinics ○ MTM via ambulatory pharmacy team
Remote patient monitoring.	○ In the process of adding remote patient monitoring to WellPatient Program and virtual visits ○ Remote patient monitoring offered for with homecare ○ Scales and BP cuffs provided with RN follow up post discharge ○ RPM predominantly for highest risk patients and/or patients with chronic conditions
Other	○ Behavioral Health Support ○ Telehealth access ○ Access to Ambulatory Surgical Centers to move care outside hospital, as appropriate

Question 3

What calendar year did you begin offering the resources?

Range: 2011-2022, most resource offering began in 2019.

Question 4

Select the provider types to whom you offer the resource.

Provider Type	Responses	
Physician	13	86.7%
Clinical Nurse Specialist or NP	13	86.7%
Physician Assistant	12	80.0%
Hospital	10	66.7%
Skilled Nursing Facility	8	53.3%
Home Health Agency	7	46.7%
Physical Therapist	6	40.0%
Inpatient Rehabilitation Facility	6	40.0%
Long Term Care Hospital	4	26.7%
Other	2	13.3%

Question 5

Do you offer the resource only to ECIP certified care partners (Yes/No/NA if not participating in ECIP)?

Answer Choices	Responses	
Yes	20.00%	3
No	66.67%	10
N/A	13.33%	2

Question 6

Do you offer the resource regardless of provider/patient participation in ECIP (Yes/No/NA if not participating in ECIP) ?

Answer Choices	Responses	
Yes	73.33%	11
No	13.33%	2
N/A	13.33%	2

Question 7

Do you offer the resource regardless of providers' employment status with your hospital or health system (Yes/No)?

Answer Choices	Responses	
Yes	92.86%	13
No	7.14%	1

*One hospital skipped this question

Question 8

If no, please briefly describe which providers are eligible to receive the resource.

- Some hospitals do not rely on the CRP waivers to support and provide resources to care partners. For example, some hospitals provides these resources to provider partners in other ways.
- For example, supports are provided through a post-acute care collaborative. The collaborative aims to drive quality improvement in post-acute transitions and develop innovative strategies to improve transitions and reduce avoidable hospitalizations, often through partnership with SNFs and other providers.

Question 9

Are the CRP waivers critical, incidental, or unnecessary for you to offer this resource?

Answer Choices	Responses	
Critical	57.14%	8
Incidental	35.71%	5
Unnecessary	7.14%	1

*One hospital skipped this question

Question 10

If the waivers are critical, please describe why.

- Compliance Risks: The terms of the Fraud and Abuse Waivers raise concerns about the impact of a failure by a Hospital or Care Partners to comply with any of the numerous requirements of the Care Partner Agreements. In particular, the Waivers do not address the consequences associated with an unintentional non-compliance with a TCOC Participation Agreement or Care Partner Agreement that could invalidate the Waiver and result in Stark or AKS liability. Proposed Modifications include:
  i) A breach of the term of a Care Partner Agreement should only trigger CMP liability. For example, a CMP penalty of $1,000, not to exceed $25,000 per year for all Care Partner Agreements would apply. This CMP penalty would take the place of the Stark "Denial of Payment" provision.
  ii) Technical "documentation noncompliance" should not trigger a Stark denial of payment or CMP.
  iii) CMS should incorporate the flexibilities related to technical non-compliance allowed under the Physician Self-Referral law regulations including without limitation: (1) the exception for certain arrangements involving temporary non-compliance (42 CFR 411.353(f)); (2) special rule to allow for reconciliation of payments (42 CFR 411.353(h)); and (3) the special rules on writing and signature requirements (42 CFR 411.354(e)).
  B. Care Partner Agreements: To utilize the Fraud and Abuse Waivers, CMS requires that each physician Care Partner and Downstream Care Partner sign either a Care Partner Agreement or Downstream Care Partner Agreement. For large academic medical centers, entering into a Care Partner Agreement with each employed physician or faculty member is administratively burdensome and inconsistent with how practices are legally structured. We appreciate that some sort of attestation is needed from the providers to ensure the Waivers are "triggered" and applicable to potential incentive payments, but the employer entities have the legal authority to bind their provider employees. Proposed modification is:
  i) Academic Medical Centers should not be required to enter into individual Care Partner Agreements with each participating physician. Rather, academic medical centers should be permitted to enter into one Care Partner Arrangement with the legal entity that has authority to bind the physician employees. The requirements of the Care Redesign Program for the employed physicians and faculty would be regulated by Hospital policy. The legal entity could attach a list of providers/NPIs and a statement obligating the listed group members to the terms of a Care Partner Agreement signed by an authorized official for the group.
  C. Post-Acute Resource Sharing: JHHS would be interested in a waiver that would allow for resource sharing with post-acute providers in order to provide additional support to our patients going to SNFs and facilitate discharges; examples include one-on-one sitters for patients who would benefit from additional supervision, or specialized bariatric beds for patients with high BMIs. Current rules and regulations are a barrier for hospitals to provide this kind of support to post-acute facilities that would decrease hospital length of stay and increase quality of care in the post-acute environment.
- Very beneficial given ECIP qualifies as an alternative payment model (APM) . This creates incentive among different care partner types to actively engage and collaboratively work on alignment among stakeholder's in the continuum of care for patients as they transition from acute hospital care to: SNF, Home Health Care, Primary Care, and Specialty Care services. This program creates alignment around coordination of care and a focus on standardizing care to deliver reliable, quality patient outcomes and improve the patient experience. Program is flexible to allow for data to drive which clinical episodes to focus on improving care delivery, patient outcomes, and in support of managing TCOC. ECIP data tools available via CRISP are beneficial in analyzing volume and cost detail to identify opportunities to manage care and costs more effectively.

Question 10 Cont'd

If the waivers are critical, please describe why.

- We have processes developed to streamline disease specific care paths which include referrals to services and providers within the ECIP/HCIP program.
- To offer the right resources to independent community providers to meet key quality metrics and utilization targets. To engage providers in the work to improve results and patient outcomes. To build relationships across provider community and better coordinate care for patients.
- The CRP waivers eliminate some of the rigidity in the regulatory environment to better align hospitals and physician activities.
- Many of our programs and supporting staff were started with Grant Money to be sustained with rewards for decreasing readmissions and avoidable utilization. The care partners in our CTI Initiatives and ECIP are Qualified Participants with eligibility for other bonuses such as MACRA.
- We are expecting shared savings in the next performance period, based on early data, assist offices, SNF, and Home Health with support services: Case management, RPM, for example.
- Many goods and/or services (e.g. RPM, navigation, CHW) that support care transformation may not be billable under Medicare therefore we seek protection under this arrangement
- The CRP waivers are critical for certain UMMS hospital participants because these hospitals may not be able to offer certain interventions without the waivers remaining in place. For its other hospital participants, even if the CRP waivers are not critical to offer its current interventions, the hospital may need to rely on these waivers in future years in order to offer a particular intervention. In either case, the CRP waivers offer hospitals increased flexibilty to design pivotal care coordination interventions with care partners without the concern of potentially violating various fraud and abuse laws.