maryland
health services
cost review commission

EQIP Subgroup

November Meeting

11/17/2023

Agenda

- AAPM and MIPS Overview (Premier)
- PY3 Administrative and Enrollment Updates
- Performance Year 4 Episode Grouper

PY 3: Administrative and Enrollment Updates

Enrollment Update for Performance Year Three

Enrollment as of November 1st:

- 4,569 Care Partners
- Representation from 41 specialties
- 129 EQIP Entities
- *Final participation will not be determined until 1/1/24

Through the end of 2023, the HSCRC and CRISP will work with participants to:

- Finalize CMS vetting status and eligibility
- Adjust Care Partner list as determined by eligibility audit
- Complete contracting and payment operations with UMMC

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EQIP Enrollment Process

September 1st , 2023

- Deadline for Submission of Care Partners in EEP for CMS vetting

September 2023

- EQIP Entities finalize their episode and intervention selection
- EQIP Entities may split or combine with others if their Care Partners were included in vetting to CMS

October 2023

- CMS Vetting Results are available in EEP
- Care Partner Arrangements Distributed

October – December 2023

- EQIP Entities follow-up with their Care Partners to ensure Arrangement signature

December 15th 2023

- All Care Partners who signed their Arrangement will be determined ‘enrolled’
- Care Partners who do not sign their Arrangements are removed from EQIP Entities for Performance

Care Partner Arrangement – PY3

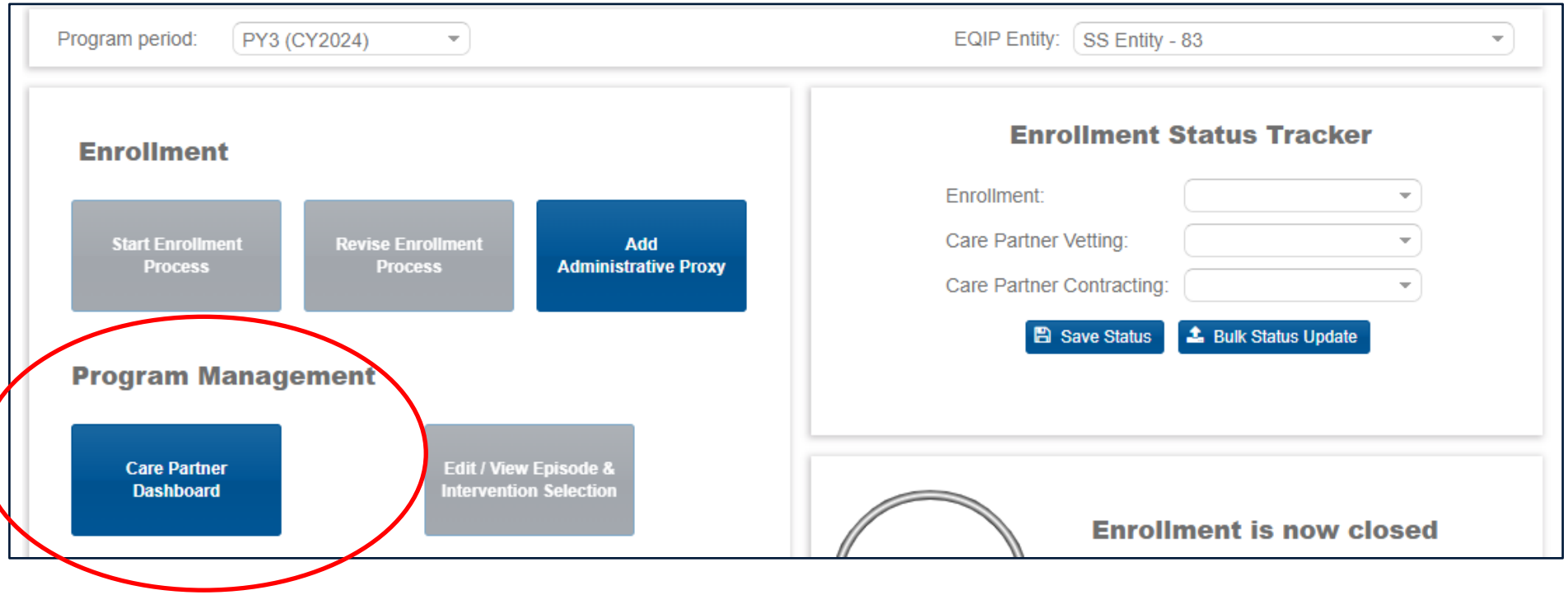
- All Care Partners will be required to sign a Care Partner Arrangement

- Care Partner Arrangements were sent out to EQIP Entity Lead Care Partners and Administrative Proxies starting 11/6
  - Each entity received a unique link to access a SharePoint folder
  - Contracts are be pre-filled and standardized across the state
  - LCP and APs will be responsible for disseminating information to individual Care Partners
  - Electronic signatures are accepted, and full CPA must be returned

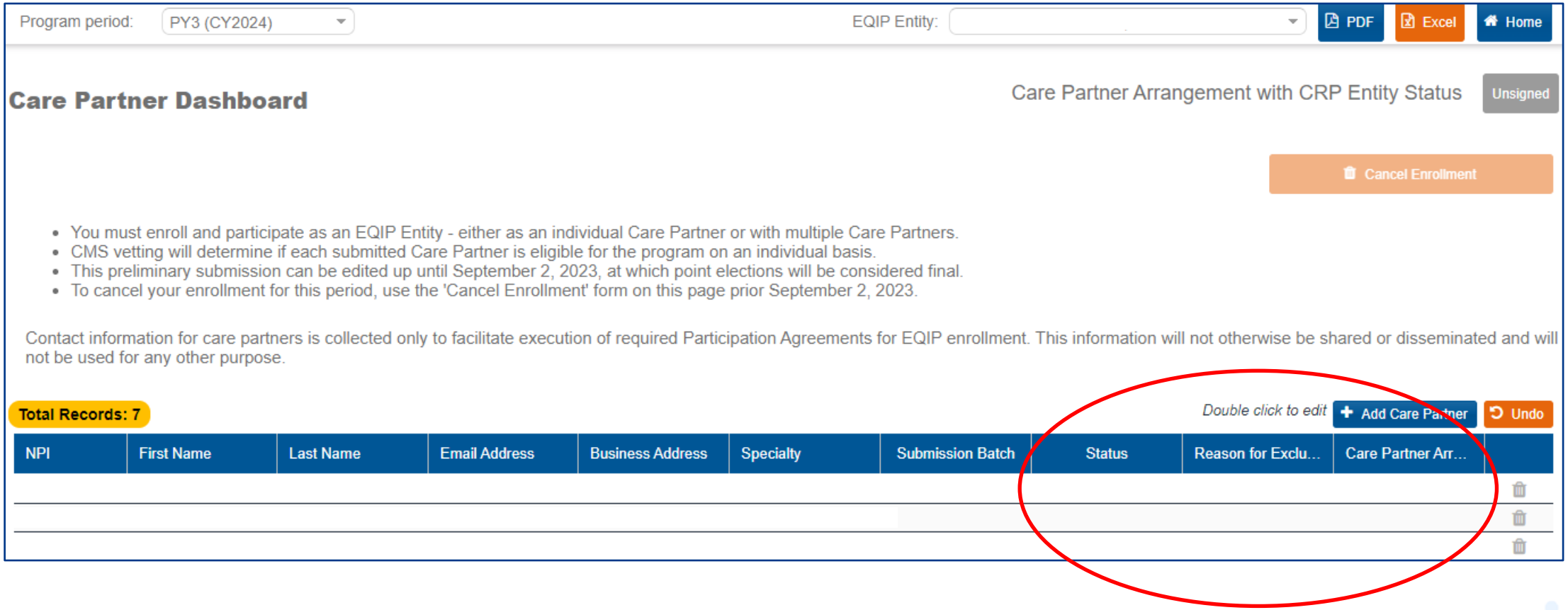
Signed copies must be sent to EQIP@umm.edu prior to December 15, 2023

Care Partner Arrangement – Status

LCP and APs can view the status of their Care Partners in the EQIP Entity Portal (EEP)



Care Partner Arrangement – Status



CMS Vetting and Care Partner Arrangement Status are updated weekly

Final Eligibility Audit and Probation Status

- Dec 2023: PY2 Care Partners Final Probation Status
  - Care Partners on Probation in PY2, who did not touch a claim during PY2 Q1-2 will no longer be eligible for PY3 . Care Partners can re-enroll for PY4.
- Jan 2024: After CPAs have been returned HSCRC/CRISP will run a final eligibility audit and communicate probation status:
  - Volume Thresholds: Due to the composite of final Care Partner lists, some entities may fall below threshold for certain episodes.
  - Claim Threshold: EQIP Entities must have at least 75% of their enrolled Care Partners with at least one claim included in an episode's window for the baseline period (CY 2019).
  - Quality Metrics: If Entity did NOT meet minimal quality performance during baseline period, entity will be placed on probation.

PY4 Episode Development

Performance Year Four (CY2025) Episode Development Process

Fall/Winter 2023

- Stakeholder Input into Episodes of Interest
- Analytic Plan development

Winter 2024

- PY4 Episode Policy Design
- CMMI Approval of new Episodes

Spring 2024

- PY4 Recruitment and Episode Education

July 2024

- PY4 Enrollment Opens for new Care Partners and EQIP Entities

Additional Episode Development

- We welcome ideas from other stakeholders. In order to develop an episode, stakeholders will need to identify:
  - A list of triggering procedures or diagnosis
  - Included and excluded costs for the episode

- The HSCRC is committed to working with all interested stakeholders, but we have limited bandwidth.
  - We anticipate adding 1-2 new episodes per year
  - We will prioritize based on the number of interested physicians

PY4 Episode Grouper

Prometheus Contract Ends Dec 2024 – What Next?

PROMETHEUS Considerations

- Development since 2006, currently acquired by Change Healthcare (part of Optum)
- 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
- Alignment with CareFirst's episode program
- Detailed grouper methodology is a 'black box'
- Prometheus episode development has stalled. HSCRC must create custom episodes outside of the 97 available.
- Limited to quarterly data runs for performance data
- CareFirst's considering future strategy

Patient-Centered Episodes of Care System (PACES)

- Independent, 501(c)(3) organization operating in a community model on the following principals:
- Governance: PACES is led by a dedicated leadership team and governed by a non-profit board of directors comprised of healthcare industry experts.
- **Transparency:** All episode definitions are open-source, and all the details of the grouping logic are available. There is no "black box.“
- The sole focus of the PACES Center is on developing a clinically sound episode grouper in collaboration with the clinical community and market stakeholders and keeping it up to date over time
- PACES is *NOT* a software as a service offering, nor will we be developing business intelligence/analytic applications, beyond the episode definitions and the associated grouper business rules

PACES – Episodes of Care

- There currently are 1,090 PACES procedural, chronic condition, and acute condition episodes in various stages of refinement
  - 90 are considered finalized and fully deployable
  - 100 are in queue to be finalized withing the next 12 months
- All the episodes are grouped into 15 Clinical Chapters based on their clinical domain
- The 33 PY3 Prometheus clinical episodes align with finalized deployable PACES episodes
- PACES convenes expert clinical panels in all relevant specialties to review the detailed codes for every episode
  - Clinical experts who are willing to spend 2-3 hrs can assist with finalizing episodes that are not currently deployable
- HSCRC/CRISP can run monthly performance reporting using PACES definitions

Current Fully Vetted Episode Inventory

PROCEDURES = 41

Cardiology/CV
- Cardiac Catheterization
- CABG
- Percutaneous Cardiac Intervention
- Open Heart Valve Surgery
- Pacemaker Insertion

General Surgery
- Mastectomy
- Ventral Hernia Repair
- Inguinal Hernia Repair
- Breast Reconstruction

GI
- Cholecystectomy
- Colonoscopy
- Colectomy
- EGD Endoscopy
- Bariatric Surgery
- ERCP
- GE Reflux Surgery

GU
- TURP
- Prostatectomy
- Urinary Endoscopy

OB/GYN
- Colpopexy
- Colporrhaphy
- C-section
- Vaginal Delivery

Ophthalmology
- Cataract Surgery IOL
- Cataract Surgery Secondary Membranous
- Glaucoma Surgery
- Retina and Vitreous Procedures
- Retina/Choroid Destructive Therapy

Ortho Surgery
- Hip Replacement
- Knee Replacement
- Shoulder Arthroscopy/Rotator Cuff Repair
- Shoulder Replacement
- Lumbar and Sacral Spine Surgery
- Fracture/Dislocation Treatment Pelvis/Hip/Femur
- Repair Fracture/Dislocation of Arm, Wrist, Hand
- Repair Fracture/Dislocation of Lower Leg, Ankle, Foot

Thoracic Surgery
- Lung Resection

Vascular Surgery
- Leg Vein Ablation
- Leg Revascularization
- Leg Vein Angioplasty
- AV Fistula Creation and Revision

CONDITIONS = 48

Cardiology
- Acute MI
- HF Acute
- HF Chronic
- IHD
- Atrial Fibrillation/Flutter Acute
- Atrial Fibrillation/Flutter Chronic
- Chronic HTN, Essential
- Chronic HTN, Secondary

Endocrine
- Diabetes
- Osteoporosis

ENT
- Sleep Apnea
- Acute Sinusitis
- Chronic Sinusitis

GI
- Chronic Cholecystitis
- Diverticulitis of Colon
- C-Difficile Colitis
- Acute Cholecystitis
- Acute Intestine Perforation
- Chronic Esophagitis
- Acute Peptic Ulcer
- Chronic Peptic Ulcer
- Acute UGI Bleed/Hemorrhage
- Chronic UGI Bleeding Other

Hematology
- Acute DVT Extremity
- Chronic Anemia

ID
- Cellulitis

Musculoskeletal
- Osteoarthritis
- Spine Stenosis/Spondylosis, Cervical
- Low Back Pain
- Spine Stenosis/Spondylosis Thoracic

Neuro
- Acute Ischemic Stroke
- Parkinsons DX

OB/GYN
- Pregnancy

Oncology
- Colon Ca
- Lung Ca
- Breast Ca

Ophthalmology
- Macular Degeneration

Primary Care
- UTI
- Diabetes

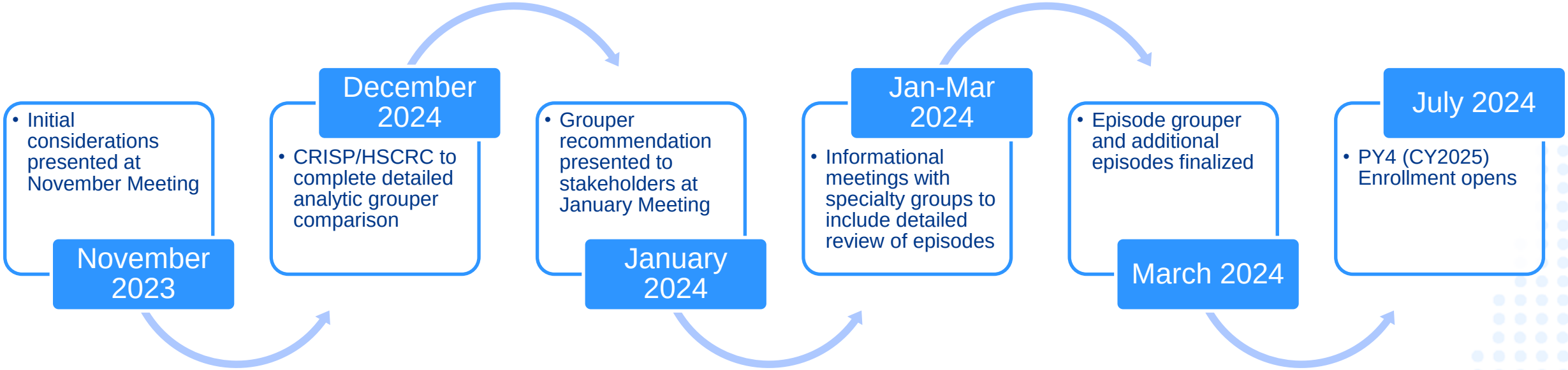
Pulmonary
- Acute URI
- Acute PE
- Pneumonia
- Asthma
- COPD

Rheumatology
- Rheumatoid Arthritis
- Osteoarthritis

Vascular
- Abd Aneurysm
- Thoracic Aortic Aneurysm
- Peripheral ASVD
- Varicose Veins (Venous Insufficiency Varicosities)

PACES
Patient Centered Episode System

Episode Grouper Decision Timeline



Resources

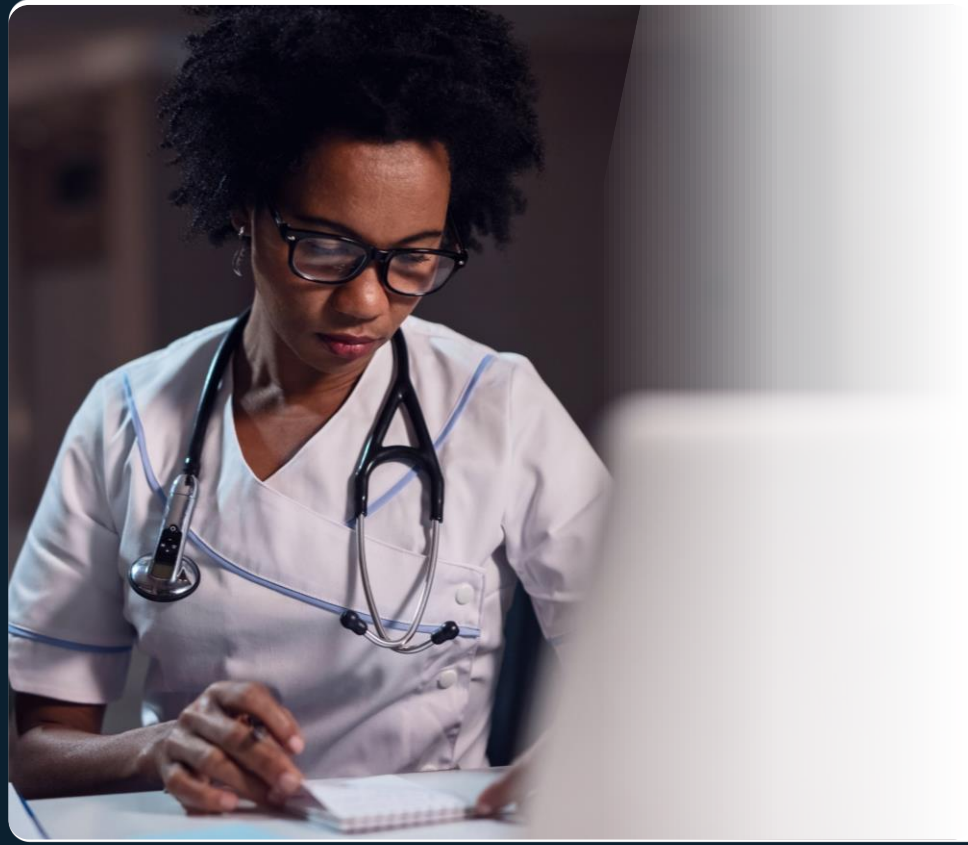
- Prometheus Grouper:
  - http://prometheusanalytics.net/deeper-dive/definitions-readable
- PACES Grouper:
  - https://www.pacescenter.org/episodes-of-care
- EQIP Contact:
  - eqip@crisphealth.org

Thank you!

Quality Payment Program (QPP)
Overview

Seth Edwards, Vice President, Strategic Collaboratives
Bryan Smith, Principal, Innovative Design, Economic & Analytic Services

Quality Payment Program (QPP): Refresher



MDPCP sunsetting Track 1 presents an opportunity to re-exam QPP/MIPS participation

THESE DECISIONS ARE CRITICAL AS EACH PROVIDER EVAUATES ENTERING TWO-SIDED RISK

- Value-based Care Trends: 2023 and beyond
- QPP program review
- QPP options: Traditional MIPS, MIPS-APM & Advanced APM

* Unblinded peer-to-peer benchmarks only available with PHMC Advanced membership.

CMMI Strategy Refresh

Drive Accountable Care

- ✓ Total cost of care
- ✓ Focus has shifted from providers taking on risk → more beneficiaries in value-based care
- ✓ Use of MSSP as an innovation platform
- ✓ Integration of bundles into ACOs (or "shadow bundles")

Advance Health Equity

- ✓ New health equity requirements around reporting and screening
- ✓ New payment incentives to address historical underutilization
- ✓ Lowering barriers to provider participation – safety net providers

Support Innovation

- ✓ Adoption of more patient-reported outcome measures
- ✓ Focus on sharing data to support care coordination and addressing disparities in care

Address Affordability

Potential for:

- ✓ Models focused on drug pricing
- ✓ New waivers around beneficiary cost-sharing

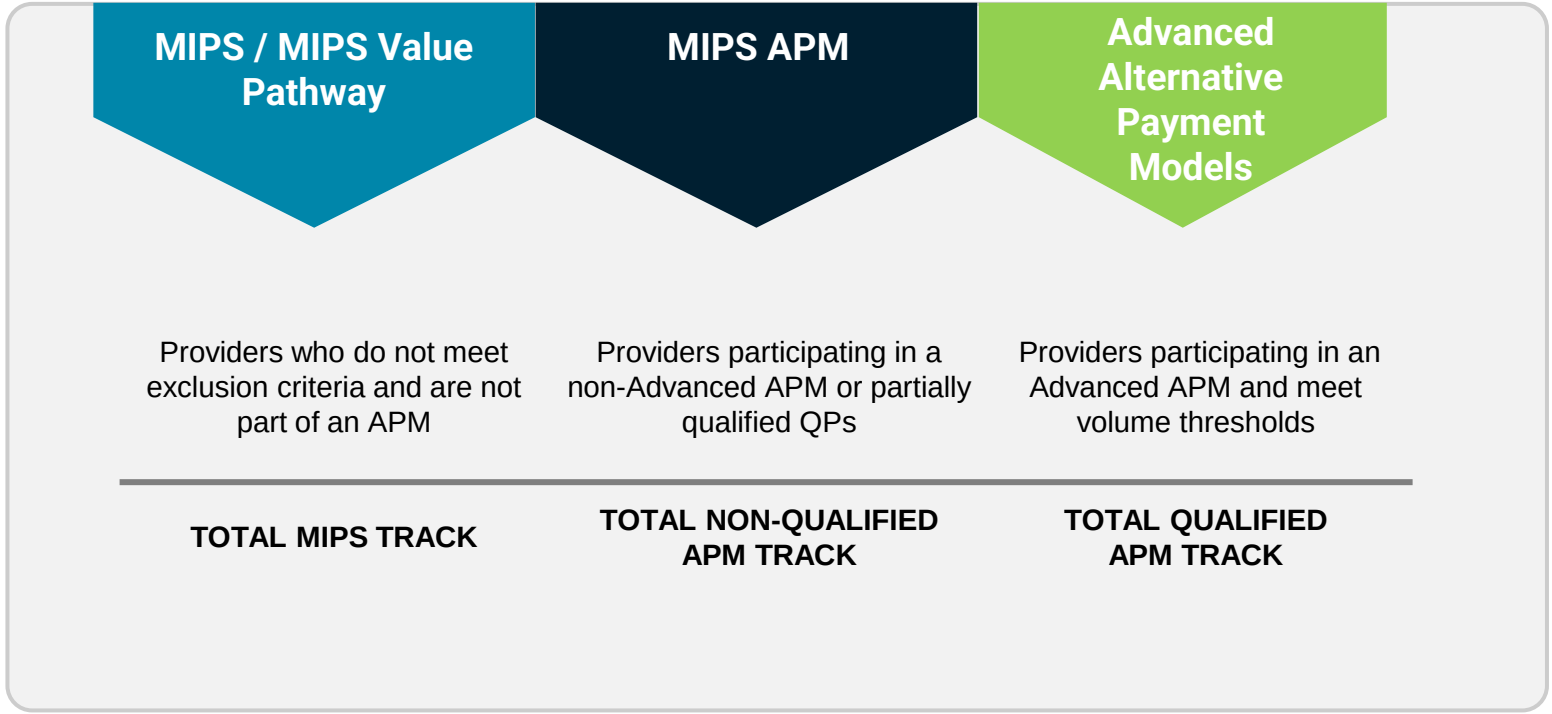
Partnership

- ✓ Roadmap for multi-payer alignment
- ✓ Data transparency
- ✓ Input from stakeholders – including patients/caregivers – early in model design

Potential Models on the Horizon

- ➢ Advanced primary care model
- ➢ Mandatory bundled payment model

QPP Options & Considerations



QPP MIPS: Overview

01

WHAT'S MIPS?

The Merit-based Incentive Payment System (MIPS) governs how clinicians will be reimbursed for Medicare Part B fee-for-service revenue moving forward.

Clinicians submit patient care data under four categories:

Quality
Evaluates clinicians on self-reported performance outcomes

Promoting Interoperability (PI)
Promotes patient engagement and electronic exchange of health information using 2016 CEHRT

Improvement Activities (IA)
Rewards clinicians for patient-centered activities that improve health outcomes

Cost
Measures the resources used to care for patients and the Medicare payments per episode of care

Merit-based Incentive Payment System (MIPS): Eligibility & Timeline

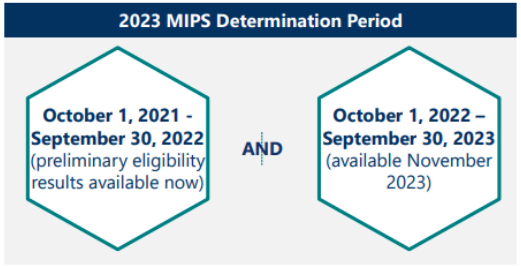
Exclusions from MIPS

- New Medicare-enrolled eligible clinicians
  - Enrolled during the performance year
  - Not previously part of a group or billing under a different TIN
  - Eligibility determined quarterly
- Clinicians below the low-volume threshold
  - Less than $90,000 in charges **OR**
  - Provides care for fewer than 200 Beneficiaries **OR**
  - Provides provide fewer than 200 services

MIPS Eligible Clinician Type

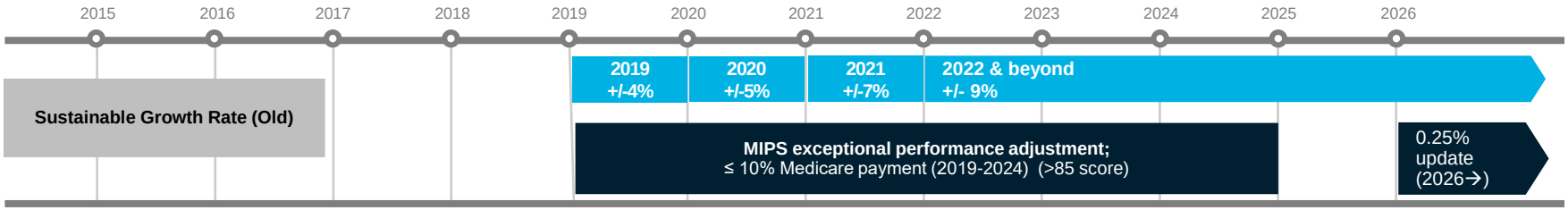
- Physicians (including doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry)
- Osteopathic practitioners
- Chiropractors
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Physical therapists
- Occupational therapists
- Clinical psychologists
- Qualified speech-language pathologists
- Qualified audiologists
- Registered dietitians or nutrition professionals
- Clinical social workers
- Certified nurse midwives

Timeline



CY 2023 Performance Year
CY 2024 Data Submission & Feedback
CY 2025 Payment Adjustment

QPP: 2023-2024



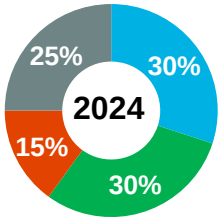
CY 2024 is performance period for 2026 payment. Quality/Cost- Full year; PI/Improvement- any continuous 180 days

- **Quality** — Quality Measures, Readmissions
- **Cost** — MSPB, Total Per Capita Cost, Episode-Based Cost Measures
- **Improvement activities** — Expanded access, population management, care coordination, beneficiary engagement, patient safety, social and community involvement, health equity, emergency preparedness, behavioral and mental health integration and Alternative Payment Models.
- **Promoting Interoperability (PI) Performance Category** — e-Prescribing, Health Information Exchange, Provider to Patient Exchange, Public Health and Clinical Data Exchange

- **Sets performance targets in advance, when feasible**
- **Performance threshold will remain at 75 points in 2024**

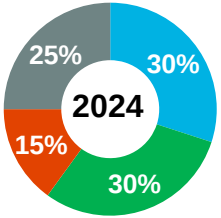
Traditional MIPS

Individuals, Groups, Virtual Groups



MIPS Value Pathways (MVPs)

Individuals, Groups, Virtual Groups



2023 MIPS Scoring Components

Quality	Cost
• 30% of MIPS final score • 12-month performance period. • Total of 198 quality measures; select 6 individual measures	• 30% of MIPS final score • 12-month reporting period • CMS retrieves data from claims • Up to 25 cost measures for 2023
Improvement Activities	**Interoperability**
• 15% of MIPS final score • 90 continuous days minimum • 106 improvement activities • Attest to between 1 and 4* activities to earn the full points	• 25% of MIPS final score • 90 continuous days minimum • Performance-based scoring • Requires 2015 Edition Cures Update CEHRT

*Small practices, non-patient-facing clinicians, and/or clinicians located in rural or health professional shortage areas (HPSAs) receive 2 times the points for each activity in traditional MIPS. These clinicians report on no more than 2 activities to receive the highest score.

MIPS Projected Results

Projected 2023 MIPS Participation and 2025 Payment Adjustments

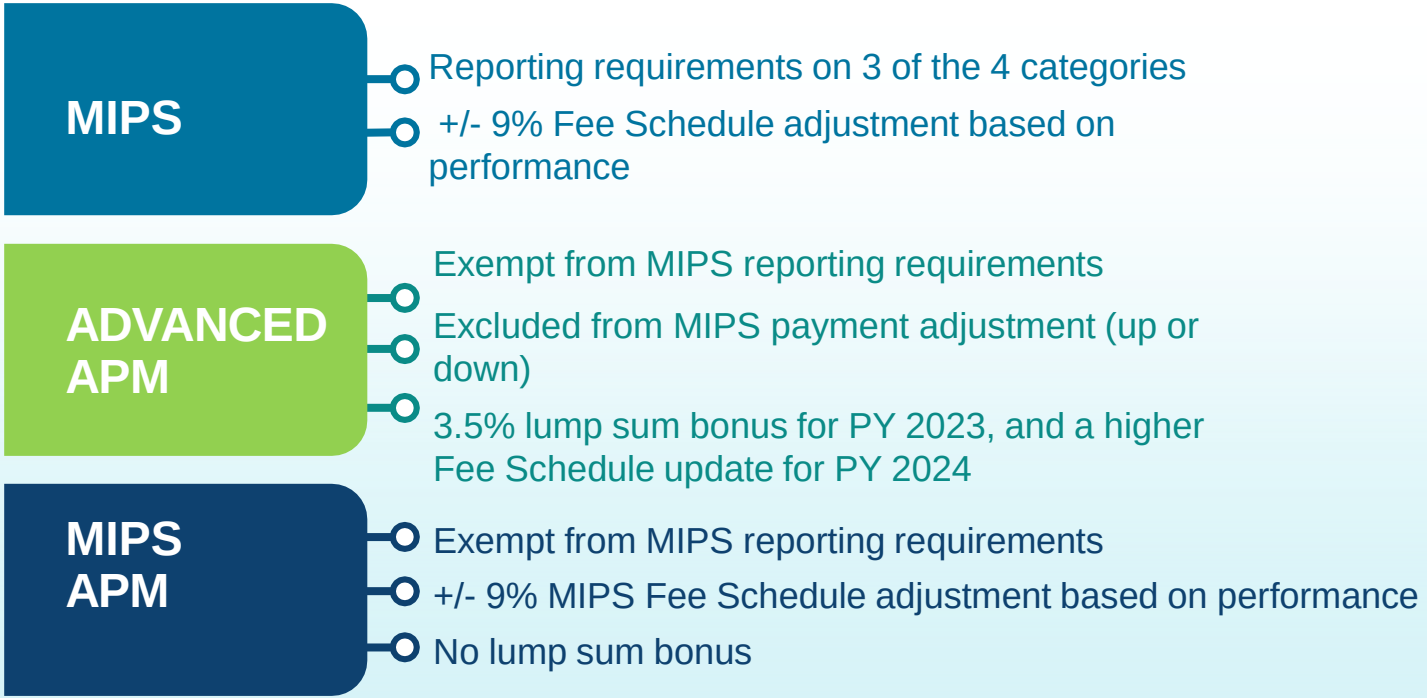
CMS estimates that 719,516 physicians and qualified health care professionals will be MIPS eligible in the 2023 performance period.

- Two-thirds of MIPS eligible clinicians who submit some data to CMS would receive a positive or neutral payment adjustment

Average positive payment adjustment is estimated to be	**3.71%**
Average penalty is estimated to be	-1.81%
Maximum bonus would be	**6.09%**
Maximum penalty would be	-9.00%

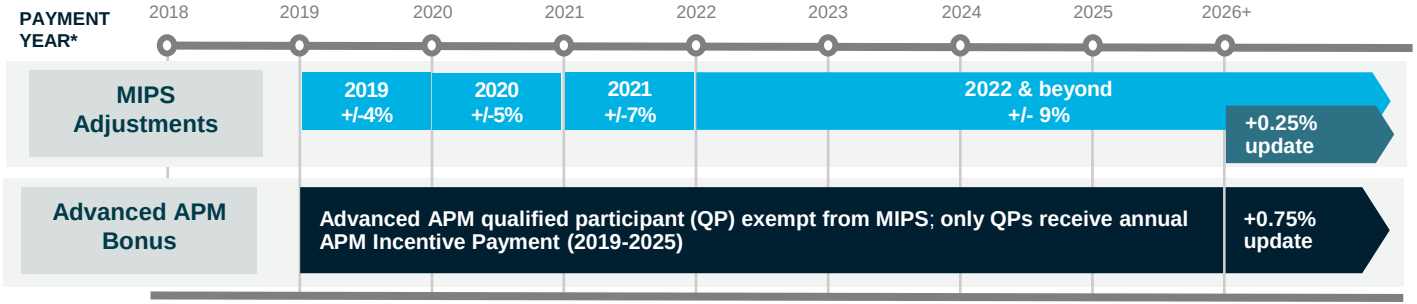
https://www.ama-assn.org/system/files/2023-pfs-qpp-final-rule.pdf

QPP Options & Considerations



Advanced APM Incentive Payments

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) incented adoption of advanced alternative payment models (APMs) by **providing clinicians in advanced APMs an incentive payment.**
  - MACRA originally set the incentive payment at 5% for Payment Years 2019-2024 (based on 2017-2022 performance)
  - Congress recently extended the incentive payment for Payment Year 2025 (based on 2023 performance) at a lower rate of 3.5%
- **Advanced APM Incentive Payments are set to expire this year** – 2023 is the last performance year with payment in 2025
  - ➢ **Premier continues to advocate for a multi-year extension of the Advanced APM Incentive Payments at 5%**
- **Beginning in Performance Year 2024 / Payment Year 2026,** incentive structure under the Quality Payment Program (QPP) for eligible clinicians in Advanced APMs (+0.75%) stands in contrast to MIPS eligible clinicians (+0.25% plus maximum adjustment of +9%)



*For both the Advanced APM Bonuses and the MIPS Adjustments, the payment year is two years after the measurement period. As a result, 2023 is the last performance year for the Advanced APM Bonus

Advanced APM Track

Eligible clinicians participating in Advanced APMs that meet certain criteria are considered

Qualifying APM Participants (QPs):

When bearing more than nominal financial risk

QPs receive the following benefits, which include burden reduction and financial incentives:

- Exclusion from MIPS reporting
- Exclusion from MIPS payment adjustments
- For performance years 2017 – 2022, a 5 percent APM Incentive Payment
- For performance year 2023, a 3.5 percent APM Incentive Payment
- For performance years 2024 and beyond, an increased physician fee schedule update based on the QP conversion factor

To be considered Advanced APM, entity must:

1. Use certified EHR technology,
2. Pay based on MIPS comparable quality measures,
3. **Bear more than "nominal" financial risk for losses OR be a Medical Home Model**

Clinicians who do not achieve the full threshold may be eligible as **Partial QPs** if meet lower thresholds

- Can choose not participate in MIPS (i.e., do not report to MIPS and do not receive a MIPS payment adjustment)

Advanced APM Track - Maryland

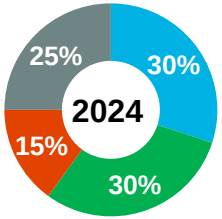
Qualifying Maryland Programs

In Maryland, the following programs qualify as a pathway to obtaining Qualifying Alternative Payment Model (APM) Participant (QP) status under an Advanced APM:

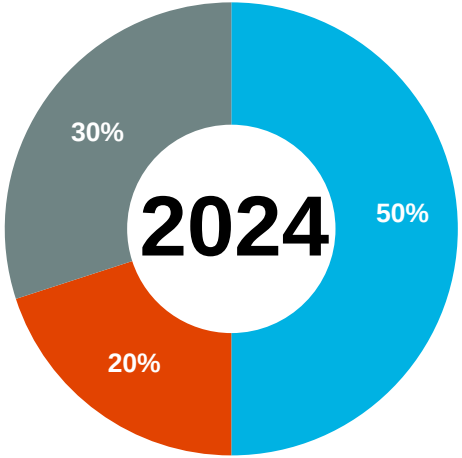
Episode Care Improvement Program (ECIP)
Episode Quality Improvement Program (EQIP)
Maryland Primary Care Program (MDPCP), Track 3 Only

Preferential Treatment As MIPS-APM

Traditional MIPS



MIPS-APM



Preferential MIPS-APM Scoring

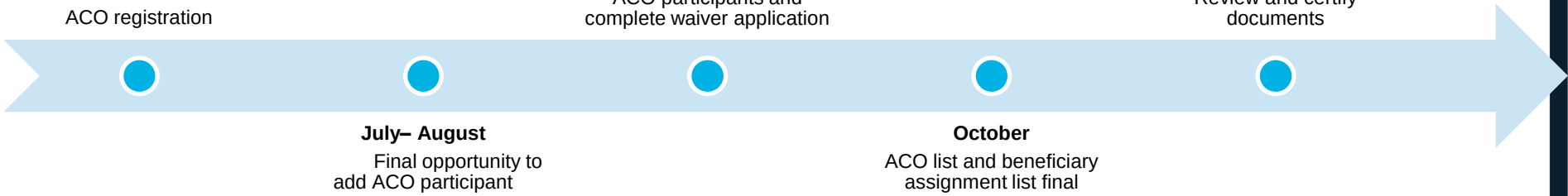
Interoperability: Score based on ACO in aggregate
Quality: Calculated using ACO quality scores
Improvement: Automatic 100% score
Cost: Removed and Remaining Sections Reweighted

MIPS-APM Advantages

- Qualifies for a +/- 9% fee schedule adjustment
- Not missing out on the lump sum for Advanced APM – it was discontinued
- MDPCP track II qualifies
- Two-side risk not required
- Historically, MIPS-APM is the best performing QPP track
- Cost and Improvement removed, leaving only Interoperability & Quality
- No induvial reporting
    - Reporting completed through the ACO

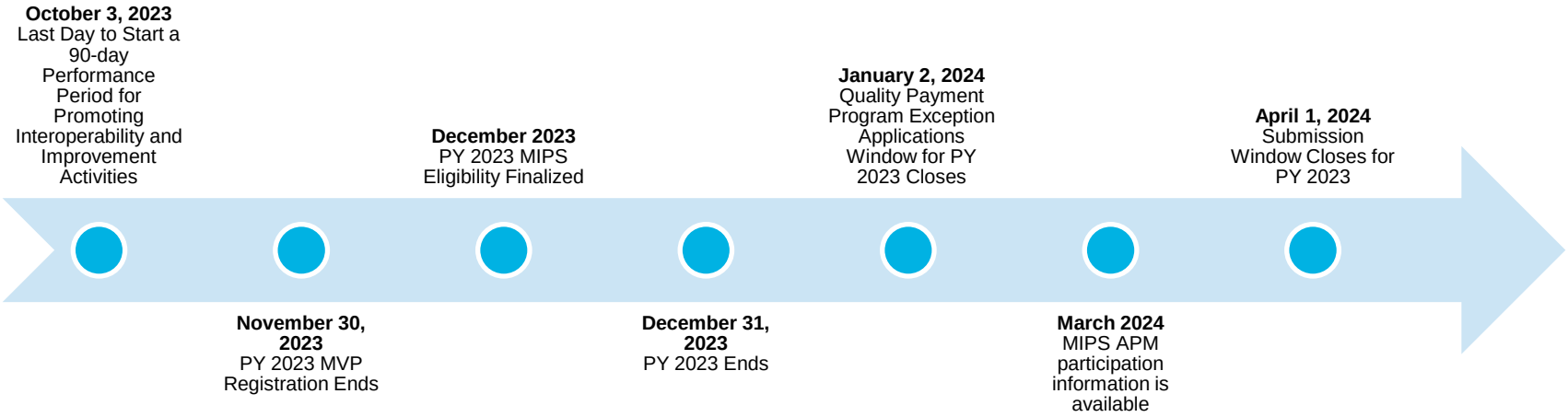
Timeline for Decision Making: ACO

ACO



Timeline for Decision Making: QPP

QPP



Premier Strategic and Performance Improvement Collaboratives

100 Top Hospitals / QUEST

This Collaborative enables member organizations to be data driven, focused on continuous process improvement. Members perform 29% better in receiving value-based purchasing incentive payments than like peers*1* and perform 12% better in the Centers for Medicare & Medicaid Services' Hospital Quality Star Ratings

Population Health Management

Medicare ACOs in our Population Health Management Collaborative have outperformed others nationally achieving a higher rate of shared savings and better quality outcomes. Leverages claims data.

Bundled Payments

Designed to support member hospitals and health systems in their participation in episodic payment models, with CMS or other payers. Leverages claims data.

Perinatal

Leveraging unparalleled analytics and operational expertise, we work side-by-side with hospitals to transform their overall perinatal outcomes. Uses QA data.

Health Equity

Designed to support members on their journey of addressing health equity and implementing sustainable models to support the social determinates of health. Uses QA data.

Workforce Innovation Network

Designed to leverage Premier's proven Collaborative methodology to support the continued approach to address short-term workforce issues, while working to innovate to prepare for the workforce of the future.

QUESTIONS?