CRISP

ECIP FAQ Supplement 1

Revised 2018.09.10

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1 General Questions

1.1 Where can I submit my questions about ECIP?

All inquiries can be emailed to Care.Redesign@crisphealth.org.

1.2 Does ECIP apply to Medicare or all payers?

ECIP will only apply to Medicare fee-for-service (FFS) beneficiaries in the first year, as ECIP operates under the Maryland Care Redesign Program. Throughout the first year, CRISP and HSCRC will actively monitor the program and seek input from hospitals and MHA to make changes and enhance the program in subsequent years. Only Medicare FFS beneficiaries can trigger clinical episodes in ECIP.

1.3 Does that mean that only Medicare patients are included in Care Redesign, and/or that only Medicare patients are included in program measurements and data?

Correct - both the baseline analysis used in design of the program and calculations during the Performance Period will be based solely on Medicare fee-for-service beneficiaries and the associated Medicare claims data.

1.4 How does ECIP interact with Accountable Care Organizations (ACOs)?

In order to avoid duplicative payments for the same savings achieved through more than one program, CMS has developed overlap and interaction rules with respect to ACOs. Any Medicare beneficiaries aligned with ACO Track 3 or Next Generation ACO will not trigger clinical episodes in ECIP. Beneficiaries aligned with other ACOs, such as Track 1, 1+ and 2, can trigger clinical episodes. However, in the reconciliation process there will an overlap calculation that will recoup a portion of the savings attributed to ACO based on proportional savings of an ACO relative to ECIP. Full specifications are available in the ECIP documentation, and this methodology is the same as in BPCI Advanced.

1.5 Is the cumulative aspect of the program [reconciliation at the facility rather than episode category level] modeled after BPCI Advanced, or does it differ as risk in BPCI Advanced is double-sided?

ECIP uses the same methodology as used in BPCI Advanced, which reconciles payments against aggregate targets across all clinical episodes at the facility level. Both programs are intended to spur the development of comprehensive care redesign and care management efforts, and so look to a participant's success as a whole rather than just at individual components of the program.

2 ECIP Eligibility & Participation

2.1 Are there specific disqualifiers for any stakeholders (participants, care partners, etc.)? The program appears very open.

There are no specific disqualifiers. One of the core concepts behind ECIP was to be as open as possible, with participating hospitals given a wide degree of latitude in choosing how to operate under ECIP.

3 Methods & Implementation

3.1 Does the retrospective target price risk adjustment go to the level of the APR ARG severity code, or just to the APR DRG level?

Retrospective target price adjustments will occur at the APR DRG - severity code level. This policy was implemented based on feedback from MHA stakeholders and because of the observed heterogeneity among the severity levels.

3.2 Does the outpatient 'bucket' include hospital observation stays?

The hospital outpatient 'bucket' includes anything that would normally be paid under the Outpatient Prospective Payment System or as a regulated outpatient space. Payment determination is based on the claim type submitted. If a claim is submitted for an inpatient stay, it will be considered an inpatient service and excluded from ECIP calculations; if a claim is submitted for an outpatient service, it will be included in the hospital outpatient 'bucket.' That said, observation is typically considered an outpatient service under Part B, and so would be included. Any changes in status later submitted would be captured during the retrospective 'true-ups' during reconciliation period.

3.3 Will there be an opportunity to add hospital inpatient admission and readmission costs in the future?

Due to interaction / overlap with Maryland's Global Budget Revenue model, HSCRC decided to exclude index inpatient admission and readmission costs in the first year. However, HSCRC will be evaluating the program on an ongoing basis and has the authority to modify ECIP in future years to include inpatient and readmission costs if the evidence warrants their inclusion and an appropriately robust methodology can be developed to do so.

3.4 If a patient had chemotherapy during the post-acute period of an unrelated episode – MJRLE, for example – is that excluded from payment calculations? What payments are excluded besides few items highlighted in the ECIP webinar?

No, in this example, the chemotherapy would not be excluded. Payments associated with inpatient admissions (both the index admission and any readmissions) are excluded from payment calculations, per a decision by HSCRC and the SIG. However, chemotherapy costs incurred in an outpatient setting are included in the episode. This aligns with CMS' BPCI Advanced Model. Unlike in the original BPCI program, CMS does not exclude any Part B services based on specific diagnoses or procedures. So, if a patient received chemotherapy services under any of the applicable prospective payment systems during the post-acute period, those would be included in the episode (both in the target price calculation as well as reconciliation calculation).

3.5 Are payments for services from out-of-state providers captured in ECIP [for providers with service areas overlapping bordering states]?

Data used in ECIP is based on beneficiaries who are Maryland residents. However, Maryland Medicare FFS beneficiary that received care at an out-of-state provider (e.g. SNF) during a clinical episode initiated at a Maryland hospital would be included, as would any associated claims data, as these are otherwise included in the Total Cost of Care.

3.6 Which calculations will be performed by CMS (e.g. quality measure scores) and which will hospitals be required to track (e.g. conditions of payment) as we look at the reconciliation calculation samples?

CRISP will provide a range ECIP reporting services, and additional information will be made available as those services are developed and rolled out. The reports will be available through the CRS Portal. All these payments will be tracked and reported similarly to how they are reported in HCIP. Most calculations will be done by CRISP and CMS, but hospitals are encouraged to track those Care Partner payments individually as outlined in hospitals' IP Track Templates. Reporting tools will be available for performance reconciliation.

3.7 When is the next performance period for which a hospital may submit an IP after the January 1st, 2019 performance period begins?

Performance Periods will align with calendar years. After updates and changes to ECIP have been formalized for Performance Period 2 and materials for baseline price calculations for the next performance period are made available, hospitals may submit IPs for the next performance period. Submission dates will align with other CRP Tracks in MD.

4 Program Materials

4.1 Are the ECIP webinars recorded and available for viewing?

Webinars are recorded and will be made available on the HSCRC Care Redesign website at https://hscrc.maryland.gov/Pages/CareRedesign.aspx along with copies of the slides presented.

4.2 Will CRISP hold boot camps like HCIP to assist organizations in learning from leaders and one another?

Initially, those aims will be achieved through the three ECIP Office Hour Webinar series. Once the program is up and running, CRISP will build on the HCIP boot camp concept to share experiences, what kinds of adjustments needed to be made, and which challenges participants are facing.

4.3 In the Baseline Analysis Workbook, why would episodes appear for procedures our facility does not perform (for example, CABG)?

These are transfer cases where the initial procedure was performed at another facility, and then transferred for care before final discharge. The transfer logic in ECIP assigns these episodes to the discharging hospital, with the thought that the latter will be able to manage and effect change in post-acute care planning, which is a major focus of ECIP.

4.4 On the Hospital Summary Report if our Mean Historic Payment amount is less for all episodes than the Mean Standardized Payment amount, is it safe to assume we are a lower cost hospital in Maryland for these episodes? Are we reaching an accurate conclusion?

No. The mean standardized payment amount removes the payment adjustments and reflects only the Medicare 'base payments'. A low standardized payment indicates that the hospital is in an area with lower wages, receives less IME/DME payments, and/or receives other adjustments. The standardized payment amount does not indicate whether the hospital is lower cost for those episodes. Differences in the standardized payment amount reflects differences in the utilization of services within the episode. To check whether the hospital is lower cost, compare the mean standardized payment amount with the 'benchmark standardized payment amount' on the 'payment details' worksheet.

4.5 What is the formula for the Annual Threshold Reduction on the Hospital Summary report?

The Annual TCOC Reduction is calculated by taking the difference between the total historical payments for a given clinical episode category during the baseline period, subtracting the aggregate target price for

that clinical episode category during the baseline period (target price x baseline volume), dividing by 30, and multiplying by 12. The last two steps take thirty months of index admission data (of the three years of baseline data, 3 months are used for lookback and 3 months are used for follow-up) and annualize to a single year.

4.6 The Sample Payment Flow workbook contains an example distribution of incentive payments to care partners, and it appears that the largest distribution is 50%. Is there a limit on sharing at no more than 50%, or any other requirements related to how much hospitals are allowed to distribute to care partners?

There is no limit on how much the hospital is allowed to share – the 50% is just an example for illustrative purposes. However, there are individual provider limits imposed by CMS that will be observed, such as the requirement that physicians receive incentive payments totaling no more than 25% of the total Part B payments that they receive from CMS.

4.7 In the sample calculation, episode 1 payments were lower than the target price, but for episode 2 they were not. Yet incentive payments were calculated for care partners involved in episode 2. Can you explain why?

A hospital must distribute incentives in a consistent fashion as described in the Implementation Protocol Track Template and cannot differentiate by episode / care partner.

5 IP Track Template & Supplemental Workbook

5.1 Once episodes are selected, are all providers included or can the episodes be limited to specific providers?

As part of the ECIP enrollment process, hospitals may select which providers they will include as aligned Care Partners. However, any Medicare FFS beneficiary with a discharge APR DRG matching one of the clinical episode categories will trigger a Clinical Episode if that hospital has selected to participate in ECIP for that Clinical Episode – regardless of whether their care was provided by designated Care Partners.

Modifications to Care Partner lists may not be made for a given year after the Implementation Protocol Track Template has been submitted. Until the start of the program (January 1, 2019), hospitals may work with CRISP and HSCRC to select and finalize their selected Care Partner provider types.

5.2 What is the difference between ECIP Interventions and Conditions of Payment?

ECIP Interventions are specific care redesign initiatives that hospitals and their care partners will be undertaking as part of the program to improve the quality and lower the costs of care. Conditions of Payment are specific metrics that will be evaluated, and which care partners must meet, in order to quality for incentive payment distributions. Both ECIP Interventions and Conditions of Payment are set at the hospital's discretion, per the requirements of the Implementation Protocol.

5.3 Is there a minimum required number of Conditions of Payment for care partners?

Care partners must be held to a minimum of one Condition of Payment. The number of Conditions of Payment beyond this is set at the hospital's discretion based on their planned care redesign interventions and relationship with the care partner.

The language in the Track Template on page 10, number 4, has been clarified to state, "In order to qualify for payment, a care partner must meet a minimum of one condition of payment, as specified by the hospital in the Supplemental Excel workbook."

5.4 The Track Template states that CPs must use CRISP. However, most non-MDs such as SNFs, PTs, HHAs and hospices do not use CRISP, and our facility was uncertain as to the final resolution of this issue. What is the current status of this requirement?

Section 6.3 (e) of the current care redesign program Participation Agreement states that the care partner arrangement between the hospital and a care partner shall require "the Care Partner to electronically transmit such summary [record of care] to a state -designated health information exchange in more than 10 percent of the instances when the Care Partner transitions or refers a patient to another setting of care." Care partners are encouraged to use CRISP however it best applies to care delivery. For example, a care partner can subscribe to CRISP ENS to monitor the transitions of care for patients in a given episode. CRISP staff can provide support to help providers sign up and use CRISP tools effectively.

5.5 Page 4 of the Track Template addresses payments being made to hospitals via the MPA adjustment. How does the timing of payments to hospitals correspond with the biannual reconciliation? This point will impact applicant responses regarding when incentive payments will be made to care partners.

The timing of the ECIP payments aligns with the MPA adjustment. An ECIP payment for the 2019 calendar year will be made beginning in July of 2020 when the MPA adjustment is made for the hospital. Further, the ECIP adjustment is not a cash payment to the hospital but rather an adjustment on future Medicare payments to the hospital.

5.6 On page 6 of the Track Template it states "29" episodes instead of the latest list of 23 that appears on page 18. Can you clarify?

This is a typographical error and has been corrected.

5.7 Page 8 of the Track Template refers to the Implementation Protocol and "attached Supplemental Excel Workbook" which must be submitted to CRISP. Where can applicants access this workbook?

The Supplemental Workbook was made available via the ECIP card on the CRS portal in the same location as the other Program Materials on September 5, 2018.

5.8 Do we provide the performance on the Conditions of Payment to the HSCRC to be used by the HSCRC to prepare the final incentive calculations per care partner, or do we have to perform that calculation?

The hospital will report performance on conditions of payment in its quarterly CRP report to the HSCRC. The HSCRC will then prepare final incentive calculations per care partner.

5.9 When can we see the amount of the 'Incentive Payment Pool' referred to on Page 10 of the Track Template so that we know whether care partners will be limited in payment by a small pool of dollars for our facility?

The Incentive Payment Pool is set by the HSCRC, and preliminary pool amounts will be released in the coming weeks. HSCRC has not yet finalized this calculation as they are evaluating whether the preliminary amounts allocated are appropriate and sufficient for program needs.

The ECIP Incentive Payment Pool is based on reductions in Potentially Avoidable Utilization — in particular, the reduction in 30-day readmissions statewide for Medicare FFS beneficiaries from CY 2016

(9.56 percent of Medicare FFS revenue) to CY 2017 (9.42 percent). This decline in Medicare FFS readmissions, as applied to Medicare FFS revenue, amounts to savings in Potentially Avoidable Utilization of $8,711,274. The HSCRC has preliminarily apportioned the savings to individual hospitals according to their share of statewide Medicare hospital revenue. CRISP can facilitate a conversation with HSCRC if individual applicants have specific concerns.

5.10 Our CRP Committee was formed for HCIP over a year ago. With this understanding, how should applicants respond to the question of whether the committee existed prior to our participation in CRP? It didn't exist before our participation in HCIP so is the answer "no"? Or, since it existed before ECIP is the answer "yes"?

If the committee was not pre-existing prior to the **care redesign program as a whole** you may indicate "no."

5.11 What does "Is the CRP Committee a System Wide Committee" mean?

"System Wide Committee" refers to multi-hospital systems; it applies to any committee with the same membership across multiple hospitals in a system.

5.12 Do we need to add ECIP providers to the CRP Committee right away to comply with this program on January 1, 2019, or will HCIP physician representation be sufficient until such time as we add ECIP Care Partners?

The current care redesign Participation Agreement relaxes the CRP Committee requirements. The CRP Committee listed in the ECIP track template must include one Medicare beneficiary representative. We encourage you to add ECIP care partner representatives to the CRP Committee as you plan ECIP care partner engagement. That said, your CRP Committee would be approved if it includes only HCIP physician representation on January 1, 2019 as long as you indicate there are plans to bring ECIP care partners on board.

5.13 Are Care Partners defined as Groups/TINs or individual physicians?

HSCRC is awaiting CMMI confirmation on this topic as of 9/10/2018. We anticipate that for the first four categories of care partners included in the ECIP track template (physician, nurse specialist or nurse practitioner, physician assistant, physical therapist), the first name, last name, and individual NPI will be required as is the case for HCIP and CCIP. For the subsequent five categories (SNF, HHA, LTC hospitals, hospice, IRF), facility TIN, name of facility, and address will likely suffice. CRISP awaits information from

CMMI regarding whether the facility information should always be at the corporate level, or if there are scenarios where CMMI would want to get information on an individual site.

5.14 Are there eligibility requirements for Care Partners?

No, eligibility requirements will be up to each hospital to determine.

5.15 Can Care Partners be subsidiaries of the participating hospital?

There is no prohibition against hospital subsidiaries having Care Partners arrangements with their parent hospital.

5.16 When should hospitals begin developing Care Partner agreements?

Hospitals should begin work on templates to use for care partner agreements as early as they are able. Hospitals are encouraged to share template versions of such documents with CRISP to review and take key components and principles to share with other participating hospitals.

5.17 If agreements were created with large post-acute providers, would downstream agreements be required with individual Skilled Nursing Facilities (SNFs)?

No, Care Partners agreements do not necessitate any downstream arrangements under ECIP.

5.18 Can a participating hospital have multiple care partners for the same services under ECIP? For example, selecting a few SNFs or home health agencies. How can we avoid Stark implications if selecting one provider over another?

Yes, you can have multiple care partners providing the same services. For example, as with CJR and BPCI Advanced, many look carefully at the quality and cost of services delivered by SNFs with the aim of collaborating to ensure patients receive the best care at the best price. However, as with any CMS program, patient choice cannot be limited under ECIP. A participating hospital may make recommendations but cannot limit patients' choice of facility, agency or care partners from which to receive care. With respect to Stark implications, that would need to be addressed by internal counsel as this document nor CRISP may provide legal guidance on this issue.