



Maryland Chapter

AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

ED Episode Quality Improvement Program

JULY 2022

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EQIP in Maryland

Starting 1/23, **first-ever govt APM in EM**. Similar to ACEP's AUCM model. All MD EDs eligible. The hope is for all EDs in Maryland to participate.

Shared savings for lowering 14-day total cost of care for participating physicians. Baseline period = 2019 visits; Performance period = 2023 visits. Tailwind = Secular trend in declining admit rate

Episodes are 535 ICD-10 codes where there is variation in the decision to admit (e.g. chest pain, syncope) ~27% of visits. EDs "win" by safely lowering admissions through protocols and feedback

Applies to Medicare FFS currently. Open question: Will CareFirst participate? This should be known within the next 3-4 weeks.

Recommended Operational Strategy : 1) Clinical protocols, 2) Clinician dashboard, 3) Coaching
Recommended Comm Strategy: 1) Clinician, 2) Leadership, 3) Hospital.

Developed in partnership with MD ACEP, HSCRC, Maryland Hospital Association, and MedChi (MD Medical Society)

Maryland's ED EQIP Program

Administered through HSCRC through CMS waiver, is a physician-centric payment model (NPI)

Aligns with goals of MD GBR to lower TCOC

- MD GBR has been the most successful APM (NEJM 2021)

Was built in long-term partnership and led by emergency physicians

- MD ACEP, MHA, MedChi, HSCRC

UMMS is “administrative partner”. Hospital where pts are seen is not involved

- EM docs lobbied heavily for this structure

Change Healthcare provides a dashboard with 6-8mo delay on claims

- So...would recommend creating a structure to assess in real-time

Maryland's ED EQIP Program

535 ICD-10 trigger dx diagnosis are eligible (see next slide)

2023 Medicare FFS visit with trigger dx

14-day total cost of care (TCOC) monitored by HSCRC

Calculation of average TCOC in Baseline period (2019) v. Performance period (2023)

Hospitals gets 1st dollar shared savings

- Proportion of savings is 20%, 50%, or 80% depending on baseline “efficiency” – ie if target prices are low, shared savings will be at a higher % and vice versa
- Payout starts after a 3% savings is achieved – ie if savings is 1% or 2%, no payout
- Program is upside only, no downside risk. Program is voluntary, no plans to make this mandatory

Serves as an “AAPM” for CMS QPP program

- Docs are not in MIPS

535 ICD-10 diagnoses (~27% of visits)*

Abd pain	Hyperglycemia
COPD/Asthma	Hypertension
Atrial fibrillation	Nephrolithiasis
Chest pain	Pneumonia
Deep vein thrombosis	Shortness of breath
Dehydration / electrolyte derangements	SSTI
Diverticulitis	Syncope
Fever / fatigue / weakness	UTI

*This list of diagnoses was chosen through a rigorous process with Dr. Pines, his team, and vetted by MD ACEP leadership. Publication pending shows that this list of diagnosis is stable within EDs over time AND stable within clinicians allowing for use in feedback

Key dates and actions

As of July 20, 2022, each hospital / healthsystem should be able to upload NPIs into HSCRC portal to get baseline pricing (contact HSCRC for details if you don't have this)

The final date for uploading NPIs is September 2, 2022

Program starts January 1, 2023 and runs to December 31, 2023

Portal will be available through Change Healthcare with a 6-9 delays on claims

Keys to Success in ED EQIP

Clinical protocols to decrease testing and admission variability

- E.g., HEART pathway for chest pain

Facilitate post-ED care

- Work with hospital/groups/community for improved continuity of care
- Cardiology follow up programs
- Wound care referrals
- Follow up with high risk patients (post-discharge phone calls or surveys)

Benefits of participation

Financial: Large, upside only! Eliminates MIPS risks, costs

Reputational: Local focus on innovation

Quality improvement: Develops practice change muscle and prep for inevitable future of VBC

Hospital alignment: 100% aligned with GBR

EQIP APM vs. MIPS: It's better than MIPS!

EQIP APM

Shared Savings Example

- 5k patients included in model
- Target price \$2500
- Lower by \$200 per patient
- Get 50% of reduction = \$500,000

No downside risk in the first year

Included ICD-10s selected by ED clinicians

MIPS

9% Potential upside of MIPS

- Max \$500 million for everyone in program

9% Potential downside risk of MIPS

- Likely a large absolute amount given more patients included than in APM

Measures can be hard to influence from an ED perspective

EM Cost Measure 2025 will hold EM clinicians responsible for post-discharge costs

Contact info

If you would like to learn more about the program, please contact Dr. Jesse Pines

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