**Key Provisions for purpose of developing the Hospital Care Improvement Program Implementation Protocol**

**Performance Year 2017**

**Hospital Name**

(Not approved by CMS – subject to continuing review process)

# Introduction

The Hospital Care Improvement Program (HCIP) seeks to align Maryland hospitals’ payment incentives with that of eligible physicians. The program is intended to improve inpatient medical and surgical services delivery, support effective transitions of care, and support effective delivery of care during acute care events even beyond hospital walls, with a focus of maintaining and improving the quality of care. Though the program focuses on reducing avoidable utilization, the byproduct is reduced cost per acute care event.

The Hospital Care Improvement Program will also focus on the efficient use of resources. Efficient resource management examples include implementing more efficient practice patterns to discharge patients in a timely manner, using generic drugs wherever warranted, and using critical care beds (e.g. ICU and CCU beds) and operating rooms effectively. Even further, physicians assisting with post discharge responsibilities – follow up appointments, coordination with skilled nursing care, use of home care – will be more likely to discharge patients efficiently, reducing length of stay, and possibly preventing future readmissions and re-encounters. The program provides hospitals with an opportunity to share cost savings with physicians that manage inpatient resources efficiently, improve quality of care delivery and support effective transitions of care.

Overall the program is designed to:

* Improve inpatient medical and surgical services delivery
* Provide effective transitions of care
* Ensure an effective delivery of care during acute care events even beyond hospital walls
* Encourage the efficient management of inpatient resources
* Reduce avoidable utilization with a byproduct of reduced cost per acute care event

Implementation Protocol Instructions

Prior to completing this protocol, please read the Hospital Care Improvement Program (HCIP) Template as it is intended to help aid completion of this document. Please complete all required sections of this protocol as indicated in Section A.

The HCIP Template includes detailed requirements that are referred to in the Participant Hospital’s Participation Agreement between CMS, the State, and the Participant Hospital. The successful completion and approval of the Implementation Protocol by the State activates the Participant Hospital’s ability to access the necessary waivers needed to share resources, obtain patient-identified Medicare data, and offer Incentive Payments to Care Partners. CMS will review the Implementation Protocol for program integrity only.

**Section A**, Participant hospital provides general information.

**Section B**, Participant hospital provides a description of the Oversight Committee and key personnel responsible for the Hospital Care Improvement Program.

**Section C,** Participant hospital provides details of the model plan.

**Section D,** Participant hospitalexplains plan for implementing care redesign activities and how you intend to monitor them.

**Section E,** details the Savings Pool calculation and incentive payments.

# Hospital Information

**Date of Implementation Protocols Submission:** XXXX, XX, 2016

**Organization Name and D/B/A:** Name

**TIN:**

**CMS cert #(s) for organization:**

**Contact Person for Agreement:**

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| --- | --- |
|  | **Hospital** |
| Name: |  |
| Title: |  |
| Street Address: |  |
| City, State, Zip: |  |
| Telephone: |  |
| Fax: |  |
| Email: |  |

**Name the key personnel and describe the function of the key management personnel for this program.**

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| --- | --- | --- |
| **Key Personnel** | **Responsibilities** | **% Of Time  Dedicated** |
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# Governance

Oversight Committee must include hospital CEO, CFO, CMO, a consumer representative, and must comprise at least 50% physicians. See the Participation Agreement for additional detail regarding requirements of the Oversight Committee.

**Provide the names of your Oversight Committee members and their organization.**

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| --- | --- | --- | --- | --- |
| **Name, Credentials** | **Job Title and Organization, if applicable** | **Please check one to indicate who the member is representing:** | | |
| **Hospital Employee** | **Physician Representative** | **Consumer Representative** |
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**Provide an explanation of how the Oversight Committee will provide oversight, guidance, and management to the program. Detail the process as well as expected meeting frequency.**

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| **Please answer the following questions about how the Care Redesign Program Oversight Committee will provide oversight, guidance, and management to the Complex and Chronic Care Improvement Program.** | |
| How often will the Oversight Committee meet? (monthly, bi-monthly, quarterly, bi-annually) |  |
| Does the member composition of your Oversight Committee meet the qualifications outlined in the Participation Agreement? |  |
| Will the Oversight Committee be provided with progress/dashboard reports on program performance from hospital personnel involved in the program? |  |
| If yes, how often will the Oversight Committee require these reports? (monthly, bi-monthly, quarterly, bi-annually, annually) |  |

# HCIP Model Plan

Multiple changes to the existing hospital care model are needed to perform the stated interventions of the HCIP. Please briefly explain how the necessary elements list below will be executed.

**Table 1. Background: Programmatic Information**

| **Category** | **Hospital changes to current care model** | **Describe programmatic information at a general level (200 words or less)** |
| --- | --- | --- |
| **Infrastructure** | Please describe your process for engaging care partners (Responsible Physicians) (i.e. service line pilot, by specialty, hospital wide). |  |
| Please describe the information systems that your hospital will use to track the interventions performed by the care partners. |  |
| Please identify what staff will be responsible for administering the HCIP program at your hospital. |  |
| **Data** | Please describe your hospital’s process for sharing clinical and other key information with providers. |  |
| Please describe how your hospital will utilize monthly CMS data files in the care redesign program. |  |
| Please describe how data will be used to support incentive payments and processes. |  |
| **Processes; redesign care** | Please describe how your hospital will identify opportunities for improvement. |  |
| Please describe the monitoring and reporting process. |  |
| Please describe your processes for communicating and educating physicians and clinical staff regarding the care redesign program. |  |
| Please describe how you will use feedback from care partners in order to improve interventions in the care redesign program. |  |

# D. Care Redesign Interventions

In order to participate in the Hospital Care Improvement Program, and thereby gain access to the associated waivers and Medicare data**,** hospitals must develop and deploy meaningful care redesign interventions. There are seven approved categories of care redesign within which a hospital may choose to implement interventions. A hospital may select to enact interventions in as many categories as it wishes, and may select one or more of the care redesign interventions in each category. Allowable care redesign interventions for this program include, but are not limited to, the list in Table 2 below.

Please indicate the Care Redesign Interventions you intend to implement as part of the Hospital Care Improvement Program, and how you plan to implement them.

**Table 2. Care Redesign Interventions**

| **Category of Allowable Activity** | **Hospital Interventions** | **Will Include** | **Existing Strategy** | **Interventions Used as a Condition of Payment?** | **Are any non-cash resources provided to Care Partner for performing this intervention? If yes, please describe briefly** |
| --- | --- | --- | --- | --- | --- |
| **Care Coordination** | Medication reconciliation forms completed per protocol  If yes, please explain: |  |  |  |  |
| Care alert or care plans completed for high risk patients per protocol |  |  |  |  |
| Home management plans in care document are completed and reviewed with the patient and care givers before discharge  If yes, please explain: |  |  |  |  |
| Patients with a high risk of readmission are identified, per protocols, and subsequently connected with transitions of care services  If yes, please explain: |  |  |  |  |
| Other evidence-based, reliable, and valid intervention(s)  If yes, please explain: |  |  |  |  |
| **Discharge Planning** | Necessary follow-up appointments are scheduled before hospital discharge  If yes, please explain: |  |  |  |  |
| Bedside delivery of medications at discharge (for new or high-risk medications) |  |  |  |  |
| Other evidence-based, reliable, and valid intervention(s)  If yes, please explain: |  |  |  |  |
| **Clinical Care** | Core compliance activities are completed*,* including documenting core measures, using evidence-based order sets, and documenting the rationale behind diversions.  If yes, please explain: |  |  |  |  |
| Heart failure activities are completed, such as giving heart failure patients ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD) and documenting evaluation of LV systolic function.  If yes, please explain: |  |  |  |  |
| Surgical improvement activities are completed, including compliance with requirements for surgery registry and compliance with pre-surgery safety checklists, including surgical markings.  If yes, please explain: |  |  |  |  |
| Other evidence-based, reliable, and valid intervention(s)  If yes, please explain: |  |  |  |  |
| **Patient Safety** | Medication error prevention and general harm prevention activities are completed, including self-reporting adverse events to appropriate departments in a timely manner, using appropriate risk assessment tools to identify patients at-risk for falling, and implementing appropriate interventions for the at-risk patients.  If yes, please explain: |  |  |  |  |
| Infection and sepsis prevention activities are completed, including adhering to sepsis treatment protocols and checklists and complying with universal infection prevention protocols, including hand hygiene  If yes, please explain: |  |  |  |  |
| Compliance with VTE prophylaxis |  |  |  |  |
| Other evidence-based, reliable, and valid intervention  If yes, please explain: |  |  |  |  |
| **Patient and Care Giver Experience** | Advanced directives obtained per protocol  If yes, please explain: |  |  |  |  |
| Maryland MOLST compliance documented per protocol  If yes, please explain: |  |  |  |  |
| Interdisciplinary palliative care consults and interventions completed per protocol  If yes, please explain: |  |  |  |  |
| Comprehensive, individualized patient/family education (considering health literacy, preferred method of education, use of Teach Back) documented |  |  |  |  |
| Staff development activities are completed, including attending agreed upon number of educational sessions per quarter and 100% completion and compliance of CPOE training  If yes, please explain: |  |  |  |  |
| Other evidence-based, reliable, and valid intervention(s)  If yes, please explain: |  |  |  |  |
| **Population Health** | High blood pressure counseling and treatment are completed  If yes, please explain: |  |  |  |  |
| Obesity counseling and treatment are completed  If yes, please explain: |  |  |  |  |
| Vaccination status is addressed and needed vaccinations are administered to patients  If yes, please explain: |  |  |  |  |
| Depression/substance use screening conducted and referral to appropriate community resources documented |  |  |  |  |
| Other evidence-based, reliable, and valid intervention(s)  If yes, please explain: |  |  |  |  |
| **Efficiency and Cost Reduction** | Procedures and patient flow activities are completed in a timely manner, including writing discharge orders by the hospital goal time (e.g. noon), and reducing median time from Emergency Department arrival to departure or admission to a bed.  If yes, please explain: |  |  |  |  |

Define your process and frequency for monitoring the completion of your care redesign activities. Please attach sample reports you intend to use with Responsible Physicians to ensure completion of required activities.

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How will you communicate care redesign activity and results to Care Partners and the Hospital Oversight Committee? Please attach sample reports or dashboards you intend to use, and how often you plan to provide them.

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# Incentive Payments

The second major component of the Hospital Care Improvement Program is an optional incentive payment. Participant Hospitals may share cash incentive payments with hospital-based providers who demonstrate positive financial results by reducing unnecessary utilization and resource use, improve practice efficiency, and/or improve quality. The incentive payments are designed to encourage the creation and proliferation of evidence-based care redesign processes and programs. Receiving an incentive payment will be contingent on completing approved activities and meeting required quality metrics. At a minimum, the Health Services Cost Review Commission (HSCRC) or its third party designee will determine the “Responsible Physician” – i.e. the physician most responsible for inpatient resource utilization decisions identified directly from the Uniform Bill – and calculate the internal cost savings attributed to admissions overseen by the Responsible Physician. Incentive Payments to the Responsible Physician, the Care Partner for the HCIP, will be calculated utilizing the AMS PBIS® or similar methodology tool reflecting financial performance. A uniform methodology will be used across all participating providers.

**Determining Total Available Incentive**

The opportunity for savings (Best Practice Variance) is determined by computing the difference between the Best Practice Norm and the actual costs for each admission. The total available incentive (Total Available Incentive) is computed by taking 10% of the Best Practice Variance across all hospitals in the region for each APR DRG (and for each severity level within the APR DRG) for which a Best Practice Norm is established. The resulting amount by APR DRG is the Maximum Physician Incentive (Maximum Physician Incentive or MPI). The Hospital may elect to have these amounts adjusted so that the MPI is never less than $100 per case or more than $3,000 per case. This and other payment decisions will be independently established by the Hospital, subject to the overall constraints of the Incentive Program.

**Apportioning the Maximum Physician Incentive between Performance and Improvement**

The calculated incentive payment includes two components – performance and improvement. Performance is defined as each physician’s cost per case, adjusted for case mix and SOI, compared to the Best Practice Norm. Improvement is defined as each physician’s Prior Year performance compared to his or her actual performance during the relevant Incentive Program Year (i.e., the Current Year). The two incentive formulae were developed to balance two objectives: encourage Improvement while, at the same time, recognize the achievement of physicians (and institutions) that enter the Program already performing efficiently. An overarching goal was to implement a system of incentives that would encourage good Performance, while promoting continued improvement for the institution. The savings is equal in value whether it comes from a physician that improves, or one that is already efficient.

The Improvement Incentive is transitional; the objective of the Program is to reach 100% Performance. Rather than continuing to pay inefficient physicians to improve, the most desirable result is for each physician to reach the Best Practice Norm, and to maintain that level of Performance. (As a practical matter, the Performance Incentive is designed to continue to encourage Improvement since attaining perfection, however desirable, is unlikely.) However, it is understood that Improvement is the higher priority in the initial year(s) of the Program. Accordingly, the allocation between Improvement and Performance for each Hospital is weighted initially 2/3 Improvement, 1/3 Performance. The Oversight Committee at each institution has the flexibility to change this allocation. This enables each institution to respond to the progress and the conditions unique to its own situation. (Change is not recommended until data is received and analyzed following the conclusion of the first year of the Program – i.e., 2 incentive payment periods.) The methodology was designed to be flexible; but it also assures that regardless of the allocation, incentives are paid only on cases that either compare favorably to the Best Practice Norm, or have improved since the Prior Year. Incentives are only paid on cases that have savings.

The Oversight Committee may also impose other conditions to balance the objectives of the Incentive Program in light of unique circumstances at the Hospital.

**Performance Incentive Formula**

The Performance Incentive is intended to provide a positive example by rewarding demonstrated levels of performance. Accordingly, RPs will receive incentive payments in proportion to the relationship between their individual performance and the Best Practice Norm. A non-linear distribution formula is used to assure that the relationship to the Best Practice Norm among physicians is both fair and proportionate. This computation is the same for surgical and medical cases. An equation illustrating the computation of Performance Incentives for individual RPs is as follows:

**75th Percentile Cost - Physician's Actual Cost**

**75th Percentile Cost - Best Practice Cost**

**X**

**Maximum Performance Incentive**

This computation is performed at the case level for each admission. Payment for the Performance Incentive is made to all physicians except the 25% of physicians with the highest cost.

**Improvement Incentive Formula**

The Improvement Incentive is intended to encourage change in behavior that results in more efficient performance while improving the quality of care delivered. For surgery and medicine, Improvement Incentive payments are made unless an individual physician does not demonstrate measurable improvement in operational performance. However, because physicians who admit medical cases may be forced to sacrifice professional income to achieve Program objectives, the methodology for the Improvement Incentive is slightly different.

The Improvement Incentive formulae for medical and surgical RPs are as follows:

For Medical RPs:

**Prior Year Case-Mix Adjusted ALOS—Current**

**Year Case-Mix Adjusted ALOS[[1]](#footnote-1)**

**X**

**Per Diem**

**X**

**Current Year Admissions**

For Surgical RPs:

**Prior Year Case-Mix Adjusted Cost—Current**

**Year Case-Mix Adjusted Cost**

**Xth Percentile Base Year Cost**[[2]](#footnote-2)**—Best Practice**

**Cost**

**X**

**Case Mix Adjusted Maximum**

**Improvement Incentive**

**X**

**Current Year Admissions**

This methodology will be uniform across all participating hospitals. For each APR DRG there is a maximum physician incentive established. Payments to individual physicians may not exceed 25% (or lower percentage depending on program and limits approved by the Oversight Committee of the total Medicare approved amounts under the Physician Fee Schedule (PFS) for services furnished to the participant hospital’s Medicare beneficiaries by that participating physician. Incentives related to individual cases may not be paid for exceeding best practice norms established by the Plan. The resulting calculated incentive may be adjusted based on the performance on specific quality measures selected by the Oversight Committee. Prior to the start of the performance period the Oversight Committee will determine the weights for conditions of payment which must equal 100%.

No physician will receive any incentive payment generated by any cost savings unless the physician performs the approved activities and satisfies required quality metrics.

**Example**

An illustrative example for APR DRG 165 – Coronary Bypass with Cardiac Cath or Percutaneous Cardiac Procedure (SOI Level 3):

**Overview of HCIP Savings Pool and Physician Opportunities**



The Oversight Committee will review the independent administrator’s report of potential incentives based on financial performance and adjust the incentive payout, as necessary, for the quality measure selected under the HCIP. Hospitals may adjust the calculated incentives based on the approved outcomes and quality measures. The amount paid cannot exceed the calculated incentive amount. Data files will be made available to the All-Payer Team and/or HSCRC including the calculated incentives, adjustments to calculated amounts, and final amounts to be paid. Data will also be provided regarding the hospital internal cost savings.

Beginning in year two, the total amount of money that may be distributed may not exceed the cumulative cost reductions achieved due to internal cost savings, net the apportionments of incentives and interventions that may be included in another program.

The calculation compares costs from current period to a prior period adjusted for case mix and severity using APR DRGs with outliers excluded (over three standard deviations) and hospital-specific cost adjustments as determined by the HSCRC (IME, DSH, labor market, markup, etc.). In order to compute supply and drug costs a separate methodology to measure improvement.

The actual internal cost savings will be calculated by HSCRC or designee semi-annually based on hospital cost reports and claims data using AMS PBIS® or similar tool.

**How will you work with the third party administrator to ensure you are distributing the incentive pool based on the formulas and calculations provided?**

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**Signed and Approved by:**

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| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **PARTICIPANT HOSPITAL**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Legal Name of Participant Hospital  By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Authorized Signatory  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **CENTERS FOR MEDICARE & MEDICAID SERVICES**  By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dr. Patrick Conway, Director, Center for Medicare and Medicaid Innovation |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **HEALTH SERVICES COST REVIEW COMMISSION**  By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Donna Kinzer, Executive Director, Health Services Cost Review Commission |

1. Because an individual physician or surgeon is unlikely to treat patients with the identical case-mix and levels of severity in the Prior Year and in the Current Year, the adjustment made to facilitate the comparison are a physician-specific case-mix/SOI index for the Prior Year and the Current Year. [↑](#footnote-ref-1)
2. Percentile will be set to eliminate the outlier effect caused by high-utilizing physicians. [↑](#footnote-ref-2)