Care Transformation Initiative
Frequently Asked Questions

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1. What are "Care Transformation Initiatives" (CTIs)?

A Care Transformation Initiative (CTI) is any initiative undertaken by a hospital, group of hospitals, or collaborative partnering with a hospital to reduce the total cost of care (TCOC) of a defined population. CTIs are describable, quantifiable and within individual hospital purview to implement, therefore the return on these investments can be awarded to the individual entity, if earned. Currently, these populations may only include FFS Medicare beneficiaries, though staff may develop a framework for other payers in the future. The CTI framework will likely not encompass all investments in patient care, population health, and care redesign. Rather, it will focus on finding individual hospital investments that provide a return on investment to the hospital through beneficiary-level total cost of care reductions. Longer-term investments into public health will still be prioritized in HSCRC policy development, though are specifically delineated from CTIs as seen in the figure. Ideas that cannot identify specific beneficiaries impacted or reliably calculate a short-term TCOC savings impact will not be included in this CTI framework.

1.1 What is the purpose of the CTI?

Under the All-Payer Model, hospitals engaged in a number of efforts to reduce avoidable utilization of health services by investing in initiatives and programs to help address specific population needs and provide more valuable health services to the beneficiaries they serve. With the TCOC Model, HSCRC staff would like to evaluate these efforts, defined as Care Transformation Initiatives (CTIs) in order to advance, refine and reward innovation within Maryland's health system. Developing policy around CTIs will achieve the following objectives:

1. **Industry Development**: Evaluating hospitals' individual CTI efforts will help to develop a systematic understanding of best practices for improving care and reducing unnecessary utilization across the State. This ultimately will lead to further dissemination, broader implementation and acceleration of care transformation in Maryland.

2. **Reward Care Transformation Success and Investment**: Investing in care transformation has been a fundamental way that Maryland produces savings under the Maryland Model. The HSCRC would like to continue to develop mechanisms for savings produced outside of hospital global budgets to be rewarded to hospitals who put forth the investments effort to meaningfully connect the system and transform care. HSCRC staff would like to reward individual hospitals for their investment in the system's success, and therefore further incentivize the practice.

2. CTI Methodological Questions*

*Please note that the User Guide provides additional details on CTI methodology with many examples. If you still have methodological questions after reading these FAQs, we recommend referencing the User Guide.

2.1 How are CTI savings measured?

Hospital's care transformation efforts will be 'quantified' by a pre/post or cohort analysis. A three part process is used:

1) Identify the Population
2) Construct the Episode
3) Establish and calculate a Target Price
4) Compare the TCOC during the Performance Period to the Target Price

2.2 How do we identify the population for our CTI?

Step 1: Choose the eligible Medicare population targeted by the CTI intervention

- Identify beneficiaries who could benefit from the intervention (e.g. diabetic beneficiaries for a diabetes intervention). The population should be the "intent-to-treat" population and not the actual enrolled population.
- The population must be identifiable through the Medicare Claim and Claim Line Feed (CCLF) data, i.e. Medicare claims.
- The trigger must be identifiable in Medicare claims data (Part A & B), but may include any combination of:
    - Receipt of a service or procedure(s), e.g. hospitalization or count of ED visits (ICD-9/ICD-10 or CPT/HCPCS);
    - Condition (chronic condition flag, ICD-9/10 code or DRG);
    - Geographic residency (by zip code or county);
    - Receipt of services from an indicated provider (CCN, TIN or NPI, or type of provider or specialty of supplier);
    - Beneficiary demographics (Age, Race).

Step 2: Restrict the population to those most likely to be impacted or enrolled in the intervention

- Identify which eligible beneficiaries could have received the intervention from the hospital
- Some options include:
    - Plurality of claims for a type of service;
    - Receipt of services from a specified provider type or provider (CCN, TIN or NPI, or type of provider or specialty of supplier);
    - Inclusion in another policy or program such as MDPCP or MPA attribution; and

    - Admission, discharge, referral or other point of transition;
    - Any exclusion criteria chosen from the Trigger Restriction or Eligible population criteria.
- The HSCRC staff are working to include Part B drug claims and Medicare Part D claims and allow triggers based on medication.

Step 3: Choose the intervention duration

- The window could be 30, 60, 90, 120, 150, 180, or 365 days
- All costs during the window (regardless of setting of care) are included
- Duration will be subject to literature review and further analysis by staff for appropriateness
- Dates for baseline period

The final trigger is a combination of the eligible population and those who may have been impacted by the intervention.

2.3 What is included in an episode?

Episodes constructed for CTIs include Medicare Part A & Part B total cost of care. However, there are numerous exclusions and procedures applied to ensure fairness and consistency. Such exclusions include End-Stage Renal Disease (ESRD) beneficiaries, claims for blood clotting factors, and others that can be found within the User Guide. If an episode finishes outside the specified episode duration, specific procedures are in place to prorate the claims depending on the site of service. Additionally, if two separate CTIs overlap the beneficiaries will be assigned to the CTI that is triggered first. This represents just a highlight of the methods used to construct CTI episodes, more details on these methods and exclusions can be found within the User Guide.

2.4 How are the target price and reconciliation payments calculated?

Spending in each episode's Performance Period will be compared to a Target Price to determine savings. The overall process is summarized as follows:

1. **Target Price Calculation**: Use a Baseline Period per beneficiary total costs trended forward by an inflation factor. Staff will identify the Baseline Period costs per beneficiary by dividing the aggregate constructed Baseline Period Episode Costs by the number of beneficiaries included in the hospital's CTI. The steps to adjust and update Baseline Period costs per beneficiary into a Target Price are as follows:
    a. Risk Adjust the claims based on beneficiary characteristics
    b. Update the costs into current year prices using a trend factor
    c. Finalize the Target Price by converting standardized prices back to real dollars
2. **Performance Period Costs Calculation**: Measure TCOC for the episodes that fall within the Performance Period. HSCRC staff will determine the total costs for each Episode in the Performance Period and divide it by the number of beneficiaries in the cohort to determine the Performance Period per beneficiary amount for each hospital in a CTI.
3. **Reconciliation Payment:** Compare the Target Price to the Performance Period costs to determine savings, if any, and the Reconciliation Payment due back to the hospital through the MPA Reconciliation Component (more details in 2.7). The savings will be determined via the following two step process, for each hospital participating in a CTI:

a. Calculate the difference between the Performance Period average per beneficiary, real, risk-adjusted episode costs and the statewide CTI
b. Multiply the episode savings by the number of beneficiaries from the performance period

2.5 Who is the comparison group to determine savings?

The counterfactual or comparison group is a CTI's baseline population. The HSCRC will use a panel analysis that determines the baseline population and performance population using the same population definition. The baseline and performance populations can have overlapping beneficiaries, but this methodology is not designed to follow the exact same beneficiary cohort from the baseline to the performance period. This intent-to-treat approach allows us to avoid methodological concerns, such as selection bias, regression to the mean, and intervention attrition.

2.6 How far back can a baseline population be measured?

The HSCRC is limited to data from 2016 forward. As such, a baseline population cannot be established before 2016. If a hospital's CTI interventions started before 2016, the HSCRC can work with hospitals to identify restrictions that limit the population definition to those that have yet to receive the intervention. However, if the CTI population is small it might be beneficial to use the entire population to achieve more savings.

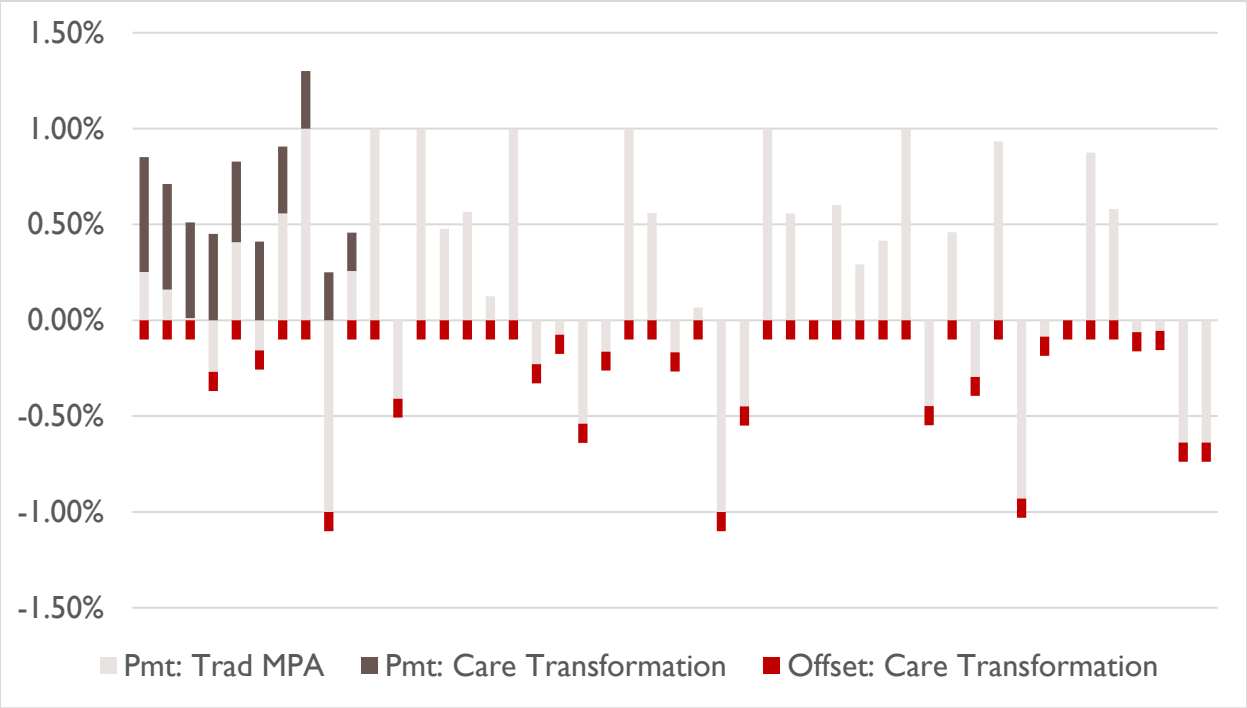
2.7 How does the Medicare Performance Adjustment (MPA) interact with CTI and CTI payments?

The HSCRC Commission approved the creation of the MPA Framework policy in October 2019, which created two new components called the MPA Savings Component (MPA-SC) and MPA Reconciliation Component (MPA-RC). CTIs that are successful in producing savings will be paid 100% of the savings that they produce through the Reconciliation Component of the Medicare Performance Adjustment (MPA-RC). The MPA-RC adjustment will be calculated from the TCOC savings produced by a hospital's CTI divided by total hospital Medicare revenue. This MPA adjustment will occur in addition to the "Traditional MPA", which attributes a population to hospitals and rewards or penalizes their performance on the total costs of care.

2.8 What is the offset in the MPA Framework?

To discourage "free riders", statewide CTI savings paid through the MPA-RC will be made in a net neutral manner. Any positive Reconciliation Payments to an individual hospital will be offset by a MPA cut that is spread across all Maryland hospitals in proportion to each hospital's share of Medicare hospital revenues. The purpose of the offset is to encourage hospital participation and CTIs that successfully reduce the total cost of care. The HSCRC will reevaluate the fairness and need for the offset as hospital participation is assessed. Figure 1 demonstrates how the traditional MPA, MPA-RC from CTI savings, and statewide offset for a net neutral effect will interact for an overall adjustment to hospital Medicare revenues.

Figure 1. Illustration of the MPA-RC Net Neutral Statewide Offset and MPA Payment Interaction



2.9 How are CTI savings paid out?

If savings are realized, Medicare charges will be adjusted to increase by the MPA-RC percentage in the year following the completion of a hospital's CTI. The MPA acts as an adjustment to Medicare payments to hospitals, just like the adjustments for things like sequestration and the public payer differential.

2.10 Are CTIs upside-only risk, or do they include down-side risk?

CTIs will only reward programs for savings and not directly penalize programs that do not achieve savings. However, the offset within the MPA Framework does apply downward pressure to all hospitals in order to encourage hospital participation and programs to be successful.

2.11 Is there a threshold for achieving CTI savings?

This will depend on the scale of the intervention, with larger scale interventions not requiring a threshold and smaller scale interventions requiring some savings threshold to ensure actuarial stability. For CTIs with small populations, the HSCRC will set a savings threshold based on a power calculation. The savings threshold is designed to avoid paying out reconciliation payments for savings that are produced by statistical variation and not an actual impact, and will be set at a level for which the observed savings rate is reasonably statistically significant. The power calculation will be based on the number of beneficiaries in the baseline period cohort and the variance in the TCOC between individual episodes in the baseline period. As the HSCRC develops this savings threshold, details will become available in the CTI User Guide.

2.12 How much should we expect in savings from CTIs?

Hospital savings first depend on how much the hospital CTI saves relative to their baseline TCOC. However, final savings also depend on the size of the offset (i.e. success of other hospitals). If the hospital's CTI produced minor savings, but other hospital CTIs were much more successful, the offset could result in a net loss for the hospital with minor savings.

2.13 Does CTI measure all-payer savings?

At this time, CTI will only measure savings to Medicare FFS (Parts A & B) due to data restrictions. If the HSCRC is able to gain access to all-payer data, CTI proposals that impact populations outside of Medicare will be considered.

2.14 Will risk adjustment be included in the calculation of CTI savings?

Yes, the Target Price will include risk adjustment. For interventions beginning in the hospital, APR-DRGs & SOI combinations will be used. For interventions beginning outside of the hospital, the Hierarchical Condition Category (HCC) will be used. Other adjustments, such as outlier exclusion, are also included. Please see the User Guide for further information on how risk adjustment is calculated and applied.

2.15 Is CTI performance assessed prospectively or retrospectively?

All performance periods will be followed prospectively. The baseline period used in the target price calculation will occur in the past, but the performance period will occur into the future. The soonest a performance period can start is July 2020 and the earliest a baseline period can start is January 2016. Furthermore, MPA-RC payments will only be made into the future on performance starting in July 2020 or later for payment starting in July 2022.

2.16 Can beneficiaries be in more than one CTI?

Definitional overlap within the population definitions will not be allowed between the same hospitals' CTIs. If definitional overlap occurs, one or both population definitions will require amendment. However, the HSCRC recognizes that operational overlap may still occur even if population definitions differ. For example, beneficiaries eligible for a CTI targeting those with 3 or more chronic conditions might also be eligible for a CTI targeting hip and knee replacement patients. As such, if the same beneficiaries are eligible for two separate CTIs, the beneficiaries will be assigned based on which trigger occurs first and excluded from the second CTI. The HSCRC is considering developing a threshold to allow overlap if less than 15% of the episodes overlap, with more details available in the CTI User Guide.

2.17 Will beneficiaries who die be excluded from the analysis?

This depends on the CTI Thematic Area. For most CTIs, beneficiaries who died during the episode period or index hospitalization will be excluded from the CTI. However, for a CTI like Palliative Care that targets beneficiaries near the end of their life, deaths are not excluded to allow for a fuller picture

of the CTI results. The Care Transformation Steering Committee will determine whether beneficiary deaths should be excluded or included for each Thematic Area.

2.18 What is winzorization?

Winzorization is a statistical method to minimize the influence of outliers. The method maintains the outliers in the analysis, but adjusts their value or weight. This is important for preventing beneficiaries that impose an abnormally high or low cost on a population from skewing the overall trend of the CTI. All CTIs will be winsorized, with values below the 1st percentile being set at the 1st percentile and values above the 99th percentile being set at the 99th percentile

3. CTI Process Questions

3.1 What is required to participate in a CTI?

Two documents are used for constructing CTIs: the *Care Transformation Initiative Assessment Form* (optional to participate) and the *Care Transformation Initiative Intake Template* (required to participate).

The *Care Transformation Initiative Assessment Form* is intended for generating new CTIs. Hospitals should consider submitting the *Assessment Form* if they have a CTI proposal that does not fit into the Thematic Areas approved or being discussed by the Care Transformation Steering Committee (CT-SC). All submitted *Assessment Forms* are available on the HSCRC website for hospitals to review. This one-page form asks hospitals to give an overview of the CTI, define care interventions, identify a population, and propose an episode trigger. The HSCRC reviews the *Assessment Form* to generate Thematic Areas and to prioritize what is discussed by the CT-SC. HSCRC staff will work with hospitals throughout the submission process to refine their CTIs. Hospitals may submit the *Assessment Form* by emailing, hscrc.care-transformation@maryland.gov. You can find the form on our website: https://hscrc.maryland.gov/Pages/Care-Transformation-Steering-Committee.aspx. The HSCRC commits to building a Reconciliation Payment for all proposals with a valid population definition and trigger, as time and prioritization permits.

Once a Thematic Area is approved by the CT-SC, the HSCRC will develop a *Care Transformation Initiative Intake Template* specific to that Thematic Area. This is the only form required for a hospital to be able to participate in a CTI. The *Intake Template* will take interested participants through all the specifications they can select for that Thematic Area, as approved by the CT-SC. Hospitals that completed an *Assessment Form* for the relevant Thematic Area are still required to submit an *Intake Template* and hospitals that did not complete an *Assessment Form* for the relevant Thematic Area are still eligible to participate by completing the *Intake Template*.

3.2 What is the HSCRC's process for forming CTIs?

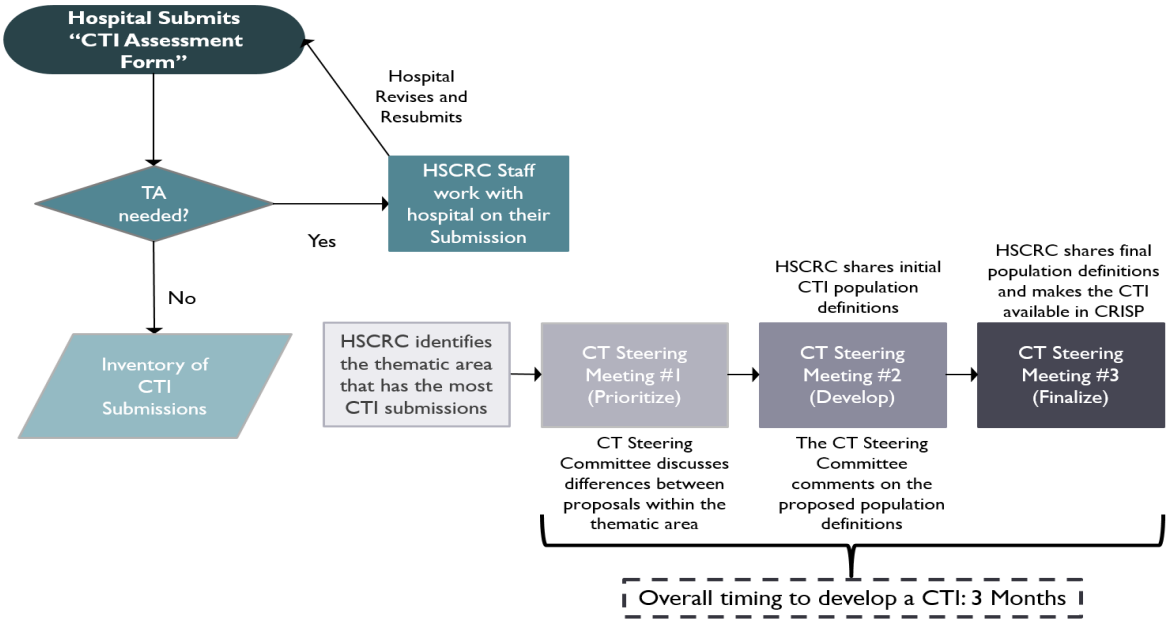
When *CTI Assessment Forms* are submitted to the HSCRC, the HSCRC will review the submission to ensure the necessary components are included for further consideration. If further refinement is needed, the HSCRC will provide technical assistance to the submitting hospital. The HSCRC will then categorize completed *CTI Assessment Forms* into Thematic Areas to be discussed by the CT-SC. The HSCRC will rank order CTI Thematic Areas based on the number of hospitals submitting proposals in that area, but commits to getting to all *CTI Assessment Forms* over time.

To the extent possible, HSCRC staff will standardize eligible population cohorts across hospitals' individual CTI submissions to maximize opportunities for participation. For example, if multiple hospitals propose a CTI focused around palliative care, HSCRC staff will work with the CT-SC to find a standard set of criteria that encompass all relevant populations for a "Palliative Care CTI," which hospitals may then elect to participate in.

Each CTI will be reviewed by the CT-SC in a series of three meetings with the meetings refining the CTI as follows (see Figure 2 below for more details):

1. **Prioritization**: The HSCRC will share the current CTI submissions, the Thematic Area groupings, and number of hospitals proposing a CTI in each area. Discussion of the trigger parameters and population definition from the Thematic Area with the highest number of participating hospitals will inform development discussions in the following meeting.
2. **Development**: In meeting 2, the HSCRC will present an initial approach to identifying a unified population from the CTI submissions grouped under meeting 1's Thematic Area. This approach will include the population, trigger, and length of intervention options for the CTI. The Committee will provide feedback for further refinement.
3. **Finalization**: HSCRC staff will present the final population cohort for the CTI to the CT-SC and provide any relevant analysis or details. A CTI is considered final once it is approved in its third CT-SC meeting.

Figure 2. CTI Process Map



3.3 How long does it take for a CTI to be developed?

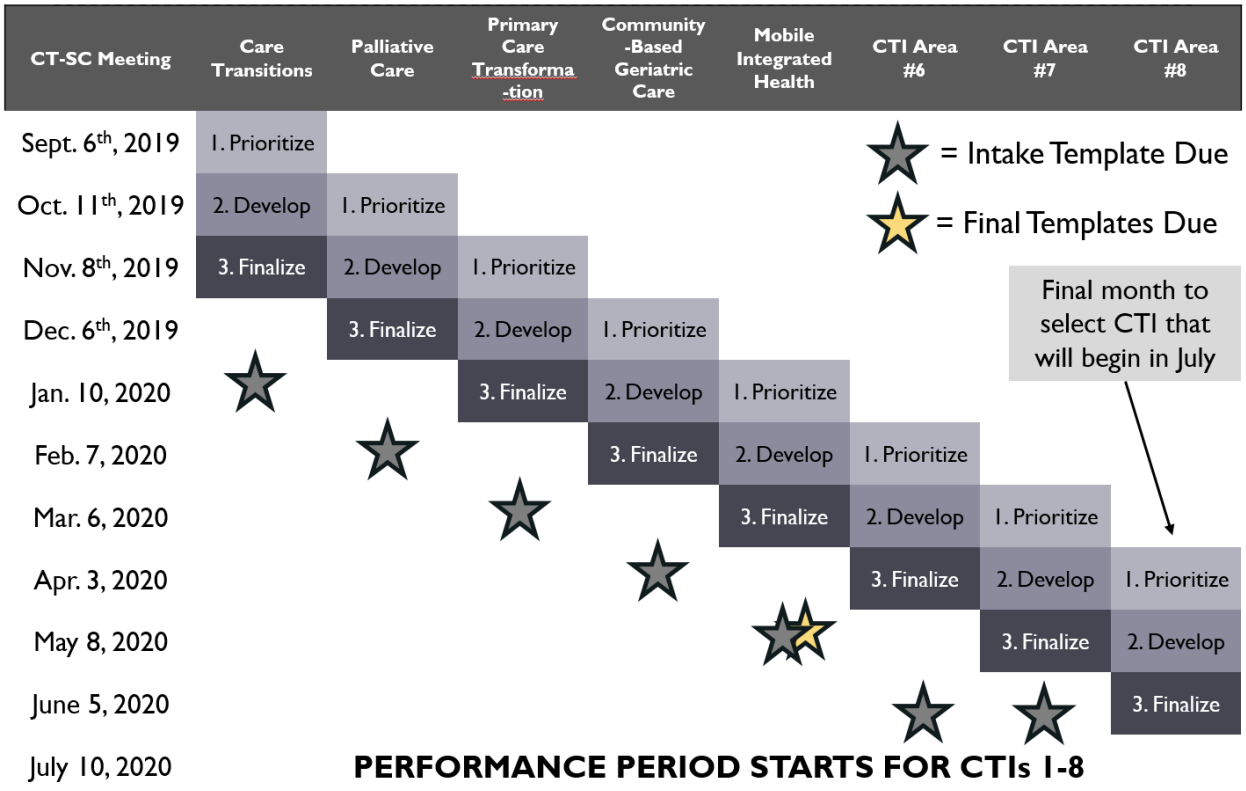
Once a hospital submits their *CTI Assessment Form* to the HSCRC, Staff will review the submission and provide feedback in a timely manner. If a complete *CTI Assessment Form* is submitted two weeks before the next CT-SC, Staff will work to categorize the CTI in a Thematic Area and include the submission in the meeting materials for discussion at the next CT-SC Meeting. The CT-SC will develop proposed CTIs in a rolling manner.

Once a Thematic Area is prioritized for review by the CT-SC, it takes roughly three meetings held over three months for a CTI to be finalized by the Committee. Performance Periods begin annually on July 1st. Please note that for a CTI to be measured in the next performance period, the CT-SC must prioritize the CTI Thematic Area by the April Meeting. CTIs that are prioritized after the April Meeting will start in the following year's performance period to allow for the full development process.

Following the finalization of a CTI Thematic Area by the CT-SC, the HSCRC will email an Intake Template to all hospitals within a week. The deadline for hospitals to submit Intake Templates are generally two months after finalization by the CT-SC. The first two CTI Thematic Areas approved by the CT-SC (Care Transitions and Palliative Care) were given the opportunity to resubmit a second and final CTI definition by May 2020. Resubmissions will not be permitted for any other Thematic Areas finalized by the CT-SC.

See Figure 3 below for a tentative timeline for the CT-SC and the above question for details on each of the CT-SC Meeting objectives.

Figure 3. Initial CTI Development for Performance Year 1



3.4 What are the deadlines for hospitals participating in CTIs?

The HSCRC will accept *CTI Assessment Forms* on a rolling basis. The CT-SC will review new CTI proposals each month and we ask for *CTI Assessment Forms* to be submitted two weeks before the next CT-SC meeting to be included in the discussion. If you would like your CTI to be considered for the performance period starting July 1st, please submit your *Assessment Form* two weeks before the April CT-SC Meeting. *CTI Assessment Forms* received after the April Meeting will be considered for the following performance period. We recommend submitting *CTI Assessment Forms* as early as possible for

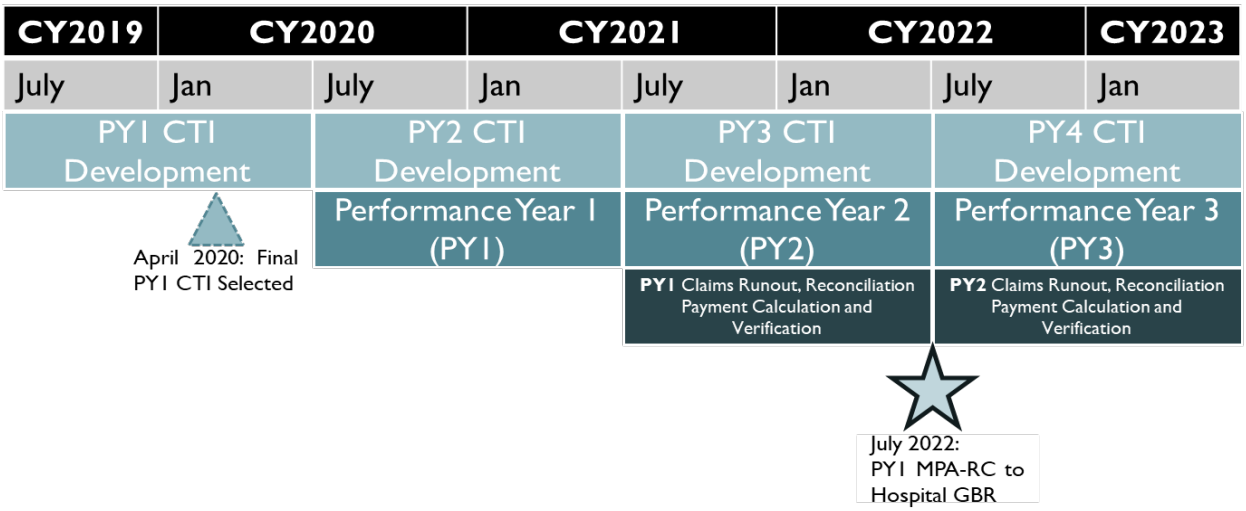
the best chance to be included in the upcoming performance period and/or to inform the construction of the CTI that best fits the hospital's intervention.

CTI Intake Templates are typically due two months after the Thematic Area is approved by the CT-SC. The Care Transitions and Palliative Care CTIs are given an opportunity to revise and resubmit their *Intake Templates* in May 2020.

3.5 What is the general timeline for CTI performance and payment?

Once approved, CTIs will have an annual performance period, starting July 1st and ending June 30th. Reconciliation Payments for the CTI will made beginning on July 1st of the following performance year. This timing accommodates episode completion (6 months), claims runout (3 months) and a calculation and verification period (3 months). For CTIs that elect to have a 365 day episode duration, this timeline will be lagged another 6 months to allow for appropriate episode completion. Figure 4 below outlines the overall development, performance, and reconciliation process and timing. Overall, it takes approximately two years to receive a reconciliation payment once the performance period begins.

Figure 4. Overall Timing of a Care Transformation Initiative



3.6 Will CTIs be combined or standardized?

Proposed CTIs are first grouped into Thematic Areas by the HSCRC staff. The methodology for grouping CTIs is unscientific, with staff using the following algorithm:

1. Group CTI by setting where the trigger occurs
    - Hospital
    - Primary Care
    - Community
    - Etc.
2. Identify similarities in how beneficiaries were restricted
    - DRG / Diagnosis
    - NPI touch
    - Etc.
3. Identify 'clusters' of similar restrictions that frequently occur together

- DRG / Prior hospitalization
- Age / Touch with a palliative care consult

4. Separate thematic groupings into clusters based on clinical interventions and difficulty of programming

From there, the CT-SC will review Thematic Areas and discuss if there are clinically substantial differences in the submissions. Specifically, they will look at the proposed CTI populations to see if they reflect clinically different groups. For example, are the initiatives clinically different if the population is 65+, 75+, 80+, or 85+ years of age? The HSCRC staff would like to standardize minor differences across interventions but not at the consequence of analytic validity. See the overall model in Figure 5 for determining if a CTI will be combined or separated. Generally, the CTI is focused on populations that hospitals are accountable for, it is not intended to isolate the effect of two interventions that affect the same population.

Figure 5. Metrix for Grouping CTIs

		Are the proposed interventions clinically similar?	
Are the proposed populations clinically similar?		Yes	No
	Yes	1 CTI	1 CTIs
	No	2 CTIs*	2 CTIs

*The HSCRC may combine/unify populations in the future so everyone has an incentive to expand the CTI's intervention and impact

3.7 Can hospitals submit more than one CTI for a single Thematic Area?

Yes. Hospitals can submit more than one Intake Template for a given Thematic Area if they have distinct CTI populations that cannot be accounted for in one Template. For example with the Care Transitions CTI, if a hospital wanted to follow Sepsis and Heart Failure patients for 30-day episodes but wanted to follow Diabetes patients for 180-day episodes, they could submit two Intake Templates and be in two CTIs within the same Care Transitions Thematic Area. However, the HSCRC reserves the right to combine CTIs from hospitals that appear to have definitional overlap.

3.8 Who can apply for CTIs?

Savings from CTIs are distributed back to hospitals through the MPA-RC, therefore, a hospital or group of hospitals must be participating in the CTI. However, hospitals can partner with community organizations (such as Regional Partnerships) to deliver the CTI and share their savings at their own discretion.

3.9 We have many programs that would fit under CTIs, which should we submit?

Hospitals should submit every intervention they are doing that is quantifiable under the CTI algorithm. The HSCRC fully intends to create an algorithm for each proposed CTI, however, the HSCRC will prioritize the CTIs that begin in the first Performance Period as discussed above. Since Thematic Areas

that encompass the most CTI proposals will be prioritized, hospitals should review the list of CTI submissions on the HSCRC website to see if they have an intervention that fits into one of the current or upcoming Thematic Areas. Furthermore, the HSCRC suggests hospitals lead with what gives them the biggest credit as that will have the best likelihood of being prioritized.

Lastly, MPA-RC payments are made once savings show up, which make shorter-term interventions more pragmatic for hospitals investing their resources. The HSCRC does not want to dis-incentivize longer-term interventions and will be using other programs to provide those incentivizes (RP, DPP, etc.). However, the HSCRC will be able to look back to data from 2016 to allow for evaluation of longer term interventions that have been in place before the start of CTI.

3.10 When a CTI is selected, can hospitals that did not initially submit a *CTI Assessment Form* for that Thematic Area still participate?

Yes. After the CTI Thematic Area is finalized, all hospitals indicate if they would like to participate by submitting an *Intake Template*. Hospitals do not have to be the ones to propose the CTI to participate in the Thematic Area. However, hospitals electing to participate in a CTI after it is finalized must agree to the specifications determined by the CT-SC. A "Requested Modifications" tab is provided on *Intake Templates* to allow hospitals to propose a change to the parameters, but these changes are not guaranteed to be implemented by the performance period. Submitting a *CTI Assessment Form* provides the best chance to influence a Thematic Area's parameters.

3.11 What additional reporting is required from hospitals after they begin participating in a CTI?

Outside of the *CTI Intake Template*, there are no reporting requirements for hospitals. The HSCRC worked with CRISP to produce reports on savings and performance, which will be shared with hospitals through the Care Transformation Profiler (CTP).

Future evaluations may be developed to ensure the hospital is engaging in a meaningful intervention related to the CTI. The TCOC Workgroup will discuss methods, but such evaluation could include requiring hospitals to submit budget and FTE information for the program, or through amendments to hospital cost reports.

3.12 What reports will the HSCRC and CRISP produce on CTI performance and will those reports be shared with hospitals?

The HSCRC and CRISP created a new tool that will report on hospital's CTI performance so that hospitals can track and manage their initiatives month-to-month. The tool, called the Care Transformation Profiler (CTP), provides an automated view of each hospital's performance in each CTI with data updated each month to the most recent Medicare claims data. All hospitals will be able to view aggregate non-PHI data on other hospitals in order to predict their MPA-RC Offset.

The tool will provide:

- Documentation for hospitals to review their CTI population definitions
- The CTI's target price and hospital aggregate performance versus the target price

- The number of episodes initiated by CTI and by hospital
- The hospital costs of the episodes in the performance & baseline periods
- Demographic breakdown of episodes in the performance & baseline periods

The tool is expected to go live in winter 2020.

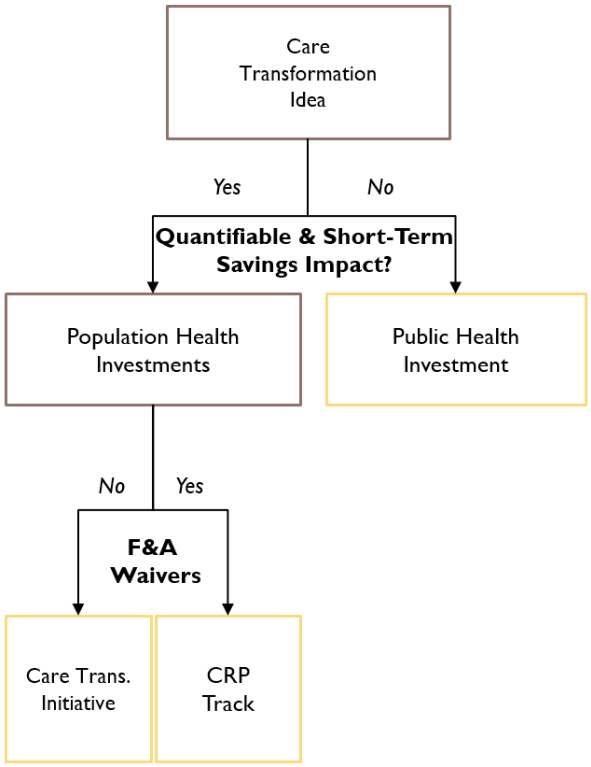
3.13 Will hospitals' CTI submissions be publically shared?

Yes, the HSCRC has posted each *CTI Assessment Form* to the Care Transformation webpage of the HSCRC website: https://hscrc.maryland.gov/Pages/Care-Transformation-Steering-Committee.aspx. Hospitals participating in CTIs will also have access to the Care Transformation Profiler (see 3.12), which provides information on each of the parameters hospitals select in their *CTI Intake Templates*.

3.14 How does CTI fit into other HSCRC and Maryland Model programs (ECIP, HCIP, Care Redesign, MDPCP, and Regional Partnerships)?

CTI and ECIP are anchored at the hospital and use hospital claims to construct episodes. In 2020, ECIP will fall under CTI and pay out savings through the MPA-RC, removing the 3% discount in ECIP savings. Moving forward hospital submitted CTIs should not overlap by definition with ECIP if the hospital is participating in ECIP (e.g. a hospital participating in the Sepsis ECIP bundle should not submit a CTI for their ECIP Sepsis population).

Figure 6. CTIs versus CRP



Programs that are anchored elsewhere, e.g. non-claims based or longer-term public health investments, fit under HCIP and Regional Partnerships. The grant structure of the Regional Partnerships support programs that require upfront infrastructure investments, but programs under the Regional Partnership can transition to CTI when grant funding expires.

More broadly, the Care Redesign Program (CRP) is focused on statewide initiatives that require negotiations with the federal government (e.g. fraud and abuse waivers; participation agreements). Currently, CTIs are not designed to support aspects such as incentive payments or waivers, but the CRP can be involved if such structures are needed to develop a CTI.

Finally, the Maryland Primary Care Program (MDPCP) is transforming primary care in ways similar to what CTIs can achieve, but CTIs provide a way for hospitals to be more directly accountable for their TCOC.

3.15 Do CTIs involve participation agreements or fraud and abuse waivers?

Not necessarily. Participation agreements are only needed when making incentive payments to doctors and fraud and abuse waivers will only be sought on a case-by-case basis (e.g. to create additional flexibility to discharge to a SNF and to allow providers to be MACRA-tized). If a CTI requires either to be developed the HSCRC can involve the Care Redesign Program (CRP). Otherwise, CTIs operate separate from federal government programs.

4. Glossary

Claim and Line Feed (CCLF): Medicare data file which contains claims, beneficiary services and data from hospital and non-hospital utilization.

CMS Certification Number (CCN): Medicare certification number for a facility.

Common Procedural Code (CPT): Codes used to describe tests, surgeries, evaluations, and any other medical procedure performed by a healthcare provider on a patient.

Chesapeake Regional Information System for our Patients (CRISP): Maryland's state-designated health information exchange.

Care Redesign Program (CRP): Provides tools for greater provider alignment, population health activities, episodes of care coordination, and delivery system transformation.

Care Transformation Initiative (CTI): An intervention, care protocol, population health investment or program undertaken by a hospital or group of hospitals to reduce unnecessary hospital utilization and/or the Medicare Total Cost of Care.

Care Transformation Profiler (CTP): a CRISP tool designed to support the monitoring and reporting of CTIs; available to hospitals participating in CTIs.

Care Transformation Steering Committee (CT-SC): Committee convened by the Health Services Cost Review Commission (HSCRC) to review, prioritize and advise CTI development. Members consist of key hospital, payer and health policy representatives and meetings are held monthly for the public.

Diabetes Prevention Program (DPP): Program to prevent or delay the onset of diabetes in individuals who are at high risk for the disease.

Diagnosis Related Group (DRG): Classification system and set of codes which groups hospital cases into one of approximately 500 groups expected to have similar hospital resource use.

Episode Cost Improvement Program (ECIP): A bundled payment approach developed by the HSCRC to align incentives across hospitals, physicians, and post-acute care facilities to generate savings and improve quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge emergency department visits and hospital readmissions.

Hierarchical Condition Category (HCC): Coding is a risk-adjustment model originally designed to estimate future health care costs for patients.

Hospital Cost Improvement Program (HCIP): A program created by the HSCRC to encourage care redesign interventions such as care coordination, discharge planning, clinical care, patient safety, patient and caregiver experience, population health, and efficiency and cost reduction.

The Healthcare Common Procedure Coding System (HCPCS): Codes used represent procedures, supplies, products and services which may be provided to patients.

International Classification of Diseases, Tenth and Ninth Revisions (ICD-9/ICD-10): The system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care.

Maryland Primary Care Program (MDPCP): A voluntary program open to all qualifying Maryland primary care providers that provides funding and support for the delivery of advanced primary care throughout the state.

Medicare Performance Adjustment (MPA): An annual adjustment to individual hospital Medicare revenues to reward or penalize a hospital's performance on controlling total costs of care for an attributed population.

Medicare Performance Adjustment Reconciliation Component (MPA-RC): An additional adjustment available under the MPA framework.

National Provider Identifier (NPI): A unique identification number provided to facilities and other medical entities or providers.

Tax Identification Number (TIN): Number used to identify tax payments from an individual or group entity.

Regional Partnership (RP): An HSCRC grant program designed to foster collaboration between hospitals and community partners and enable partners to create infrastructure, test, and measure the impact of interventions.

Total Costs of Care (TCOC): Medicare costs in Parts A and B services for fee-for-service beneficiaries.