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The Episode Quality Improvement Program

Value-Based Medicare Incentive Payment Opportunity for Maryland Practitioners

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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

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 practitioners

Practitioner ownership of performance.

- *Policy tailored to independent and employed practitioner practice*

Upside-only risk with dissavings accountability.

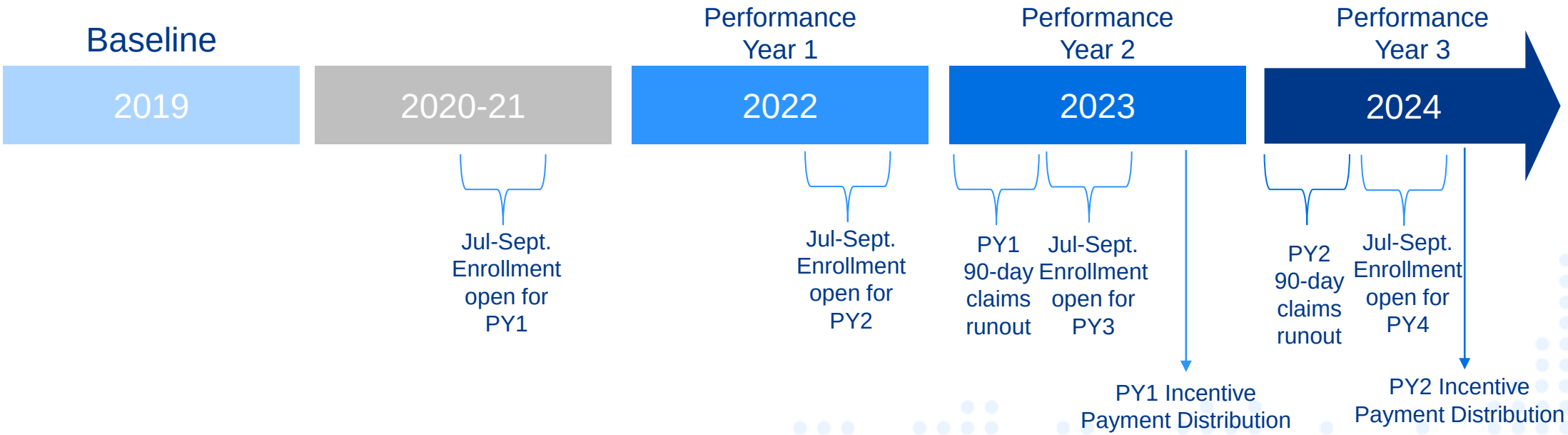
- *EQIP will provide a lumpsum bonus to normal Medicare Payment*

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

- *MIPS reporting exemption, Bonus from Medicare payment*

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 PY3

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

Pulmonary/Critical Care

Acute CHF / Pulmonary Edema, Chronic Obstructive Pulmonary Disease, Deep Vein Thrombosis / Pulmonary Embolism, Pneumonia, Sepsis

Orthopedics

Accidental Falls, Hip Replacement & Hip Revision, Hip/Pelvic Fracture, Knee Arthroscopy, Knee Replacement & Knee Revision, Low Back Pain, Lumbar Laminectomy, Lumbar Spine Fusion, Musculoskeletal Disorders, 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***

EQIP Roles – Definitions and Responsibilities

"CRP Entity" (UMMC)

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

"EQIP Entity"

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

"Care Partner" (a specialty practitioner)

- **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

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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EQIP's CRP Entity is The University of Maryland Medical Center

- The State has partnered with UMMC to enable EQIP as an Advanced Alternative Payment Model with CMS
- Any qualifying practitioner in Maryland will be allowed to participate in EQIP, regardless of previous contracting, relationship and/or privileges at UMMC
- UMMC's main roles will be:
  1. Signing an individual Care Partner Arrangement with each participating Care Partner in the EQIP Entity, and,
  2. Printing checks for earned Incentive Payments to the EQIP Entity.
- The HSCRC and CRISP will facilitate interactions between UMMC and Care Partners/EQIP Entities
  - Policy decisions and operations support will remain transparent and set at the State level
  - Any changes to the policy will be made at the CRP Committee and EQIP stakeholder level

CRP Entity Operations

- The CRP Entity will receive a list of:
  - Care Partners contacts who have been submitted for CMS vetting, used to generate Care Partner Arrangements
  - EQIP Entities who elect participation in EQIP for PY1 and their Payment Remission Recipient, used to generate Care Partner Arrangements and,
  - A final Incentive Payment list for EQIP Entity Payment
  - The CRP Entity will not have:
    - Protected Health Information
    - Access to EQIP Entity or Care Partner performance analytics
- All program data, inquiries and policy procedure will be managed by the State (HSCRC and CRISP), including CRP Entity operations.

Participation Requirements

Qualify as a Care Partner with CMS

- Must be licensed and enrolled in the **Medicare** practitioner 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

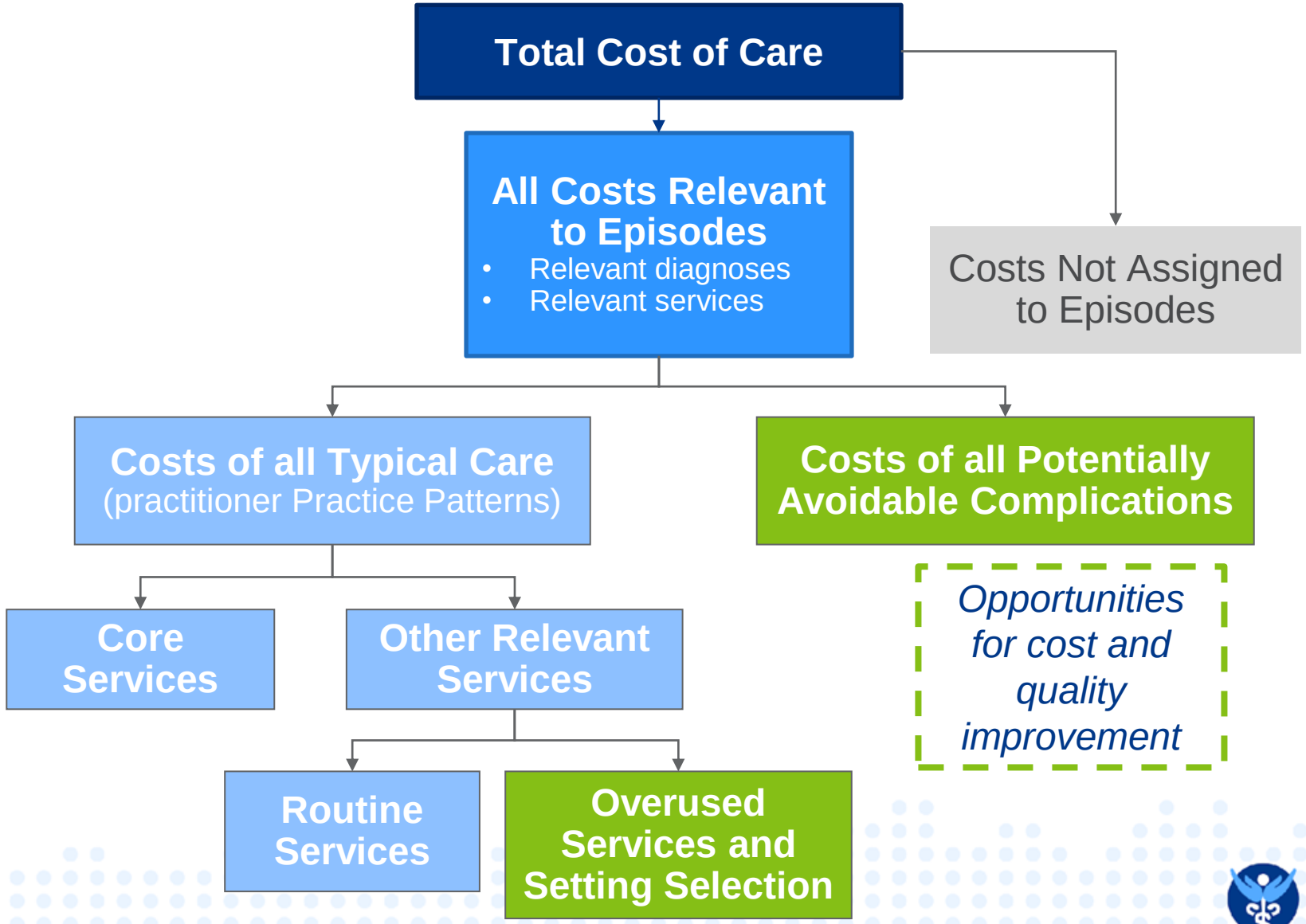
- Provide care in **Maryland**
- For a **single episode, threshold = 11** episodes in the baseline
- Across **all episodes of participation, threshold = 50** episodes in the baseline

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

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

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

Prometheus Episode

Full Episode Playbook

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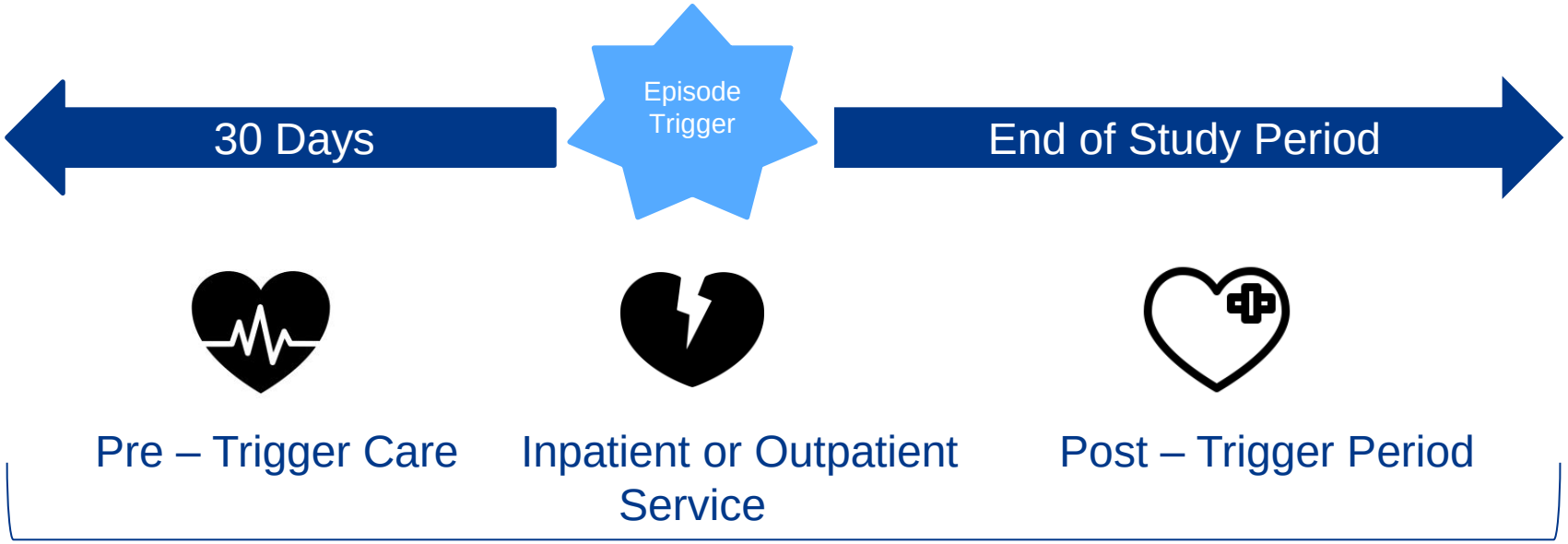
Low Back Pain (LBP)

Low Back Pain (LBP) is a chronic condition open from 30 days prior to the date of the trigger service until the end of the study period. The trigger service can be an inpatient service with a low back pain-specific principal diagnosis code or an outpatient or professional E&M service with a low back pain-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional low back pain-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to Low Back Pain such as lumbago or sciatica have been defined as typical care for Low Back Pain, and conditions such as electrolyte disturbances or GI bleed due to use of pain medicines without proper protection have been labeled as complications.

Episode Length – LBP



Total Episode Cost = All expected services and complication costs associated from index service until the end of the post-trigger window.

Duration Pre-Trigger Window	Duration Post-Trigger Window
30	End of Study Period

Episode Triggers – LBP

Trigger Group Name	Code Type	Codes
Backache	ICD10	M5405, M5406, M5407, M5408, M5409, M5489, M549, M62830
Inflammatory spondylopathies	ICD10	M4650, M4655, M4656, M4657, M4658, M4659, M4680, M4685, M4686, M4687, M4688, M4689, M4690, M4695, M4696, M4697, M4698, M4699
Low Back Pain, Radiculopathy	ICD10	M4646, M4647, M4720, M4726, M4727, M4728, M47816, M47817, M47818, M47819, M47896, M47897, M47898, M47899, M479, M5116, M5117, M5126, M5127, M5135, M5136, M5137, M5146, M5147, M5186, M5187, M519, M5415, M5416, M5417, M5430, M5431, M5432, M5440, M5441, M5442, M545
Low Back Pain, Radiculopathy, Myelopathy	ICD10	M4716, M4806, M48061, M48062, M4807, M5106
MS - head / neck - infection	ICD10	M5400
MS - joint nos - jnt derangmnt - other	ICD10	M532X9
MS - pelvis - sprn/strn	ICD10	S338XXA, S339XXA
MS - soft tissue - nos- symptoms / findings	ICD10	M5410, M5418
Other arthropathies	ICD10	M9903
Other Back Pain, Radiculopathy, Myelopathy	ICD10	M4710, M4800, M4808

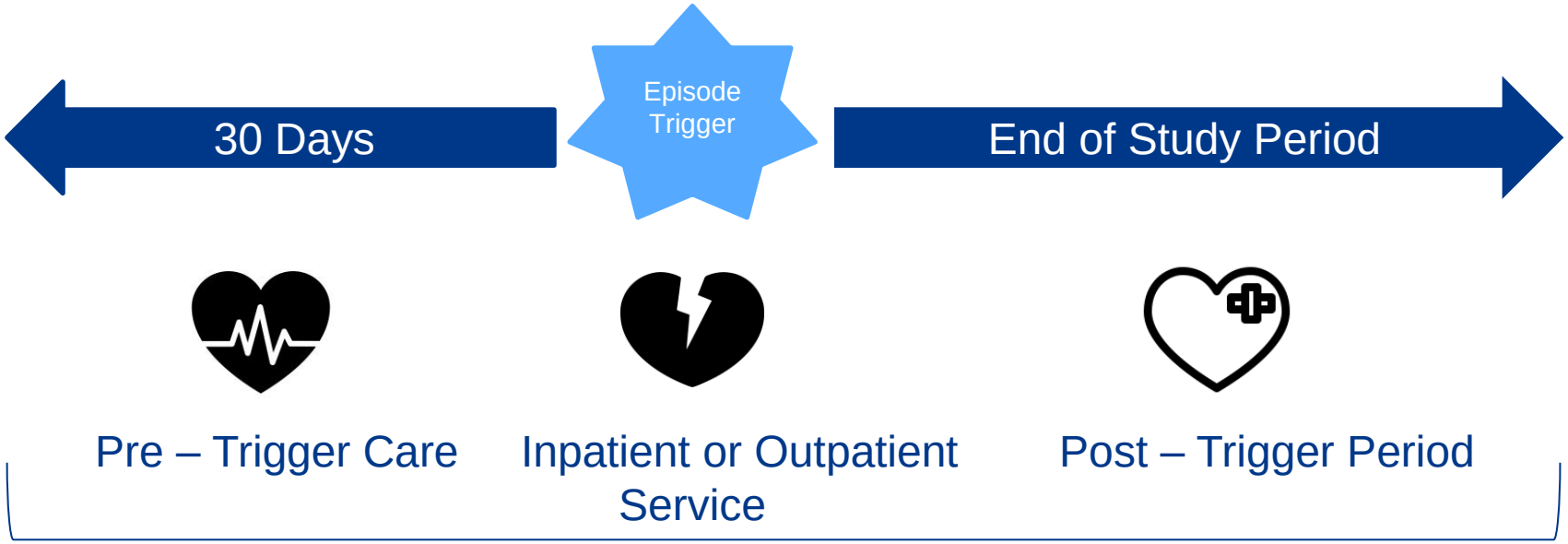
Episode Triggers – LBP

Trigger Group Name	Code Type	Codes
Other bone infections	ICD10	A1801
Other Spine Problems	ICD10	M2578, M4300, M4305, M4306, M4307, M4308, M4309, M438X9, M4600, M4605, M4606, M4607, M4608, M4609, M4640, M4648, M4649, M4830, M4835, M4836, M4837, M4838, M488X6, M488X7, M488X8, M488X9, M489, M4980, M4985, M4986, M4987, M4988, M4989, M532X6, M532X7, M532X8, M533, M5380, M5385, M5386, M5387, M5388, M539, M9923, M9924, M9925, M9926, M9929, M9933, M9934, M9935, M9936, M9939, M9943, M9944, M9945, M9946, M9949, M9953, M9954, M9955, M9956, M9959, M9963, M9964, M9965, M9966, M9969, M9973, M9974, M9975, M9976, M9979
Post Laminectomy Syndrome	ICD10	M961
Sprain Lower Back	ICD10	S335XXA
Stiff Spine	ICD10	M4810, M4816, M4817, M4818, M4819, M4820, M4825, M4826, M4827

Osteoarthritis (OSTEOA)

Osteoarthritis (OSTEOA) is a chronic condition open from 30 days prior to the date of the trigger service until the end of the study period. The trigger service can be an inpatient service with an osteoarthritis-specific principal diagnosis code or an outpatient or professional E&M service with an osteoarthritis-specific diagnosis code in any position. The professional trigger also requires a confirming inpatient, outpatient or professional osteoarthritis-related E&M service at least 30 days later. Services with diagnosis codes for signs and symptoms related to Osteoarthritis such as joint derangement have been defined by physician consultants as typical care for Osteoarthritis, and conditions such as deep vein thrombosis or muscle weakness have been labeled as complications.

Episode Length – OSTEOA



Total Episode Cost = All expected services and complication costs associated from index service until the end of the post-trigger window.

Duration Pre-Trigger Window	Duration Post-Trigger Window
30	End of Study Period

Episode Triggers – OSTEOA

Trigger Group Name	Code Type	Codes
Osteoarthritis	ICD10	M19021, M19022, M19029, M19031, M19032, M19039, M19121, M19122, M19129, M19131, M19132, M19139, M19221, M19222, M19229, M19231, M19232, M19239, M1990
Osteoarthritis, ankle & foot	ICD10	M19071, M19072, M19079, M19171, M19172, M19179, M19271, M19272, M19279
Osteoarthritis, Hip	ICD10	M160, M1610, M1611, M1612, M162, M1630, M1631, M1632, M164, M1650, M1651, M1652, M166, M167, M169
Osteoarthritis, Knee	ICD10	M170, M1710, M1711, M1712, M172, M1730, M1731, M1732, M174, M175, M179
Osteoarthritis, other joints	ICD10	M150, M151, M152, M153, M154, M158, M159, M180, M1810, M1811, M1812, M182, M1830, M1831, M1832, M184, M1850, M1851, M1852, M189, M19041, M19042, M19049, M19141, M19142, M19149, M19241, M19242, M19249, M1991, M1992, M1993
Osteoarthritis, Shoulder	ICD10	M19011, M19012, M19019, M19111, M19112, M19119, M19211, M19212, M19219

Chronic Episode Attribution Algorithm

Step 1: A triggering services identifies patients who are eligible for the episode.

I.e. The trigger service can be an inpatient service with a rhinitis/sinusitis-specific principal diagnosis code or an outpatient or professional E&M service with a rhinitis/sinusitis-specific diagnosis code in any position.

Step 2: The episode is assigned to the physician who provides the plurality of the relevant E&M services to the beneficiary.

Attribution will be run quarterly with a one-year look back. In other words, beneficiaries are assigned to the physician who provided the plurality of the relevant E&M services to that beneficiary over the past year.

Attribution will be run quarterly. Patient can be reassigned, if another provider now provides the plurality of E&M services. Additionally, patients with newly developing episodes will be assigned to the physician who provides the plurality of their care.

Step 3: The episode will be attributed all costs that are incurred during the performance year.

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 practitioners 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, nine months after the end of the performance year
- In addition to incentive payments, if QPP thresholds are met, Medicare will pay a bonus to practitioners 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 practitioner 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 PY1-3

Measure Characteristics

- Measures within the PY2021 MIPS Set
- Applicable at practitioner-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)	✓	✓	✓

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

EQIP PY3 Timeline

Jul. 7th 2023	• EEP opened for PY3 enrollment
Sep. 1st 2023	• EEP closes for PY3 enrollment
Sep-Dec 2023	• CMS Vetting & Contracting
Dec. 31st, 2023	• Care Partner Arrangement Contracting Deadline
Calendar Year 2024	
Jan 1, 2024	• Performance Year 3 Starts
Jan, 2024	• PY3 Preliminary Target Prices and Baseline Data available in EEP
Q3 2025	• PY3 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