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EQIP: Moving Forward under the Care Redesign Program Structure

Stakeholder Innovation – EQIP Subgroup

November 6, 2020

New EQIP Framework

The Purpose of EQIP

- Maryland physicians largely remain on fee-for-service reimbursement incentives and, as a result of the TCOC Model, are left out of other value-based reimbursement programs.
- Therefore, it is imperative that the State creates new value-based reimbursement opportunities for non-hospital providers to align the system and ensure equitable opportunity across the system.
- Additionally, EQIP will induce further incentives for:
  1. Collaboration and care coordination,
  2. Physician-focused care transformation,
  3. Multi-payer programs in Maryland, and,
  4. Improved patient care and outcomes.
- Today's discussion will outline changes from the July Request for Information (RFI) notice necessary to implement EQIP underneath the CRP structure

Moving Forward with EQIP

- CMMI has indicated that moving a **new** model program forward for the State of Maryland is increasingly unlikely given the implications of COVID-19 and competing priorities within the administration
- HSCRC staff have identified an existing policy structure, the Care Redesign Program (CRP), to implement EQIP
  - Discussions with the Center for Medicaid and Medicare Innovation (CMMI) this fall have been ongoing and there is indication that the program will be able to start as early as 1/1/2022
  - EQIP will not have direct adjustment to FFS physician payment but rather is shifting to incentive payments on top of regular FFS billing flowing from a CRP participating hospital
- While CRP is more traditionally hospital-focused, staff have designed a Track Template that is generally acceptable to CMS and maintains the following attributes of the original EQIP:
  - Physician ownership of performance
  - AAPM participation opportunities for previously excluded MD physicians
  - Alignment with other payers episode payment program
- In addition to maintaining attributes of the prior proposal, this alternative approach has allowed the HSCRC to change the program in ways that we think will make it more attractive for physicians

Maryland's Care Redesign Program

- The Care Redesign Program (CRP) is a voluntary program that started in 2017 under the Maryland All-Payer Model
  - The program grants Fraud and Abuse waivers to participants so that they may partner on care redesign and aligning financial incentives across hospitals and other providers
  - CRP provides Maryland hospitals the opportunity to provide incentives and resources to other providers in exchange for performance improving quality of care and reducing growth in total cost of care for Maryland Medicare beneficiaries.
  - Per the TCOC Model Agreement, the HSCRC can design and add new programs or "Tracks" within specified parameters
- CRP is considered an Advanced Alternative Payment Model (AAPM), meaning partnered providers may meet Qualified Payment Program standards and be eligible for additional Medicare payment incentives
- Currently, the HSCRC operates two CRP "Tracks":
  - Episode Care Improvement Program (ECIP): *Allows a hospital to link payments across their providers during an episode of care*
  - Hospital Care Improvement Program (HCIP): *Encourages hospitals to work with care partners to improve inpatient medical and surgical services*

Overview of Revised Episode Approach

EQIP as a Care Redesign Track

- While some policy changes are necessary to move EQIP into CRP, the program will remain a bundled-payment care transformation incentive as follows:

Summarized Changes to EQIP

Episode Design shift to Prometheus Grouper

Now upside risk only with new sharing mechanism

Removal of Global Budget Revenue (GBR) Savings Discount

Direct Multi-Payer Alignment and Participation Opportunity

Hospital EQIP Administration

- The CRP is based on hospital administration, thus, EQIP will entail more hospital participation than previously envisioned
- However, the new design aims to minimize direct hospital involvement in physician opportunity and performance in the program
- For the initial performance year, only one hospital will participate in EQIP
  - This hospital will aggregate administrative activities in the program, but will not receive financial benefit
  - The HSCRC will work with the hospital to enroll all interested participants and implement EQIP as a physician-driven care redesign program
- HSCRC staff is requesting a letter of interest from hospitals who may be interested in performing EQIP administration activities

EQIP Care Redesign Program Participation

“CRP Entity” or a Maryland hospital

- Will not trigger episodes or receive incentive payments in EQIP
- Signs a **CRP Participation Agreement** with CMS and the State
- **Pays incentive payments** or savings to physicians (reimbursed through their MPA for a net neutral impact to GBR)
- Along with the HSCRC, will facilitate reporting, Care Partner Enrollment and track **administration**

“Care Partners” or Specialty Physicians/Physician Groups

- **Triggers episodes** and **perform EQIP care interventions**
- Sign a **Care Partner Arrangement** with the CRP Entity
- Receives normal PFS payments and a potential “Incentive Payment” from the CRP Entity
- Will enroll in the program **independently or with a physician group** and submit required reports to the HSCRC
- 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**
- Adjusts the CRP Entity’s **Medicare Performance Adjustment** (MPA) to ensure payments a net neutral
- Will facilitate **Care Partner Enrollment**, Reporting and Learning Systems

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Convener Roles in EQIP Under CRP

- Convener entities will not be parties to the CRP Participation Agreement or involved in risk aggregation
- Staff will walk through some incentive structure changes that remove the need for risk aggregation
- Per the CRP structure, payments must flow from a hospital to a care partner

- **Physicians and Physician Group Practices may still independently contract with convener entities should they want support with data analysis, report aggregation, quality improvement and other clinical, financial or operational optimization practices**
  - HSCRC is committed to implementing reporting in a way that will facilitate Convener support to participating providers (e.g. Convener level aggregation and organization in reporting tools)

Allowable EQIP Interventions

- To enable incentive payments and resource sharing, CRP maintains a number of Fraud and Abuse waivers from Medicare Payment.
- These waivers require some documentation and reporting of specific activities to ensure that they are used with the intention of the program.
- As a part of CRP, physicians in EQIP will be required to report and perform allowable EQIP Interventions within the following categories:
  - Clinical and Care Redesign
  - Beneficiary and Caregiver Engagement
  - Care Coordination and Transitions of Care
  - Other Relevant and Approved Care Transformations

Multi-Payer Demonstration

- The HSCRC and CareFirst have aligned episode program definitions so that the Episodes of Care (EOC) program and EQIP can provide parallel incentives physicians who choose to participate
  - Prometheus episodes and methodologies will be utilized in both programs (although risk adjustment and reward sharing rules will be separate and different)
  - This will effectively increase the share of a specialist physician's patient panel where there is reward to control cost and quality, thus increasing program outcomes of cost containment and quality
  - The HSCRC hopes this will encourage other payers to start programs similar to EQIP and value-based payment programs operating in Maryland
- CareFirst and the HSCRC will maintain separate contracts and operations
  - However, efforts are ongoing to outline combined policy decision-making structures and other areas of recruitment alignment to increase the impact of both programs

Episode Structure and Gain Share

Episode Design – Shift to Prometheus

- EQIP will apply the Prometheus episode definition grouper to Medicare beneficiary claims
  - Will allow for more rapid alignment with the commercial space,
  - Lends clinical validity and vetting for code updates, and,
  - Add an opportunity to increase participation opportunity in EQIP rapidly with new specialty and episode types.
- Shift from TCOC to Related Costs where all services considered typical/routine and related to the procedure during episode timeframe are counted.
- Allows Care Partners in EQIP to achieve savings through specific episode definitions that identify opportunities to create savings from:
  - Potentially Avoidable Complications
  - Core Services that may be underutilized or missing in episodes
  - Potentially Avoidable Services (based on Choosing Wisely)
- **PY1 Episodes:** The HSCRC intends to keep the initial episode areas from the July Request for Information (Orthopedics, Cardiology, Gastrointestinal)
  - There may be additional episodes in the Prometheus suite in these specialty areas that are easily added

Episode Design – Shift to Prometheus, cont.

- **Future Performance Year Episodes:**
  - Prometheus currently does not have Emergency Medicine tailored episodes, though due to stakeholder interest the HSCRC hopes to work to develop some for PY2
  - Other specialists and interested clinicians should submit letters of interest for EQIP participation with Prometheus's other 97 episodes or other areas where they think episodes could be added
- **Episode Lengths :** Based on the clinical episode definition episode lengths 15-90 days post trigger and may include a pre-trigger window for cost inclusion.
  - E.g. Three days prior to the operation to capture pre-operation consults etc.
- **Exclusions:** Based on the clinical episode definition certain costs or beneficiaries may be excluded to stabilize episode the Target Price
- **Risk Adjustment:** HSCRC Staff are still determining whether to develop a risk adjustment methodology based on some combination of HCCs/APR-DRGs OR use Prometheus risk adjustment which flags for key ICD-10 codes that indicate comorbidities, behavioral risks, age etc. on an episode-specific basis.

Incentive Payment Methodology

Incentive Payments *in CRP mean a monetary payment made by the Hospital directly to a Care Partner solely for Allowable CRP Interventions actually performed on a Medicare FFS Beneficiary by the Care Partner during a Performance Period. I.e. the previously conceived Reconciliation Payments.*

Tiered Shared Savings Rate	HSCRC staff are exploring changing the EQIP Incentive Payments to a shared savings structure where any first dollar savings achieved under the Target Price will be shared between Medicare and physicians. The split or 'share' between Medicare and Care Partners will be based on a statewide ranking of the Care Partner's Target Price, or relative episode efficiency. EQIP previously proposed a 3% discount off of the Target Price where Care Partners first had to create 3% savings to Medicare before earning savings. This threshold has been eliminated. In addition, the proposed GBR discount has been eliminated. Staff are determining if a threshold should be set at which Care Partners must exceed a specific level of savings prior to earning an Incentive Payment. Once this threshold is met first dollars savings would be counted. This would help reduce the risk of paying savings for non statistically significant performance.
Dissaving Accountability	Direct collection of downside risk is not possible without the ability to directly adjust physician FFS payments. 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. If a Care Partner's Target Price is in the lower two terciles of the Tiered Shared Savings Rate (0-66th percentile), two consecutive years of dissavings will result in removal from EQIP.

Tiered Shared Savings Rate and GBR Effects

1. 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.
2. The Shared Savings split with Medicare will be based on the Care Partner's Target Price rank

Target Price Rank	Savings to Care Partner	Savings to Medicare
Up to 33rd percentile	50 percent	50 percent
34th – 66th percentile	65 percent	35 percent
66th + percentile	80 percent	20 percent

- These tiers and shares are not final, the HSCRC is still modeling the policy to ensure there is equitable distribution and no unintended impact.
- HSCRC staff developed this new methodology in response to RFI comments indicating that the GBR effect discount to savings was a deterrence to participation.
  - With Shared Savings, Medicare should recoup enough savings below the Target Price that offset any impacts of the GBR increasing costs for reduced regulated utilizations.
  - HSCRC staff plan to carefully monitor this dynamic and will make changes to future methodologies should there be an unintended effect.

Example: Incentive Payment Calculation

Care Partner Participating in two EQIP episodes

		Episode A	Episode B	*Calculation*
A	Baseline period Care Partner episode payment benchmarks	$15,000	$10,000	*Prometheus Grouper*
B	**Episode Target Price**	$15,000 (**35th percentile in State**)	$10,000 (**67th percentile in State**)	*A X 100% (**no discount**)*
C	Episode Volume, Performance Year	25	50	*Prometheus Grouper*
D	Performance Year episode cost	$14,300	$9,500	*Prometheus Grouper*
E	Aggregate actual performance year episode costs	$357,500	$475,000	*D X C*
F	Aggregate Savings/Dissavings Achieved	$17,500	$25,000	*(B-D) X C*
G	**Tiered shared savings rate**	65%	80%	*HSCRC Methodology*
H	Incentive Payment per Episode	$11,375	$20,000	*G X F*
I	**Total Incentive Payment Due***	**$31,375**		*Ep. A + Ep. B*

*Less dissavings from prior year (if any)
*Adjusted for Quality Performance Score

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Incentive Payment Distribution

1. The Care Partner will receive an Incentive Payment if the Calculated Savings is positive. Calculated Savings are the sum of:
   - Positive amounts by which Medicare expenditures for selected clinical episodes are below the Target Prices of those episodes
   - Negative amounts by which Medicare expenditures for selected clinical episodes are above the benchmark Target Prices for those episodes
   - Dissavings from a Prior Performance year

2. Aggregate incentive payments earned by Care Partners will be put into the CRP Entity's rates via the Medicare Performance Adjustment

3. The CRP Entity will send payments to Care Partners who earned Incentive Payments in the prior performance year

- There will also be a Physician Incentive Payment Cap is twenty-five percent (25%) of the Average Care Partner PFS Expenditures for the preceding calendar 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.

Next Steps

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Future EQIP Subgroup Topics and Timeline

- Please submit any comments on the new EQIP design and program to HSCRC Staff:
  - William.Henderson@Maryland.gov and Madeline.jackson@Maryland.gov
  - The EQIP subgroup will reconvene in late 2020/early 2021 based on additional feedback and stakeholder input
- Areas for Discussion
  - Updates to financial methodologies as analytics are finalized
  - Quality measure selection and methodology
  - Care partner enrollment, reporting and required documentation
  - Initial episode selection, new episode additions and developments

Early Spring 2021: Development and completion of episodes and methodologies (currently ongoing)
Late Spring 2021: Track template submission to CMMI, Commission Approval
Summer 2021: Operations, monitoring and learning system development
Fall-Winter 2021: Care Partner Arrangements developed and signed
1/1/22 Start: Care Partner participation opportunity would remain quarterly.