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).

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: Western Maryland Health System 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).	Western Maryland Health System is focused on strategies that will significantly drive positive impact to improve the quality of care delivered, collaborate with community partners to avoid duplication of resources, reduce avoidable utilization and thus maintain alignment to the goals and objectives defined with the Triple Aim; limiting hospital growth, cap and control hospital revenue with global budgets, and the All-Payer Waiver demonstration. **Strategy: Implement a multi-faceted Behavioral Health (BH) strategy** including outpatient behavioral health case management, early detection, and effective and timely support for at-risk patients.
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.	**Strategy:** Behavioral Health Focused Interventions: **Intervention 1.1: Community Based Behavioral Health Case Management-**provides patients with specialized behavioral health case management resources to bridge the gap from discharge to connection with appropriate community based services; an intervention aimed to reduce inpatient readmissions and ED revisits. • Care Partners: Community and hospital based resources include BH specialists, Psychologist, Licensed Social Workers and MD. **Intervention 1.2: Integrated Behavioral Health Professionals into Primary Care** Involves a standardized approach to depression screening which leads to early detection and early intervention; allowing Behavioral Health Professionals (BHPs) and primary care providers in coordination to develop collaborative treatment plans with the patient. These efforts support early detection and treatment to ward off escalation and crisis, which often lead to avoidable ED and inpatient utilization.

	• Care Partners: Continuation of this initiative will sustain the health system employed Behavioral Health Professionals (BHPs) embedded in primary care and in union rescue mission
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,	**Strategy: Behavioral Health-** At risk individuals; not necessarily those with high utilization. • Intervention 1.1: All persons discharged from the inpatient BH unit with primary behavioral health diagnoses (mental health or substance abuse) • Intervention 1.2: All adult patients in an employed primary care practice who screen positive for depression. (Screenings done on a rolling annual basis.)
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,	**Strategy: Behavioral Health (interventions for "at-risk" individuals)** • Intervention 1.1: Behavioral health community based case management (BHCM) o *Ask-risk population; not necessarily high utilizers.* • Intervention 1.2: Patients engaged in services provided by Integrated Behavioral Health Professional embedded in primary care. •
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.	