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# Episode Care Improvement Program (ECIP) 101

23 August 2018

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# Webinar Recordings

All webinars will be recorded and available for download at

<https://hscrc.maryland.gov/Pages/CareRedesign.aspx>

Questions can be directed to

[Care.Redesign@crisphealth.org](mailto:Care.Redesign@crisphealth.org)

# Agenda

- Program Overview (20 mins)
- Operationalizing Clinical Episode Selection
  - Baseline Analysis Workbook (15 minutes)
  - Payment Flow Workbook (20 minutes)
- Case Study & Walkthrough - AAMC (15 minutes)
- Questions & Discussion (20 minutes)





# Program Overview



## ECIP – Brief Definition

The Episode Care Improvement Program (ECIP) is a new Care Redesign Track under the Maryland Total Cost of Care Model. It is an upside-only, voluntary episode payment model, inspired by and based upon the federal Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model.

ECIP tailors the approach underlying BPCI Advanced to help hospitals and the State continue to improve and streamline care in Maryland. Its primary focus is on post-acute care management and care coordination outside the walls of the hospital.

It will begin on January 1<sup>st</sup>, 2019, and run for five years, with application periods each year. During this period, CRISP will actively monitor the program and modify it as needed. The content presented in this webinar specifically addresses the first model year.



# Why Participate?

- Upside-only introduction into episode-based payment systems – the direction the US healthcare system is moving in
- Extremely flexible program structure, with 23 clinical episodes & hospital discretion in selecting and engaging with 9 different potential care partner types
- New opportunities, tools and payment mechanisms that support improved care processes, greater care coordination and post-acute care management after the patient leaves an acute care setting
- Qualifies as a pathway to obtaining Qualifying Alternative Payment Model (APM) Participant (QP) status under an Advanced APM



# Background: Stakeholder Innovation Group

- Requested by Maryland Health Secretary
- Industry led, state supports staffing
- Interacts with Secretary's Vision Group
  - Industry and State agency executives
  - Coordination and accountability to transformation efforts
- Initial focus areas:
  - Inventory transformation efforts
  - Identify high-opportunity strategies in support of population health and TCOC goals
  - Run stakeholder-driven process to propose payment model or population health improvement programs



# Stakeholder Innovation Group Recommendation

- Strengthen collaboration across care continuum with data and tools to support:
  - Smooth transitions and enhanced information exchange
  - Strong outcomes at appropriate level of care
  - Caregiver and family support with connection to social services
- State should seek federal approval of voluntary bundled payment programs through:
  - Hospital-led effort to create new Care Redesign track for January 2019; and
  - Multi-stakeholder effort to develop a New Model Program for non-hospital conveners





# CMS Input into ECIP Development

- CMS supported development of ECIP Track, complementing the existing HCIP and CCIP Care Redesign Programs
- ECIP model built upon key concepts and lessons from other CMS initiatives, particularly BPCI, BPCI Advanced and CJR
- CMS granted the State significant flexibility in tailoring the new model to Maryland's unique situation
- Primary concern was ensuring that Implementation Protocol provided sufficient detail regarding potential flow of savings to downstream Care Partners



# Approach to ECIP Track Template

- Similar in structure to HCIP and CCIP Track Templates
- Content modeled after federal BPCI Advanced Request for Applications
- Intended to maximize hospital flexibility in designing interventions
- Care Partner incentive payment decisions left to hospitals
- Provides tools and support for making program participation & design decisions



- CRISP conducts administrative review of implementation protocols to make sure requirements are met
- Review is intended to be supportive and iterative
- Goal of CRISP review is to raise anything likely to be flagged by CMS, enabling hospitals to address such issues **prior** to HSCRC and CMS submission
- Process has worked well for HCIP and CCIP, with hospitals seeing few questions from CMS by the time protocol goes through federal review



# ECIP-Specific Elements

- Key differences from HCIP / CCIP:
  - Broader range of potential Care Partners, including post-acute care providers
  - In addition to implementation protocol, hospitals will complete a supplemental Excel workbook to simplify clinical episode category selection & care redesign intervention submission
- Key differences from BPCI Advanced:
  - Only hospitals can be Episode Initiators
  - ECIP track template identifies broad intervention categories with option for hospitals to propose interventions (BPCI Advanced doesn't specify allowable interventions)
  - Episodes begin upon discharge from anchor stay
  - Use of APR DRGs instead of MS-DRGs
  - Post-acute care focus



# General Policy Decision Framework & Approach

- Program developed collaboratively with input from CRISP, HSCRC, CMS, and MHA Members
- Modeled after BPCI Advanced, modifying where necessary to meet the needs of Maryland's unique situation
- Built upon and leveraged existing programs developed by CMS and the State of Maryland wherever possible and reasonable
- Designed to create as much opportunity and flexibility for participants as possible
- CRISP will monitor program progress, gather participant feedback, and may make adjustments in subsequent program years





# Clinical Episode Categories

## Merged due to APR DRG conversion:

Clinical Episode under BPCI Advanced	Clinical Episode under BPCIM
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	

## Excluded due to low volume:

- Cardiac defibrillator
- Disorders of liver except malignancy, cirrhosis or alcoholic hepatitis

## No outpatient episode categories

## Included otherwise unmodified:

- Acute myocardial infarction (AMI)
- Back and neck except spinal fusion
- Cardiac arrhythmia
- Cardiac valve
- Cellulitis
- Chronic obstructive pulmonary disease (COPD), bronchitis/asthma
- Congestive heart failure (CHF)
- Coronary artery bypass graft surgery (CABG)
- Fractures, femur and hip/pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Hip and femur procedures except major joint
- Major bowel procedure
- Pacemaker
- Percutaneous coronary intervention (PCI)
- Renal failure
- Sepsis
- Simple pneumonia and respiratory infections
- Stroke
- Urinary tract infection (UTI)

## Episode Construction

- All inpatient payments (anchor stay + readmissions) excluded
- Same basic episode inclusion / exclusion criteria and method as BPCI Advanced
- Payments standardized prior to target price generation to ensure comparability (same as BPCI Advanced)
- Payment update factor method used also the same as BPCI Advanced
  - Only exception hospital outpatient payments, which use a specific method to address GBR



# Target Price Determination

- ‘Anchored average blend’ approach adapted from CJR program for ECIP
  - Robustness given Maryland episode sample sizes
  - Ease of explanation, reporting, and interpretation
  - Builds on experience with existing federal model
- Target prices will be retrospectively adjusted to reflect actual, experienced case mix during performance period
- Hospitals must have > 30 episodes during the baseline period to be eligible to participate in a given clinical episode category
- In rare cases where the target price is above projected spend, a hospital will be ineligible to participate in that clinical episode category
- Annual opportunity to re-submit IP Template for episode selection; once enrolled in a clinical episode category, a hospital is committed for the entire model year.





# Reconciliation

- No downside risk
- 20% program stop-gain
  - Calculated as percent of aggregate target price at episode initiator level
- Two performance period per year, with corresponding reconciliation true-ups
- Two-stage (initial and final) reconciliation to allow for appeals process and retrospective quality adjustments
- Specific timeline for performance periods, reconciliation dates, and appeals process to be finalized and distributed



# Quality Adjustment

- Maximum 5% positive earned quality adjustment
- Adopts quality measures and calculation approach from BPCI Advanced
  - All measures weighted evenly within clinical episode categories
  - Single composite quality score (CQS) calculated for each participant, weighted by volume in elected clinical episode categories
  - Scored based on performance scaled relative to highest and lowest performing hospitals in the state of Maryland
- Added to retrospective reconciliation payments allowing for collection, analysis, and benchmarking of administrative (claims-based) quality measures during performance period



# ECIP Quality Measures

- All-Cause Hospital Readmission Measure (NQF #1789)
- Advanced Care Plan\* (NQF #0326)
- 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)
- CMS Patient Safety Indicators (NQF #0531)

*\* Note that this is the adapted measure used in BPCI Advanced*



# Care Partner Incentive Payments

- Hospitals may elect to distribute incentive payments to care partners
- Hospital selects proportional distribution of payments between care partners (if any)
- Conditions of payment required for incentive earn-out; hospital sets weights for these as well
- Caps imposed on care partner payments where appropriate

## 9 Care Partner Types

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





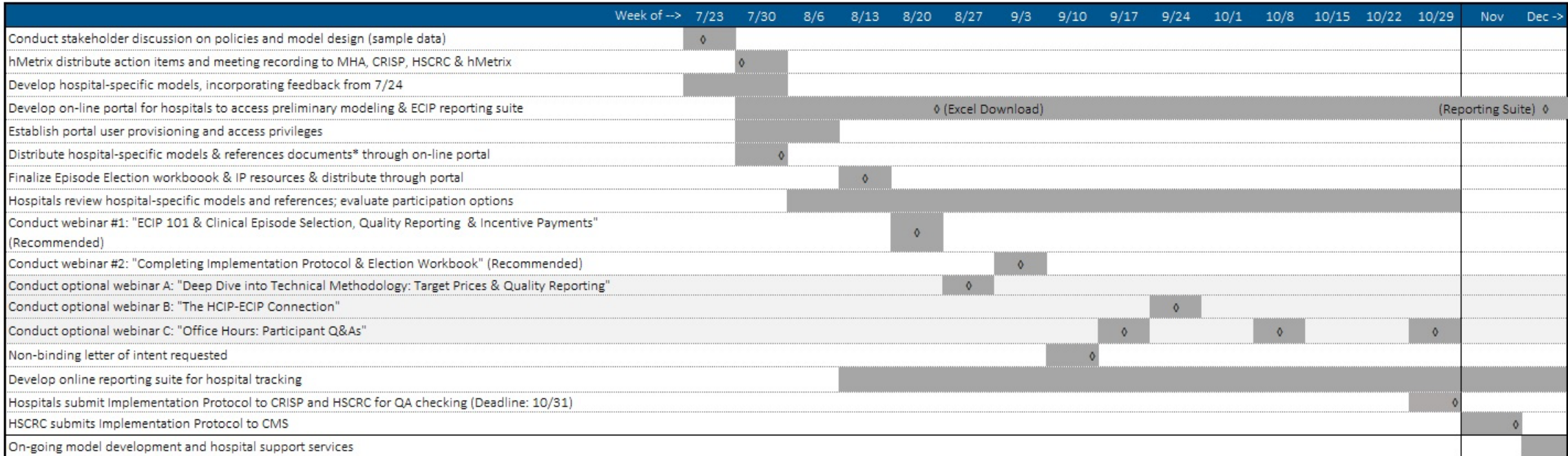
# Program Roll-out & Timeline



# Timeline

## Episode Care Improvement Program (ECIP) Roll-Out Timeline

as of August 1, 2018



◊= Deadline

- \* Reference Documents include:
- ECIP Model Development Rationale
  - ECIP FAQs
  - ECIP Payment Flow Examples
  - ECIP Quality Measure Weights
  - ECIP APR DRG Episode Category Mapping
  - BPCI Advanced Episode Creation Specs
  - BPCI Advanced Quality Measures
  - BPCI Advanced Reconciliation Specs
  - CJR Target Price Specs



# ECIP Resource Center

All ECIP resources except webinar recordings will be made available for download on the CRISP Reporting Services application under the 'ECIP' card at

<https://reports.crisphealth.org>



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CRISP REPORTING SERVICES

### Your Dashboard

ECIP

Casemix

Executive Dashboard

Maryland Hospital Acquired  
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# Baseline Analysis Workbook





# Purpose

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1. Understand baseline period payments and volume
2. Understand target prices and TCOC reduction thresholds
3. Identify areas of opportunity for evaluation and consideration
4. Understand program impact & implications

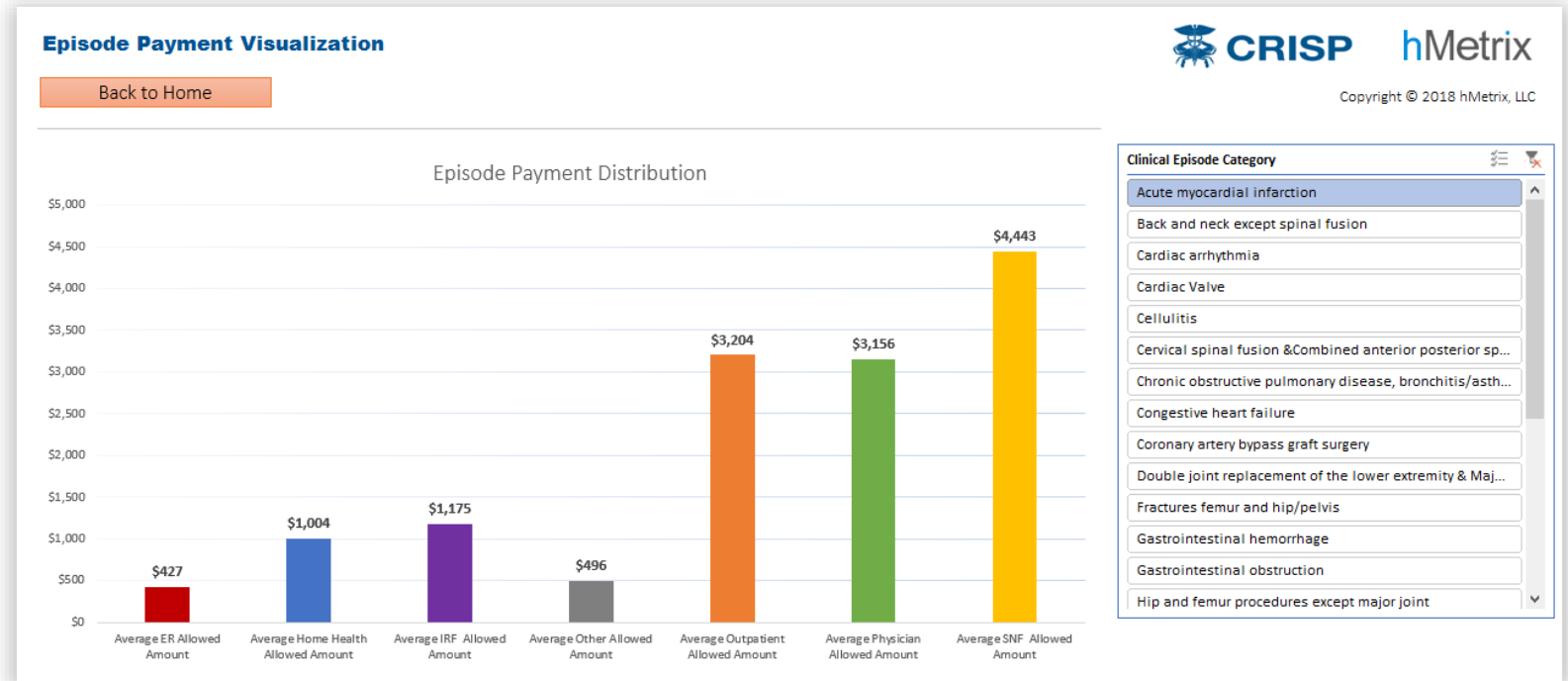
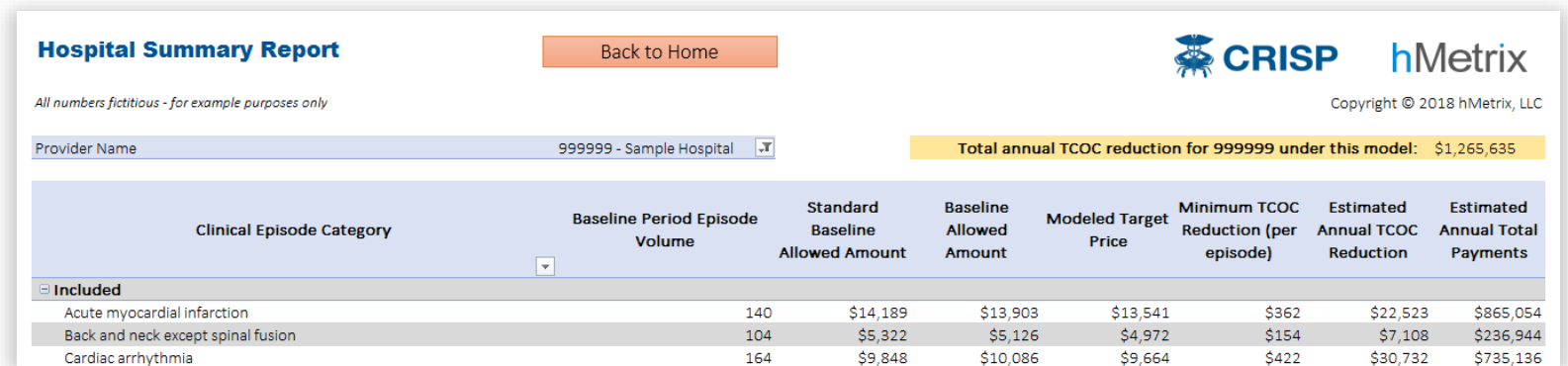


# Hospital Baseline Analysis Workbooks

All Maryland hospitals will be provided with a baseline analysis workbook containing detailed information on their volume, payments, and preliminary target prices for the modeled clinical episode categories.

Additional resources for episode evaluation and selection will be made available during the roll-out period.

Resources will be distributed via a new application panel within the existing CRS portal.

**Hospital Summary Report**

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All numbers fictitious - for example purposes only

Provider Name: 999999 - Sample Hospital

Total annual TCOC reduction for 999999 under this model: \$1,265,635

Clinical Episode Category	Baseline Period Episode Volume	Standard Baseline Allowed Amount	Baseline Allowed Amount	Modeled Target Price	Minimum TCOC Reduction (per episode)	Estimated Annual TCOC Reduction	Estimated Annual Total Payments
<b>Included</b>							
Acute myocardial infarction	140	\$14,189	\$13,903	\$13,541	\$362	\$22,523	\$865,054
Back and neck except spinal fusion	104	\$5,322	\$5,126	\$4,972	\$154	\$7,108	\$236,944
Cardiac arrhythmia	164	\$9,848	\$10,086	\$9,664	\$422	\$30,732	\$735,136



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# Payment Flow Workbook

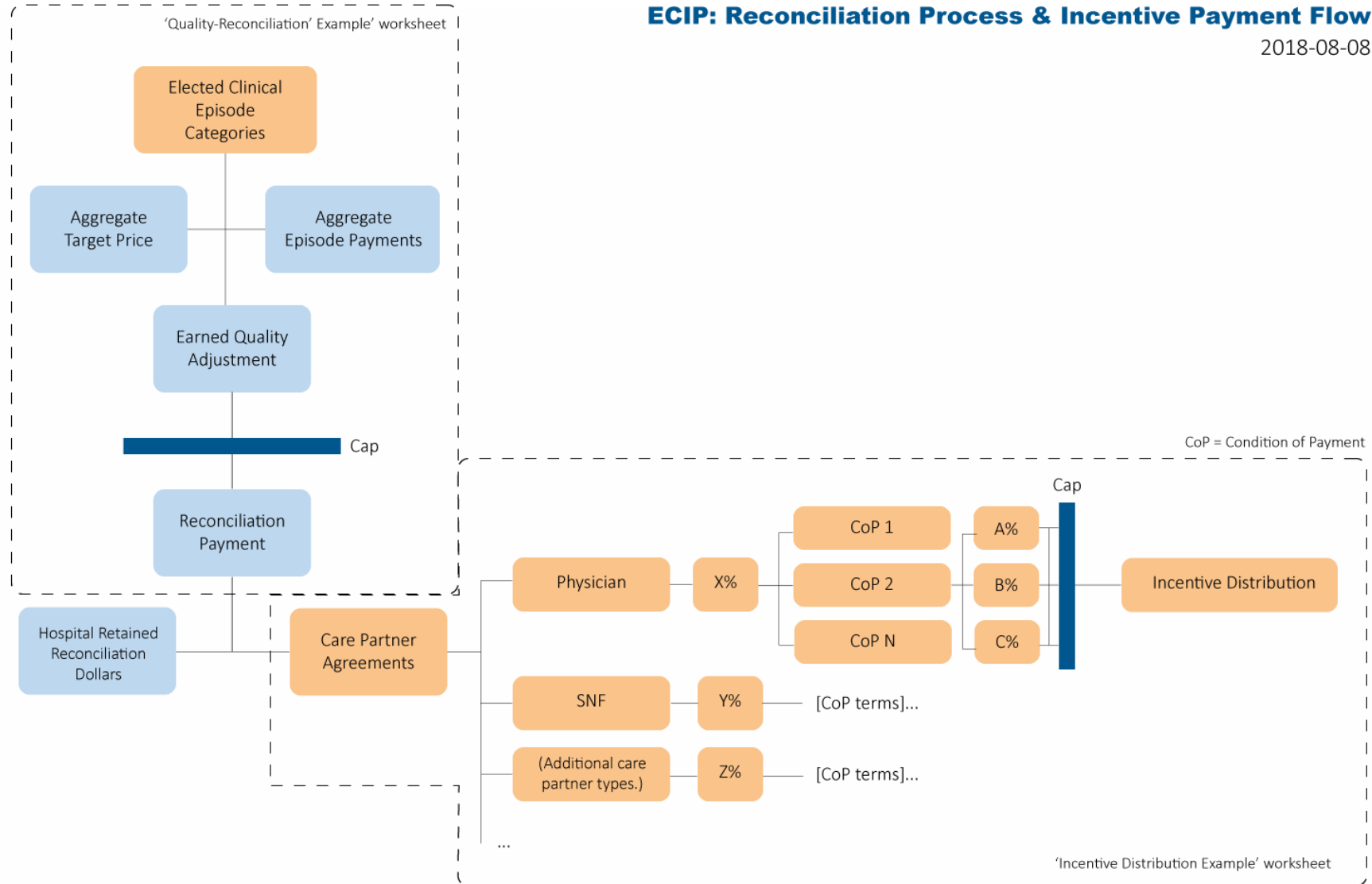


# Purpose

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1. Assist in evaluation and modeling of care partner inclusion & coordination
  1. Which care partners to include?
  2. If / how to approach incentive payment distribution
2. Composite Quality Score (CQS) modeling & evaluation

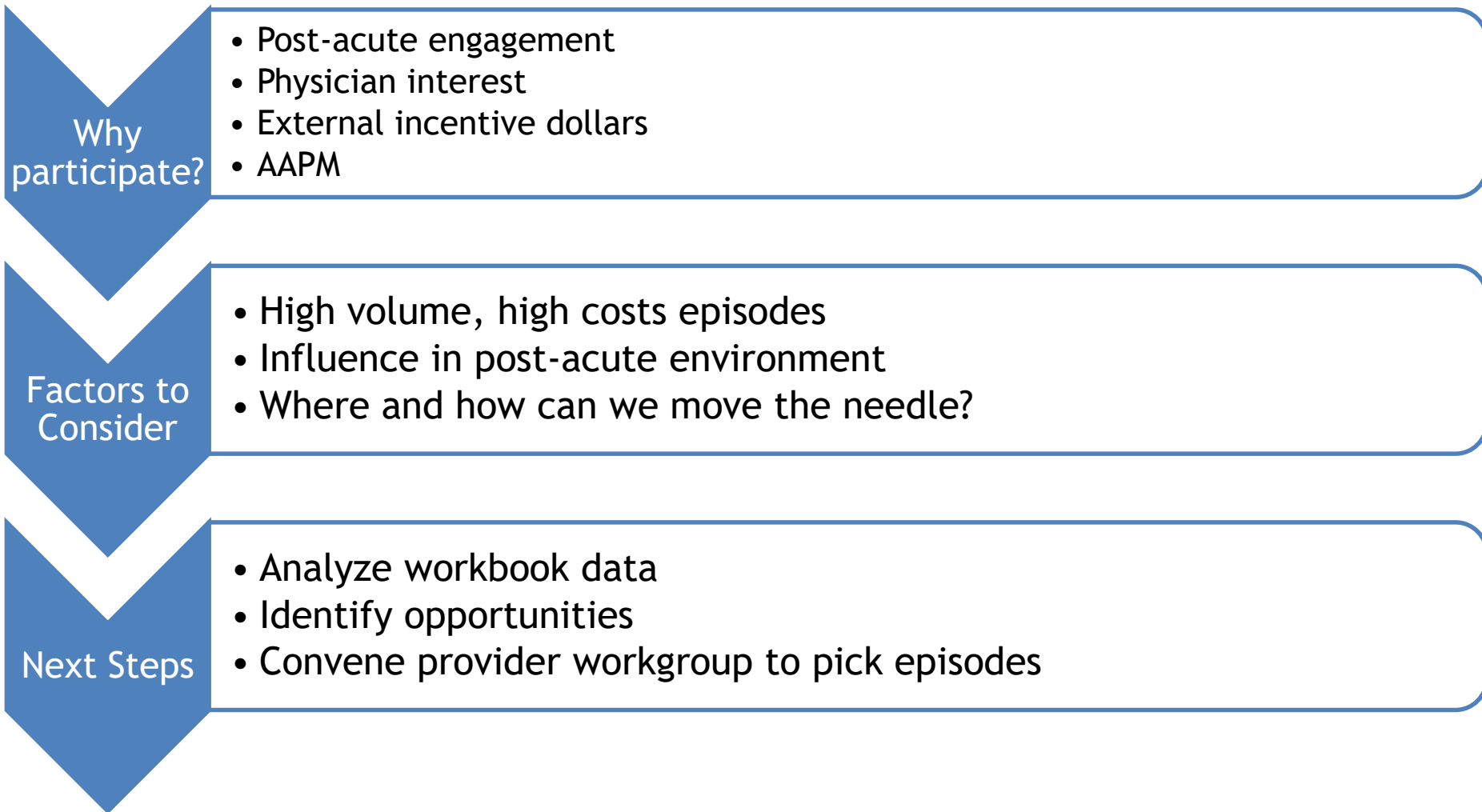
# Payment Flow Summary





## Case Study - AAMC

# Operationalizing ECIP





## Q & A

*Next up:*

*ECIP Technical Webinar – Supplemental (August 29)*

*ECIP IP Template Completion (September 5)*