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.

MedStar House Call Program—Drafted by J. Beecher, AVP-Operations

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).	• Home-based primary care to frail elders, age ≥ 65 in designated catchment geography. • Expert mobile teams of geriatricians, nurse practitioners, social workers, and coordinators focused on highest cost, elderly patients who meet criteria for Medicare home visit. Each team can manage ~ 300-350 patients/caregivers • Proven model under Centers for Medicare & Medicaid Innovation—Independence at Home Shared Savings Demonstration—Years 1-4 showed 12-27% annual reduction in TCOC. Now in 6th Year
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.	**Interventions** • Core Services a. Home-based primary care (HBPC)—routine & urgent visits b. Mobile lab & radiology c. 24/7 on-call medical staff d. Transport arrangements e. ER/Acute Care: Coordinate transitions and oversee hospital care at designated MedStar hospitals f. Coordinate subspecialty care at designated MedStar hospitals g. Mental health and dementia care h. Pharmacy and DME delivery i. Skilled home health—PT/OT/RN j. Arrange inpatient rehab and skilled nursing facility care k. End-of-life/hospice care l. Mobile real-time electronic health record m. Social work case management - Caregiver counseling and support - Coordinate home health aides

	- Linkages to community resources and additional governmental supports if eligible - Legal counsel for elderly—guardianship - Minor home modifications & extermination services - Food and utility resources - Housing transitions & nursing home placement **Care partners**: Hospitals (MedStar Good Samaritan & MedStar Union Memorial); Home Health Agencies (e.g. MedStar Visiting Nurses Association); Radiation Physics & other mobile diagnostic companies; Senior living communities (e.g. Stadium Place, Roland Park Place, Keswick); area hospice programs (e.g., Gilchrist, Seasons hospice); Sub-acute facilities; Transportation services (e.g. MedStar transport, Action in Maturity); MedStar IS Support for EMR/laptops, server supports and protections, cell phones, etc.
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,	• Age 65 & older • Reside in zip code catchment (21210, 21211, 21212, 21213, 21214, 21218, 21239, 21206) • Two or more chronic conditions (recommend using CMS Chronic Care Warehouse ICD-10 list) • Hospitalization in the past 12 months • Received subacute rehab services or episodic skilled nursing services in past 12 months • Proxy to identify ADL/IADL impairment (recommend Claims Frailty Index (CFI) developed by DH Kim, used by CMS)
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,	• Pt enrolls in MedStar House Call Program for primary care • Identified by first visit claim (E/M code for a home visit) under clinicians' NPIs & TIN. • Must have 2 home visits in 90 days to assure alive in community and prevent high cost 'dumping' from other providers

For HSCRC Analysis and Consideration:

TCOC Impact and Duration of Episode

Duration of Episode & Protections

- Performance year July 1, 2020- June 30, 2021 (FY'21) to start
- Costs to be measured from patient enrollment into MHCP (trigger point) until end of performance year or involuntary disenrollment whichever comes first.
  Reasons for involuntary disenrollment include:
  - Death
  - Moving outside provider service area
  - Becoming no longer eligible for Medicare Part A or B
  - Permanently moving into a nursing facility, or
  - Other reason which must be specified—such as safety
- For patients who voluntarily disenroll after more than 6 months or more in MHCP, they will be included in calculations based on the full performance year. However, patients who disenroll voluntarily after fewer than 6 months will not be included in the patient population for the entire performance year for purposes of establishing spending target and calculating savings.
  Reasons for voluntary disenrollment include:
  - Enrollment in a Medicare Advantage (MA) plan or Program of All-Inclusive Care for the Elderly (PACE)
  -

Proposal to measure TCOC Impact

Spending Target (Hierarchical Condition Category (HCC) risk score X Avg FFS county rate $ X Adjustments) MINUS Actual Expenditure = IMPACT (cost savings, cost neutral, or cost increase)

- **Setting Spending Target**
  Intended to establish a reasonable spending target derived from claims and based on expected Medicare FFS utilization for each patient in the absence of the intervention.
  HCC Score
  For each enrolled patient (Trigger point), claims look-back 12 months to obtain HCC score (V.24 Concurrent model)
  Request classify enrolled dialysis patients (ESRD) into separate strata since considerably more expensive than non-ESRD patients.
  Adjustments
  - Frailty adjustment to account for additional health care costs of impairment in ADLs. Recommend addition of Claims Frailty Index points added to spending target
  - Inflation factor (per HSCRC)

  Avg FFS County Medicare Rate
  Used to set $ amount

Spending target will equal the average of these per patient predicted costs, weighted by the number of months of each patient's participation

Additional Resources:

Independence at Home Demonstration by Centers for Medicare and Medicaid Innovation
https://innovation.cms.gov/initiatives/independence-at-home/

CPT Codes used to bill for home-based primary care

In-Home Visit

CPT Code	Description
99341	Home visit, new patient; low severity problem, 20 min.
99342	moderate severity problem, 30 min.
99343	moderate to high severity problem, 45 min.
99344	high severity problem, 60 min.
99345	patient unstable or significant new problem requiring immediate attention, 75 min.
99347	Home visit, established patient; self-limited or minor problem, 15 min.
99348	low to moderate problem, 25 min.
99349	moderate to high problem, 40 min.
99350	patient unstable or significant new problem requiring immediate attention, 60 min.
99324–99328	Domiciliary or rest home visit for the evaluation and management of a new patient
99334–99337	Domiciliary or rest home visit for the evaluation and management of an established patient
99339–99340	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and or revision of care plans
All of the above codes must be billed in conjunction with one of the following Place of Service codes: (12) home (13) assisted living facility (33) custodial care facility (14) group home (32) nursing facility	