Total Cost of Care (TCOC) Workgroup

June 27, 2018

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions
- Updates on initiatives with CMS
  - Amendment to current All-Payer Model (APM) contract
  - TCOC Contract language
  - Bundled Payments for Care Improvement in Maryland (BPCIM)
- Y1 MPA implementation
  - Update on MPA reporting tool for hospitals
  - New spreadsheet with modeling for CY 2017 vs. CY 2016, etc.
- Y2 MPA issues
  - Attainment (not doing in Y2)
  - Risk adjustment (or not)
  - Linking doctors to hospitals
  - PSAP zip codes
  - Quality Adjustment

Updates on Initiatives with CMS

APM Amendment #2 to implement MPA was signed and effective June 19, 2018

- Medicare Performance Adjustment (MPA) required for our Care Redesign Programs (CRP) to be MACRAtized
  - Participating clinicians who are Qualifying Participants (QPs) will receive 5% incentive payment on Medicare payments*
- All CRP hospitals (new and prior) had to sign the new Participation Agreement (PA) by yesterday
  - State and federal signatories need to sign by 7/1 for MACRAtization
- New MACRAtized CRP performance period is 7/1-12/31/18
  - CRP Performance Period 1 was July 1 – Dec. 31, 2017
  - CRP Performance Period 2 is Jan. 1 ~~– Dec. 31, 2018~~ – June 30, 2018
  - New CRP Performance Period 3 is July 1 – Dec. 31, 2018
  - CRP Performance Period 4 will be under new TCOC Contract: CY19

* See slides from April 4 TCOC Work Group meeting for additional background.

MACRA for CRP Performance Period 3

- Since MACRAtization of CRP just occurred …
  For Maryland clinicians in CCIP and HCIP in 2018 to be assessed for MACRA QP determination, they must be on the Certified Care Partner List:
  - Sent by a CRP hospital* to AMS/CRISP/HSCRC by **July 13**
  - Sent by AMS/CRISP/HSCRC to CMS by July 27
- To be on the hospital's Certified Care Partner List, a clinician:
  - (1) must already have been vetted eligible by CMS,
  - (2) meet HCIP/CCIP track criteria, and
  - (3) sign HCIP or CCIP care partner arrangement (or be a downstream care partner in the group's care partner arrangement).
- QP Threshold Score for MACRA
  - High-level summary in April 4 TCOC Work Group slides
  - CMS to publish FAQs shortly

* That is, a hospital that has an executed new Participation Agreement (i.e., signed by all parties)

TCOC Contract Update

- Contract language in near-final stages
  - Purpose is to make consistent with provisions agreed to with federal government in Term Sheet, as amended for federal clearance approval (as announced by Gov. Hogan on May 14, 2018)
  - Contract language shared with stakeholders, state partners and Commissioners for any technical comments
- Hoping for State and Feds to sign in mid-July

Bundled Payments for Care Improvement in Maryland (BPCIM)

- Bundle Basics
- Overview of Federal Programs
- Tailoring Bundles for Maryland
- Model Launch Timeline
- Additional Details in Appendix

Bundle Basics

Definition: **Bundled Payment**

noun

1) Providers and/or healthcare facilities are paid a single payment for all the services performed to treat a patient undergoing a specific episode of care.

2) An "episode of care" is the care delivery process for a certain condition or care delivered within a defined period of time.

Objectives of Bundled Payments

Promote care redesign and incentivize care coordination

Reward high quality care and prevent readmissions

Reduce health care costs

Overview of Federal Bundled Programs

Bundled Payments for Care Initiative (BPCI)

- 4 tracks, ends in September 2018
- Saved ~$300 million since 2014

Bundled Payments for Care Initiative Advanced (BPCI-A)

- Announced in January 2018
- Features include:
  - Voluntary model, single retrospective payment with 90 day Clinical Episode duration, 29 Inpatient Clinical Episodes, 3 Outpatient Clinical Episodes, qualifies as an Advanced Alternative Payment Model (APM), payment is tied to performance on quality measures.

Reduced

Comprehensives Care for Joint Replacement (CCJR) Program

- *Voluntary in 33 MSAs*
- *Projected to save CMS $189 million over 5 years*

Canceled

Episode Payment Models and Cardiac Rehabilitation (CR) Incentive Payment Models

- *Canceled in favor of other programs*
- *Projected to save Medicare $170 million over 5 years*

Introducing Bundled Payments for Care Initiative for Maryland (BPCIM)

- BPCIM is based on the BPCI Advanced Model but tailored for Maryland and simplified for implementation ease.

What's the same?

Features	BPCI- Advanced	BPCI-Maryland
Participation	Voluntary	Voluntary
Episodes	90-day episode -- from triggering inpatient stay	90-day episode -- from discharge from triggering inpatient stay
CMS Savings Discount	Episode targets are set 3% below average total cost of care	Episode targets are set 3% below average total cost of care

Introducing Bundled Payments for Care Initiative in Maryland (BPCIM)

- BPCIM is based on the BPCI Advanced Model but tailored for Maryland and simplified for implementation ease.

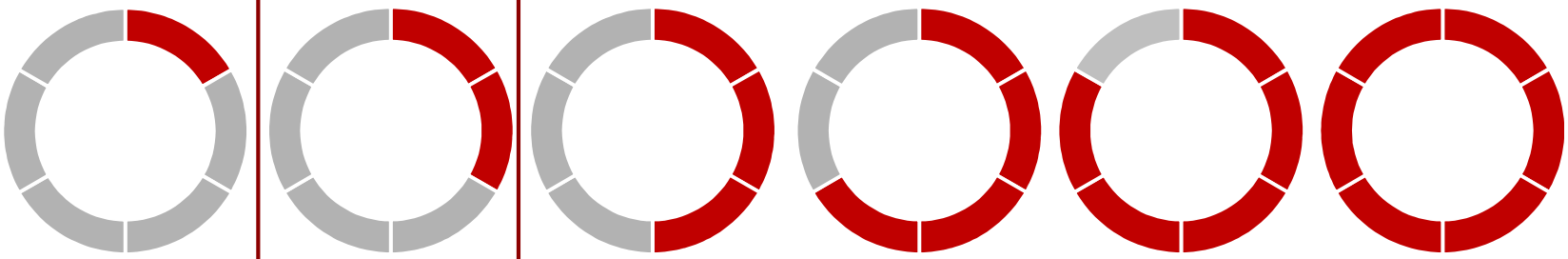
What's NOT the same?

Features	BPCI- Advanced	BPCI-Maryland
Clinical Episodes	29 Inpatient Clinical Episodes 3 Outpatient Clinical Episodes	Only Inpatient Clinical Episodes
Clinical Data Formatting	MS-DRGs	APR-DRGs
Charge Inclusion	Includes Inpatient Anchor Stay, Physician Payment, Post-Acute Care, and Readmission costs	Excludes inpatient (anchor and readmission) charges
Benchmarks	Payment adjusted for 1) efficiency, 2) risk adjustment, and 3) peer group	Simplified payment adjustment
Quality Measures	A Composite Quality Score (CQS) is calculated to adjust payments +/- 10%	A Composite Quality Score (CQS) is calculated to adjust payments <10% (amount TBD)

Hospitals and care partners are offered a flexible menu of care redesign interventions

Intervention Category	Intervention
Clinical Care and Care Redesign 	• Standardized, evidence-based protocols are implemented, for example for discharge planning and follow-up care.
	• Implementation of enhanced coordination with post-acute care providers.
	• Interdisciplinary team meetings address patients' needs and progress.
	• Pharmacists embedded on unit.
Beneficiary and Caregiver Engagement 	• Patient education is provided pre-admission and addresses post-discharge options.
	• Shared decision-making processes and/or tools are implemented to help patients assess treatment options.
	• Methods for fostering "health literacy" in patient/family education are implemented.
	• Patient supports, items, and/or services are furnished to beneficiaries.
Care Coordination and Care Transitions 	• Patient risk assessment/stratification is used to target services.
	• Assignment of a care manager/ coordinator/ navigator to follow patient across care settings (e.g., to help coordinate follow-up appointments and to connect patient to needed community resources).
	• Performance of medication reconciliation.
	• Remote patient consultation monitoring.

Timeline and Application Process



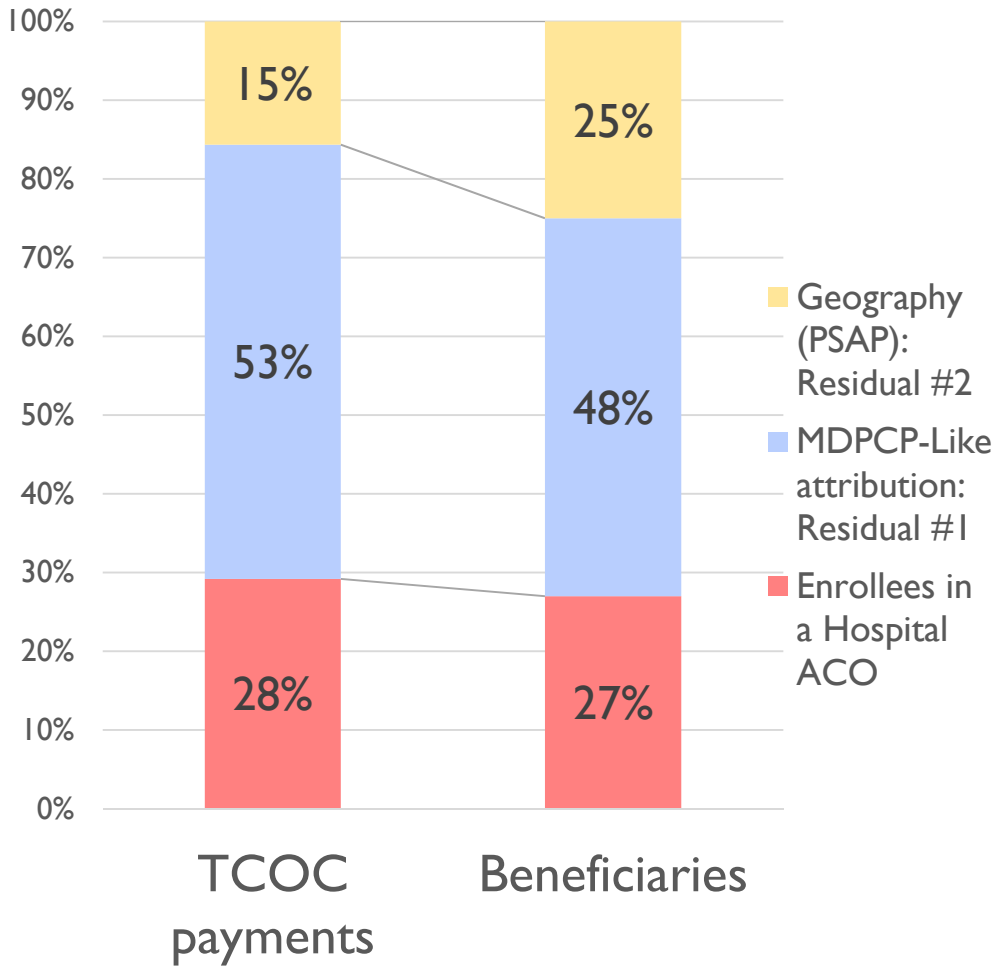
May	June 4	Summer	Sept./Oct.	Oct. 31	Jan. 1, '19
• Developed BPCIM Template Protocol	• State submitted draft Protocol to CMMI for approval • Meeting with CMMI on changes	• Hospital-specific episode prices developed • Design details finalized	• Informational meetings and webinars for hospitals and potential care partners	• Participating hospitals submit Protocol to HSCRC for approval	• BPCIM launch

Current Status

Y1 Implementation: CRISP MPA Reporting Tools for Hospitals

Y1 Implementation: New spreadsheet with modeling for CY 2016-7, etc.

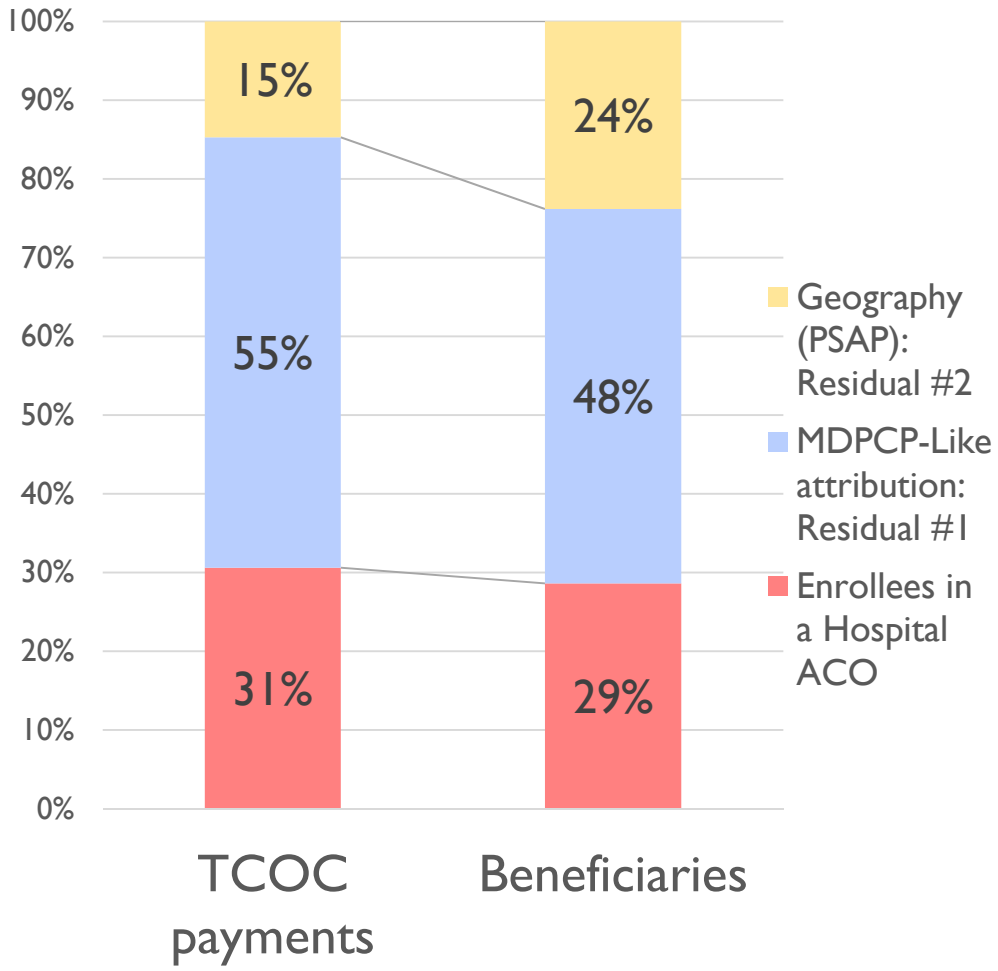
Attribution Algorithm: 2016 data of hierarchy of ACO-Like / MDPCP-Like / Geography



- Attribution occurs prospectively, based on utilization in prior 2 federal fiscal years, but then using their current CY TCOC
  1. Beneficiaries attributed first based on service use of clinicians in hospital-based ACO
  2. Beneficiaries not attributed through ACO-like are attributed based on MDPCP-like
  3. Finally, beneficiaries still not attributed would be attributed with a Geographic approach
- Performance would be assessed on TCOC spending per capita
- For hospitals not in an ACO, attribution would be MDPCP-like + Geography, among beneficiaries not in a hospital-based ACO

Source: Draft HSCRC analysis based on CY 2016 Medicare (CCW) data

Y1 MPA Base Year: 2017 data of hierarchy of ACO-Like / MDPCP-Like / Geography



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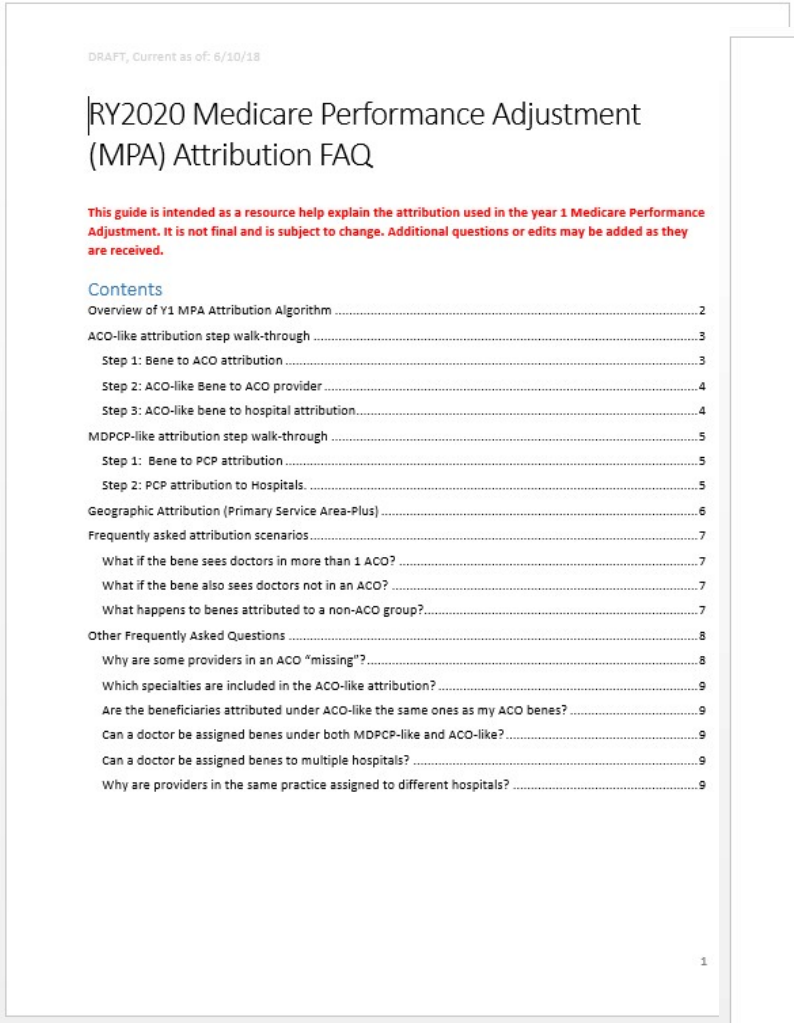
Source: Draft HSCRC analysis based on CY 2017 Medicare (CCW) data

FAQ posted on MPA Attribution Algorithm

- http://hscrc.maryland.gov/Documents/Work%20Group%20Uploads/Total%20Cost%20of%20Care%20(TCOC)/FAQ/RY2020%20Medicare%20Performance%20Adjustment%20FAQ%206.10.18.docx



DRAFT, Current as of: 6/10/18

RY2020 Medicare Performance Adjustment (MPA) Attribution FAQ

This guide is intended as a resource help explain the attribution used in the year 1 Medicare Performance Adjustment. It is not final and is subject to change. Additional questions or edits may be added as they are received.

Contents

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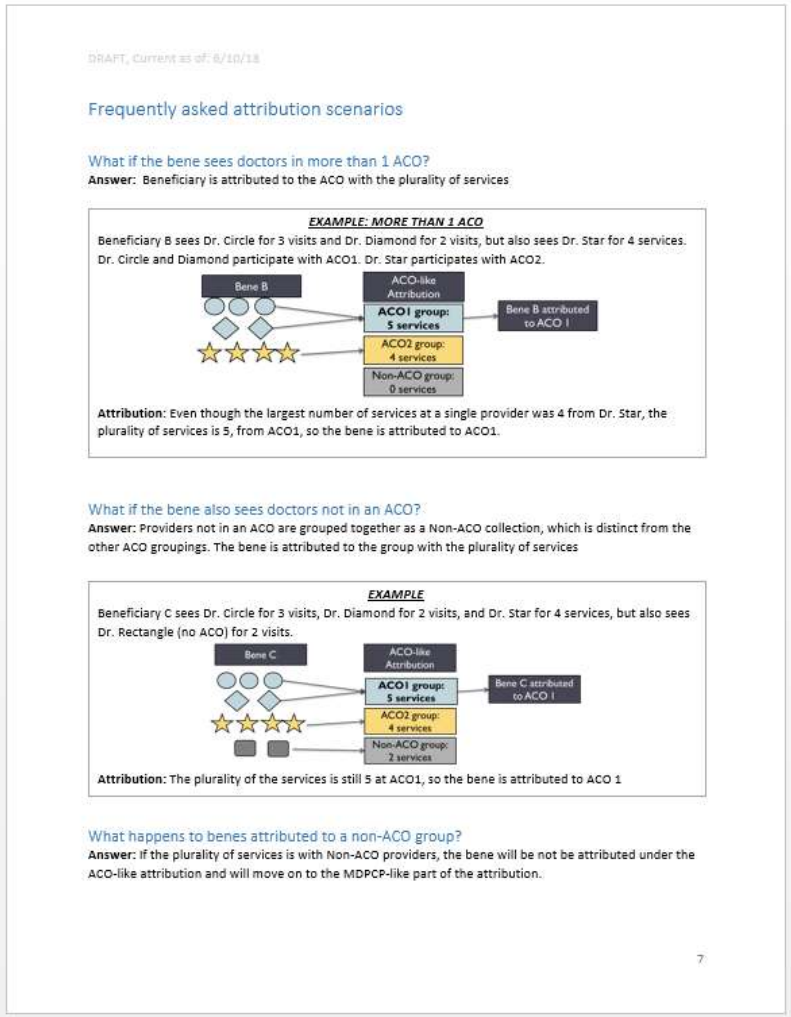

DRAFT, Current as of: 6/10/18

Frequently asked attribution scenarios

What if the bene sees doctors in more than 1 ACO?

Answer: Beneficiary is attributed to the ACO with the plurality of services

EXAMPLE: MORE THAN 1 ACO

Beneficiary B sees Dr. Circle for 3 visits and Dr. Diamond for 2 visits, but also sees Dr. Star for 4 services. Dr. Circle and Diamond participate with ACO1. Dr. Star participates with ACO2.

Attribution: Even though the largest number of services at a single provider was 4 from Dr. Star, the plurality of services is 5, from ACO1, so the bene is attributed to ACO1.

What if the bene also sees doctors not in an ACO?

Answer: Providers not in an ACO are grouped together as a Non-ACO collection, which is distinct from the other ACO groupings. The bene is attributed to the group with the plurality of services

EXAMPLE

Beneficiary C sees Dr. Circle for 3 visits, Dr. Diamond for 2 visits, and Dr. Star for 4 services, but also sees Dr. Rectangle (no ACO) for 2 visits.

Attribution: The plurality of the services is still 5 at ACO1, so the bene is attributed to ACO 1

What happens to benes attributed to a non-ACO group?

Answer: If the plurality of services is with Non-ACO providers, the bene will be not be attributed under the ACO-like attribution and will move on to the MDPCP-like part of the attribution.

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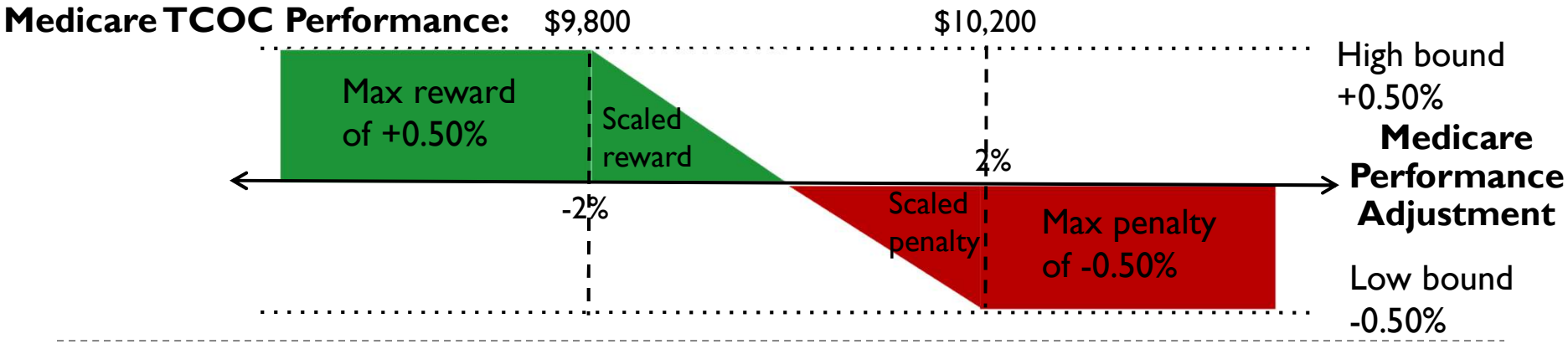
Y2 MPA Issues

Year 1 MPA is "improvement only" with 0.5% hospital Medicare Max Revenue at Risk

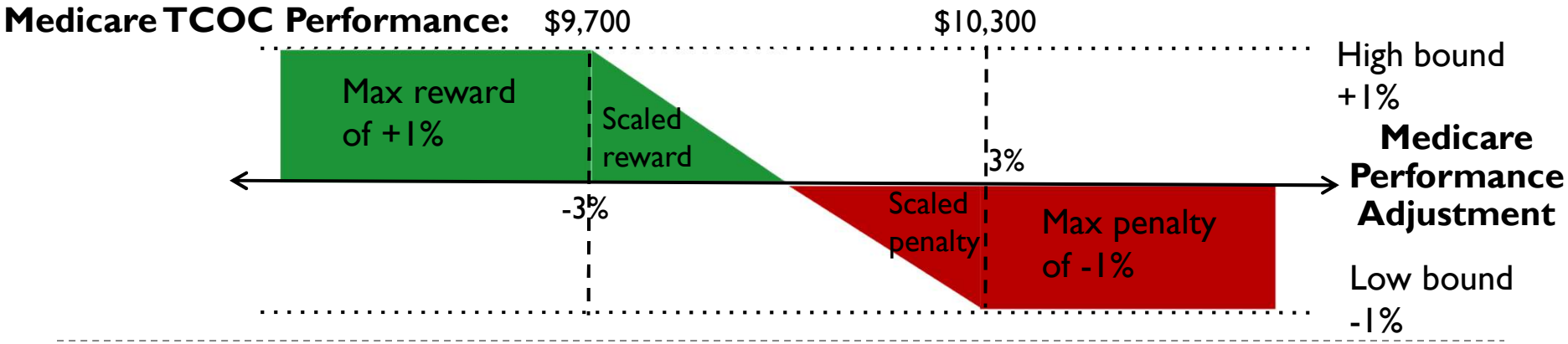
- Maximum Performance Threshold = 2%
- National Medicare FFS growth in CY 2018 (totally made-up example) = 1.83%
- TCOC Benchmark = $9,852 * (1 + 1.83% - 0.33%) = $10,000
- If CY 2018 per capita TCOC is:
  - $10,200+ (2%+ above Benchmark), then full -0.5% MPA
  - $9,800 or less (2%+ below Benchmark), then full +0.5% MPA
  - Scaled MPA ranging from -0.5% to +0.5% between $9,800 and $10,200



Note: For simplicity's sake, example assumes Quality Adjustment of 0%.

Year 2 MPA: Increase Max Medicare Revenue at Risk to 1%

- Maximum Performance Threshold to 3%
  - CMS wants ratio of Maximum Revenue at Risk / Maximum Performance Threshold to be at least 30%
  - Y1 ratio is 25% (0.5%/2%)
  - Y2 ratio is 33% (1%/3%)
- Besides Maximum Revenue at Risk, HSCRC may also apply "Efficiency Adjustment" in MPA – for example, to provide Medicare-only payments to hospitals under BPCIM



Note: For simplicity's sake, example assumes Quality Adjustment of 0%, and dollar amounts in prior slide applied here as well (i.e., updated one year).

Staff is recommending that Y2 MPA still use "improvement only"

- Attainment adjustment makes sense conceptually
- Only readily available Medicare TCOC measure is comparing Maryland hospitals to Maryland hospitals
  - Not necessarily indicative of TCOC success but other factors (e.g., rural vs. urban)
  - Need analyses comparing Maryland hospitals to comparable hospitals nationally
  - Work is underway to obtain these data/analyses
- No attainment adjustment in MPA until we have appropriate benchmarks/comparisons

Y2 MPA Issues: Risk Adjustment

- Hospital's own MPA population's changing risk profile YOY as affecting Improvement Only
- ~~Hospital MPA population relative to other Maryland hospitals as affecting Attainment Adjustment~~

Y2 MPA Risk Adjustment options

- No risk adjustment

- CMS-HCC New Enrollee (NE) Risk Scores based on national data
  - Relies on Gender/Age-Band/Dual Status/ESRD Status
  - Risk Scores published for Medicare Advantage, generally for those without 12 months of claims experience (same buckets as above)
  - Does not adjust for diagnoses

Staff remains opposed to using full CMS-HCCs that reflect diagnoses

- May be worth further investigation when an Attainment Adjustment is considered again
- Use of Risk Adjustment in MPA different than in other programs
  - CMS-HCCs designed for Medicare Advantage to prospectively predict next year's expenditures based on current year's diagnoses and next year's demographics – to ensure plans have adequate funding under capitation
    - MPA does not provide capitation dollars
  - If the state were to implement HCCs in the MPA, the state would need to enhance auditing medical records
  - Replicating CMS steps in ACOs to account for potential upcoding could be detrimental to hospitals with high-needs patients
  - Use of HCCs in CRP and MDPCP is for identifying and/or funding specific patients requiring additional resource utilization

Risk Adjustment modeling: Effect on hospitals' improvement

- Newest numbers (spreadsheet):
  - Adjust 2016 actual per capita to show what the 2016 per capita would have been with 2017 risk profile
- Focuses on reducing the impact of beneficiary characteristics change within each hospital's population from year to year
  - Does not compare risk profiles between hospitals
- The change in the risk profile from 2016 to 2017, and its modeled effect on the MPA if in place in 2017, does not predict effects in future years
- Policy question: Should the HCC-NE Risk Adjustment be used to account for a hospital's changing population year over year?

Y2 MPA Issue:
Linking Doctors to Hospitals

Linking doctors to hospitals: Revise for Y2?

- ACO-like attribution
- NEW? MDPCP-ACTUAL
  - Using actual TINs and NPIs participating in MDPCP for attribution
  - All NPIs in the same MDPCP practice attributed to the same hospital, potentially aligned with Care Transformation Organization (CTO)
  - Should beneficiaries be attributed to NPIs (current MDPCP-like approach) or to groups of NPIs (current ACO-like approach)?
- MDPCP-like
  - Link beneficiaries to NPI based on plurality (same as existing)
  - Instead of linking NPIs directly in hospitals, should we try to link NPIs to practices and link practices to hospitals?
- PSA-Plus

Linking doctors to hospitals: TINs and MDPCP-like

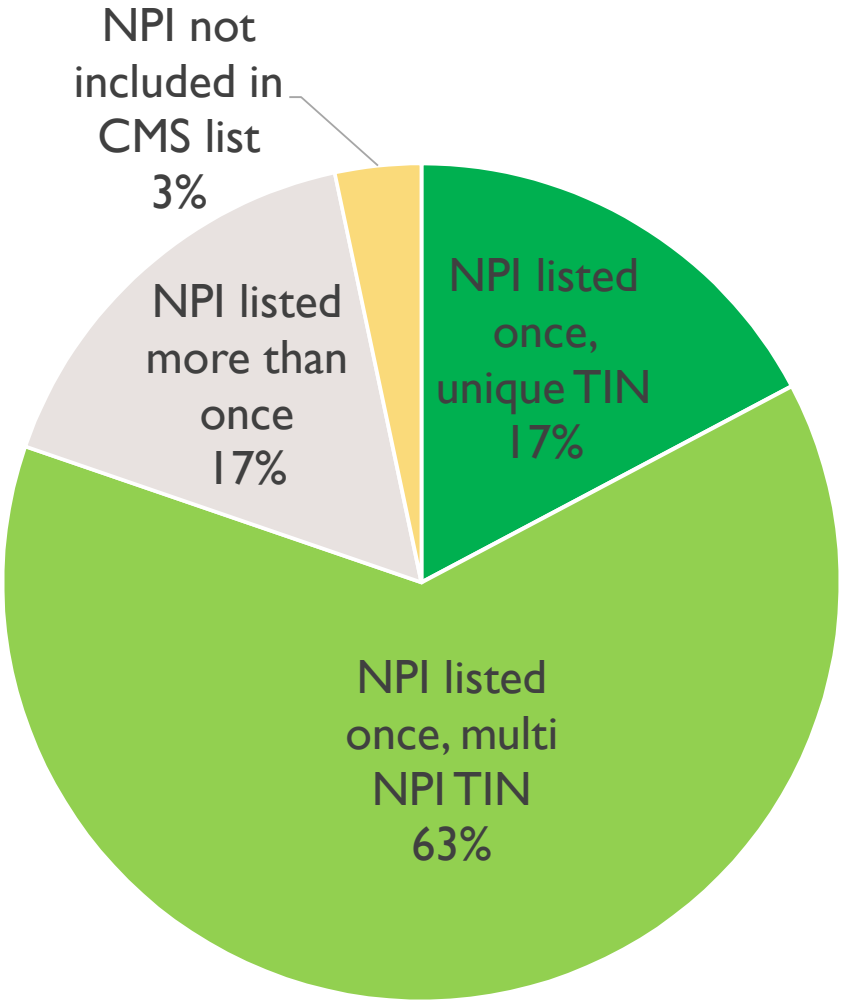
- Interest in using tax identification numbers (TINs) to group providers so providers in the same practice are attributed to the same hospital.
  - Would not affect how beneficiaries are attributed to NPIs

- CMS finally sent groupings of providers by de-identified TIN information
  - Represents a point-in-time analysis
  - CMS used NPPES (NPI registry) and PECOS information to populate the database, and determined TIN linkage using claims and zip codes
  - CMS linked providers in the state with "pseudo" TINs; CMS did not send actual TINs because some providers may use Social Security Numbers as TINs
  - All providers who billed under that TIN were assigned the same number
  - Providers who billed to different TINs were listed multiple times

Process

- Original dataset with a total of 95,734 rows.
- Step1: Kept only unique NPI-TIN combinations (regardless of address), which reduced the dataset to 34,996 rows.
- Step 2: Limited to specialties applicable under MDPCP-like. This resulted in 12,334 TIN-NPI combinations.
- Step 3: HSCRC used information from Physician Compare and ACO lists to provide educated guesses about TIN identity.
- Step 4: Kept providers that qualified for MDPCP-like portion of the algorithm
  - Qualifying providers were required to have 60% of their Medicare costs be for primary care services and at least 25 beneficiaries with office visits.
- Step 5: Added back NPIs who were attributed benes in the MPA but were not on the MDPCP-like qualifying list (e.g., some ACO participants)
- **Final dataset used for analyses consists of providers who were attributed beneficiaries in 2018 (5,070 unique NPI-TIN combos)**
  - The TIN information is based on the information sent by CMS, with educated guesses on TIN based on the list generated in Step 3.

Distribution of NPIs with Pseudo TINs



Details on distribution of NPIs with Pseudo TINs

- Out of 1,452 pseudo TINs and 4,361 NPIs, there are 5,215 NPI-TIN combos.
- 752 rows appear to be unique NPI-TIN combinations, where both the NPI and TIN are listed once in the dataset (22% of beneficiaries)
- The remaining 3,609 providers participate in at least 1 of the 700 remaining TINs.
  - 2,748 participate with a single multi NPI-TIN (62% of beneficiaries)
  - 716 participate with more than one TIN (14% of beneficiaries)
  - 145 are NPIs from border states that were not in the CMS data (2% of beneficiaries)
- NPIs that are listed multiple times in the TIN dataset (16% of NPIs and 14% of beneficiaries) are difficult to attribute to a single practice because HSCRC would need to determine the provider's primary practice.

*Due to small data cell limitations, provider bene counts less than 11 default to "." which appear as 0 in sum calculations

Among NPIs listed once with multi-NPI TIN

- Analyzed whether there was consistent hospital attribution among NPIs in the same TIN
- Limited this portion of analysis ONLY to those NPIs listed once with a TIN listed more than once.
  - Ignores whether NPIs listed multiple times were associated with the TIN

Categories	Definition
1. All aligned	Practices in which 100% of NPIs attributed to same hospital system
2. All aligned with wrap around	Practices in which 100% of NPIs attributed to same system, assuming ACO-like attribution prevails if there is a conflict
3. 80%+ aligned with wrap around	Same, but only 80% of NPIs must be attributed to same system.
4. Large independent practices	Large independent practices with multiple regions and no clear hospital attribution (such as Kaiser or Privia)
5. Not aligned or known	NPIs in practice conflict on hospital attribution

- In categories 2 and 3, most NPIs and beneficiaries would already be attributed to the practice's system, but a small number would need to be reassigned to ensure all in the practice were linked with the same system

Among NPIs listed once with multi-NPI TIN

	Practices		NPIs			Benes*		
			Total	%	Realigned			Realigned
All aligned	199	62.0%	838	30.5%		122,673	33.8%	
All aligned with wrap around	15	4.7%	806	29.3%	83	71,151	19.6%	**15,711**
80%+ aligned	12	3.7%	479	17.4%	21	69,708	19.2%	**1,517**
Large independent practices	10	3.1%	382	13.9%		67,230	18.5%	
Not aligned or known	85	26.5%	243	8.8%		31,702	8.7%	
Total	321	100.0%	2748	100.0%		362,464	100.0%	

- Most reassignment among NPIs in multi-NPI TINs occurs for providers with conflicting ACO-like and MDPCP-like attribution, or multiple ACO-like attributions (wrap-around)
- When a single ACO-like attribution is allowed to prevail, a max of around 16,000 beneficiaries are realigned
  - Actual number is likely much smaller as some of these beneficiaries would have already been attributed to the "correct" hospital*

* For ease of analysis, all MPA-attributed benes to an NPI were considered a unit that moved together, even if some were attributed through MDPCP-like and some ACO-like

Takeaways

- The pseudo TIN data provides helpful information, but does not automatically enable HSCRC to group doctors into practices for purposes of the MPA
  - Some doctors are listed with multiple TINs,
  - Relies on some subjective decision-making (evaluation of linked data and the % of NPI attribution)
  - Regional variation within practices
- Pseudo TIN data is based on a point-in-time analysis
  - Requires annual updates from CMS
  - Providers may switch TINs throughout the year
- Requires substantial, time-consuming analysis

Potential solutions

- Explore using pseudo TIN data in conjunction with employment data to link NPIs to practices
  - Would likely be limited to the subset of clearly hospital- and system-associated practices
  - Requires a list of employed doctors from hospitals
- Adjust attribution so that NPIs are only attributed to one hospital
  - Would need to make rules around what to do when ACO-like and MDPCP-like conflict, or when there are multiple ACO-like attributions
  - May be able to use pseudo TIN data to help determine which attribution is appropriate

From prior discussions: Ways to link doctors to hospitals

- New possibilities such as:
  - Employment/ownership
    - Concerns about data source and definition issues
  - Others?
- Reassess ACO-like and MDPCP-like
  - Adjust specialties to include when PCP not found?

Specialty Breakdown 2017

ACO-LIKE ATTRIBUTION			
Specialty	2017 Benes	2017 TCOC	2017 TCOC per Capita
Internal medicine	127,676	$1,561,592,232	$12,231
Family practice	55,687	$614,952,430	$11,043
Nurse practitioner	15,937	$223,200,406	$14,005
Physician assistant	5,163	$67,032,331	$12,984
Geriatric medicine	3,810	$52,856,302	$13,872
Cardiology	2,876	$28,947,064	$10,067
Pulmonary disease	1,001	$13,734,397	$13,723
Neurology	631	$7,007,192	$11,103
Pediatric medicine	553	$6,666,452	$12,064
Hem/onc	493	$9,163,634	$18,572
Medical oncology	447	$12,498,520	$27,945
Psychiatry	409	$3,168,557	$7,750
OB/GYN	339	$1,909,859	$5,628
General practice	334	$3,944,021	$11,803
Nephrology	318	$8,819,339	$27,770
Physical med /rehab	175	$1,555,284	$8,909
Hematology	82	$1,123,093	$13,780
CNS	56	$1,014,847	$17,988
GYN ONC	30	$273,049	$9,230
Preventive medicine	9	$161,447	$18,106
	216,025	$2,619,620,454	$12,126

MDPCP-LIKE ATTRIBUTION			
Specialty	2017 Benes	2017 TCOC	2017 TCOC per Capita
Internal medicine	210,869	$2,884,038,859	$13,677
Family practice	73,913	$859,175,649	$11,624
Cardiology	20,191	$341,020,445	$16,890
Nurse practitioner	12,563	$154,605,363	$12,306
Pulmonary disease	11,038	$217,447,296	$19,699
Psychiatry	7,605	$107,828,212	$14,178
Gastroenterology	5,139	$68,645,400	$13,358
OB/GYN	3,900	$33,148,448	$8,499
Geriatric medicine	3,120	$46,839,225	$15,015
Nephrology	2,922	$119,550,865	$40,912
General practice	2,109	$27,186,491	$12,891
Medical oncology	501	$12,595,131	$25,148
Hem/onc	361	$10,008,792	$27,764
	354,231	$4,882,090,176	$13,782

Y2 MPA Issue: PSAP Zip Codes

Primary Service Area – Plus (PSAP)

- Hospitals selected Primary Service Areas (PSAs) but not all the state's zip codes were captured
- To create PSA-Plus, remaining zip codes were assigned to the hospital with the most Medicare Equivalent Case-Mix Adjusted Discharges (ECMADs)
- Medicare ECMADs are also used when multiple hospitals selected a zip code in their PSA – to apportion the TCOC to those hospitals
- To the extent PSAPs may differ based on all-payer ECMADs, should we move to all-payer PSAPs?
- Both sets of PSAPs will be shared for assessment

Y2 MPA Issue: Quality Adjustment

MPA Quality Adjustment

- Rationale
  - Payments under an Advanced APM model must have at least some portion at risk for quality
  - Because the MPA connects the hospital model to the physicians for MACRA purposes, the MPA must include a quality adjustment
- Other requirements
  - Must be aligned with measures in the Merit-Based Incentive Payment System (MIPS) to the extent possible

Quality adjustment for Y1

- Use RY19 quality adjustments from Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Conditions (MHAC)
- Mechanism
  - MPA will be multiplied by the sum of the hospital's quality adjustments
  - For example, a hospital with TCOC scaled reward = 0.3%, then with MHAC quality adjustment =1% and RRIP quality adjustment = 0% would receive an MPA adjustment of 0.303%.

Quality adjustment for Y2

- At prior work group meetings (e.g., April 4), discussed potentially using new measures focused on population health
- However, to ensure simplified continued MACRAtization, the draft TCOC Contract requires the MPA to continue to use measures on readmissions and hospital-acquired conditions
  - Nothing prevents including additional measures
- For the Y2 MPA policy, staff is recommending:
  - Using the RY20 quality adjustments from Readmission Reduction Incentive Program (RRIP) and hospital-acquired infections
- Additional measures may be considered for Y3 MPA policy, consistent with TCOC goals

Future meetings

- TCOC Work Group meetings
  - July 25
  - Sept. 26
  - Oct. 24
  - Nov. 28
- HSCRC Commission meetings
  - Oct. 10
  - Nov. 14
  - Dec. 12

Next meeting:

8:00 a.m. Wednesday, July 25

Total Cost of Care (TCOC) Workgroup

HSCRC
Health Services Cost Review Commission

APPENDIX: BPCIM Details

BPCIM: Common Terms and Definitions

- *Episode Initiator (EI):* Hospital participating in BPCIM will act as the "episode initiator," facilitating coordination with and among care partners.
- *Clinical Episode Trigger:* Inpatient claim from an ACH with a qualifying MS-DRG or Hospital outpatient claim with a qualifying HCPCS code.
- *Clinical Episode Length:* Inpatient Clinical Episode: Anchor Stay + 90 days following discharge
- *Certified Electronic Health Information Technology (CEHRT):* CMS and the Office of the National Coordinator for Health Information Technology have established standards and other criteria for structured data that EHRs must meet in order to qualify for participation in PI programs.
- *Payment Reconciliation:* Where actual Medicare fee-for-service (FFS) expenditures for all clinical episodes attributed to the hospital are compared to the final target price for those clinical episodes.

CMS List of Inpatient Clinical Episodes

Please note that not all Clinical Episodes will be offered to every hospital.

1. **APR-DRG Conversion:** Certain Clinical Episodes may be collapsed in the MS-DRG to APR-DRG conversion.
2. **Low Volume Limits:** Hospitals with fewer than 30 episodes for a particular category during the baseline period of the most recent three years are ineligible to participate in that bundle and will not receive target prices for those episode categories.

CMS BPCI-Advanced Inpatient Clinical Episodes

- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis
- Acute myocardial infarction
- Back & neck except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- COPD, bronchitis, asthma
- Combined anterior posterior spinal fusion
- Congestive heart failure
- Coronary artery bypass graft
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Hip & femur procedures except major joint
- Lower extremity/humerusprocedure except hip, foot, femur
- Major bowel procedure
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Pacemaker
- Percutaneous coronary intervention
- Renal failure
- Sepsis
- Simple pneumonia and respiratory infections
- Spinal fusion (non-cervical)
- Stroke
- Urinary tract infection

Care Partners in BPCIM

Care partners provide care under the BPCIM initiative, participate in BPCIM interventions, and are paid separately by Medicare for their services. Hospitals may choose care partners from the following provider types:

- General or specialist physician;
- Clinical nurse specialist or nurse practitioner;
- Physician assistant;
- Physical therapist;
- Skilled nursing facility (SNF);
- Home health agencies;
- Long term care hospitals;
- Inpatient rehabilitation facilities;

Care Partner Qualifications

- Each potential care partner must meet, at a minimum, the following care partner qualifications specific to BCPIM in addition to the care partner requirements described in the Participation Agreement:
  - A clinician must have a National Provider Identifier (NPI) and a facility must have a Taxpayer Identification Number (TIN);
  - The provider must participate in the Medicare program;
  - The provider must be licensed;
  - The provider must use CEHRT and CRISP, Maryland's Health Information Exchange; and
  - The provider must pass the federal program integrity screening process.
- Care partners must sign a care partner arrangement with the hospital and comply with all applicable requirements under the Participation Agreement.
- A care partner may participate in multiple hospitals' BPCIM programs.

Measuring Quality in BPCIM

- BPCIM plans to follow the general quality framework from the BPCI-A model.
- In order to provide a path for MACRA eligibility, BPCIM is required to adjust payments for quality. The HSCRC acknowledges that other state quality programs also focus on readmissions and the PSI measures.

All Bundles:

- All-cause Hospital Readmission Measure (NQF #1789); and
- Advanced Care Plan (NQF #0326)

Condition Specific Bundles:

- Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268);
- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550);
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558);
- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881); and
- AHRQ Patient Safety Indicators (PSI 90).