# Maryland All-Payer Model Transformation and Care Redesign Program FAQs

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Table of Contents:



## General Care Redesign Program FAQs

1. **How do hospitals enroll in the CCIP and HCIP programs?**
   **A:** For both programs, hospitals must: (1) submit a non-binding LOI by Nov. 18th to hscrc.care-redesign@maryland.gov; (2) complete and submit an Implementation Protocol that describes their program(s); (3) sign a Participation Agreement with the State and CMS; and (4) sign a GBR Agreement Amendment. Hospitals will also need to sign a Care Partner Agreement with their participating Care Partners.

2. **How are these programs aligned with our transformation strategic plans and regional partnerships?**
   **A:** The care redesign programs, regional partnerships and other strategic initiatives are all focused on the activities that are going to lead to high quality, well-coordinated episodes of care and reduced avoidable utilization from things like readmissions and ambulatory-sensitive conditions. The Hospital Oversight Committee is provided the flexibility to implement the care redesign activities in ways that link and accelerate the respective initiatives, ensuring Maryland's hospitals are optimizing opportunities to improve care.

3. **How do providers enroll as Care Partners in the CCIP and HCIP programs?**
   **A:** For both programs, eligible physicians and Participant Hospitals will sign a Care Partner Agreement. Physician participation is subject to CMS approval.

4. **Can providers participate in the HCIP and CCIP programs of more than one hospital? Are there any additional limitations or requirements around provider eligibility?**
   **A:** Yes, physicians can participate in more than one hospital's HCIP or CCIP program. Employed and contracted physicians are eligible and both are required to complete the Care Partner Agreement. Physicians participating in ACOs are also eligible to participate in the CCIP and HCIP.

5. **What is PECOS and why is it relevant to participation in the Care Redesign programs?**
   **A:** PECOS is a verification tool used by CMS and others to determine a physician's status and will be used in CMS's validation of physician eligibility to participate as a Care Partner. To participate in HCIP and/or CCIP, physicians must log in at least quarterly to maintain active status. If physicians are not active on PECOS in any quarter, they are not eligible to participate in that

quarter. CMS will follow up with a more detailed process for submission of the quarterly provider list.

6. **What is the Oversight Committee?**
   **A:** The Participant Hospital must establish and operate a Care Redesign Oversight Committee that will monitor the Participant Hospital's Care Redesign Program(s) to ensure compliance with the requirements of the program(s). The Oversight Committee should be comprised of at least 50% Care Partners that are representative of the Care Partners participating in all of the Participant Hospital's Care Redesign Programs, and one consumer representative. Participating hospitals are encouraged to evaluate the composition of existing committees to determine if they can be used as the Oversight Committee.

   The Oversight Committee will:
   - Provide oversight for implementing the care redesign and quality improvement components of the program, including the selection of care redesign initiatives and activities
   - Provide a forum for sharing ideas, identifying problems, and developing solutions as well as offering the internal framework and leadership to ensure the integrity of, and opportunity for, success of the program(s)
   - Monitor the participants in the program(s) to ensure that they comply with the requirements of the Global Budget Review (GBR) and Total Cost of Care (TCOC) Guardrails, the Implementation Protocol(s), and any other specific program requirements, including reporting

   If a hospital is participating in more than one Care Redesign Program, hospitals may choose to set up a Steering Committee for each Care Redesign Program in which they are participating that would report to the Oversight Committee.

7. **Is there opportunity to provide feedback on these models?**
   **A:** Yes. Stakeholders will have the opportunity to provide feedback in the coming months. The Amendment provides the flexibility necessary to modify and grow these programs on an annual basis, based on evaluations of what is and isn't working. A process for Stakeholder feedback from hospitals, physicians, patients, and others is being developed.

8. **Can you clarify what "comprehensive Medicare data" means? Will it be patient identified, or de-identified?**
   **A:** Hospitals will receive patient identified data for all Medicare patients with a visit to the hospital within the last three years. This data will include all hospital data and Part B data. It will not include Part D data. More detail was provided in the November 30th Webinar 5: Comprehensive Medicare Data Process and Use. Please visit http://hscrc.maryland.gov/care-redesign.cfm for a recording and the slides used in this presentation.

9. **Will the Medicare data set be available to hospitals participating in only one of the Care Redesign Programs?**
   **A:** Yes, hospitals participating in either one or both programs will be eligible to receive comprehensive Medicare data.

10. **Can you please clarify how the Medicare data will complement the HCIP data and would be most applicable to CCIP?**

    **A:** These data sets are complementary. HCIP relies on abstract data to focus on inpatient utilization. The Medicare data set is more expansive in that it looks at the entire episode. This

Medicare data includes information related to post-acute services for hospitals to use as part of their care redesign initiatives. This data set will provide hospitals with a complete picture of a patient's interaction with the healthcare system throughout an episode and could enhance hospital ability to use some of these measures to condition payments to change behavior in the inpatient setting. The CMS data set, in conjunction with HCIP and CCIP data, will help hospitals identify some of those patterns, particularly with re-admissions and emergency department utilization.

11. **What integration capabilities does CRISP have currently with common EHRs?**
    **A:** CRISP is capable of integrating with any EHR system so long as it is Meaningful Use Stage 2 compliant. CRISP has created the following webpage for hospital leaders to answer questions about ambulatory integration of their EHR to enable care redesign efforts: https://crisphealth.org/services/ambulatory-integration/

12. **When will the TCOC Workgroup be formed and when is the expected first meeting? Is this open to the public?**
    **A:** The first TCOC Workgroup meeting will be held in December 2016. All meeting dates, materials, and information on workgroup membership will be posted to the HSCRC website. Meetings are open to the public. Workgroup members will be selected to represent a broad group of stakeholders.

## Medicare Data FAQs

1. **Will multi-hospital systems be able to access datasets for all of their member hospitals?**
   **A:** Yes. Each hospital will indicate those individuals who should have access to their data files. If a hospital system wants to provide a central point of contact to receive the data on behalf of each member hospital prior to distribution, they are free to do so.
2. **How do we identify the appropriate people to receive and access the data files?**
   **A:** CMMI will provide the required forms and process for identification of individuals who have access to the files at a later date.
3. **When does the registration, logging in, training and receipt of the data start?**
   **A:** The data will become available once the Participation Agreements have been signed. Please refer to the timeline in Webinar 4 for further details.
4. **Will the files include the patient Medicare HCC value?**
   **A:** No, not at this time.
5. **How current is the data that is updated every 30 days?**
   **A:** Data will be current as of the previous month.
6. **Will the data include information on utilization in non-inpatient settings of care (e.g. chronic hospitals, outpatient practices, post-acute care, etc.?**
   Yes. The data should include different settings of care for beneficiaries who are admitted to your hospital so you will have a broad vision into the services they receive across all settings of care. There will be some suppression of SAMHSA data.

## Complex and Chronic Care Improvement Program (CCIP) FAQs

1. **What providers are eligible for participation in the CCIP and how is a Patient Designated Provider (PDP) defined?**
   **A:** Physicians and practitioners eligible for the CCIP program are family practice, general or specialist physicians, clinical nurse specialists, and nurse practitioners who are willing to take responsibility for the overall management and coordination of patients with chronic and complex conditions, and meet the following requirements:
   - Designated by a patient as the patient's primary provider of care
   - Provide services to beneficiaries who are within the service area of the Participant Hospital
   - Have a National Provider Identifier (NPI); and
   - Participate in the Medicare Program

   A Patient Designated Provider must enter into a Care Partner Agreement with a Participant Hospital and agree to perform Care Intervention Activities described in the CCIP Program Template.

2. **What determines patient eligibility for participation in the Care Redesign programs?**
   **A:** The hospital may use their own criteria for risk selection of patients or they may use the State-defined "best practice" recommendation for defining high need and rising need patients, outlined in the CCIP Program Template.

3. **How would participation in the CCIP Care Redesign Program benefit providers?**
   **A:** Physicians participating in CCIP will benefit through:
   - Increased access to care management resources and technology
     - Care resources to execute the provider's orders, handle care coordination, and manage care transitions for high and rising need patients
     - Care management supports to ensure care plans are being implemented
     - Access to CEHRT
   - Participation in programs intended to align with MACRA requirements (MIPS and APM)
   - Access to potential financial incentives from the hospital for performing activities that will improve quality of care, reduce potentially avoidable utilization (PAU).

4. **How are incentives calculated in the CCIP?**
   **A:** The CCIP incentive calculation can be found on the HSCRC website in Webinar #3. In general, the incentive is calculated on a patient-by-patient basis after the patient-designation provider (PDP) meets the threshold of performing 80% of the required activities on 80% of the enrolled patients. As long as an incentive pool is generated from hospital savings and the TCOC guardrail is met, incentives are paid.

5. **How do patients sign up for the CCIP?**
   **A:** Hospitals identify a list of high need and rising need patients and contact physicians who are providing primary care to the patients. The PDP will enroll a patient into the program in his or her office through a discussion about the program and signing a written agreement. The Participant Hospital will provide PDPs with a template for the discussion and materials to be used with the patient, including a written agreement for CCIP participation. The written agreement includes: an agreement to electronic communication of medical information to medical partners, an explanation of care management services, an explanation of how to revoke

program participation, and an explanation of patient's cost sharing (if billing for the Medicare Chronic Care Management Fee (CCM).

6. **If the patient does not consent to CCM billing, can the patient still participate in the CCIP? Likewise, could providers still qualify for incentive payments?**
   **A:** Yes to both.

7. **May a provider bill for the Transition of Care (TOC) activity and the CCM fee in the same month?**
   **A:** No. Per CMS regulation, a provider cannot bill for both the CMM and TOC fees within the same month due to the overlap in services.

8. **Can patients already engaged in HSCRC-approved care management be rolled into CCIP for the purpose of reporting to the State?**
   **A:** Yes, as long as the care management provided meets the requirements of the CCIP program.

9. **Patients must be enrolled in the CCIP through a face-to-face visit with his or her PDP. Do you envision this being tacked onto a regular sick visit or physical, or would this be during a separate uncompensated visit?**
   **A:** If the patient has not had their Welcome to Medicare visit or their annual Medicare Wellness visit, these would also be ideal times to talk to the patient. If not, the enrollment could occur during a regular visit.

10. **Can patients be added and removed from the CCIP panels throughout the performance period?**
    **A:** Yes. Patients may change PDPs or dis-enroll from the program as they choose.

11. **What are the PDP's responsibilities under the CCIP?**
    **A:** The PDP must agree to direct the care management of the patient for all health care services. They must also agree to perform care interventions, such as overseeing the development, deployment and ongoing management of the care plan, completion of an HRA, medication reconciliation and management, and ensuring that a timely appointment is available after a hospitalization. PDPs must use CMS certified Electronic Health Records. Details are provided in Webinar #3.

12. **Is there flexibility in the composition of care management teams CCIP participating hospitals could deploy to meet the care management needs of high and rising risk patients in the program?**
    **A:** Yes. Hospitals are encouraged to think creatively and push themselves to truly deploy resources based on what they think will be the most effective strategy to care for their specific patient population. The care team, at a minimum should include the PDP and a care manager, but additional team members may vary based on patient need. Best practice is to integrate care managers, community health workers, behavioral health providers, social workers, and other allied healthcare professionals in efforts to improve patient care coordination. The care team could also include existing hospital case managers, contracted care management support, behavioral health specialists, licensed clinical social workers, community health workers, behavioral health counselors, and others.

13. **For what period of time are care management teams provided and how does this align with continuing to deliver CCM?**
    **A:** The care management team is expected to work with the patient for the length of program enrollment. The aim of the program is continuous care management for the patients that are most severely or most likely to be severely impacted by complex and chronic disease.

14. **If a Care Partner in the CCIP chooses to bill for the CCM fee, will the patient still be required to pay the patient co-pay?**
    **A:** Yes. CMS cannot grant the State a waiver from the required CCM patient co-pay.

15. **If a physician bills for the CCM fee, but is aided by members of the hospital-deployed care team, will the hospital receive a share of the CCM fee?**
    **A:** No. The CCM fee belongs solely to the provider, as it is a billing code CMS implemented for physician compensation. Physicians bill for the CCM fee based on specific CMS billing requirements, where care managers work under the direction of physicians. The waiver allows the hospital to cover the costs of care management, which accelerates the deployment of necessary care coordination services for high and rising need patients, leading to improved patient outcomes and reductions in potentially avoidable utilization. For more information on CCM billing please visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf

16. **If a PDP is part of a health system, are the incentives still based on individual PDP performance, or system-wide performance?**
    **A:** They are based on the PDP's individual performance.

17. **What is the HCC score and what is its relevance to the CCIP program?**
    **A:** The HCC score or "hierarchical condition category" is used to adjust the incentive amount to account for the additional time needed to care for sicker patients.

16. **Under what circumstances would a Care Partner Agreement or a patient's enrollment in CCIP be terminated? What would be the implications for the provider, hospital, and patient?**
    **A:** Questions regarding agreements and conditions under which agreements may be terminated will be discussed in more detail in the Care Partner Agreement Webinars.

## Hospital Care Improvement Program (HCIP) FAQs

1. **What determines provider eligibility for participation in the HCIP?**
   **A:** Physicians must be on staff for a minimum of twelve (12) months to be eligible for participation and maintain their credentials in good standing at the participating hospital.

   Participation will be tied to cases seen by the "Responsible Physician." For medical cases, this is defined as the "attending physician;" for surgical cases, this is the "surgeon of record." Thus, physicians would need to have patient cases at participating hospitals to be eligible. If employed physicians participate, the hospital should review physician contracts to avoid any duplication of payments.

2. **How does HCIP differ from CCIP in terms of the types of physicians hospitals select?**
   **A:** The HCIP program is more focused around inpatient hospital-based physicians and specialists. The two programs connect through care redesign initiatives, which will complement what is being done on the outpatient side, be it CCIP, an ACO or some other ambulatory strategy. For example, a hospital might establish protocols in the emergency department to avoid an unnecessary ED visit. Hospitals may choose to target certain kinds of ED visits and use a care manager to reach out to the primary care provider as part of the CCIP. Then, if the patient is admitted, a CCIP care redesign intervention is that the primary care visit should be set up within 7 days of discharge.

3. **What determines patient eligibility for participation in the Care Redesign programs?**
   **A:** Eligible patients include any patients admitted to the hospital for an inpatient visit, including observation cases, in the past three years.

4. **What is the objective of HCIP?**
   **A:** The HCIP applies to inpatient care and has the following objectives: (1) to enhance the quality of patient care by adoption of evidence based and other standardized practices; (2) to improve physician and organizational efficiencies in providing patient care; and (3) to reduce the cost of care and eliminate medically unnecessary services.

5. **How would participation in the HCIP Care Redesign Program benefit providers?**
   **A:** Providers participating in HCIP will benefit through:
   - Access to patient identified Medicare Claims data
   - Participation in programs intended to align with MACRA requirements (MIPS and APM)
   - Access to potential incentives from the hospital for performing activities that will improve care, reduce potentially avoidable utilization (PAU) and reduce the Total Cost of Care (TCOC)
   - Access to detailed physician performance reports to allow physicians to improve their individual performance and achieve greater incentive payments and improved patient outcomes over time

6. **What is the source of the data for the physician reporting?**
   **A:** The incentive methodology is based on HSCRC inpatient abstract data.

7. **Will each hospital need to vet this initiative through their own compliance process?**
   **A:** It will be the hospital's responsibility to ensure the program is being implemented as agreed upon and that the information is being accurately submitted, to the best of their ability. Hospitals are ultimately paying incentives to physicians based on submitted data.

If someone's quality score is based on an activity he or she has indicated was performed, a hospital's role in compliance might be to check that those activities were actually performed and that those reports are accurate. As with all information used to facilitate payment, it will be the individual hospital's responsibility to make sure the information they provide to the State and CMS that results in hospital payment disbursement is: (1) accurate to the best of their ability and (2) that hospitals are using good techniques to ensure that information is accurate. Additional information and requirements around compliance will likely be included in the final Participation Agreement.

8. **How are patients informed about a hospital's participation in HCIP?**
   **A:** There is a requirement for patient notification in HCIP. This differs from CCIP where a patient is enrolled into the program. Typically, hospitals include a patient notification in the admission packet that informs the patient that the hospital is participating in the program and that a patient's physician may be part of the program. A sample notification that has been used in other programs is available from MHA, and the final template will be shared once it is approved by CMS.

9. **How do you see the use of this data aligned with the LDS reports that are also related to physician performance?**
   **A:** The HCIP data and reports are based on actual utilization within the inpatient stay. The LDS information is actual claims or payment data for each Medicare FFS patient across all settings of care beyond the inpatient hospital stay (e.g. SNFs, nursing homes, hospice, outpatient care, etc.). This data set will allow hospitals to broaden the way they look at the patient's entire episode of care, regardless of where treatment is received, and not merely focus on the inpatient stay at a single hospital. These data sets are complementary to one another.

10. **How many care redesign initiatives are required?**
    **A:** There is no requirement, but hospitals would likely want to start with at least two or three to get started. Typically, once the program matures, most hospitals are undertaking five or six initiatives. Hospitals may also want to consider using initiatives they've already been trying to roll out, but haven't been able to get physician traction on instead of trying to re-invent the wheel. Hospitals may also want to consider more universal measures, whether there are some that are surgical, some that are medical. Hospitals are encouraged to consider data availability, ease of collection, and appropriateness of the measure when determining which measures will be tracked and submitted to the administrator on a quarterly basis. If a hospital is paying incentives, then metrics that will be used as a condition of payment should be available at the physician level.

11. **Are HCIP Participating hospitals required to pay provider incentives?**
    **A:** No. Payment of provider incentives is optional, and a participating hospital may change its decision to pay in any year when updating implementation protocols. Provider incentive payments are intended as a tool hospitals can use to improve provider engagement and align incentives. Regardless of a hospital's decision to pay incentives, all participating hospitals will receive the HCIP reports, which provide valuable information at the hospital, service line and physician level.

12. **Do all savings go to the physicians or can some be allocated to supporting the infrastructure necessary to operationalize the program?**

**A:** The Oversight Committee with the hospital would make decisions about how they would like to allocate incentives. Hospitals could have the incentives go entirely to physicians, to a specialty, to departments, etc. Incentive payments must be uniform within a specialty so all physicians are being treated in the same way, but there can be variation across specialties. All methods would be reviewed and approved by the Oversight Committee as part of its oversight function. MHA and AMS can also be helpful here to help suggest potential alternative options hospitals might want to consider.

13. **If a hospital chooses not to do the physician incentive portion does the hospital still need to have a provider list vetted by CMS and set up an Oversight committee?**
**A:** Yes, both requirements still apply regardless of a decision to pay incentives. Non-monetary support may be provided under the care redesign programs that require the fraud and abuse waivers and requisite physician vetting. Oversight Committee selection of care redesign initiatives and reporting requirements apply to both programs, regardless of a decision to provide incentives. Hospitals may choose to provide incentive payments in future performance cycles. In addition, HSCRC envisions the program evolving to meet MACRA requirements as an Advanced Alternative Payment Model. The infrastructure provided by the Oversight Committee and vetting physicians through the CMS process will prepare hospitals for the future phase of the program.

14. **What is the source of funds that will be available to make incentive payments?**
**A:** The incentive payments are derived from internal cost savings. So, as hospitals realize cost reductions, that comprises the pool of dollars from which incentives can be paid out to eligible physicians. If there are no cost savings, the hospital does not realize those opportunities, and the physicians may not be able to receive incentives.
Hospitals participating in an incentive program may want to consider this and set up a budget at the beginning of the fiscal year. That budget is something that may be used by the Oversight Committee as well to make sure that it is planning for the potential to make disbursements based on the actual performance of the programs. The simulation data provided will help hospitals estimate anticipated cost reductions and potential incentive payments.

15. **Can physicians participate in the HCIP with more than one hospital?**
**A:** Yes, physicians can participate in more than one hospital's program. If a physician is enrolled in the HCIP at multiple hospitals and has cases at one hospital as well as another hospital, he/she is credited only for those occurring at each hospital. Regardless of enrollment, if the physician has privileges at more than one hospital he/she is considered a "splitter." The number of admissions the physician had in the preceding year at the participating hospital will be used to determine incentive payments. If the physician is a splitter, this attributable admission volume may be capped at the hospital(s) where he/she enrolls. For example, if a physician became eligible on January 1, 2017, admissions for the year January 1 to December 31, 2016 to the participating hospital would be the basis for the cap for the first year of participation. If a physician is not a splitter, there is no cap on volume.

16. **What have other hospitals and their medical staffs achieved when this program has been implemented in other states?**
**A:** Experience varies depending upon how the Program is implemented, but generally hospitals have seen:
    - More efficient discharge planning, such as discharging before noon and on weekends;

- More timely consultations;
- More efficient use of ORs;
- Appropriate reduction in length of stay; and
- Evidence-based selection of medical devices

17. **When should participating providers expect their first incentive payment?**
    **A:** The timing of incentive payments is important to help support physician engagement. Incentive payments are calculated on 6 months of data. The exact issuance of the payments is dependent upon when the hospital begins the Program. In general, the first payment cycle is 9 months after implementation and then every six months thereafter.

18. **How are quality measures used? What is the reasoning behind conditioning payments?**
    **A:** To sustain this initiative over the long term, the Program must strike a balance between improved financial performance and quality that produces benefits for both the physicians and the institution. The Steering Committee identifies specific quality measures to be used to condition the payment of physician incentive payments. Most physicians are aware of steps they can take in their individual practices, such as improving hospital/physician coordination that will generate savings — "low hanging fruit." But some of the changes that hold the potential for significant savings may not be obvious, such as internal scheduling (e.g., OR), adhering to specific infection control practices, effective discharge and post-acute planning and follow-up. The gainsharing component will capture the cost reduction and determine the incentive amount; but the payments may be made only if the quality measures — those that are part of the Program, as well as measures agreed upon by the Steering Committee to condition payment — are achieved. This is the link between cost reductions and quality improvement.

19. **How often are quality measures reported?**
    **A:** Hospitals collect the quality measures and report them to the Steering Committee and participating physicians quarterly. Hospitals will also report specific information, consistent with the Implementation Protocols, to CMS as part of data collected by HSCRC or its designee.

20. **How are incentives calculated, and what is the difference between the Performance Incentive and the Improvement Incentive?**
    **A:** This is outlined in the Physician Handbook that will be provided to Participating Hospitals. A thorough discussion of the calculation of the components is included in Attachment A. In general, the total amount available for payments to physicians (Total Available Incentive) is divided into performance (Performance Incentive) and improvement (Improvement Incentive) components. Allocation is determined by the Hospital's Steering Committee.
    - The Performance Incentive recognizes a physician's use of inpatient services and practice patterns compared to his or her peers, adjusted for case mix and severity of illness.
    - Payments for the Improvement Incentive are based on the physician's current performance compared to his or her Prior Year performance, adjusted for case mix and severity of illness. The Improvement Incentive for medical admissions includes an adjustment for the loss of income resulting from length-of-stay (LOS) reduction. This is to ensure that physicians are not forced to sacrifice professional income to assist in improving efficiency. The Improvement Incentive may be gradually phased out, and allocated amounts merged into the Performance Incentive.
    - The two components combined comprise the physician incentive payment which is conditioned upon the quality measures.

21. **When looking at the simulation data, what is the difference between the opportunity and maximum physician incentive?**

**A:** The opportunity is the utilization changes. So, you look at actual costs based on utilization and then we have the best practice norm, which is set at the 25th percentile of the lowest cost for each APR-DRG. That difference would include cases that are good (i.e cases that are at or close to the norm), and cases that aren't. This is what we would refer to as the variance. When we look at opportunity, it is just those cases that fall above the best practice norm. Those are cases for which there truly is opportunity (e.g. their costs are higher).

The maximum physician incentive is determined for each APR-DRG. It is an upper limit that is set to approximate about 25% of professional fees. Experience has shown that this is sufficient in terms of dollars needed to drive the program and it equates to typically about 15% of the savings that a hospital might achieve. It is not an 'all or nothing' type of program in terms of financial performance. As a physician gets closer to the best practice norm, he is she would earn more and more, up to the maximum incentive. It should be noted that the calculated incentive is how much a physician is *eligible for*. In order for her/him to earn that incentive, the physician must meet all of the conditions of payment, which are part of the care redesign initiatives. This is how the combination of a hospital's financial performance and performance on quality measures are linked together.

22. **How are outliers accounted for?**

**A:** Outliers are identified using three standard deviations. They are excluded from the calculation of Best Practice Norms (BPN), improvements, savings and incentive payments. If the costs exceed the Best Practice Norm (BPN), there is no incentive payment, but there is also no penalty.

23. **The AMS provider reports include "eligible" cases. What are the exclusion criteria?**

**A:** There must be a best practice norm (BPN) established for the case. To establish a best practice norm, there must be: (1) a sufficient number of cases in the APR-DRG, and (2) there must be a sufficient number of physicians treating those cases. This ensures that no one physician can influence the norm.

For the purpose of physician incentive payments, the following cases are excluded: (1) cases where patients have died, (2) transfers to other facilities and, (3) outliers that are three standard deviations above the mean.

24. **How are difficult, high cost cases accounted for?**

**A:** Key to the HCIP is measuring severity of illness, utilizing the classification system known as All Patient Refined Diagnosis Related Groups or APR DRGs. This severity weighting is important because some physicians attract more difficult cases as a result of experience, skill and reputation. The cornerstone of the Program's methodology is a system of measurement designed to ensure that each patient receives the correct amount of hospital services and resources given the patient's specific clinical diagnosis and severity of illness. This is linked to provider Improvement and Performance Incentives that recognize both efficient physician performance, as well as improvements in performance.