UMMS CTI Submittal: High Risk Clinics

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).

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:

Required from Hospital: Background Components	
Overview • 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).	**Overview:** A High Risk Clinic (HRC) is a multidisciplinary clinic dedicated to comprehensive chronic condition and primary care management of high-risk patients who are frequent users of the emergency department and inpatient care. The goal is to provide comprehensive clinical and psychosocial support to improve health outcomes and reduce utilization. HRCs are usually co-located within the hospital. **UMMS Participating Hospitals**: 1) Baltimore Washington Medical Center 2) St. Joseph's Medical Center 3) Upper Chesapeake Health 4) University of Maryland Medical Center
Defined Care Interventions • Briefly describe a standardized intervention pathway to address unmet clinical or social needs. • Identify care partners at the hospital, or in the community, who will implement the intervention.	**Intervention Pathway:** 1) High risk patient identified in the hospital setting and referred to HRC based on patient identification criteria 2) HRC consists of multidisciplinary care team that evaluates the patient's needs. 3) Multidisciplinary team creates a care plan aimed at

	graduating the patient to disease self-management. 4) The multidisciplinary care team also works to connect the patient to other services/resources as appropriate, which may include: a. Connection to community based organizations to address social needs b. Providing disease self-management education c. Connecting patients to primary care providers and specialists **Care Partners:** 1) Multidisciplinary Care Team 2) Community Care Partners 3) Primary Care Physicians 4) Specialists
Required from Hospital: Analytic Components	
Identifiable Intervention Population • Medicare FFS beneficiaries only, until further payer data available • 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,	**1) Baltimore Washington Medical Center:** Medicare FFS beneficiaries with primary diagnosis of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Diabetes, or Sepsis and greater than three inpatient or emergency department admissions in the past 12 months. **2) St. Joseph's Medical Center:** Medicare FFS beneficiaries with no primary care physician (PCP) and two or more inpatient visits within the last 12 months. **3) Upper Chesapeake Health:** Medicare FFS beneficiaries with a primary diagnosis of Diabetes, Hypertension,

	COPD, CHF, Coronary Artery Disease, or Sepsis and greater than one inpatient admission within the last 30 days 4) **University of Maryland Medical Center:** Medicare FFS beneficiaries with no PCP, or uncontrolled chronic disease diagnosis, or new onset of hypertension, diabetes, COPD, or any diagnosis of CHF
Episode Trigger • A "trigger" event, or combination of factors, to identify when a beneficiary is enrolled in the intervention • Must be identifiable in Medicare claims; cannot be triggered with an EHR or clinical data point,	1) **Baltimore Washington Medical Center:** Inpatient or emergency department admission. Episode window is 90 days 2) **St. Joseph's Medical Center:** Inpatient admission. Episode window is 30 days 3) **Upper Chesapeake Health:** Inpatient admission. Episode window is 90 days. 4) **University of Maryland Medical Center:** Inpatient or emergency department admission. Episode window is 90 days
For HSCRC Analysis and Consideration:	
TCOC Impact and Duration of Episode • 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.	
Reconciliation Payments • 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. • 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.	