Analysis IN BRIEF

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Medicare Patient Hospital Transfers in the Era of Health Care Reform Supplemental Information

Glossary:

Accountable Care Organization (ACO)
The Center for Medicare and Medicaid Services (CMS) defines accountable care organizations (ACOs) as groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated, high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. For additional information see: https://www.aamc.org/members/osr/communications/legislative_affairs/283312/whatisanaco.html

Bundled Payment Care Initiative (BPCI)
On January 31, 2013, CMS announced the health care organizations selected to participate in the Bundled Payments for Care Improvement (BPCI) initiative, an innovative new payment model that comprises four broadly defined models of care. Under the BPCI initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare. An example of an episode of care is a hip replacement where the start date is triggered by the start of the hip replacement hospitalization and ends 90 days after discharge from the hospital. CMS will pay the "bundler" or admitting hospital one fee that will cover all inpatient institutional and professional care, outpatient institutional and professional care, and any other skilled nursing, intermediate, and/or home care. The bundler will be responsible for reimbursing all the component entities participating in the patient's care. If readmissions occur during the episode period and not to the admitting hospital, the readmissions will likely also be included in the bundle, which has significant implications for the accountability related to transfer cases. See: https://www.aamc.org/initiatives/patientcare/reform/demosandpilots/327264/bpcibackground.html

Case Mix Index (CMI)
Each Medicare patient is classified into a diagnosis-related group (DRG) on the basis of clinical information. CMS assigns a relative weight to each DRG based on a neutral value of "1." DRGs that are high complexity and/or high work intensity will have values significantly higher than "1," while those that are lower complexity will have a lower CMI and a value less than "1." As illustrated below, each hospital is assigned a single CMI based on the weighted average of all of the cases that occurred within that hospital.

Illustrative Example of Computations for Medicare CMI for a Particular Hospital

DRG	Weight	No. of Cases	Aggregate Case Weight
A	0.8	10	8.0
B	1.20	10	12.0
C	1.60	10	16.0
TOTAL		**30**	**36.0**

This hospital's average CMI would be 36.0/30 = 1.2

Examples of DRGs and Their Respective Weights

MS-DRG	MS-DRG Title	Weight
007	Lung Transplant	9.5998
103	Headaches w/o major complications or co-morbidities (MCC)	0.6239
313	Chest Pain	0.5314

Source: FY2009 IPPS Final Rule Impact File

Diagnosis-Related Group (DRG)
Diagnosis-related group (DRG) is a patient classification system adopted on the basis of diagnoses consisting of distinct groupings. It is a scheme that provides a means for relating the type of patients a hospital treats with the costs incurred by the hospital. DRGs are based upon the patient's principal diagnosis, ICD diagnoses, gender, age, sex, treatment procedure, discharge status, and the presence of complications or co-morbidities. It is a system developed for Medicare as part of the prospective payment system that utilizes a predetermined rate per case or type of discharge. Since 1983, DRGs have been used in the U.S. in inpatient hospital discharge and emergency department encounter query modules to determine how much Medicare pays the hospital since patients within each category are similar clinically, and some groups of patients that have common demographic, diagnostic, and therapeutic attributes use the same level of hospital resources. See: http://definitions.uslegal.com/d/diagnosis-related-group-drg/. As of October 1, 2007 (Version 25 of the CMS DRGs), a refinement was made to further quantify severity associated with each DRG, and this revised DRG system is sometimes referred to as the MS-DRG system.

Patient-Centered Medical Home (PCMH)
The medical home is a concept or model of care delivery that includes an ongoing relationship between a provider and patient, around-the-clock access to medical consultation, respect for the patient/family's cultural and religious beliefs, and a comprehensive approach to care and coordination of care through providers and community services. Its functions are similar to those of effective primary care proposed several decades ago by the Institute of Medicine and the World Health

Organization, among others. In fact, the term was originally coined in 1967 by the American Academy of Pediatrics, but the concept in its current form was formulated by the academy in a 1992 position paper as "an approach to providing comprehensive primary care." See: https://www.aamc.org/download/60628/data/medicalhome.pdf

Pay-for-Performance
Pay-for-performance refers to any number of legislatively mandated or policy recommended programs that incentivize care providers (hospitals, physicians, etc.) for providing care more efficiently, effectively, or with higher quality as compared to their peers. The "pay" may be in the form of a financial incentive or reduction depending on the program. There are programs specific to professional providers such as the Physician Quality Reporting System as well as institutional pay-for-performance programs, such as payment bundling, readmission reduction program, and value-based purchasing.

Value-Based Purchasing (VBP)
Beginning October 2012, hospitals are paid under a new CMS program that ties a percentage of their Medicare reimbursement to performance on a set of quality metrics, including patient satisfaction. Called a value-based purchasing (VBP) program, it is one of three new performance-based payment programs under the Affordable Care Act. In its initial year (FY2013), the VBP program will combine a hospital's score on a patient satisfaction survey, known as the Hospital Consumer Assessment of Healthcare Providers and Systems, with the facility's success on 12 process-of-care measures in areas such as heart failure, pneumonia, and health care-associated infections. Poor performance on these measures can mean a reduction in Medicare reimbursement to the hospital up to 1 percent of base operating DRG payments, while good performance may result in the reverse. See: https://www.aamc.org/newsroom/reporter/january2012/271170/value-basedpurchasing.html