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The Episode Quality Improvement Program

Value-Based Medicare Incentive Payment Opportunity for Maryland Physicians

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Introductions

- Jessica Heslop, Program Manager, CRISP
  - Jessica.Heslop@crisphealth.org
- Willem Daniel, Deputy Director, HSCRC
  - Willem.Daniel@Maryland.gov
- EQIP Inbox
  - eqip@crisphealth.org

Agenda for Today

1. Overview of Maryland's Episode Quality Improvement Program
    1. Prometheus Episode Grouper
    2. EQIP's Policy and Methodology
2. Cardiology Episodes & PY1/2 Participation

The Episode Quality Improvement Program – EQIP

- EQIP is a **voluntary program** that will provide **incentive payments to physicians** who **improve the quality of care and reduce the cost of care** that they provide to Maryland Medicare patients
- EQIP tests an approach that **ties healthcare payments to the quality and cost** of services provided under a clinical ‘episode’ for a set period. This includes relevant set of services delivered to a related to a medical condition, procedure or health care event during a defined time period.
- EQIP will utilize the **Prometheus Episode Grouper** to define a clinical ‘episode’.

Benefits for Maryland Providers

Physician ownership of performance.

- *Policy tailored to independent and employed physician practice*

Upside-only risk with dissavings accountability.

- *EQIP will provide a lumpsum bonus to normal Medicare Payment*

Alignment with CareFirst's episode program.

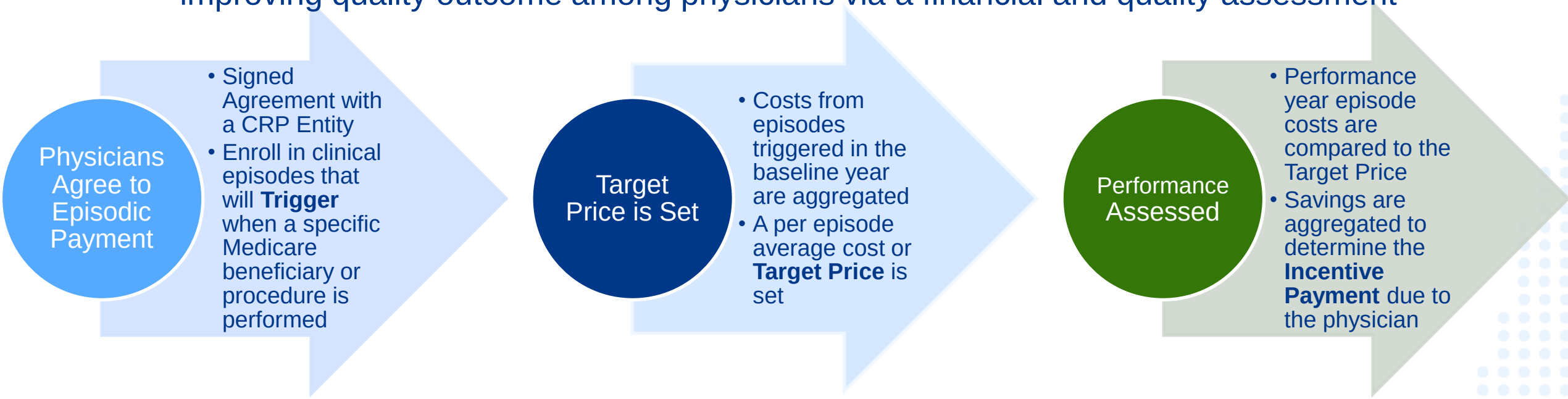
- *Methodology can apply to both Medicare and Commercially insured patients*

AAPM/value-based payment participation opportunities for MD physicians.

- *MIPS reporting exemption, Bonus from Medicare payment*

Episodic Value-Based Payment

- Bundled-payment programs are effective at controlling episodic care costs and improving quality outcome among physicians via a financial and quality assessment

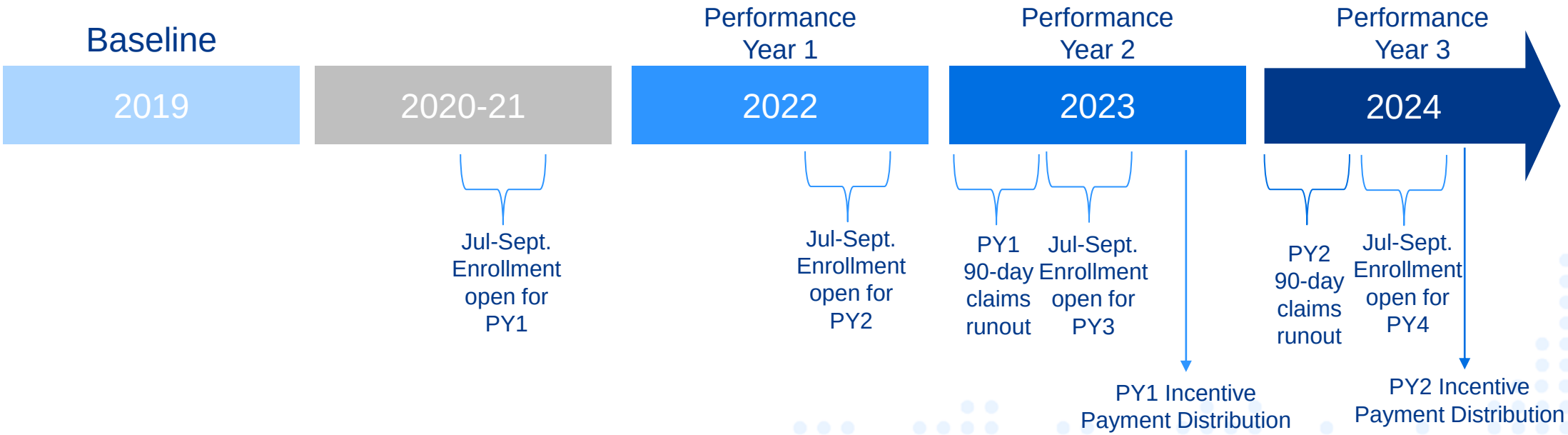


- Analyses of CMS bundled-payment programs have shown 4-6 percent reductions in gross Medicare spending

Source: https://innovation.cms.gov/files/reports/episode-payment-models-wp.pdf

Participation Timeline

- EQIP will have an annual opportunity to enroll in EQIP. The enrollment period will open **July through September** of each year prior to the performance year.
- The policy may be updated, and participation opportunities increased year to year through HSCRC's stakeholder engagement process



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HSCRC Episodes for PY2

Allergy

Allergic Rhinitis/Chronic Sinusitis, Asthma

Cardiology

Pacemaker / Defibrillator, Acute Myocardial Infarction, CABG &/or Valve Procedures, Coronary Angioplasty

Dermatology

Cellulitis, Decubitus Ulcer, Dermatitis

Gastroenterology

Colonoscopy, Colorectal Resection, Gall Bladder Surgery, Upper GI Endoscopy

Ophthalmology

Cataract Surgery, Glaucoma

Orthopedics

Accidental Falls, Hip Replacement & Hip Revision, Hip/Pelvic Fracture, Knee Arthroscopy, Knee Replacement & Knee Revision, Low Back Pain, Lumbar Laminectomy, Lumbar Spine Fusion, Osteoarthritis, Shoulder Replacement

Urology

Catheter Associated UTIs, Prostatectomy, Transurethral Resection Prostate, UTI

Emergency Department

Abdominal Pain & Gastrointestinal Symptoms, Asthma/COPD, Atrial Fibrillation, Chest Pain, Deep Vein Thrombosis, Dehydration & Electrolyte Derangements, Diverticulitis, Fever, Fatigue or Weakness, Hyperglycemia, Nephrolithiasis, Pneumonia, Shortness of Breath, Skin & Soft Tissue Infection, Syncope, Urinary Tract Infection

*Full Episode Playbook can be found **here***

Participation Requirements

Qualify as a Care Partner with CMS

- Must be licensed and enrolled in the **Medicare** Provider Enrollment, Chain, and Ownership System (**PECOS**)
- Must use **CEHRT and CRISP**, Maryland's health information exchange

Enroll in EQIP

- Establish **EQIP Entity** with **multiple Care Partners**
- **Select Episodes and Interventions** and agree to quality metrics*
- Each Care Partner Signs a **Care Partner Arrangement**
- Determine **Payment Remission Recipient***

Meet Episode Thresholds

- Provide care in **Maryland**
- For a **single episode, threshold = 11** episodes in the baseline
- Across **all episodes of participation, threshold = 50** episodes in the baseline

**All Care Partners in an EQIP Entity will share the same episodes, quality metrics and payment recipient.*

EQIP Policy: Where is each methodology determined?

Prometheus Episode Definition

- Episode Definitions and Triggers
- Relevant Cost Methodology

HSCRC/CMS Policy

- Target Price Methodology
- Shared Savings/Incentive Payment Methodology
- Quality Measures
- Reporting and Monitoring (via CRISP)
- Participation Specialty Areas
- CMS Policy (including QP status)

Prometheus Episode Grouper

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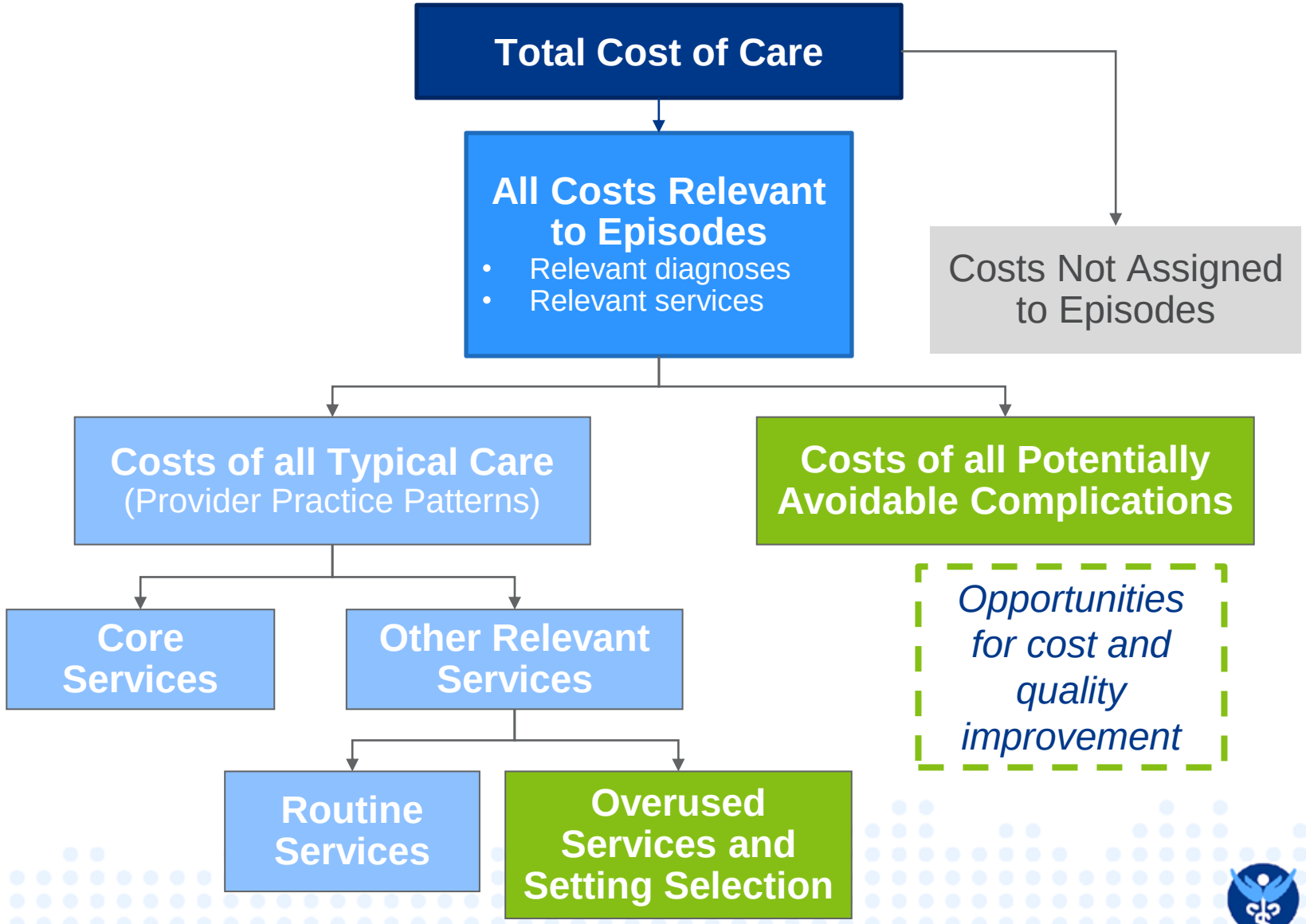
PROMETHEUS Background

- Iterative development since 2006, maintained by HCI3/Altarum and recently acquired by Change Healthcare
- Promotes coordination and collaboration across the continuum of care at the specialist level
- 97 episodes grouped into clinically relevant areas: Procedural, Acute, Chronic and Other (Reference full list here)

PROMETHEUS Relevant Cost Analysis



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PROMETHEUS Episode of Care Overview

- Value-based mode designed to engage specialists
- Full spectrum of services related to and delivered for a specific medical condition, illness, procedure or health care event during a defined time period
- Coordination, communication, collaboration across the continuum of care

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EQIP Policy and Methodology

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Target Price Methodology

- 2019 will serve as a **Baseline** for the first three performance years for EQIP Entities
  - Each EQIP Entity will have their own **unique Target Price** per episode
  - The baseline will be trended forward in order to compare to current performance costs
  - Target Prices are not final until the end of the Performance Year as final inflation will need to be applied
  - The baseline for entities that join in subsequent performance years will be the year prior to them joining
- Each episode will have a **singular Target Price**, regardless of the setting of care (Hospital, Outpatient Facility, ASC)
  - The price gap between ASC and Hospital is significantly larger under the Medicare fee schedule than under commercial, particularly in Maryland where hospital rates are regulated.
  - This will **create incentive to shift lower acuity procedures** to lower cost settings, aligning with GBR incentives.

Incentive Payment Methodology

***Incentive Payments** will be direct checks made from the CRP Entity to the EQIP Entity for aggregate positive performance after a minimum savings threshold, shared savings split, and quality adjustment are applied.*

1. Performance Period Results

- The Performance Period Episode costs are less than the Target Price in the aggregate across all episodes in which the EQIP Entity participates.
- At least three percent of savings are achieved (stat. significant)
- Dissavings from prior year (if any) are offset

2. Shared Savings

- Each Care Partner's Target Price** will be compared to the statewide experience and annually ranked based on relative efficiency. Lower cost providers will be in a higher tier and vice versa.
- The Shared Savings split with Medicare will be based on the Care Partner's Target Price rank

Target Price Rank	% of Savings to due EQIP Entity
Up to 33rd percentile	50 percent
34th – 66th percentile	65 percent
66th + percentile	80 percent

3. Clinical Quality Score

- 5% of the incentive payment achieved will be withheld for quality assessment
- The EQIP Entity's quality performance will indicate the portion of this withholding that is 'earned back'

4. Incentive Payment Cap

- The result is no more than 25 percent of the EQIP Participant's prior year Part B payments

5. Final Incentive Payment

- Paid directly to the payment remission source indicated by the EQIP Entity*
- Paid in full, six months after the end of the performance year
- In addition to incentive payments, if QPP thresholds are met, Medicare will pay a bonus to physicians and increase rate updates in future years.

**The EQIP entity can direct the payment remission source to distribute payments to individual Care Partners however it desires.*

*** In Year 1 the Target Price will be used to determine the tercile, in subsequent years, prior year performance will be used.*

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Dissavings Accountability

- Direct collection of downside risk is not possible without the ability to directly adjust physician FFS payments.
- However, it is important to ensure the program drives meaningful improvements in cost efficiency and quality.
- EQIP's **Dissavings Policy** will help to ensure outcomes in lieu of downside risk:
  1. Participants who create dissavings in a performance year will be required to offset those dissavings in the following performance year, prior to earning a reward.
  2. An EQIP Entity will be removed from EQIP if its Target Price is in the lower two terciles of the Tiered Shared Savings Rate (0-66th percentile) and there have been two consecutive years of dissavings.
     - HSCRC staff will monitor the effects of this policy to ensure there are no unintended consequences

EQIP Quality Measure Selection for PY1

Measure Characteristics

- Measures within the PY2021 MIPS Set
- Applicable at physician-level
- Part B claims measurable

Applicable CMS Quality Payment Program (QPP) Standards

- High Priority or Outcomes Measure
- 3-6 measures available

HSCRC Priorities

- Alignment with CareFirst
- Agnostic to episode-type, to avoid low cell size variability
- Alignment with Maryland's Statewide Integrated Health Improvement Strategy

Measure Name	Orthopedics	Gastroenterology	Cardiology
Advance Care Plan (NQF #326)	✓	✓	✓
Documentation of Current Medications in the Medical Record (NQF #419)	✓	✓	✓
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (MIPS #128)	✓	✓	✓

The Benefits of EQIP

- Value-based payment opportunity tailored to Maryland physicians
- No downside risk collection
- System alignment, regardless of care setting
- Episodes tailored to provider practice patterns and scope of impact
- Opportunity to improve patient outcomes and contribute to health system improvement

Cardiology Episodes & PY1/2 Participation

Cardiology Episodes for PY1&2

Cardiology Episode	Triggering Procedures (CPT)
Pacemaker / Defibrillator *Procedure, 30*	Insertion of Pacemaker Insertion of Generator Alone Insertion of Leads Insertion of Defibrillator
CABG &/or Valve Procedures *Procedure, 90*	Heart Valve Repair, Outflow Reconstruction Heart Valve Replacement Coronary Artery Bypass Graft (CABG) Re-Do Coronary Artery Bypass Graft (CABG)
Coronary Angioplasty *Procedure, 90*	PCI with stents, atherectomy Procedure - coronary - ptca – angioplasty Procedure - coronary - thrombectomy
Acute Myocardial Infarction (AMI) *Acute, 30*	**Triggered on diagnosis (ICD-10)** STEMI Subendocardial Infarction

Statewide Cardiology Estimates, 2019

	Statewide Episodes	Unique NPIs	Average Cost per Episode	Total Cost Statewide
Acute Myocardial Infarction	2,787	1,004	$ 29,254	$ 81,531,764
CABG &/or Valve Procedures	1,532	117	$ 65,593	$ 100,489,684
Coronary Angioplasty	3,400	292	$ 25,382	$ 86,301,395
Pacemaker / Defibrillator	3,561	234	$ 30,981	$ 110,323,755
Total	12,584	1,395	$ 33,567	$ 378,646,600

PY1 & 2 – Cardiology Episode Participation

	PY1			PY2		
	# Entities	Baseline Episodes	Avg. Target Price	# Entities	Baseline Episodes	Avg. Target Price
Acute Myocardial Infarction	10	562	$ 31,315	12	612	$31,946
CABG &/or Valve Procedures	7	608	$ 66,164	6	583	$ 67,295
Coronary Angioplasty	10	1,158	$ 25,476	10	1,189	$ 27,193
Pacemaker / Defibrillator	11	1,135	$ 30,261	11	1,129	$ 31,305
TOTAL	19	3,463	$ 35,893	20	3,513	$ 35,985

EQIP Timeline

Jul. 20222	• EEP opened for PY2 enrollment
Sep. 2022	• EEP closes for PY2 enrollment
Dec. 31st, 2022	• Care Partner Arrangement Contracting Deadline
Calendar Year 2023	
Jan 1, 2023	• Performance Year 2 Starts
Feb 24, 2023	• PY1 Q2 data available in EEP • PY2 Preliminary Target Prices and Baseline Data available in EEP
April 28, 2023*	• PY1 Q3 data available in EEP
July 1, 2023	• PY3 (2024) Enrollment Opens
July 28, 2023*	• PY1 Q4 data available in EEP
Q3 2023	• PY1 Incentive Payments distributed

** Performance Data Release Schedule may vary to ensure QA*

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Thank you!

Appendix

Glossary

- **HSCRC** - Health Services Cost Review Commission
- **CRISP** - Chesapeake Regional Information System for our Patients
- **CMS** - Centers for Medicare & Medicaid Services
- **TCOC -** Total Cost of Care
- **CRP** - Care Redesign Program
- **EQIP** - Episode Quality Improvement Program
- **EEP** – EQIP Entity Portal
- **CMMI** - Center for Medicare and Medicaid Innovation
- **AAPM** - Advanced Alternative Payment Models
- **GBR** - Global Budget Revenues
- **CPA** - Care Partner Agreement
- **QP** - Qualifying Participant
- **QPP** - Quality Payment Program
- **MIPS** - Merit-based Incentive Payment System
- **HIE** - Health Information Exchange
- **PAEC** - Potentially Avoidable Episode Complications
- **MST** - Minimum Savings Threshold
- **ATP** - Aggregate Target Price
- **CQS** - Composite Quality Score

EQIP Roles – Definitions and Responsibilities

"Care Partner" (a specialty physician)

- **Triggers episodes** and **performs EQIP care interventions**
- Signs a **Care Partner Arrangement** with the CRP Entity
- Receives normal fee-schedule payments from Medicare and a **potential "Incentive Payment" with the EQIP Entity**
- Eligible to achieve **Quality Payment Program Status** and bonuses

"EQIP Entity"

- Consists of an **individual Care Partner** or **multiple Care Partners**
- **Performance evaluation** occurs at the EQIP entity level
- Receives **Incentive Payments**

"CRP Entity"

- Signs a **Care Partner Arrangement** with all Care Partners
- **Pays incentive payments** or savings to EQIP entities

HSCRC and CRISP

- Will calculate episodes, monitor performance and **determine Incentive Payments**
- Maintains reporting and monitoring requirements per the Participation Agreement and to **support CRP Entity**
- Will facilitate **EQIP Entity and Care Partner Enrollment**, Reporting and Learning Systems

Administrative Proxies (*)

EQIP Entities can delegate management of their program administration. This contractual arrangement, if any, will be determined between Administrative Proxy and Participant outside of Care Partner Arrangements.

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Overview of Acute Episodes

The Episode begins with a Triggering diagnosis…

AND

Performed by one of the EQIP entities' Care Partners

The Physician is responsible for care that occurs during the episode window…

The Episode Costs are compared to a Target Price for that Episode

Unrelated costs will be excluded from the Episode.

Overview of Procedural Episodes

The Episode begins with a Triggering procedure and diagnosis…

AND

Performed by one of the EQIP entities' Care Partners

The Physician is responsible for care that occurs during the episode window…

The Episode Costs are compared to a Target Price for that Episode

Unrelated costs will be excluded from the Episode.

Overview of Complications Episodes

The Episode begins with a Triggering procedure…

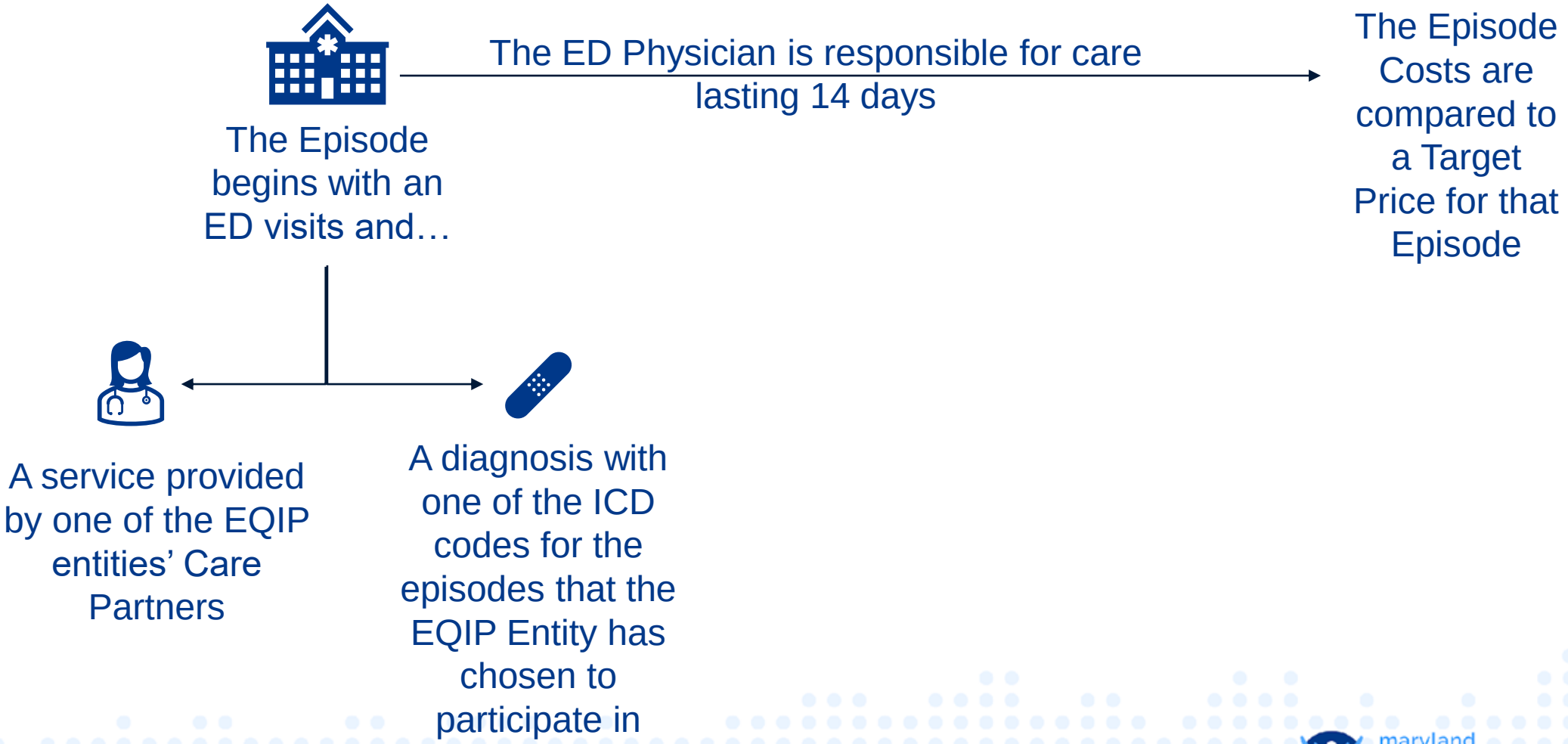
Performed by one of the EQIP entities' Care Partners

The Physician is responsible for care that occurs during the episode window…

The Episode Costs are compared to a Target Price for that Episode

Unrelated costs will be excluded from the Episode.

Overview of ED Episodes



Overview of Chronic Episodes

A chronic episode is attributed to the physician.

The physician is responsible for managing all costs that occur during the episode.

The physician gets credit for managing the episode cost and avoiding downstream procedures.

Quality Metric Definitions and Parameters

- For each triggered episode, the HSCRC will assess if the three measures were **performed 364 days prior to the end of the episode**, by any physician. Defined by:
  - **Advance Care Plan (NQF #326) :** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record **or** documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
  - **Documentation of Current Medications in the Medical Record (NQF #419):** Percentage of visits for patients aged 18 years and older for a clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter
  - **Body Mass Index (BMI) Screening and Follow-Up Plan (MIPS #128):** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter