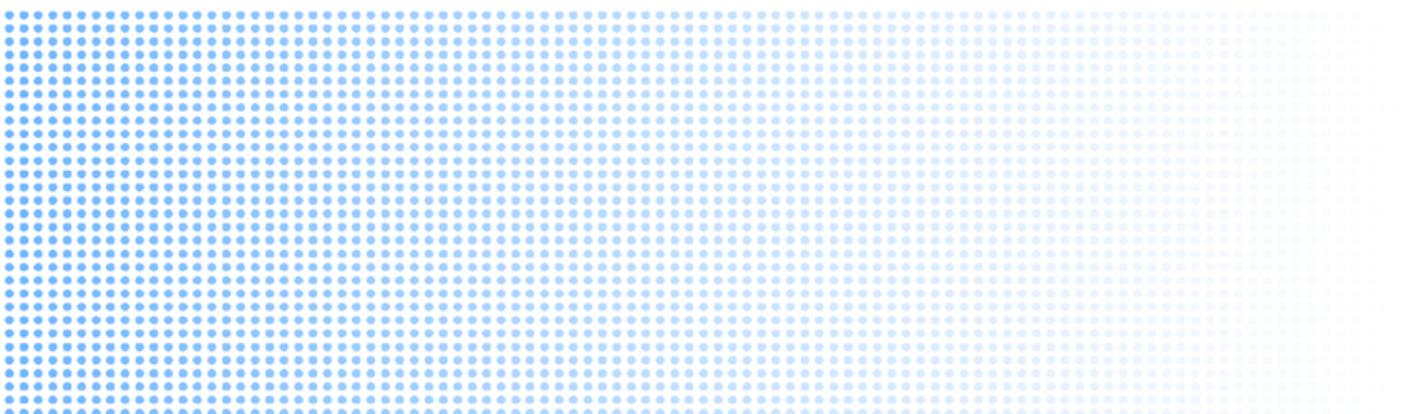




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EQIP and PY2 Episodes

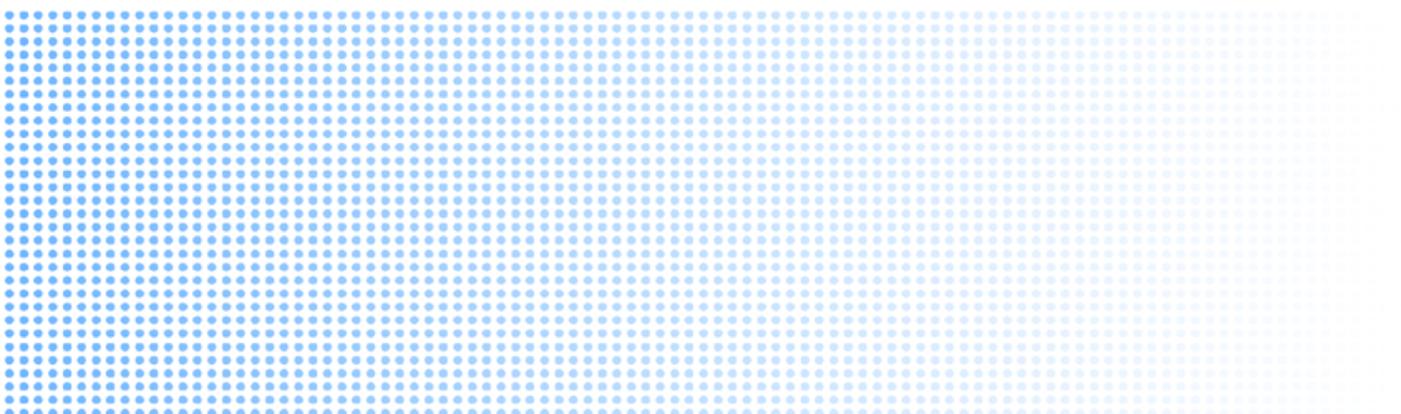
May 2022



Agenda

Agenda

1. Administrative Update
2. New Episodes and Policy Decisions
3. EQIP Toolkit

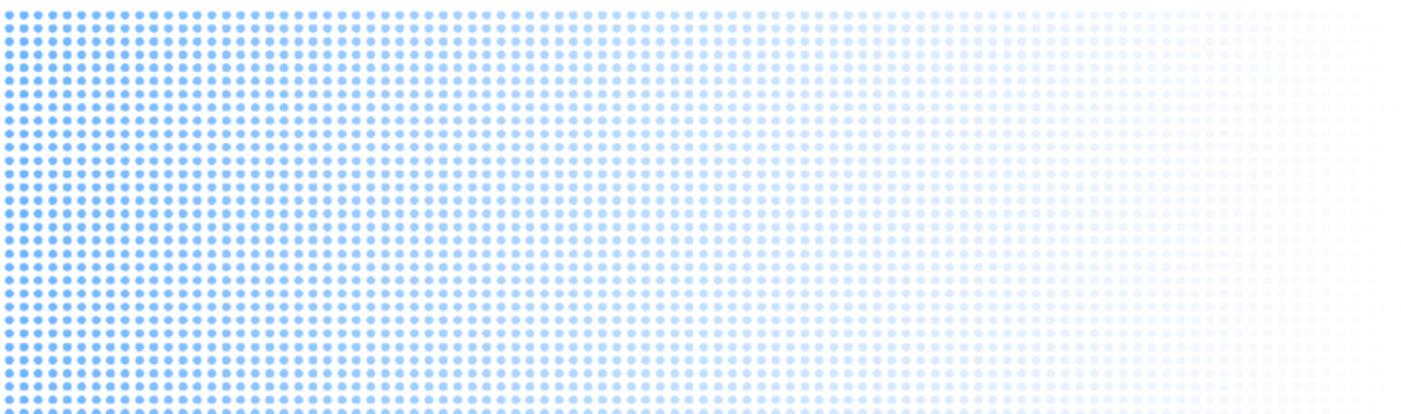


CRP Update

Administrative Update



- “CRP Entity” (UMMC)
 - Signs a Care Partner Arrangement with all Care Partners
 - Pays incentive payments or savings to EQIP entities
- In Preparation for 2023 Payments, UMMS needs to enter all Entities into their internal system
- UMMS requires a completed W9 from each entity by May 31st
- Any questions, please contact EQIP@umm.edu



PY2 Episodes and Policy

Overview of new Episodes

We have finalized the additional episodes that will be included in Year 2 of the EQIP program.

- We will include all ED Episodes proposed by the ED physicians except for Hypertension and Hyperglycemia which we determined did not have enough volume to be viable.
- We will include only the relevant costs as proposed by the ED physicians.

We will also add additional Prometheus episodes for Allergy, Dermatology, Ophthalmologist, Orthopedic Surgery, and Urology.

- Any specialty may participate in these episodes (e.g. internal medicine) if they perform enough episodes.
- These include procedural episodes, chronic episodes, and complications episodes.

We will provide the triggering diagnosis codes and relevant costs to interested physicians upon request. Please email: equip@crisphealth.org.

New Prometheus Episodes for Yr 2

Specialty	Episode Name	Episode Type
Allergist	Allergic Rhinitis/Chronic Sinusitis	Chronic
	Asthma	Chronic
Dermatologist	Cellulitis, Skin Infection	Complications
	Dermatitis, Urticaria	Complications
	Decubitus Ulcer	Complications
Ophthalmologist	Cataract Surgery	Procedural
	Glaucoma	Chronic
Orthopedist/Orthopedic Surgeon	Low Back Pain	Chronic
	Osteoarthritis	Chronic
	Accidental Falls	Complications
Urologist	Catheter Associated UTIs	Complications
	Urinary Tract Infection	Complications
	Transurethral resection prostate	Complications
	Prostatectomy	Procedural

Yr 2 ED Episodes

ED Episodes	
Chest Pain	Pneumonia
Atrial Fibrillation	Asthma/COPD
Deep Vein Thrombosis	Skin & Soft Tissue Infection
Abdominal Pain & Gastrointestinal Symptoms	Syncope
Diverticulitis	Fever, Fatigue or Weakness
Hyperglycemia with Diabetes Mellitus	Shortness of Breath
Dehydration & Electrolyte Derangements	Hyperglycemia
Urinary Tract Infection	Skin and soft tissue infections
Nephrolithiasis	Deep vein thrombosis

Overlaps between Episodes

During the previous workgroup meetings, we discussed a concern about the potential overlaps between episodes.

- If two episodes occur within the same time window, the savings created in that episode would be double counted.
- We were considering policies to correct for the overlaps between two different episodes

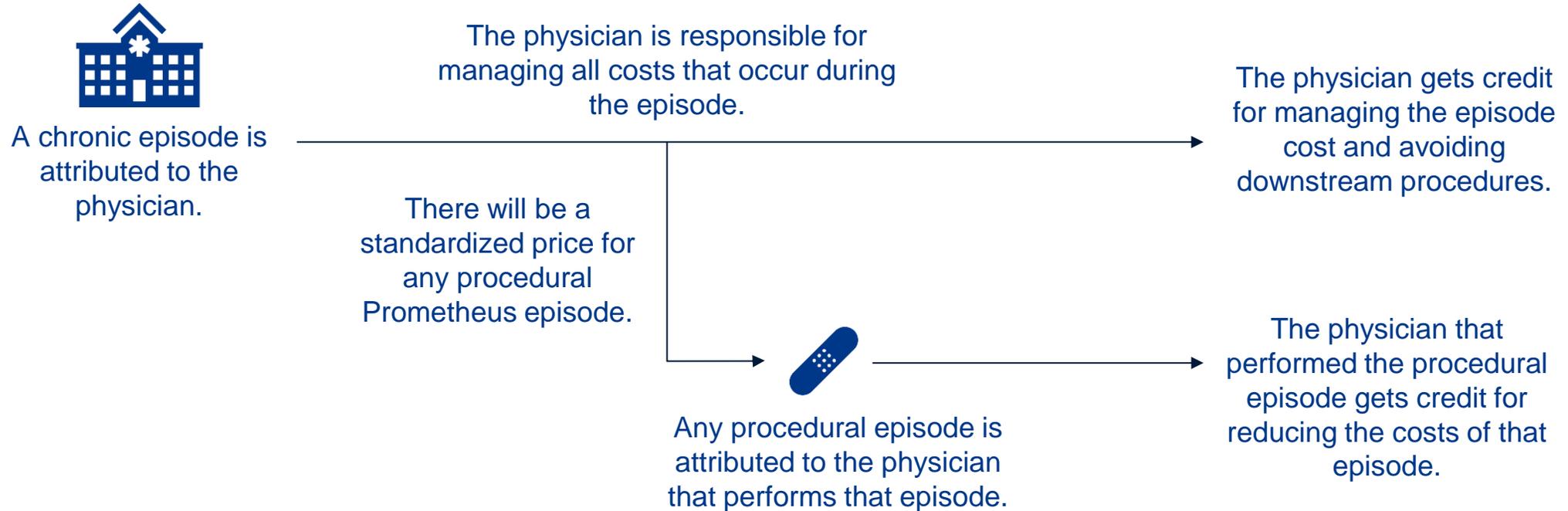
We did not find significant overlaps for procedural, Chronic, or ED episodes. Therefore, we decided that no correction was needed.

Chronic Episodes

Chronic episodes (glaucoma, lower back pain, etc.) have a longer episode window and do not have a clear procedure-based start. This requires that we correct for overlaps and use different attribution rules.

- We will attribute chronic overlaps to the NPI that provides that plurality of office-based E&M codes during the episodes;
- We will 'standardized' the cost of any downstream episodes that occurs. This will allow the initiating physician to get credit for avoiding an unnecessary procedure.

Overview of Complications Episodes



Example

Suppose a physician is attributed a lower back pain episode. Lower Back Pain episodes frequently overlap with Lumbar Laminectomy episodes so there is an overlaps problem.

- We will set a standardized price of \$12,000 for each Lumbar Laminectomy.
- Suppose the patient incurs \$18,000 in non-Lumbar Laminectomy costs. If they have a Lumbar Laminectomy, then we will add \$12,000 in costs to the total episode costs for a net of \$30,000.
- If the target price is equal to \$30,000, then the physician could earn savings either by reducing the non-Lumbar Laminectomy costs or by avoiding the need for a Lumbar Laminectomy.

However, the physician managing the lower back pain episode will not get credit for managing the costs of the Lumbar Laminectomy episode once it occurs.

- Any savings in the Lumbar Laminectomy will be paid to the physician that performed the Lumbar Laminectomy.
- E.g. if the costs of the Lumbar Laminectomy was less than \$12,000 then the physician performing the Lumbar Laminectomy would earn the savings.

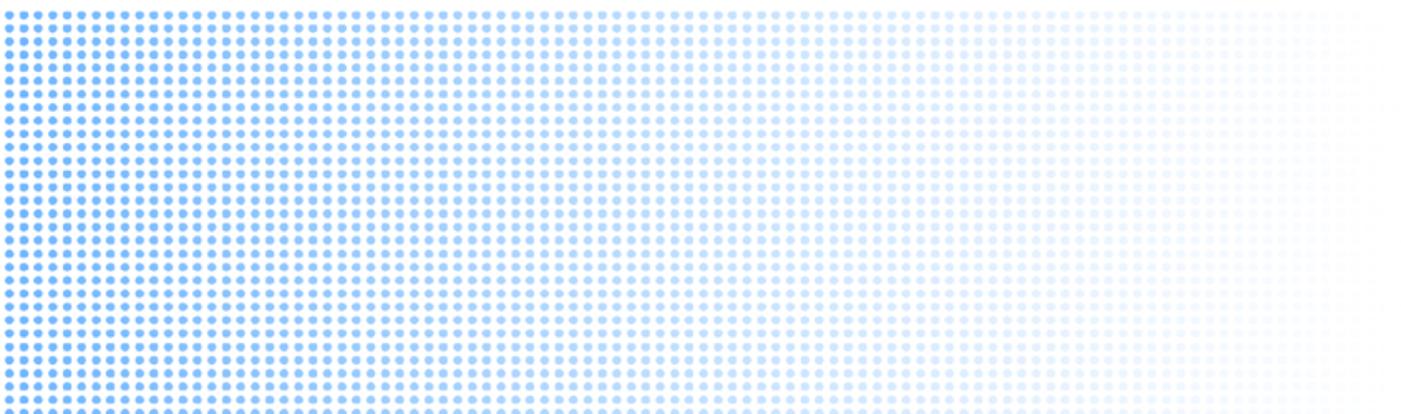
* All numbers are made up and do not reflect actual episode costs.

Standardize Cost Approach

We are examining different options for determining what the standardized costs should be.

- Use the state average for the procedural episode. This holds the physicians attributed the chronic episode harmless for any variation in the procedural episode costs.
- Use a physician / facility average of the rendering physician for the standardized costs. This allows physicians attributed the chronic episode to earn savings if the procedural episode occurs in a more efficient setting of care.

Our preference is to use the later approach but there are data and reporting issues that we need to work through.



EQIP Toolkit

EQIP Meeting Presentation

Liz Gipson, MPH, Researcher | Emily Elstad, PhD, MPH, Senior Researcher

EQIP Presentation | May 20, 2022

Agenda

1. Introduction
2. Search Criteria and Approach
3. Review Process
4. Common Themes
5. Examples of Key Resources
6. Questions

Introduction

- At CRISP's request, AIR conducted a literature scan of publicly available, peer-reviewed and gray literature to identify strategies and best practices that EQIP participants can use to improve care quality and efficiency within episode-based payment (EBP) arrangements.
- Based on the results of the scan, AIR created a Resource List that summarizes key lessons and best practices from each source.

Search Criteria and Approach

- The literature scan focused on publicly available resources published in the US from 2012 through 2022.
- To ensure that our scan was relevant for Year 1 participants, AIR aimed to identify resources related to cardiology, gastroenterology, and orthopedics, where possible.
- AIR searched for resources from a variety of sources including professional associations, state and federal government agencies, peer-reviewed journals, and health care industry news sources.

Review Process

- AIR identified 81 potential resources and narrowed the list down to 26 items included on the resource list. During our review process we looked for:
 - » **Clear recommendations** and **actionable lessons learned** from providers participating in episode-based payment models
 - » Effective approaches to succeeding in EBPs, from **leveraging time-driven activity-based costing** to **building consensus** among health care staff
 - » **A variety of formats**, including clinically-based studies, perspectives of industry leaders, memoranda, and long-form research reports

Common Themes

- Of the 26 resources selected for the final list:
 - 4 focus on cardiology, 2 focus on gastroenterology, and 6 focus on orthopedics*
 - 3 provide an introduction to EBPs
 - 3 offer insights on gaining buy-in from health care staff
 - 3 discuss using time-driven activity-based costing methodology for estimating internal costs
 - 3 discuss using the PROMETHUS methodology for EBPs
 - 17 offer insights on best practices for participating in an EBP including investing in data infrastructure, developing care pathways, identifying risk, and fine-tuning discharge planning.

* We found more resources on orthopedics than the other two specialties largely because two CMMI models - Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) – have been studied extensively.

Examples of Key Resources

- **Transition to new payment models – American Medical Association**
 - A four-step guide for providers on how to successfully participate in alternative payment models, including episode-based payments
 - Recommendations include:
 - » Creating a utilization budget with an exhaustive list of every service included in the bundle, including all CPT, HCPCS, ASA, CDT, ICD-10-CM codes and modifiers;
 - » Determine the volume and demographic information of the eligible patient population; and
 - » Calculate the cost allocation for each covered service and determine if the budgeted allowance will cover those costs.
- **Getting Bundled Payments Right in Health Care – Harvard Business Review**
 - A short article that shares lessons learned on EBP implementation from both a specialty orthopedic hospital and private-practice physician.
 - The article recommends practices:
 - » Use time-driven activity-based costing to track costs for each episode of care; and
 - » Develop a comprehensive pre-operative risk screening that includes psychosocial factors to better proactively identify patients who may benefit from greater care coordination.

Questions?
