**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)

**Green text – hospital completion**

**Red text – standard for all hospitals**

# 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, 2017

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

**TIN: 123456**

**CMS cert #(s) for organization: 987654**

**Contact Person for Agreement:**

|  |  |
| --- | --- |
|  | **Hospital** |
| Name: | Mary Smith |
| Title: | Program Coordinator |
| Street Address: | 1 Elm Street |
| City, State, Zip: | Anywhere, MD 11111 |
| Telephone: | 667-123-4567 |
| Fax: | 667-123-4568 |
| Email: | m.smith@genhosp.000 |

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

|  |  |  |
| --- | --- | --- |
| **Key Personnel** | **Responsibilities** | **% Of Time Dedicated** |
| Mary Smith | Program Coordinator | 25% |
| Ann Black, MD | CMO | 5% |
| Frank Brown | CFO | 5% |
| William White | CEO, Administrative oversight | 2% |
|  |  |  |
|  |  |  |

# 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.**

|  |  |  |
| --- | --- | --- |
| **Name, Credentials** | **Job Title and Organization, if applicable** | **Please check one to indicate who the member is representing:** |
| **Hospital Employee** | **Physician Representative** | **Consumer Representative** |
| Mary Smith | Program Coordinator | [x]  | [ ]  | [ ]  |
| Ann Black, MD | CMO, Internist | [x]  | [x]  | [ ]  |
| Frank Brown | CFO | [x]  | [ ]  | [ ]  |
| William White | CEO, Administrative oversight | [x]  | [ ]  | [ ]  |
| Sally Doe |  | [ ]  | [ ]  | [x]  |
| Sara Glass, DO | Orthopedic Surgeon | [ ]  | [x]  | [ ]  |
| Bob Johnson, MD | Pulmonologist | [ ]  | [x]  | [ ]  |
| Rick Williams, MD | General Surgeon | [ ]  | [x]  | [ ]  |
| Bruce Jones, MD | General Surgeon | [ ]  | [x]  | [ ]  |

**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.**

|  |
| --- |
| **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) | **Quarterly** |
| Does the member composition of your Oversight Committee meet the qualifications outlined in the Participation Agreement? | **Yes** |
| Will the Oversight Committee be provided with progress/dashboard reports on program performance from hospital personnel involved in the program? | **Yes** |
| If yes, how often will the Oversight Committee require these reports? (monthly, bi-monthly, quarterly, bi-annually, annually) | **Quarterly** |

# 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).  | The Oversight Committee will use reports issued by AMS (program administrator) which detail the potential opportunities for reduction in resource utilization by Service Line to identify the initial areas on which to focus. The CMO and Program Coordinator will analyze physicians within those Service Lines, using physician reports and dashboards, to prioritize physician enrollment in the Program. Through Departmental Meetings and one-on-one discussions, the data will be presented to individual physicians in order to secure interest and participation. In addition, the Oversight Committee and physician champions will assist in identifying care redesign measures designed to achieve efficient utilization of resources. |
| Please describe the information systems that your hospital will use to track the interventions performed by the care partners. | The interventions that are used by the care partners will be tracked in several ways. Interventions that have been implemented and are being tracked by other internal committees will be reported to the Oversight Committee on a quarterly basis. In addition, any interventions that are new to the institution will be tracked by the Program Coordinator or designee. In all cases, whenever possible, electronic tracking through the electronic health record or other internal systems will be preferred over manual tracking. |
| Please identify what staff will be responsible for administering the HCIP program at your hospital.  | The Program Coordinator is responsible for staff functions of the Oversight Committee, such as scheduling, minutes, and distribution of reports. Working in conjunction with the CMO, the Coordinator will also meet with participating physicians to discuss their performance. The Coordinator will also work with the independent scorekeeper to ensure accurate and complete data is provided to them in a timely fashion. |
| **Data**  | Please describe your hospital’s process for sharing clinical and other key information with providers. | Clinical outcomes related to the interventions pursued by the Oversight Committee will be reported to various internal committees, in particular those related to specific interventions (e.g. First case start times will be reported to the OR Committee and the Department of Surgery). Key information about the impact of the Program on the utilization of resources throughout the institution will be reported to the Administrative Staff at regularly scheduled meetings; to the medical staff at the Physician Executive Committee; to the Quality Improvement Committee; and to the Hospital Board on a routine basis. |
| Please describe how your hospital will utilize monthly CMS data files in the care redesign program. | The CMS data files will supplement the inpatient data used by HCIP. The data will help to prioritize a focus on post-acute services, as well as to better track readmissions. |
| Please describe how data will be used to support incentive payments and processes. | Using reports provided by the independent scorekeeper (AMS), incentive payments for each participating physician will be reviewed. Conditions of payment, developed by the Oversight Committee, will be applied to the incentives to ensure that physicians are meeting the institution’s quality and care redesign objectives.  |
| **Processes; redesign care** | Please describe how your hospital will identify opportunities for improvement. | The Oversight Committee, working with the CMO and the Program Coordinator, will review various reports on resource utilization by Service Line and Cost Center. These reports compare internal performance against statewide benchmarks and report potential areas of improvement.  |
| Please describe the monitoring and reporting process. | On a quarterly basis, claims/abstract data for all discharges is provided to AMS. This data goes through extensive quality checks to ensure the accuracy of the data. Data is then aggregated into a number of reports each six months and provided back to the hospital. These reports are provided at the institutional level, the Service Line level, the Cost Center level, APR DRG level and the individual physician level. Dashboards are provided to the Oversight Committee to monitor progress towards more efficient use of resources. Dashboard are also provided for each participating physician to track their performance against themselves as well as against state norms. The CMO and Program Coordinator use these reports to meet with each participating physician about their performance. |
| Please describe your processes for communicating and educating physicians and clinical staff regarding the care redesign program.  | The Hospital will begin a campaign to educate physicians about the program in the months leading up to implementation. The Program Coordinator, assisted by the CMO as well as MHA and AMS, will schedule meetings with Medical Staff to discuss how they fit in with the program and what it might mean to the physicians. Additional information will be provided through flyers posted in physician lounges. A Physician Handbook, outlining the Program and providing examples of incentive calculations, will be made available to physicians. These steps will be undertaken to generate interest in the Program and to encourage participation. Once the Program is underway, feedback on the impact of the Program will be provided to participating physicians and Departments, especially those targeted for early interventions. This is done to maintain engagement and encourage cooperation in achieving efficient resource utilization. |
| Please describe how you will use feedback from care partners in order to improve interventions in the care redesign program. | The physician members of the Oversight Committee will be encouraged to discuss the impact of the program with their peers and to report such feedback at the Oversight Committee meetings. This feedback will be reviewed by the Committee to determine whether interventions should be modified. This recognizes that physicians who are not part of the Oversight Committee may have insight into the issues that affect the delivery of care and resource utilization that had not previously been considered. |

# 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 protocolIf 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 dischargeIf yes, please explain: | [ ]  | [ ]  | [ ]  |  |
| Patients with a high risk of readmission are identified, per protocols, and subsequently connected with transitions of care servicesIf yes, please explain: All adult patients are screened for complex discharge planning using tools such as the Early Screen for Discharge Planning (ESDP), or LACE, as well as inter-disciplinary roundsCare coordination team member to meet with identified patients to ensure appropriate resources are in place to prevent the need for readmission. LOS and readmissions will be monitored on these populations. | [x]  | [x]  | [ ]  | N/A |
| Other evidence-based, reliable, and valid intervention(s)If yes, please explain:  | [ ]  | [ ]  | [ ]  |  |
| **Discharge Planning** | Necessary follow-up appointments are scheduled before hospital dischargeIf yes, please explain: High risk patients have follow-up appointments scheduled 7-10 days after discharge. | [x]  | [ ]  | [x]  | N/A |
| Bedside delivery of medications at discharge (for new or high-risk medications) | [x]  | [x]  | [x]  | N/A |
| Other evidence-based, reliable, and valid intervention(s)If yes, please explain: Discharge summaries transmitted to next provider within time limits as determined. (7 days or less) | [ ]  | [ ]  | [x]  | N/A |
| **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: CDI inquiries are responded to within established time guidelines. | [ ]  | [ ]  | [x]  |  |
| 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 hygieneIf yes, please explain: Adherence to infection prevention protocols, mortality, LOS and readmissions tracked for all surgical and pneumonia patients. Hand Hygiene compliance tracked. | [x]  | [ ]  | [ ]  | N/A |
| Compliance with VTE prophylaxis Compliance with VTE prophylaxisCompliance with VTE prophylaxis will be monitored on all appropriate patients. The number of hospital acquired DVT and emboli will also be monitored. | [x]  | [x]  | [ ]  | N/A |
| Other evidence-based, reliable, and valid interventionIf yes, please explain: | [ ]  | [ ]  | [ ]  |  |
| **Patient and Care Giver Experience** | Advanced directives obtained per protocolIf yes, please explain: | [ ]  | [ ]  | [ ]  |  |
| Maryland MOLST compliance documented per protocolIf yes, please explain: | [ ]  | [ ]  | [ ]  |  |
| Interdisciplinary palliative care consults and interventions completed per protocolIf yes, please explain: | [ ]  | [ ]  | [ ]  |  |
| Comprehensive, individualized patient/family education (considering health literacy, preferred method of education, use of Teach Back) documented | [x]  | [x]  | [ ]  |  |
| Staff development activities are completed, including attending agreed upon number of educational sessions per quarter and 100% completion and compliance of CPOE trainingIf yes, please explain: | [ ]  | [ ]  | [ ]  |  |
| Other evidence-based, reliable, and valid intervention(s)If yes, please explain: HCAHPS scores meet established internal standards. | [ ]  | [ ]  | [x]  | N/A |
| **Population Health** | High blood pressure counseling and treatment are completedIf yes, please explain: | [ ]  | [ ]  | [ ]  |  |
| Obesity counseling and treatment are completedIf yes, please explain: | [ ]  | [ ]  | [ ]  |  |
| Vaccination status is addressed and needed vaccinations are administered to patientsIf 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: Completion of medical records, operative reports, discharge summaries and patient histories/physicals are completed within the hospital established guidelines. | [ ]  | [ ]  | [x]  | N/A |

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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| **Once the Oversight Committee selects the care redesign measures, the Oversight Committee will determine appropriate outcome measurements for each. Some of the outcomes may already be tracked by other committees/groups within the organization. The Oversight Committee will request results from any of these monitoring activities. Each redesign measure will be reported on at the Oversight Committee meetings and results will be included in the reports that are provided on a semi-annual basis to the hospital and the Oversight Committee. These results will also be collected by the Administrator, using an online survey tool customized to the hospital. Any missing information will be brought to the attention of the Program Coordinator in order to ensure consistent collection.****A sample of this report is shown below.** |





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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| **The Oversight Committee is responsible to identify the care redesign activities that will be undertaken at the hospital. The CMO will communicate the activities and the goals of care redesign to the Medical Executive Committee for dissemination within the affected departments. Non-physician individuals on the Committee will be communicating the activities to peers and other Committees throughout the organization. Results of the redesign efforts are reported to the Oversight Committee every six months at a minimum and to hospital administration. In addition, copies of the reports will be forwarded to the hospital quality improvement committees.****Physician dashboards will be distributed every six months as part of the incentive payment process. The CMO and the Program Coordinator will meet with participating physicians to review the results provided by the Administrator as well as any outstanding quality issues identified. A sample of the dashboard is included here:** |

# 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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| **The Oversight Committee will review this information, apply the conditions of payment developed by the Oversight Committee, issue payment for the adjusted amount to the physician and report the payments by physician and in total to the Administrator to ensure that the incentives paid do not exceed the calculated incentive. The administrator will provide an audit report with each payment cycle and indicate if any adjustments are necessary from a prior period.****The conditions of payment are:** |

**Signed and Approved by:**

|  |  |
| --- | --- |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **PARTICIPANT HOSPITAL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Legal Name of Participant HospitalBy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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)