Quantifying Care Transformation Efforts under the MPA Efficiency Component Policy

The HSCRC is developing a process to quantify hospital care transformation efforts around the State to make incentive payments to hospitals through the Medicare Performance Adjustment (MPA). Currently, hospitals may receive incentive payments for the Episode Care Improvement Program (ECIP), which focuses on reducing post-acute care costs for 23 clinical episodes. The HSCRC will add incentive payments for hospital efforts, outside of ECIP, that reduce the Medicare Total Cost of Care (TCOC) growth rate.

There are four fields which are required for hospital submission and an additional two which HSCRC staff will use in their review and approval of these care transformation efforts.

## Baltimore Region Community Health Advocate Program

| **Required from Hospital: Background Components** | |
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| Overview<br>• Description of current or upcoming program/initiative which hospitals may be implementing to impact patient outcomes, population health and total cost of care performance under Global Budget Revenues (GBR). | • Hire non-clinical community health advocates to assist patients with care coordination and health system navigation through home visiting program.<br>• Collaborate with hospital Case Management teams to assess and address social determinants of health and link to social services to improve patient health outcomes.<br>• Community based health worker program designed to support goals of care and avoid unnecessary hospitalizations in the Baltimore region. |
| Defined Care Interventions<br>• Briefly describe a standardized intervention pathway to address unmet clinical or social needs.<br>• Identify care partners at the hospital, or in the community, who will implement the intervention. | **Interventions**<br>• Care Management Referral:<br>a. Case Management identifies patients going home independently and needs care management assistance<br>b. Social determinants of health assessment by community health advocate<br>c. Focused intervention directed toward identified social needs and goals of care<br>• Medical Home Follow Up:<br>a. Post care appointment coordination with medial home and specialists<br>• Home Visits/Telephonic Outreach<br>a. Assess home environment and support network<br>b. Refer and link to social service programs<br>c. Program eligibility and enrollment assistance (transportation, SNAP, Meals on Wheels, etc)<br><br>**Care partners**: MedStar Case Management/Transitional Care Teams, MedStar Community Health, MedStar Uber Health program, City/County Social Service department and community based social service programs |

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| Identifiable Intervention Population<br>• Medicare FFS beneficiaries only, until further payer data available<br>• Must be identifiable in Medicare claims based on clinical condition, patient history and/or other criteria; cannot be identified with an EHR or clinical data point, | • Patient admitted to the hospital<br>• Baltimore City or County resident; going home independently<br>• Primary Diagnoses of CHF, COPD and Diabetes<br>• Utilizing the Cerner Readmission Risk Module, patients with a High-risk score, Medicare eligible and 3+ hospitalizations and/or ED visits in one year. |
| Episode Trigger<br>• A "trigger" event, or combination of factors, to identify when a beneficiary is enrolled in the intervention<br>• Must be identifiable in Medicare claims; cannot be triggered with an EHR or clinical data point, | • In patient discharge<br>• During discharge planning, Case Management identifies at risk Baltimore residents going home independently<br>• Patient agrees to enroll in CHA program and home visit<br>• Duration of intervention: 30 days |
| **For HSCRC Analysis and Consideration:** | |
| TCOC Impact and Duration of Episode<br>• From the information above, HSCRC will estimate the TCOC savings related to the intervention by calculating the difference in costs for the intervention population before and after the intervention went into effect.<br>o E.g. HSCRC will calculate the PBPM cost for all beneficiaries who qualify under the Community Health Advocate Program Algorithm and are discharged from a MedStar hospital in 2018 and the PBPM cost for all beneficiaries who qualify under the Community Health Advocate Program Algorithm and are discharged from a MedStar hospital in 2019. The TCOC will be equal to the difference in PBPM costs times the number of beneficiaries. | |
| Reconciliation Payments<br>• HSCRC staff will calculate the reconciliation payment that will be made to the hospital for the savings that they produce as part of a care transformation effort.<br>• The reconciliation payments will be included when the State calculates the TCOC run rate and the required savings for the TCOC Model. The costs may be offset through the MPA-EC in order to ensure any reconciliation payments will remain cost neutral and reward hospitals that meaningfully engage in care transformation efforts. | |