CRISP

ECIP FAQ

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1 General Questions

1.1 What do all these acronyms mean?

1. AAPM = Advanced Alternative Payment Model
2. BPCI Advanced = Bundled Payments for Care Improvement Advanced
3. CCIP = Complex and Chronic Care Improvement Program
4. CMS = Centers for Medicare & Medicaid Services
5. CP = Care Partners
6. CRISP = Chesapeake Regional Information Systems for our Patients
7. ECIP[1] = Episode Care Improvement Program
8. HCIP = Hospital Care Improvement Program
9. HSCRC = Maryland Health Services Cost Review Commission
10. IP = Implementation Protocol
11. NPRA = Net Payment Reconciliation Amount = Incentive Payment
12. TCOC = Total Cost of Care

1.2 When will the Episode Care Improvement Program (ECIP) start and how long will it run?

The first ECIP performance period will start January 1, 2019 and run through December 31, 2019.

1.3 What are the central design features of ECIP?

ECIP is a new care redesign track under the Maryland TCOC Model, complementing the existing HCIP and CCIP tracks. It is based on and inspired by the federal BPCI Advanced Model, adapting elements from the Comprehensive Care for Joint Replacement Model and implementing Maryland-specific modifications where beneficial. ECIP is defined by four primary characteristics:

1. It has a single, upside-only risk track for the first year (subsequent years TBD). Clinical episodes under this track are triggered by an anchor inpatient stay and consist of a 90-day global period starting the day of discharge from a participating acute care hospital;
2. 23 clinical episode categories are available for hospital selection;
3. It qualifies as an Advanced Alternative Payment Model (AAPM); and
4. Hospital-specific preliminary target prices will be provided to each participant for each clinical episode category in advance of the first reconciliation period of each model year.

[1] ECIP was referred to the "Bundled Care Improvement Program—Maryland" (BPCIM) during its early development. Per CMS, the program name was changed to the "Episode Care Improvement Program" (ECIP).

1.4 Can a hospital participate in ECIP as well as other existing care redesign tracks (HCIP and CCIP)?

Yes. ECIP is intended to be complementary to HCIP and CCIP. A care partner is not prohibited from participating in more than one care redesign track as long as the care partner meets the IP requirements of each track.

1.5 Can an ECIP care partner participate concurrently with MDPCP?

Yes. There is no prohibition on dual participation in MDPCP and ECIP.

1.6 What resources will CRISP make available to hospitals for episode evaluation and selection, and ECIP participation planning generally?

CRISP will provide both hospital-specific and general program resources through a designated card on the CRISP Reporting Services Portal (https://reports.crisphealth.org). The tools will include but are not limited to:

1. Hospital-specific baseline analysis and target price summary workbooks
2. Example funds flow workbooks for modeling incentive payment sharing with care partners
3. A track template for hospitals to complete their implementation protocols, along with a supplemental Excel workbook
4. Complete model method and definition documents, including episode construction and target price specifications, a policy development rationale, and FAQs

Recordings of all webinar training sessions will also be made available through the HSCRC Care Redesign site as they occur: https://hscrc.maryland.gov/Pages/CareRedesign.aspx.

1.7 What clinical episode categories are available for selection in ECIP?

A hospital may select to participate in one or more of the following episode categories:

1. Acute myocardial infarction (AMI)
2. Back and neck except spinal fusion
3. Cardiac arrhythmia
4. Cardiac valve
5. Cellulitis
6. Cervical spinal fusion / Combined anterior posterior spinal fusion / Spinal fusion (non-Cervical)
7. Chronic obstructive pulmonary disease (COPD), bronchitis/asthma
8. Congestive heart failure (CHF)
9. Coronary artery bypass graft surgery (CABG)
10. Major joint replacement of the lower extremity (MJRLE) / Double joint replacement of the lower extremity
11. Fractures, femur and hip/pelvis
12. Gastrointestinal hemorrhage
13. Gastrointestinal obstruction
14. Hip and femur procedures except major joint
15. Lower extremity and humerus procedure except hip, foot, femur / Major joint replacement of upper extremity
16. Major bowel procedure
17. Pacemaker
18. Percutaneous coronary intervention (PCI)
19. Renal failure
20. Sepsis
21. Simple pneumonia and respiratory infections
22. Stroke
23. Urinary tract infection (UTI)

1.8 How does the use of APR DRGs in ECIP affect the availability of clinical episode categories compared to the MS-DRG based clinical episode categories in BPCI Advanced? Are there other differences in clinical episode category options?

As a necessary result of the conversion, seven MS-DRG clinical episode categories have been collapsed into three APR DRG clinical episode categories for ECIP (see Table 1).

Table 1

BPCI Advanced Clinical Episode Category	ECIP Clinical Episode Category
Cervical spinal fusion	Cervical spinal fusion / Combined anterior posterior spinal fusion / Spinal fusion (non-cervical)
Combined anterior posterior spinal fusion	
Spinal fusion (non-Cervical)	
Major joint replacement of the lower extremity	Major joint replacement of the lower extremity / Double joint replacement of the lower extremity
Double joint replacement of the lower extremity	
Lower extremity and humerus procedure except hip, foot, femur	Lower extremity and humerus procedure except hip, foot, femur / Major joint replacement of upper extremity
Major joint replacement of upper extremity	

Additionally, two clinical episode categories are not available under ECIP due to low episode volume in the state of Maryland:

1. Cardiac defibrillator
2. Disorders of liver except malignancy, cirrhosis or alcoholic hepatitis

1.9 How will ECIP incorporate APR DRG Severity of Illness (SOI) levels?

Target prices in ECIP will be stratified by APR DRG and severity level. See the target price specification for full details on the methods used.

1.10 Which payment exclusions exist in ECIP?

Clinical episodes will exclude those Medicare FFS expenditures for:

1. Any Part A and Part B services furnished to a beneficiary during anchor stay and inpatient readmissions;

2. New technology add-on payments under the IPPS; and
3. Payment for blood clotting factors to control bleeding for hemophilia patients.

In addition, Medicare FFS expenditures on items and services furnished to Medicare beneficiaries covered under managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost- based health maintenance organizations); to Medicare beneficiaries eligible on the basis of end-stage renal disease (ESRD); to Medicare beneficiaries for whom Medicare is not the primary payer; and to Medicare beneficiaries who died during the anchor stay, are also excluded.

1.11 Will ECIP policies change over the life of the program?

HSCRC will be actively monitoring the program and gathering feedback from participants on an ongoing basis. As needed, ECIP will be updated and refined based on lessons learned from these observations, in coordination with and approval from CMS for the CY 2020 performance period and subsequent program years. Any such changes would be announced in advance of the performance period to which they would apply and with sufficient time for review before clinical episode category participation elections must be made for that year.

1.12 Will any clinical episode categories be added to ECIP?

HSCRC, in coordination with and approval from CMS, may add additional clinical episode categories to ECIP, or revise existing clinical episode categories, beginning in CY 2020. Additional changes may be made for subsequent performance periods as well.

1.13 May hospitals exclude any Medicare patients from the clinical episode categories in which they elect to participate?

Participants do not have the ability to exclude patients from the clinical episode categories they elect to participate in, regardless of a patient's acuity. Further, participants may not restrict beneficiary access to medically necessary care. To that end, CMS and HSCRC will monitor utilization to ensure that there is no degradation in the quality of care subsequent to implementation of ECIP.

It is important to note that not every Medicare beneficiary will trigger an ECIP episode due to beneficiary eligibility exclusions.

2 ECIP Eligibility & Participation

2.1 Who can participate in ECIP?

A hospital that has a signed and executed Care Redesign Program Participation Agreement can participate in ECIP. The hospital can choose to engage one or more of the following provider types as care partners:

1. General or specialist physician
2. Clinical nurse specialist / nurse practitioner
3. Physician assistant
4. Physical therapist
5. Skilled nursing facility (SNF)
6. Home health agencies (HHA)
7. Long term care hospitals
8. Hospice
9. Inpatient rehabilitation facilities (IRF)

Care partners must be vetted eligible by the federal government and must have a signed care partner arrangement with the hospital. A care partner is not prohibited from participating in more than one care redesign track as long as the care partner meets the IP requirements of each track.

2.2 If a hospital submits a care partner vetting list, are they obliged to participate in ECIP?

No. Submission of a care partner vetting list or the nonbinding ECIP emailed notice of intent to participate do not obligate participation in ECIP. To meet CMS timeframes for federal vetting of potential care partners, hospitals must submit care partner vetting lists prior to submission of the signed CRP Participation Agreement and the ECIP implementation protocol.

2.3 What documents are hospitals required to submit prior to the January 1, 2019 launch of ECIP? When are these due?

Hospitals must have a signed and executed **CRP Participation Agreement** for CY 2019. CRISP will share the performance period four Participation Agreement once it becomes available from CMS and will provide additional information on deadlines for submission. A single CRP Participation Agreement covers all care redesign tracks that a hospital participates in, so that only one Participation Agreement needs to be signed even if a hospital is participating in two or three tracks (HCIP, CCIP, ECIP).

Hospital **ECIP implementation protocols (IPs) and supplemental ECIP Excel workbooks** must be submitted prior to each performance period. Hospitals must complete and submit these to CRISP via care.redesign@crisphealth.org by October 31, 2018. CRISP will the conduct an administrative review of the IPs and workbooks and will address any needed revisions with hospitals prior to submitting the documentation to HSCRC and CMS for review. The IPs are due to CMS for review by November 30, 2018 to allow time for approval prior to January 1, 2019. IPs can be amended during the performance period, subject to HSCRC and CMS approval.

As noted above, hospitals must submit **lists of potential care partners for federal vetting**. These lists will be due to CRISP in September. Submission of the lists does not obligate hospitals or care partners to

participate. There will be subsequent quarterly opportunities to submit potential care partners for federal vetting.

2.4 How may I revise the ECIP implementation protocol or supplemental Excel workbook after it has already been submitted to care.redesign@crisphealth.org?

Prior to October 31, 2019, revisions can be resubmitted to care.redesign@crisphealth.org. Only the latest application materials received will be considered. Between October 31, 2019 and November 30, 2019, changes must be vetted with CRISP and clearly communicated via correspondence with care.redesign@crisphealth.org. IPs can be amended during the performance period, subject to HSCRC and CMS approval. Subsequent to January 1, 2019, changes must be submitted to CRISP to facilitate the request and approval by CMS.

2.5 How are ACOs and ACO beneficiaries handled under ECIP?

Entities that are a part of the Next Generation ACO model, Medicare Shared Savings Program (MSSP) Track 3, and Comprehensive ESRD Care (CEC) model are still able to apply. ECIP does not exclude these entities based on their participation in these other models.

However, beneficiaries that are prospectively aligned to a Next Generation ACO Model, Medicare Shared Savings Program Track 3, or the CEC model are not able to trigger episodes under ECIP.

If the Medicare provider serves other beneficiaries that are not prospectively aligned to the excluded models, they would be able to potentially trigger episodes under ECIP. Essentially, providers can be in both models, but beneficiaries cannot.

2.6 Our hospital will begin to participate in a Track 1+ Accountable Care Organization (ACO) on January 1, 2019. How would the savings work if we had a patient who is a part of the ACO and has a claim that triggers a clinical episode in ECIP?

Beneficiaries aligned to Accountable Care Organization (ACOs) in Track 1, 1+ and 2, will be able to trigger clinical episodes in ECIP. However, CMS will recoup a portion of the ECIP discount amount for any Medicare fee-for-service beneficiary who: 1) was aligned with a Medicare Shared Savings Program ACO in Track 1, 1+, or 2 that achieved shared savings, and 2) began an ECIP clinical episode that was attributed to an ECIP hospital that participated with the ACO to which the beneficiary was also aligned. Detailed methodological descriptions can be found in the BPCI Advanced Reconciliation Payment Methodology on Pg. 25-26. Source: https://innovation.cms.gov/Files/x/bpciadvanced-reconciliation-my1-2.pdf

In ECIP, this recoupment will take the form of an additional adjustment step in the final calculation of the Medicare Performance Adjustment (MPA).

2.7 Are patients in the Maryland Primary Care Program (MDPCP) included in ECIP?

Yes, MDPCP beneficiaries can trigger clinical episodes under ECIP.

2.8 Can a hospital participate in ECIP beginning in 2020, if the hospital did not participate in 2019?

Yes. Each of the care redesign tracks (HCIP, CCIP, ECIP) allow hospitals to make participation decisions prior to each performance period. Hospitals must participate for the full performance period. However, hospitals can use the beginning of the performance period for program planning prior to implementation.

2.9 Do hospitals need a patient's consent to treat if participating in ECIP?

Hospitals must distribute information to all admitted patients stating that the hospital and its medical staff are participating in ECIP. The disclosure will indicate that if the care partners and hospital meet specific performance goals of improving quality, streamlining care and reducing spending, the hospital and care partners may receive a payment.

2.10 Are ECIP participating hospitals required to share incentive payments with care partners?

No. Hospitals will indicate in their implementation protocols if they are planning to share incentive payments with care partners, and if so how that will occur.

2.11 Can an episode be triggered by a cancelled inpatient stay claim?

No. A cancelled inpatient claim will not initiate an episode under ECIP.

2.12 May a hospital add or remove clinical episodes with which it participates in ECIP?

Hospitals will only be able to add or remove clinical episodes on their annual IP submissions for the upcoming performance period. Hospitals cannot add or remove clinical episodes mid-performance period.

2.13 Are preferred networks for skilled nursing facilities (SNFs) and home health providers encouraged?

Participants can create and/or recommend preferred post-acute care networks, however, a beneficiary's freedom of choice of provider cannot be affected. As described in 2.9 above, hospitals must notify beneficiaries of their participation in ECIP.

2.14 What happens when a clinical episode is triggered because of an anchor stay for an APR DRG included on the definitions list, but then following discharge (but still during the 90-day episode window), a second admission occurs for a different APR DRG on the definition list?

In most cases, once a clinical episode is triggered and attributed to a hospital, the clinical episode will continue, unaffected, regardless of whether an additional clinical episode could be triggered by a readmission.

The one exception to this policy is for the Major Joint Replacement of the Lower Extremity (MJRLE) clinical episode. When a second Major Joint clinical episode is triggered during the 90-day post-discharge period, the first Major Joint clinical episode is canceled. However, if the second MJRLE admission occurred at the initial hospital or at another hospital that is an ECIP participant, a new clinical episode would begin, which will be assigned according to the precedence rules of the model using the anchor stay billed claims.

2.15 Is a hospital limited to making incentive payments only to certified care partners, or is it allowed to share with others?

Hospitals may make incentive payments only to certified care partners, and in accordance with their IP and supplemental Excel workbook. To be certified, care partners must pass federal vetting and have a signed care partner arrangement with the hospitals. There will be quarterly opportunities to vet and certify new care partners.

3 Advanced Alternative Payment Model Status

3.1 When are Participants in ECIP exempt from MIPS?

Eligible clinicians who earn AAPM QP status for a performance period are exempt from MIPS reporting requirements and MIPS payment adjustment for that year. QPs are excluded from the Merit-based Incentive Payment System (MIPS) reporting requirements and payment adjustment and will instead receive a 5% APM Incentive Payment. (See https://qpp.cms.gov/ for more information.) Participants in ECIP will have the opportunity to earn QP status beginning in 2019.

Eligible clinicians participating in an Advanced APM who do not meet the full Qualifying APM Participant thresholds in a model year may be able to earn Partial Qualifying APM Participant (Partial QPs) status by meeting a lower threshold. Partial QPs may be able to opt out from MIPS.

3.2 What are the Certified Electronic Health Record Technology (CEHRT) requirements for ECIP hospitals?

Hospitals and care partners must use Certified Electronic Health Record Technology (CEHRT) to document and communicate clinical care to their patients or other health care providers.

3.3 What are the requirements under ECIP to be considered an Advanced Alternate Payment Model (AAPM) Qualifying Participant (QP)?

The national threshold requirement for AAPM QP status determination will apply to ECIP in the same way that they apply for all other programs. Because of their implementation via regulation, CMS has very few options to provide for exceptions. This means that to qualify for the 5% payment increase in 2019, 50% of a participating clinician's Medicare payments, or 35% of their patients, must be through an eligible AAPM program. For individuals assessed under these criteria, as in the national program, AAPM payments and/or patients from different AAPMs can contribute to the threshold total. If an entity is participating in an AAPM but does not reach this threshold, they receive 'partial QP' status and may opt out of MIPS reporting, but will not receive the 5% incentive.

3.4 What kind of documentation will participants have to submit for Qualifying APM Participant (QP) determinations under ECIP?

The same requirements apply as for all other AAPM QP determinations for care redesign programs. For ECIP, eligible clinicians who are certified care partners will be considered Affiliated Practitioners in the Model for purposes of QP determinations. QP determinations for these eligible clinicians will be made at the individual level.

4 Methods & Implementation

4.1 What is the mechanism through which hospitals are paid any positive earned incentive payment?

Any positive, earned incentive payment will be paid out to the hospital via an Efficiency Adjustment to their Medicare Performance Adjustment (MPA) amount.

4.2 How is risk sharing accomplished in ECIP?

ECIP is an 'upside-only' episodic payment program; there is no downside risk for hospitals if they do not achieve their target prices. A hospital that successfully reduces episode payments below the target price during the reconciliation period can earn reconciliation payments up to 20% of the total aggregate target price. Five percent of the positive reconciliation payment is contingent on a hospital's performance in the Composite Quality Score.

4.3 Which quality measures are used in ECIP?

The seven quality measures used in the federal BPCI Advanced Program are carried over into ECIP. Measures 1, 2, and 7 apply to all episodes, and measures 3, 4, 5, and 6 are episode-specific.

1. All-Cause Hospital Readmission Measure (NQF #1789)
2. Advanced Care Plan* (NQF #0326)
3. Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268)
4. Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
5. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558)
6. Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881)
7. CMS Patient Safety Indicators (NQF #0531)

** note that this is an adapted measure developed by CMS that differs from the NQF specification*

4.4 What spending amounts are included in the historical and regional spending totals that are used to calculate episode benchmark prices?

The episode benchmark prices used to calculate target prices for the first performance period are based on a hospital's historical spending. Benchmark prices are based on episodes beginning in 2015-2017 for the first performance period. Detailed methodology documentation is available to hospitals via the CRS Portal.

4.5 What is the incentive payment sharing arrangement in ECIP?

Hospitals have autonomy in deciding how they plan to distribute any or all of an earned incentive payment to care partners, if they elect to share at all. In their IPs and associated Supplemental Excel workbooks, hospitals will designate whether and how incentive payments will flow to care partners, including which conditions of payment will apply (e.g. quality thresholds or intervention participation) to receive shares of the incentive payment.

4.6 How are reconciliation payments calculated?

The total reconciliation amount is the difference between the aggregate target price of selected episodes minus the aggregate payments for delivering care per six-month reconciliation period, summed across all clinical episode categories in which a hospital is participating. This amount is capped at 20% of the aggregate target price, and cannot be negative (e.g., there is no downside risk). Of any positive amount earned, 5% is contingent on quality performance, as measured by the claims-based Composite Quality Score described previously. Reconciliation occurs over two true-up calculations following each six-month reconciliation period. For a full description of the reconciliation calculation method, see the ECIP Reconciliation Specification.

4.7 When will reconciliation occur for the first six-month reconciliation period?

Initial reconciliation of clinical episodes for the first six-month reconciliation period will begin immediately following the start of the second reconciliation period (July 1, 2019), and continue until 31 December 2019. The first and second true-up calculations will occur in the spring and fall in 2020, respectively.

4.8 How are inpatient hospitalization and inpatient readmissions payments handled under ECIP?

ECIP does not include inpatient payments in episode payment calculations because of the mechanics of the GBR payment system under which they operate, and because existing care redesign programs in Maryland address this setting of care. Inpatient readmissions are excluded from target price calculations for the same reason. This also allows participating hospitals to focus on designing and implementing interventions to effectively manage post-acute care and care coordination following these inpatient stays.

4.9 In the episode selection workbook, why are target prices not provided for some clinical episode categories?

There are two conditions under which a hospital is ineligible to participate in a particular clinical episode category for a performance period, and as a result will not receive a target price:

1. The hospital did not have more than 30 episodes during the 2015 – 2017 baseline analysis period, and a robust target prices cannot be generated, or
2. The modeled target price is above their historically calculated average payment for that clinical episode category. These rare cases are excluded because eligibility in this scenario would reward no change in total cost of care, and any provision to include the episode by lowering payments further would include the potential to incentivize reducing medically necessary care.