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# Committee Steering Committee Meeting

April 16, 2020

# Agenda

1. Administrative Updates for CTI Starting July 1, 2021
2. Revisions to the Palliative Care CTI
3. Next Steps

# Review of Timeline

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# Timeline for the CTI

- May 16 – Hospital may submit CTI's for a July start date. Submissions must be received by HSCRC prior to May 14.
  - **Only changes to existing CTI or new CTI need to be submitted.**
  - **Any CTI submission that is unchanged will roll over to the July start date.**
- July 1, 2021 – The CTI program goes live. Episodes that meet the CTI triggering criteria will be attributed to the hospital.
- Potential: January 1, 2021 – Midyear start date for additional CTI.
- July 1, 2022 – The first performance year ends on June 30, 2022. The second performance year begins on July 1, 2022.
- July 1, 2023 – The first MPA adjustment (including both the hospital's reconciliation and the statewide offset) is implemented.

# Requirements for CTI Submissions / Re-Submissions

- HSCRC will treat all CTI currently submitted as final unless the hospital submits a change to the intake template. **Thus, hospitals do not need to resubmit their CTI for the July 1 start date.**
- Hospitals that choose to make changes to their CTI submissions may add new CTI, drop existing CTI, or modify a previous submission.
  - New submissions will not appear in the CTP until July.
  - **Submissions are due by May 14.**
- Hospitals may submit new CTI by emailing the appropriate intake template to the HSCRC.
  - Hospitals should use the Intake Templates that are on the HSCRC website, as there have been minor changes to the original templates.
  - Hospitals may also revise their existing CTI submissions by emailing the appropriate intake template and indicating which CTI is being modified.
    - Hospitals should identify an existing CTI using the CTI's full name as it appears in the CTP. E.g. "01-001 – Care Transitions-Readmission CTI".
    - Hospitals should not identify existing CTI as "our care transitions CTI" or other internal names for their submissions.
- Submissions could be sent to hscrc.care-transformation@maryland.

# Request for Ad Hoc Analysis

- Hospitals that wish to estimate the CTI population for a new submission may submit a request to CRISP.
  - CRISP will provide the hospital with the number of episodes that meet the indicated criteria. Certain cost and demographic data will be made available.
  - The results will be provided in excel. Ad hoc submissions will not be available in the CTP. However, the excel analysis will provide the same data that would appear in the CTP.
- To submit an ad hoc analytics request, hospitals should:
  - Email care.redesign@crisphealth.org and include the appropriate excel intake template with the desired specification.
  - Analytics requests will take approximately 2 weeks, but the turnaround may be longer if the numerous requests are received simultaneously. Hospitals are therefore encouraged to submit analytics requests as soon as possible.
- Hospitals that have questions about intake template and parameters should reach out to hscrc.care-transformation@maryland.gov.

# Revisions to the Palliative Care CTI

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# Overview of the Palliative Care CTI

- Numerous hospitals have indicated difficulties with the Palliative Care CTI.
  - The initial proposal was designed to allow hospitals to identify patients receiving palliative care services at the hospitals.
  - Due to a lack of granularity in the claims data for palliative care services, the HSCRC allowed hospitals the option of including an NPI List of their palliative care providers.
  - However, the turnover in NPI – particularly relative to an early baseline – discouraged some hospitals from submitting NPI lists.
- Without the NPI lists, the Palliative Care CTI and Care Transitions CTI criteria differ slightly.
  - If the hospital submits an NPI list, then the Palliative Care CTI includes patients that meet the hospitalization criteria (e.g. 3+ chronic conditions) AND has a touch with the listed NPI.
  - If the hospital does not submit an NPI list, the Palliative Care CTI includes patients that meet the hospitalization criteria (e.g. 3+ chronic conditions).
- In the later case, the Palliative Care population is functionally the same as a Care Transitions CTI. This cause both confusion and substantial overlaps between these CTI.

# Reminder Palliative Care Criteria

The Palliative Care CTI is triggered by an Inpatient Stay at the hospital. The hospital may then restrict the population using the following criteria.

| Palliative Care | Age | Geographic Service Area | Number of Chronic Conditions | Prior Hospitalization / ED utilization | IP Events | NPI Attribution | Episode Length |
|---|---|---|---|---|---|---|---|
| *Criteria Options* | Hospitals determine the age range their intervention targets | Hospitals may provide a list of 5-digit zip-codes | • Indicate a number of chronic conditions, AND/OR<br>• Hospital may provide a list of chronic conditions | • Prior hospitalization OR ED utilization threshold, AND/OR<br>• Time window for how recent that utilization was | Hospitals may submit:<br>• A list of ICD-10 primary dx codes OR<br>• A list of APR-DRG / SOIs OR<br>• Preferred ROM OR<br>• Length of stay qualifications | Hospitals may provide a list of NPIs. Beneficiaries will be included if they receive a physician service from that provider during the course of their hospitalization stay. | Hospitals may submit an episode length of: 30, 60, 90, 120, 150, 180, or 365 days |
| *Default if Criteria is not Specified* | All Medicare beneficiaries (65+) | Use no geographic restriction | Any condition and no threshold of chronic conditions | No requirement on prior utilization | Use all diagnosis and DRG codes | Use no NPI restriction | 90 day episode window |

| Care Transitions | Geographic Service Area | Number of Chronic Conditions | Prior Hospitalization / ED utilization | IP Events | Lookback / Look forward | Episode Length |
|---|---|---|---|---|---|---|
| *Criteria Options* | Hospitals may provide a list of 5-digit zip-codes | • Indicate several chronic conditions, AND/OR<br>• Hospital may provide a list of chronic conditions | • Prior hospitalization OR ED utilization threshold, AND/OR<br>• Time window for how recent that utilization was | Hospitals may submit:<br>• A list of ICD-10 primary dx codes OR<br>• A list of APR-DRG / SOIs OR<br>• Preferred ROM OR<br>• Length of stay qualifications | Hospitals may indicate whether the beneficiaries have received certain services before and/or after the index hospitalization. | Hospitals may submit an episode length of: 30, 60, 90, 120, 150, 180, or 365 days |
| *Default if Criteria is not Specified* | Use no geographic restriction | Any condition and no threshold of chronic conditions | No requirement on prior utilization | Use all diagnosis and DRG codes | Use no look forward / Look back | 90 day episode window |

# Palliative Care without NPI compared to Care Transitions

As an example, consider a hospital that submitted a Palliative Care and Care Transitions CTI.

## Palliative Care Definition

- 1 Chronic Condition
- 1 Inpatient or ED visits within 90 days
- SOI 3+

## Care Transitions Definition

- 1 Chronic Condition (COPD, Heart Failure, or Diabetes)
- 3 Inpatient or ED visits within 365 days
- APR-DRGs of 140, 141, 145, 194, & 720

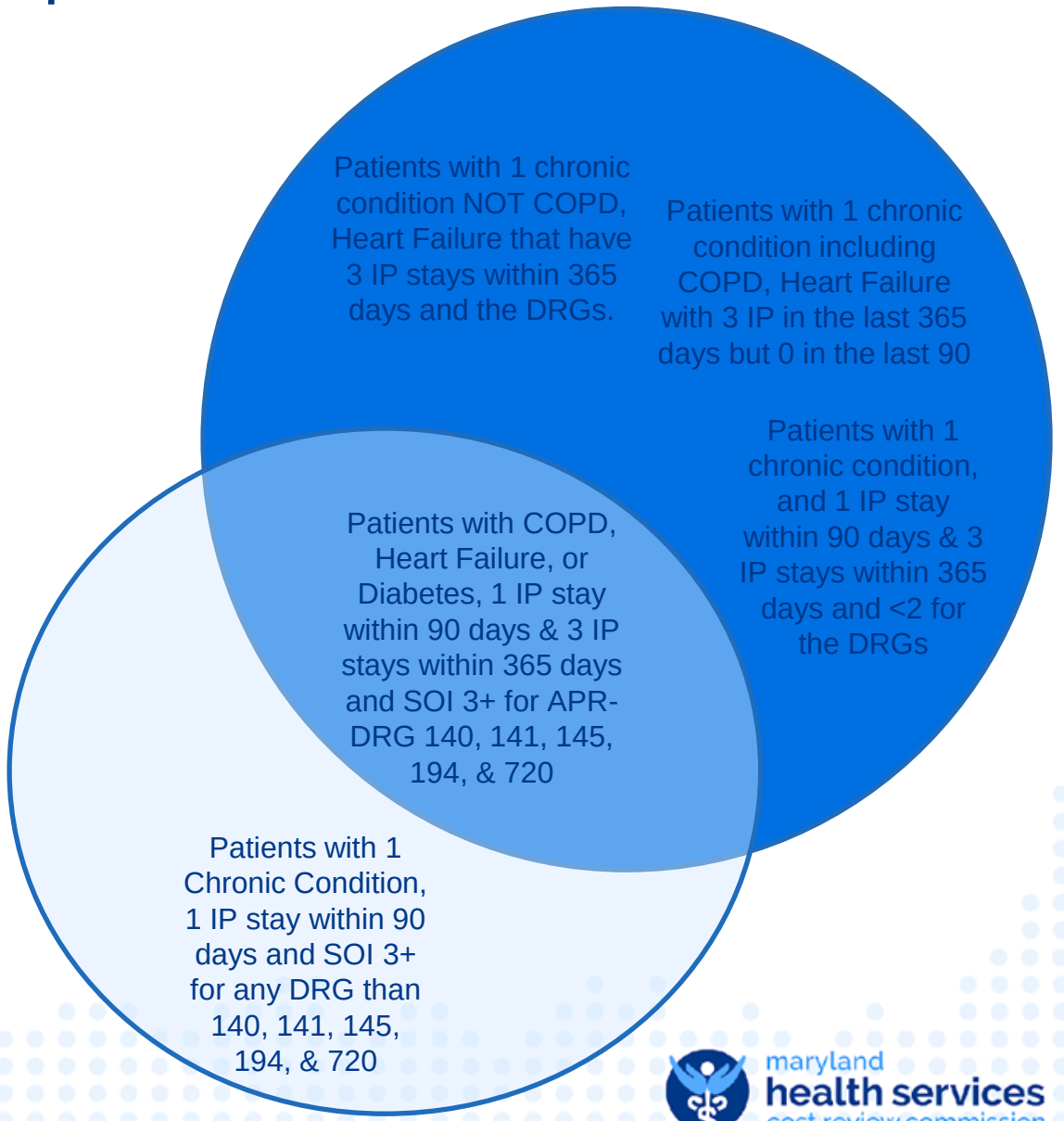
# Palliative Care without NPI compared to Care Transitions

This causes difficulties in understanding the population for each CTI.

- Determining the overlap of the beneficiaries is complex.
- The numbers of patients attributed one CTI versus the other will vary dramatically based on which CTI is prioritized.
- The residual population that is attributed to the lower priority CTI will be odd.
- The result is unlikely to well approximate the population that received palliative care.

This scenario would be easier to understand as two Care Transitions CTIs.

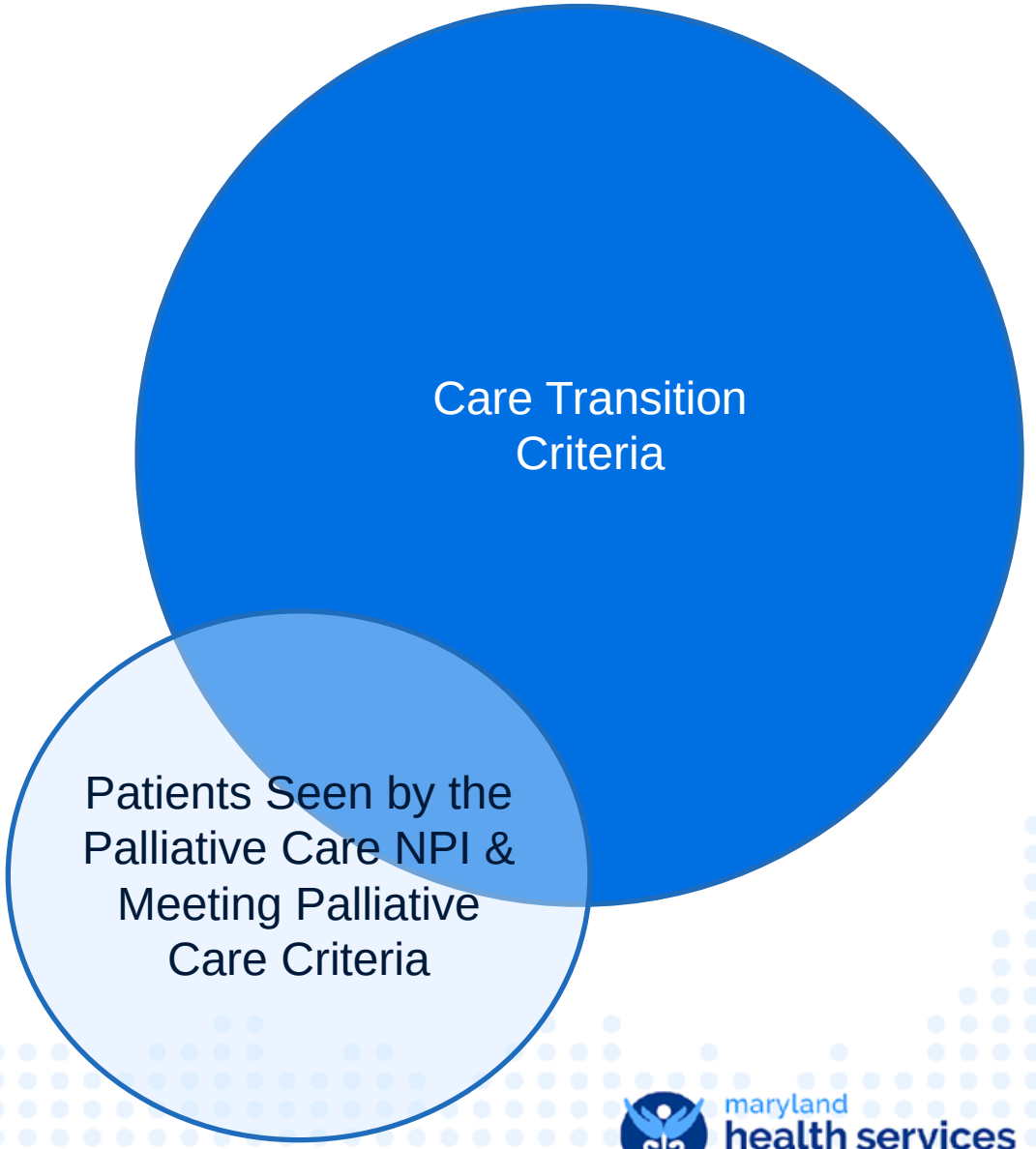
- One CTI for anyone with DRG 140, 141, 145, 194, and 720.
- One CTI for all other DRGs.



# Palliative Care with NPI compared to Care Transitions

Requiring an NPI list of the Palliative Care CTI does eliminate the overlaps problem, but it does simplify it.

- The overlap is anyone meeting the Care Transitions Criteria and seen by the NPI.
- Hospitals may decide which CTI those patients are attributed to.



# Rationale for the Optional NPIs

Originally, the HSCRC made NPI list optional because:

- Palliative care cannot be reliably identified by a single code (palliative care consults are a CTP code modifier and the use of the modifiers is not universal).
- Palliative Care NPIs and be used to identify to consults but due to methodological restrictions, an NPI must appear in both the baseline period and the performance period.

This caused issues for hospitals that implemented palliative care programs early but then experienced physician turnover.

- With physician turnover, the hospital could not accurately capture the baseline period of the palliative care intervention.
- As a workaround, hospitals submitted their palliative care using general criteria and an inpatient trigger.

In order to reduce confusion, the Palliative Care CTI will now require a list of triggering NPIs.

- Physician still must appear in the baseline period and the performance period.
- The hospital may still submit general criteria as a workaround, but it will be treated as a Care Transition CTI in order to reduce confusion.

# Next Steps for the Palliative Care CTI

Hospitals that submitted a Palliative Care CTI that did not include an NPI list will be required to resubmit their CTI.

- The hospital should add a list of NPI; or
- The hospital may convert their CTI to a Care Transition CTI.
- Hospitals must use the revised Palliative Care Intake Template that is available on the HSCRC website.
- HSCRC will email the impacted hospitals to ask for a resubmission.
- Resubmissions will be due by May 14.

Impacted Hospitals Include:

- LifeBridge Health
- Holy Cross Health
- Adventist
- Calvert
- MedStar
- Luminis Health
- JHHS
- Meritus
- Mercy
- GBMC
- UMMS

# Next Steps

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# Steering Committee Agenda

- The next meeting of the CT Steering Committee will be May 21. This meeting will discuss:
  - A comprehensive review of the CTI methodology, including target price methodology, savings calculations, minimum savings rates etc.
  - Any last minute administrative updated prior to the start of the CTI performance period.
- There will be a CTI User Group Meeting on April 30.
  - Interested attendees should email Jessica.Heslop@crisphealth.org to be included on the invite.
  - Hospitals are encouraged to actively participate and suggest topics for user group meetings.
- The following meetings of the CT Steering Committee meetings will discuss:
  - Potential changes to the CTI methodology that will allow prospective target prices (e.g. CTI for which no baseline exists).
  - Modifications to existing methodology to address physician drift issues.
  - New CTI proposed by the industry.

# Questions?