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: 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).	The Frederick Integrated Healthcare Network (FIHN) embedded care managers in Primary Care Physician and key medical specialty practices to work with patients with hospital utilization and targeted high volume/cost chronic conditions. Physicians developed and implemented Care Pathways for 10 high volume chronic conditions. 3 medical conditions of focus were identified from Medicare claim data as most critical for care management: COPD, CHF and Sepsis.
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.	Dashboards were developed for practices to monitor progress on utilization and cost metrics and course correct when needed. Quality indicators such as Annual Wellness Visits were also measured. FIHN hired community health workers, social workers, pharmacists and dieticians to assist the care management teams assist patients with medical and social needs. The system worked closely with community partners such as the Health Department, Way Station, Mental Health Association, skilled nursing facilities and others to shore up transitions in care for patients and reduce gaps in patient management. The health system also collaborated with the health department embedding Peer Support Recovery Specialists into the hospital and community to assist patients with substance use disorder. Physician practices were trained in SBIRT to improve screening and intervention.
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	Any Medicare beneficiary seen at the hospital (emergency room, observation or inpatient setting) with COPD, CHF or Sepsis who can be attributed to a primary care physician or

and/or other criteria; cannot be identified with an EHR or clinical data point,	medical specialist in FIHN, as identified by a list of NPIs.
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,	Any beneficiary with one of the 3 chronic conditions who receives a service at FMH will trigger an episode of care management. Care Management episode length varies based on the patient's needs for episodic or longitudinal care management services.
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. E.g. HSCRC will calculate the PBPM cost for all beneficiaries with one of the 3 chronic conditions and who were seen by an FIHN provider in 2018 and the PBPM cost for all beneficiaries with one of the 3 chronic conditions and who were seen by an FIHN provider in 2019. The TCOC will be equal to the difference in PBPM costs times the number of beneficiaries.	
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.	