ECIP FAQ Supplement 2

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Table of Contents

1 ECIP Eligibility & Participation

1.1 How is ECIP being paid for currently? What should a facility expect to pay to participate? We heard that HSCRC might fund the first year and have hospitals fund subsequent years? How does work currently?

To date, the State has borne the administrative costs associated with developing infrastructure, designing and administering CRP tracks. Now that we are past the initial startup phase, these costs need to be shared between participants and the State. Beginning in CY 2020, the HSCRC will implement cost sharing for participation in HCIP and ECIP.

The State intends to continue to pay for ongoing program infrastructure and the costs of designing new tracks. Hospitals will be expected to pay for costs associated with the ongoing administrative operations of the program. Based on current administrative expenses, the cost to hospitals in CY 2020 to participate in HCIP would be $75,000 and ECIP would be $25,000.

1.2 Can eligible health care providers participate in ECIP and MDPCP?

Yes, a physicians and other eligible providers may participate in both programs concurrently.

1.3 Can hospitalists participate as care partners?

Yes, hospitalists can participate as care partners subject to the same vetting & enrollment requirements as any other physician specialty, and regardless of employment by the hospital.

1.4 Is there a prohibition on care partners participating in ECIP and in a hospital's ACO?

No, there is no prohibition on participation in an ACO and ECIP. The ECIP implementation protocol states that the semi-annual reconciliation may be adjusted to account for overlapping program effects, including savings attributed to an ACO. Currently, the HSCRC does not have a final agreement with CMS regarding how this overlap will be handled, and so we will not be removing ACO beneficiaries or making any other adjustments for CY2019 or CY2020. The ACO overlap policy is required to be resolved by the beginning of CY2021, so changes may be made in the future. Any such changes would be announced during or before the ECIP application period for that year.

1.5 HSCRC / CRISP has distinguished between the CP vetting list and the CP certification for other CRPs. Does the same hold true for ECIP? What is the difference between vetting and certification? Are there different deadlines and / or processes for the different CRPs?

For all the CRP tracks, there is a difference between care partner vetting and care partner certification.

Care partner vetting is the process to make sure any potential care partners pass the federal program integrity tests making them eligible to participate with Medicare. A provider needs to be vetted only once per year, and once vetted is eligible to participate in any track. For example, a physician submitted for vetting under HCIP and found eligible can participate in ECIP without being re-vetted.

Care partner "certification" is the process of letting CMS know which eligible care partners actually signed on to participate in a given hospital's care redesign track for a given quarter. Hospitals must submit separate certification lists for each track, so that CMS knows each quarter which physicians and other providers are participating in which track with a given hospital.

Initially, ECIP won't have a portal for care partner submission – you will simply email care.redesign@crisphealth.org your Excel file of certified care partners. The CRP calendar on the HSCRC website shows due dates. Care partners are shared across programs – they do not have to be vetted for each individual track.

1.6 Can care partners be certified for ECIP on a quarterly basis as with other CRPs?

Yes, ECIP care partners will be certified quarterly, just like in other CRPs.

1.7 Do we need each post-acute partner to sign an ECIP care partner arrangement?

If you are paying incentives to post-acute partners, you will need to certify them, which includes having them sign a care partner arrangement. This must be done at the individual facility (not corporate) level.

1.8 Where is the ECIP Care Partner participation arrangements template available?

Please email care.redesign@crisphealth.org to request a sample care partner arrangement. The sample template is a suggested resource you may opt to use, subject to the review of your own legal counsel.

Care partner arrangements are between the hospital and the care partner; the care partner arrangements are not collected or reviewed by the State or CMS.

1.9 What information and in what format would you like us to submit the list of certified ECIP care partners?

Please submit in an Excel spreadsheet with the same fields that were included in the vetting submissions: for individual physicians or other providers, include individual NPI, last name, and first name. For facilities, please include facility legal entity name; facility D/B/A name; individual facility TIN; CMS Certification Number (CCN); and individual facility address.

1.10 Can we designate a Physician Group Practice (PGP) as a Care Partner in ECIP? Can the Care Partner Agreement be redesigned to make it a Group Level Agreement where a list of providers and their NPIs could be attached and a statement obligating the listed group members to the terms of the Agreement signed by the authorized official for the group?

A care partner arrangement is necessary for a hospital to make an incentive payment to another Medicare provider that would otherwise be prohibited.

- If the hospital will make the incentive payment to a PGP, then the hospital must enter into a care partner arrangement with that practice.
- The CRP Participation Agreement requires that the agreement be made in writing and legally commit its employees and contractors to comply with the terms of the agreement.
- A Group Level Agreement where a list of providers and their NPIs could be attached and a statement obligating the listed group member to the terms of the Agreement signed by the authorized official for the group could meet this requirement.
- Hospitals should rely on their own legal counsel to ensure compliance with the CRP Participation Agreement.

The CRP Participation Agreement further requires that, if the care partner is a PGP, the care partner arrangement prohibit the distribution of incentive payment to any individual or entity that is not a downstream care partner arrangement.

- This means that the PGP care partner cannot distribute incentive payments to its physician members and all incentive payments must be retained at the group level.
- The HSCRC has not allowed PGPs to enter into downstream care partner arrangements for the first year of ECIP but will revisit this decision annually.
- A downstream care partner arrangement is similar to a care partner arrangement and must require the PGP's members to comply with the requirements of CRP Participation Agreement.

1.11 Midyear hospital enrollees' participation period is a 6-month period, correct? They then resubmit an implementation protocol for a full year for January 2020?

Yes, hospitals that begin ECIP in July 2019, will have a six-month program period for 2019, at the end of which they will resubmit for participation in ECIP for 2020. Documents for the 2020 program year will be available in the fall, and all ECIP POCs will receive a notification when they are available.

2 Methods & Implementation

2.1 How do the quality adjustments impact reconciliation payments? Is it both a +5% and -5% range of adjustment or only upside based on performance compared to Maryland peers?

Only positive reconciliation payments will be paid out in the first year of ECIP. Of the total positive reconciliation amount, 95% will be paid out during the initial reconciliation, and the remaining 5% will be adjusted based on composite quality score and will be paid during the True-up period; this only applies to positive reconciliation payments. For further detail, refer to the "Incentive Payment Example Workbook" available through the CRS Portal.

2.2 If a hospital performs well in the first biannual reconciliation period but poorly in the second, are these considered 'together' in a single program year for the purposes of the MPA adjustment? In other words, would any reconciliation payment be 'recouped' based on the second reconciliation period?

No. Each reconciliation period is evaluated independently, and ECIP currently carries no downside risk. So, poor performance in a subsequent reconciliation period will not negatively impact positive earlier performance.

2.3 Incentive payments to Care Partners are weighted by DRG weight. Why were RVU weights or another post-acute weighting factor not used in this program?

A variety of concerns contributed to the decision to use a consistent weighting factor for the entirety of ECIP for the first year of the program. In short, variance between weighting systems for different care partners, issues with the robustness of different weight factors in the context of ECIP episodes and accuracy of those weights across a broad range of services, and the short timeline for mitigation of these issues of ECIP for Year 1 all contributed to the decision to weight payments using the index admission DRG

weight. HSCRC feels that this adequately represents the relative resource utilization for the episode as a whole while avoiding a number of issues. We will be monitoring this topic for evaluation in future program years and welcome feedback in this matter.

2.4 Are ambulatory surgery center (ASC) orthopedic procedures and other ambulatory procedures included in ECIP bundles? Can these procedures trigger an ECIP episode?

Procedures conducted in an ASC (orthopedic or otherwise) will not trigger an episode, which occurs only after discharge from an index inpatient stay. But payments for ASC orthopedic procedures and other ambulatory procedures that occur during an episode that is initiated at a hospital will be included in episode calculations.

2.5 When a beneficiary dies during an episode, what happens?

Similar to the CJR program, beneficiary death at any point during the index hospitalization or 90-day episode period cancels the episode, and it is excluded from reconciliation calculations.

2.6 What is the difference between total episode payments (capped) and total episode payments (uncapped)?

Payment outliers are capped under ECIP so participants aren't unduly penalized by catastrophic cases. The uncapped total episode payments are the real, total payments associated with those episodes. The capped episode payments exclude all payments above the outlier threshold, and is the value that is evaluated against the target price.

2.7 With regards to MACRA APM determination: the memorandum on the HSCRC website references 25% of Part B payments (vs. 50%) and 35% of patients seen by the hospital (vs. 20%), contrary to what has been presented in the ECIP webinars. Can you explain this difference?

The QP threshold test increases each year. The memorandum on the website references the threshold test for 2018. The webinar has the threshold tests for PY 2019, which are slightly higher. For more information, please review the information available at https://qpp.cms.gov/apms/advanced-apms?py=2019.

3 Program Materials

3.1 Will patients included in the baseline period be individually identifiable in the data provided so that we can see more detail of their expenses?

Yes; using any of the dashboard drill-down in MADE: ECIP View will enable you to see patient-level details; of particular use may be the 'Patient Level Detail' and 'Episode Level Detail' drilldowns available in the left-hand navigation bar of the application.

3.2 How often will hospitals receive updated ECIP data in CRISP?

All CRISP reports are typically updated on a monthly basis with a one-month lag. The February, 2019 update was delayed due to an issue with the data processing at CMS, which provides the CCLF data feed.

The episodes and reports presented in MADE, ECIP View and in PAVE require an additional six months of data to be presented in a robust, reliable fashion; 90 days for episode completion, and three months for claims run-out to ensure we are not presenting an incomplete picture of the episodes. So, an episode initiated on July 31, 2018 ends on October 29, 2018, and claims from the end of that episode are typically not completely processed until roughly January 1, 2019.

It is worth noting that though the episode initiation dates used to filter and present the data in reports lag by 6 months, the reports themselves contain more recent information - in the aforementioned case, an episode initiated on June 30, 2018 which is presented in the data currently shown in MADE will contain post-acute care claims from July, August, and September for that episode.

So, typically you will see a 6 to 7-month delay in terms of episode initiation in these reports, 3 months for post-acute care data at the end of included episodes.

3.3 So, when will we see data related to a given performance year?

We are currently allowing for a 3-month runout on claims to ensure the episodes are largely complete when the data is presented; adding this to the 90-day global period for the episodes, the July CCLF update will be the first containing data on episodes for a given calendar year. We are actively monitoring this topic and welcome feedback; consensus at this point has been that presenting incomplete episode data earlier would be more detrimental than beneficial.

4 IP Track Template & Supplemental Workbook

4.1 Have the proposed requirements that Care Partners use EHR and submit data to CRISP been dropped?

No. Use of a CEHRT is a required program element for participating hospitals and care partners. See the Implementation Protocol Track Template for more detail. You can check the ONC website to make sure care partners' EHRs are certified. Please contact care.redesign@crisphealth.org if you have any concerns or questions about integration.

4.2 If we're not paying incentives, the CoP column in the Supplemental Workbook automatically marks as N/A. Is completion of the tracking and measurement column still required in this situation?

Yes, hospitals must still indicate tracking and measurement processes for care redesign interventions, even if no incentive payment distributions are being made. Hospitals have flexibility to identify tracking measures. These can be process measures or outcomes measures. Only the Condition of Payment may be excluded in this case.

4.3 What are requirements related to the following language in the Implementation Protocol?

Use CRISP, Maryland's Health Information Exchange. You, or someone under your direction, must provide a monthly upload of the current patient roster of ECIP participants under your care to CRISP. This will allow the proper accounting of each member. In addition, you, or someone under your direction, must create a summary record of care formatted according the standard adopted at 45 CFR 170.205(a)(3) that includes, where applicable, the Common Clinical Data Set as defined by 45 CFR 170.102 and electronically transmit the summary to CRISP when you transition or refer a patient to another setting of care.

Our expectations are that that hospitals use MADE; a hospital can upload its roster of patients to MADE. Care partners wouldn't need to do that.