

**Request for Information:
Maryland Episode Quality Improvement Program (EQIP)**

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Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

CMMI recently notified the State that, due to COVID-19, EQIP will not be operational by January 1, 2021. The new targeted start date is July 1, 2021 (subject to further delay). Future materials will reflect a revised timeline.

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A. Background

The State of Maryland (“State”) is at risk for the total cost of care (“TCOC”) for Maryland Medicare fee-for-service (“FFS”) beneficiaries under the TCOC Model with a commitment to achieve \$1 billion in TCOC savings cumulatively during the first five years of the Model. Currently, the TCOC Model has three Maryland-specific programs that are components of the Model test. These include the Hospital Payment Program, under which hospitals are paid based on a global budget; the Care Redesign Program (“CRP”) for hospital-led care transformation efforts; and the Maryland Primary Care Program (“MDPCP”).

B. Purpose of Episode Quality Improvement Program (EQIP)

Maryland providers and suppliers are excluded from federal Center for Medicare and Medicaid Innovation (“CMMI”) episode payment models that include hospital costs in episode prices, including the Bundled Payment for Care Improvement Advanced (“BPCI Advanced”) Model, the Oncology Care Model, and the proposed Radiation Oncology Model, because of the uniqueness of the State’s hospital global budgeting system. Maryland providers and suppliers require different target pricing approaches from those used in national models to take into account the capitated payments for Regulated Maryland Hospitals under the TCOC Model. As a result, the State has proposed the Episode Quality Improvement Program (“EQIP” or “Program”), a new initiative that would be included as a component of the TCOC Model, would account for the unique Regulated Maryland Hospital payment structure in setting target prices, and allow for non-hospital provider participation in episode payment models.

EQIP is a voluntary program that will engage non-hospital Medicare providers and suppliers in care transformation and value-based payment through an episode-based approach. EQIP will hold participants accountable for achieving cost and quality targets for one or more Clinical Episodes (“EQIP Tracks”), each of which will incorporate a specified alternative payment arrangement. The first Performance Year (“PY”) of EQIP will cover a range of initial Clinical Episodes in the specialty areas of emergency department, cardiology, gastrointestinal (“GI”), and orthopedics.

The appendix to this document includes extensive detail on the proposed program including additional state-wide cost information not previously shared for many of the proposed episodes (Attachment 3).

C. Request for Information

As a component of EQIP development, the State is releasing this Request for Information (“RFI”) to Maryland stakeholders who may provide insight into the design and structure of the Program. Specific topics are listed below.

This is not an official document or Program announcement from CMS and, as such, details included are subject to change. Official guidance and Program announcements will be developed

by CMS with dissemination help from the State. For further details on program timing, please consult Section III.C of this document.

The State is interested in obtaining feedback on the following topics; respondents should feel free to address some or all questions in their response (the section references are located in the Appendix):

1. Are the proposed Y1 episodes listed in Section II.B viable? Are the episode lengths appropriate?
2. Are the trigger code lists for these episodes, listed in Attachment 1 to the Appendix, complete and accurate? Are there additional restrictions that should be applied to exclude outlier episodes — either by refining the episode definition or excluding certain beneficiary categories?
3. Are there any additional considerations the State should address in the target price calculation methodology described in Section II.B.2?
4. What are the respondent's preferences regarding the various approaches to handling episode run-out described under Section II.B.4?
5. While the State will not add any other episode categories for Y1, we are interested in recommendations for new episode categories (e.g., oncology and radiation-oncology) and specific episodes within those categories (e.g., colon cancer) to add in year 2 (CY22). Should the State add episodes related to chronic conditions like Osteoarthritis or Crohn's disease? Does the respondent have suggestions about how to design these proposed Year 2 episodes?
6. Does the respondent have other thoughts regarding the proposed program that the State should consider?

THE STATE ASKS THAT STAKEHOLDERS RESPOND TO THIS REQUEST FOR INFORMATION ON, OR BEFORE, APRIL 23, 2020. RESPONSES WILL BE RECEIVED AT THE INBOX

MD.AID@MARYLAND.GOV.

Comments received after April 23, 2020, will also be taken into account and addressed as possible and appropriate, recognizing that COVID-19 will limit some potential commenters' ability to respond by the deadline. However, for those able to respond by the deadline, the State would benefit from receiving those comments.

Appendix: Program Background and Details

I. Overview of EQIP Program

A. Overview of Program Structure

In EQIP, CMS and the State will execute agreements with an entity that is accountable for cost and quality across the entire episode (the “Episode Convener”). The Episode Convener must engage “Episode Initiators,” which are Medicare providers who trigger a covered Clinical Episode by rendering a specified service or procedure. The Episode Convener will have the option to engage additional Downstream Participants to facilitate the delivery of high-quality, coordinated care.

After the Clinical Episode concludes, the State will reconcile actual episode costs against a pre-determined episode target price, subject to CMS approval. The Episode Convener may realize a gain or loss, based on how successfully it manages resources and total costs throughout each episode of care. The Episode Convener is motivated to ensure that health care providers rendering care during the episode furnish services efficiently, better coordinate care, and improve quality of care. Additionally, the Episode Convener is at-risk to CMS for the Medicare payments for the episodes and a quality adjustment based on their Episode Initiators’ performance.

B. Summary of Anticipated Results

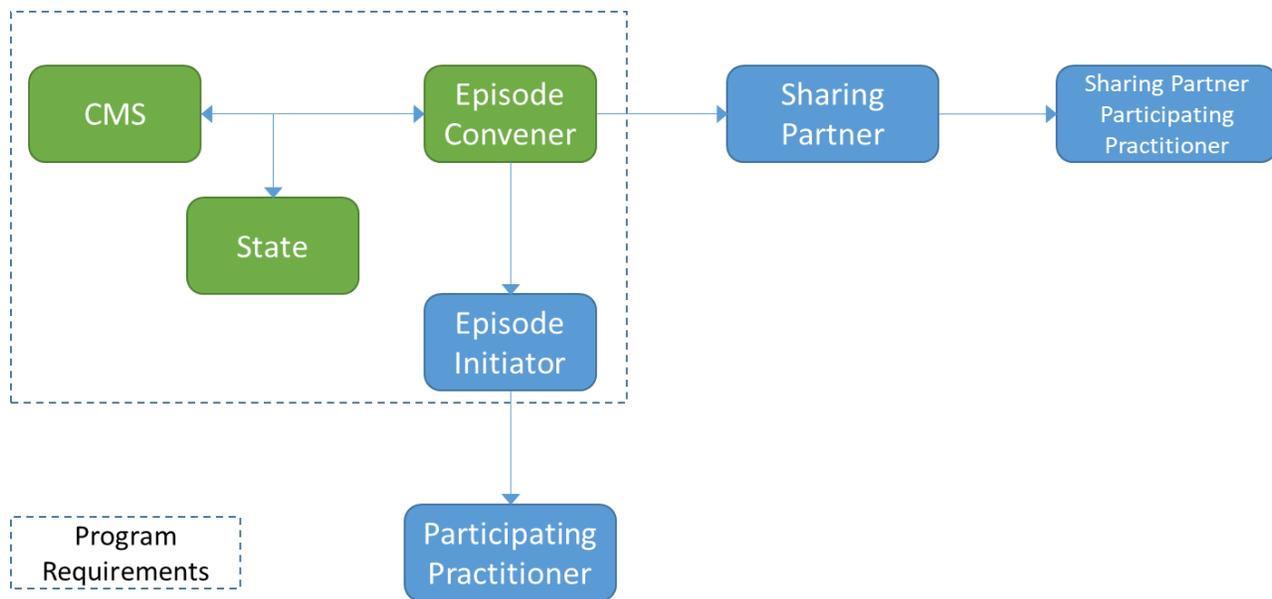
EQIP is expected to help the State produce TCOC savings through the introduction of aligned value-based incentive payments to non-hospital providers (although those providers may work in a hospital outpatient department, for example). Episode Conveners can assist Episode Initiators and other Downstream Participants in reducing avoidable costs by improving efficiency, engaging in more effective care coordination, and improving patient outcomes. Episode Conveners may also offer Episode Initiators and Downstream Participants the opportunity to share in upside and downside risk, thereby aligning payment incentives of non-hospital health care providers with Regulated Maryland Hospitals and other TCOC Model developments.

II. EQIP Design Elements

A. Participants and Downstream Participants

CMS and the State will enter into EQIP Participation Agreements only with Episode Conveners. Episode Conveners are the only entities with which CMS will have a direct relationship under the Program. Episode Conveners must enter into a downstream arrangement with Episode Initiators (a “Convener-Initiator Arrangement”), and may enter into an arrangement with one or more Sharing Partners (“Sharing Partner Arrangement”). Episode Initiators may enter into secondary downstream arrangements with Participating Practitioners, and Sharing Partners may enter into secondary downstream arrangements with Sharing Partner Participating Practitioners (See *Diagram 1: EQIP Participants & Downstream Relationships* below for how these

arrangements may be formed). Collectively, Episode Initiators, Sharing Partners, Participating Practitioners, and Sharing Partner Participating Practitioners are considered Downstream Participants. CMS and the State will not be a party to any of these downstream arrangements. However, it is important that these written downstream arrangements are in place to ensure that Downstream Participants are required to comply with certain Program requirements and that any payments between Conveners and Downstream Participants adhere to their written arrangement. All Downstream Participants will be subject to CMS program integrity screening. CMS will monitor Downstream Participants' performance by reviewing data reported by the Episode Convener.



1. Episode Conveners

An Episode Convener will be a legal entity, not necessarily a Medicare provider or supplier, that will enter into an arrangement with Episode Initiators (“Convener-Initiator Arrangement”). The Episode Convener may share the risk with its Episode Initiators. For instance, the Episode Convener may share portions of any payment earned with its Downstream Participants, or the Episode Convener may require the Downstream Participant to pay it a portion of the amount owed by the Episode Convener to CMS. However, the Episode Convener will be accountable to CMS for any monies owed under the Program. Episode Conveners may have a business address anywhere in the United States.

Regulated Maryland Hospitals may not participate in EQIP as either an Episode Convener or a Downstream Participant. However, separate legal entities affiliated with Regulated Maryland hospitals are permitted to participate. Regulated Maryland Hospitals will continue to have their own bundled payment program opportunities under the Care Redesign Program. However, hospitals/systems may create a new entity or use an existing one (e.g., ACO, CTO, ICN) to serve as an Episode Convener.

2. Application Process and Selection

If EQIP is approved by CMS for implementation, CMS may publish a Request for Applications (“RFA”) in late fall 2020 and open the application period for potential Episode Conveners to apply to participate in EQIP.

The RFA will provide potential Episode Conveners with additional Program details, including eligibility requirements, the EQIP Tracks available for PY1, quality reporting and performance requirements, and details on requirements related to the Downstream Participants including the Convener-Initiator Arrangements and Sharing Partner Arrangements. The RFA will require applicants to provide information regarding their ability to bear financial risk and to repay Medicare for any Medicare FFS spending during a Clinical Episode in excess of the Target Price, up to the stop-loss amount.

Prior to the start of every performance year, the Episode Convener will be required to submit a Proposed Downstream Participant List to CMS and the State. The Proposed Downstream Participant List must include, a list of proposed Downstream Participants for federal Center for Program Integrity (CPI) screening and prior approval to participate in the EQIP. With the RFA, Convener applications will be required to submit a list of potential Proposed Downstream Participants for the vetting noted above, but also for the State to develop draft Target Prices and Clinical Episode data for Conveners so that they may assess their own opportunities in EQIP. A final Downstream Participant List will be required thereafter, prior to the start of the Performance Year.

If selected to participate in EQIP, an Episode Convener must enter into an EQIP Participation Agreement with CMS and the State in order to participate in EQIP.

3. Episode Initiators

An Episode Initiator is a Medicare-enrolled provider or supplier (excluding Regulated Maryland Hospitals or supplier of durable medical equipment, prosthetics, orthotics and supplies), that initiates a Clinical Episode through the provision of a service or procedure. Neither the State nor CMS will have a direct relationship with the Episode Initiator under the Program.

In PY1, the Clinical Episodes may be triggered only through the provision of an outpatient service or procedure, including in a hospital outpatient department (“HOPD”). Based on stakeholder feedback and interest, in the future, the State may propose additional EQIP Tracks, episode categories and, within each episode category, specific episodes—including Clinical Episodes that may be triggered through the provision of an inpatient service or procedure. Although the definition of an Episode Initiator is meant to be broad to ensure applicability for any future EQIP Tracks proposed by the State, there may be EQIP Track restrictions on applicable Episode Initiators—for example, an oncology track may be limited to oncologists.

The Episode Initiator may only participate in EQIP with a single Episode Convener. The State will ensure this through the process of submitting Conveners' final Downstream Participant Lists to CMS.

4. Participating Practitioners

An Episode Initiator may enter into an optional financial arrangement ("Participating Practitioner Arrangement") with a Medicare-enrolled physician or non-physician practitioner in the Physician Group Practice listed at 42 C.F.R. § 410.78(b)(2), plus other eligible professionals defined at Section 1848(k)(3)(B) of the Social Security Act ("Participating Practitioners"). While not party to the EQIP Participation Agreement, participating practitioners will be required to comply with applicable terms and conditions. Pursuant to the Participating Practitioner Arrangement, the Participating Practitioner will assist the Episode Initiator in performing applicable clinical care redesign interventions ("EQIP Activities") and may be eligible for performance payment sharing. Additionally, pursuant to the Convener-Initiator Arrangement and, if applicable, the Participating Practitioner Arrangement, the Episode Initiator and its Participating Practitioners may elect to take on downside financial risk.

5. Sharing Partners

An Episode Convener may also choose to enter into a financial arrangement ("Sharing Partner Arrangement") with entities that are not Episode Initiators ("Sharing Partners"), for example, a Physician Group Practice ("PGP"), ACO, a Post-Acute Care ("PAC") Provider (e.g., inpatient rehabilitation facility, home health agency, or Skilled Nursing Facility ["SNF"]). These optional arrangements are intended to permit Episode Conveners to engage Sharing Partner entities in EQIP Activities to improve an EQIP Beneficiary's care beyond the scope of the Episode Convener and Episode Initiator relationship. The Sharing Partner will be required, through the Sharing Partner Arrangement, to comply with the applicable terms and conditions of the EQIP Participation Agreement and will also be subject to vetting via the Proposed Downstream Participant List.

B. Clinical Episodes for PY1

EQIP Clinical Episodes must include the following components:

1. An episode trigger that is identifiable through claims analysis;
2. Eligible Episode Initiators, i.e. those who perform the care/episode trigger;
3. All Medicare costs will be included in the Benchmark Price for the Clinical Episode, unless explicitly excluded in program documentation. Costs may be winsorized to the 99th percentile of all episodes in order to reduce the influence of outlier cases;
4. A description of EQIP Activities that Downstream Participants are expected to perform in exchange for a portion of the Convener's payments, and

5. Clinical Episode duration.

Episode Initiators may participate in one or more Clinical Episodes for a given EQIP Performance Year. The final documents submitted by Conveners to the State and CMS before the start of the EQIP Performance Year will identify specific EQIP Activities that the Downstream Participants must perform for the Clinical Episodes. These details will also be identified in the secondary Arrangements between Conveners and Downstream Participants (Convenor-Initiator Arrangement, Sharing Partner Arrangement, Participating Practitioner Arrangement, and Sharing Partner Participating Practitioner Arrangement).

For PY1, Clinical Episodes are limited to hospital-outpatient and community-setting triggered services and procedures. The State is seeking input as to whether to expand EQIP in future years to include inpatient-triggered Clinical Episodes and what those should be. Clinical Episodes are intended to address both acute (i.e., surgeries and acute health events) and chronic health issues, like ongoing treatment for Crohn's disease. The State is interested in hearing stakeholder thoughts on designing an episode-based approach to chronic disease management for future Performance Years.

For PY1, based on stakeholder input, the State has drafted a proposed list of 11 distinct episodes in four specialty areas. These Include:

- Orthopedics (90-day episode window)
 - a. Knee Arthroscopy
 - b. Knee Replacement & Knee Revision
 - c. Lumbar Laminectomy
 - d. Shoulder Replacement
- Cardiology (90-day episode window)
 - a. Coronary Angioplasty
 - b. Pacemaker / Defibrillator
- Gastrointestinal (GI) (90-day episode window)
 - a. Colonoscopy
 - b. Gall Bladder Surgery
 - c. Upper GI Endoscopy
- Emergency Department (ED)
 - a. Frequent Utilizers (four or more ED visits within 12 months, 30-day episode window)
 - b. Efficient Admissions (14-day episode window) (Chest pain, Syncope, Congestive heart failure, Skin & soft tissue infections, Asthma/COPD, Deep vein thrombosis, Pneumonia, Atrial fibrillation, Hyperglycemia with diabetes mellitus)¹

¹ED visit must be associated with one of the indicated conditions as a primary diagnosis. These may be subsequently split into a greater number of diagnosis-based episodes.

1. Alternative Payment Arrangement: Net Payment Reconciliation Amount (“NPRA”)

The State is developing a Target Price methodology for each Clinical Episode that includes a 3 percent Discount Factor designed to obtain savings for CMS. The State will submit its proposed methodology to CMS for review and, hopefully, approval. The State will calculate each Episode Initiator’s performance on the Clinical Episode against the Target Price using the CMS-approved methodology. The draft methodology is described in Section II.B.2 below. Performance will be assessed on a site-neutral basis such that Conveners will be rewarded for shifting services to more efficient setting when clinically appropriate. However, this particular opportunity is limited somewhat when savings are derived from reductions in hospital utilization, as described below.

CMS will make payments to Conveners, or collect amounts owed from Conveners, based on the State’s calculations. Similar to the federal BPCI Advanced, Episode Conveners will be eligible for upside and downside financial risk, with stop-loss/stop-gain provisions—likely 20 percent stop-gain and stop-loss from the Target Price. Again, Episode Conveners may share the upside and downside financial risk with the Episode Initiators (see *Diagram 2: NPRA Payment Flows*). The State will submit to CMS the reconciliation payment amounts due to the Episode Convener, or the repayment amounts owed by the Episode Convener to CMS, using the CMS-approved reconciliation payment methodology described below.

EQIP is designed to meet the Advanced APM financial risk criterion specified in the Quality Payment Program regulations at 42 C.F.R. §1415(c).

EQIP episodes will include Medicare spending for both hospital and non-hospital services. Payments for hospital services in the episode are subject to the effects of the hospital’s Global Budget Revenue (GBR). There are two primary effects of the GBR that could affect EQIP for which the State plans to implement offsetting methodologies and seeks comment: (1) Hospitals change their prices throughout the year in order to attain their global budgets, and (2) CMS does not capture 100 percent of the savings from reducing hospital utilization. Specific approaches to these concerns are described in Section II.B.2 below and Section III.B includes additional background on the global budget approach.

2. Target Pricing

For PY1, the State is developing a Target Pricing Methodology similar to BPCI Advanced, with adjustments unique to Maryland and EQIP needs. Through this RFI, the State is soliciting feedback and considerations for Target Pricing methodology. After each Performance Year, CMS and the State will institute a reconciliation process resulting in the issuance of a reconciliation report to the Episode Convener. Target Prices will be developed annually with a baseline likely ending in CY2019 for PY1 participants. The NPRA will be calculated as following this general process, with details on components listed below:

1. For each Clinical Episode, determine Total Payments from Baseline Period per Episode Initiator
2. Trend Baseline Period costs forward to current Performance Year
3. Adjust Trended Baseline Period costs for current Performance Year case-mix = **Benchmark Price**
4. Apply 3 percent Discount factor for CMS savings = **Target Price**
5. Determine Total Payments for Performance Year per Initiator, per Clinical Episode = **Performance Period Costs per Episode**
6. Determine per Clinical Episode **Regulated** savings (or dissavings) by subtracting Regulated Performance Period Costs per Episode from the Target Price
7. Determine per Clinical Episode **Unregulated** savings (or dissavings) by subtracting Unregulated Performance Period Costs per Episode from the Target Price
8. Adjust Regulated Savings (or dissavings) for GBR effects (apply a discount of 35 percent)²
9. Combine Regulated and Unregulated Per Episode Savings (or dissaving)
10. **Reconciliation Payment before Quality Adjustment:** Aggregate Per Episode Savings (or dissavings) for the Convener (i.e., multiply by number of episodes)
11. Apply the **Composite Quality Score** (“CQS”, Section II.D.) to the Reconciliation Payment = final **NPRA** to the Convener from CMS, or **Repayment Amount** from the Convener to CMS.

Historical Baseline. Target Prices will be developed annually with a likely baseline in CY2019 for PY1 participants. Participants who enter the Program in following Performance Years will be subject to a baseline set on the most recent full calendar year of claims data, typically two years prior (e.g., CY2020 for a CY2022 Program start). The State is considering not updating the baseline data after the initial Performance Year of participation for at least first three years, to reward conveners for cumulative impact achieved over a reasonable period of time. However, the State may elect to adjust target prices annually for changes in place of service, such that only one year of reward will be achievable for these changes.

Target prices for Episode Initiators will be developed based on FFS payments for Total Costs of Care in Parts A and B costs paid through traditional claims, for each beneficiary triggering an eligible Clinical Episode in the baseline period. Some exclusions may apply to remove outlier or erratic spending factors. For example, payments for blood clotting factors and end-stage renal disease (ESRD) treatment may be removed. Exclusions may also be applied at the beneficiary level, such as those who are not continuously enrolled in both Part A and B, or beneficiaries with extreme costs. In future performance years, to accommodate new Clinical Episodes and Alternative Payment Arrangements, the State may elect to include other

² Please note this methodology is still under consideration and the State is currently seeking comment for how to adjust for the effects of hospital regulated global budgets within EQIP episode costs and savings calculation. Section II.B. outlines these methodological considerations.

relevant payments in EQIP Target Pricing. For example, Part D costs could be considered for Clinical Episodes focusing on oncological care improvement.

Trending. Costs included in the Target Price will have been trended forward to the Performance Year to make appropriate cost comparisons. Unregulated (that is, non-hospital) costs will be trended forward utilizing the appropriate fee schedule updates published annually by CMS. For example, all skilled-nursing facility costs would be multiplied by the FY21/22 Skilled Nursing Facility Prospective Payment System for PY comparison. For costs associated with HSCRC Regulated entities (namely those associated with a hospital inpatient or outpatient claim), the annual Update Factor and appropriate rate updates will be applied.

Standardized GBR prices. Because hospitals change their prices throughout the year in order to attain their global budgets, the payments for hospital services provided during the episode could affect episode costs unrelated to actual performance of EQIP participants. To ensure EQIP participants are not held accountable for these effects, rather than using actual Medicare payments for hospital services, the Target Price will reflect a standardized price based on hospital rate center utilization and the most recent rate order on file with the HSCRC. Although hospitals will change their prices during the year, the EQIP methodology will essentially assume a Standardized Rate during the year and not reflect hospitals' price-changing patterns.

Case-Mix Adjustment. The State will adjust Target Prices to account for changes in case-mix between the Initiator's baseline and the actual Clinical Episodes included in the Performance Year. Potential methods for adjusting the Target Price for case-mix include:

- Rate Cells to bucket beneficiaries with similar costs into general groupings
- Risk scores such as the Hierarchical Condition Categories (HCC) to help predict and trend expenditures by beneficiary
- Regression modeling

The State may also consider the following beneficiary factors in the case-mix adjustments to Target Prices:

- Demographics of age and gender
- Diagnosis and Event combinations, for example APR-DRG, chronic condition status and hip fractures could be considered as a grouping
- Eligibility for Medicare and other programs, such as those dually-eligible for Medicare and Medicaid

Discount Factor. Once costs are accounted for and trended forward to the applicable Performance Year, the State will apply a 3 percent Discount Factor. This Discount Factor sets a guaranteed savings amount to CMS. Practically, this means EQIP participants do not earn an incentive payment unless their Episode performance costs are lower than the Target Price, which is 97 percent of the Benchmark Price. Episode performance costs above the Target Price must be paid by the Convener to CMS.

GBR Regulated Savings Discount. A second effect of hospital global budgets is that, for example, as Medicare-funded hospital volumes decline, those potential regulated savings are offset by rate increases across the entirety of the hospital's rate centers in order to meet the GBR. Thus, Medicare regulated savings within an episode will be partially offset by increases in hospital rates outside of the EQIP episodes. This must be taken into account when calculating EQIP Conveners' performance. Therefore, the State is proposing that net regulated savings at a regulated hospital facility during an EQIP episode will be discounted by 35 percent. It is important to note:

- This adjustment is applied to net regulated savings so that an intervention that shifts costs from the regulated to the unregulated savings will be scored as having generated 65 percent of the regulated savings but 100 percent of the regulated costs.
- Medicare's 3 percent discount factor is not reduced by this adjustment, Medicare savings of 3 percent must be achieved after applying this GBR savings discount

Other Adjustments for Consideration

- No standardization to account for geographic variation in spending will be included except if needed to address small cell sizes for a specific participant. Target Prices will be developed unique to each Episode Initiator based on actual claims history.
- Outliers will be winsorized at the 99th and 1st percentiles to prevent high- or low-costs Clinical Episodes from skewing Target Pricing.

3. Reconciliation Payments

As outlined in the Target Pricing Section above (II.B.2.), the proposed reconciliation payment methodology compares an Episode Convener's episode performance against the Episode Target Price. If the Target Price is lower than the actual episode costs during the performance period, the Convener will owe CMS a Repayment Amount. Conversely, if the Episode costs during the performance period are lower than the Target Price, CMS will pay the Convener a set amount via the NPRA. CMS requires that any reconciliation payment methodology includes quality measure performance specified in Section II.B. as a factor when determining reconciliation payments to EQIP participant.

4. Episode Convener Payments

If an Episode Convener's Episode Initiators performed below the Target Price for Clinical Episodes, CMS will pay the Episode Convener the aggregate NPRA amount for all of its Episode Initiators ("Convener NPRA" see *Diagram 2: NPRA Payment Flows*). If it elected to do so, the Episode Convener will distribute the pre-designated share of the NPRA to its Episode Initiators and applicable Downstream Participants in accordance with the terms of its written arrangements.

Of note, the State is soliciting information from potential participants on timing of Episode Convener payments. Some CMS programs require a full 12 months of claims runout, or

completion time, prior to finalizing Reconciliation payments. This would be a significant lag for EQIP Convener participants to either receive or owe money from/to CMS, and even longer for Downstream Partners to receive their NPRA share, if applicable. To improve on this in EQIP, the State is considering a shorter window (somewhere within 4-12 months) of claims runout to finalize Reconciliation Payments, or a two-phase payment process whereby initial payments are estimated and made based on a shorter window with a true-up applied once a full 12 months has elapsed. The State is conducting data analysis to determine where risk of a second reconciliation for Conveners is mitigated while still allowing for an accelerated Convener Payment timeline.

C. Post Episode Monitoring Period

A Post-Episode Monitoring Period will begin on the first day after the end of each Clinical Episode to ensure that the Episode Convener is not merely shifting care to the period of time immediately following the end of a Clinical Episode. The State will use the same Target Price methodology for the post-episode period spending. If the total dollar amount of Medicare FFS expenditures for items and services furnished to an EQIP Beneficiary during the Post-Episode Monitoring Period exceeds the Post-Episode Benchmark Price by a risk threshold, the result would be an excess spending amount that the Episode Convener must repay to CMS.

D. Quality Measures and Adjustment

For those Clinical Episodes in which it has elected to participate, the Episode Convener will be held accountable for performance on quality measures, including performance on at least two MIPS-comparable measures that meet the requirements set forth at 42 C.F.R. § 414.1415(b), if applicable. The measures selected for PY1 EQIP Episodes will be available in the Request for Applications (“RFA”) available late fall 2020.

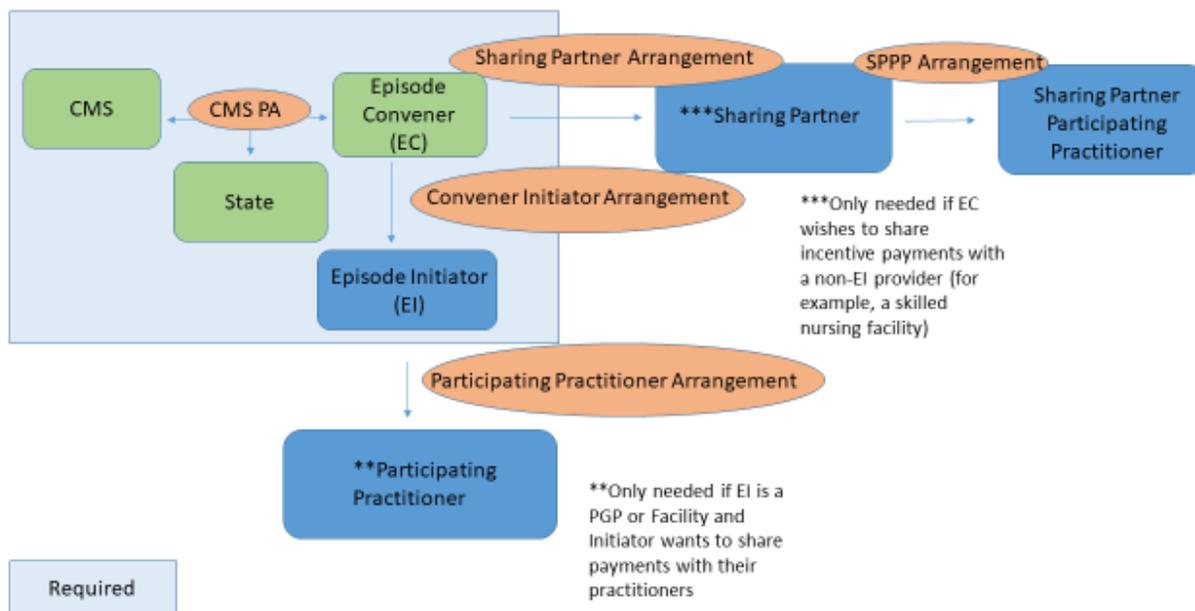
EQIP will adjust Reconciliation Payments based on selected quality measure performance, combining the distinct score into a Composite Quality Score (“CQS”). The HSCRC will calculate a quality score for each quality measure at the Episode Initiator level. Scores for all Clinical Episodes will be weighted based on Clinical Episode volume and summed across all Clinical Episodes attributed to a particular Episode Initiator to determine a Composite Quality Score (CQS). Through the CQS, performance on quality measures will be used to adjust Reconciliation Payments to Episode Conveners. The CQS Adjustment Amount is a continuous function of the CQS and will be applied during Reconciliation and then used to determine the Episode Convener’s NPRA or Repayment Amount.

E. Legal Arrangements

CMS and the State will amend the TCOC Model Agreement to include provisions around roles and responsibilities for EQIP. CMS, the State, and each Episode Convener will execute the EQIP Participation Agreement. Neither CMS nor the State will be a party to the Convener-Initiator Arrangement, Sharing Partner Arrangements, or, if applicable, any additional downstream

arrangements (see *Diagram 3: EQIP Participants & Downstream Relationship Arrangements*). However, the EQIP Participation Agreement will establish requirements for downstream arrangements, identify content that must be included in these written arrangements, and specify that CMS and the State may request to review these downstream arrangements at any time.

Diagram 3: EQIP Participants & Downstream Relationship Arrangements



F. Waivers³

CMS may issue waivers from Medicare payment rules, referred to as payment policy waivers, such as the telehealth payment policy waiver. The telehealth payment policy waiver would grant EQIP participant an exception to the geographic requirements for Medicare payment for telehealth services.⁴ The telehealth payment policy waiver is only applicable when the services are furnished to EQIP beneficiaries during a Clinical Episode. In future performance years, CMS may offer the additional Medicare payment policy waivers specified below depending on future CMS approved EQIP Tracks. Additional waivers could include the 3-Day Skilled Nursing Facility Rule Payment Policy Waiver and the Post-Discharge Home Visits Payment Policy Waiver. The State seeks comment on payment waivers for potential implementation in PY1 and future years, and the rationale for such waivers and how they can help EQIP participants be successful.

³ The authority for this initiative is Section 1115A of the Act. Under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII, and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5) of such section) of the Act as may be necessary solely for purposes of testing models described in Section 1115A(b).

⁴ Under Section 1834(m) of the Act

III. Other Program Elements and Considerations

A. Overlaps with EQIP and other Programs

EQIP Participants may not participate in any CMMI Models or CMS initiatives that have a no-overlaps policy with the TCOC Model. There are no per se restrictions on an Episode Initiator's simultaneous participation in multiple EQIP Tracks so long as its Episode Convener chooses to participate in the EQIP Track, but certain EQIP Tracks may contain restrictions in the appropriate EQIP Track Implementation Protocol that either prohibit or limit Episode Initiators from participating in another EQIP Track

1. Episode Care Improvement Program

Regulated Maryland Hospitals participate in the Episode Care Improvement Program ("ECIP"), an episode-based program triggered by certain inpatient hospital discharges.⁵ The State does not anticipate overlap between EQIP and ECIP during Performance Year one (PY1) of the Program, in which EQIP Clinical Episodes are triggered by an outpatient service or procedure. If CMS approves the inclusion of inpatient Clinical Episodes in EQIP in future performance years, CMS and the HSCRC will collaborate on a sufficient overlaps policy to ensure no duplicate payments received for those Medicare providers and suppliers participating in both EQIP and ECIP. Generally, the State plans to develop a hierarchy where providers or physicians in EQIP would "win" an episode over a hospital participating in the same episode in ECIP.

2. Accountable Care Organizations

Currently, the State is considering excluding prospectively attributed ACO beneficiaries from EQIP.

B. Background on Maryland Global Budgets

Since 2014 Maryland hospitals have operated under a Global Budget Revenue (GBR) system. Under this system, all hospitals are reimbursed a fixed annual amount for all regulated services they provide across all payers. This system removes the incentive for hospitals to grow volume and rewards them for eliminating potentially avoidable utilization by allowing them to reinvest retained revenues in population health and other initiatives with a benefit to the community.

Because hospitals are still paid for services on an individual claims basis, hospitals adjust payment rates during the year according to their changing volumes so that total payment for the

⁵ ECIP started under the CRP on 1/1/19 under the parameters of the CRP Hospital Participation Agreement. ECIP's episode-based approach aligns incentives across hospitals, physicians, and post-acute care facilities to generate savings and improve quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge Emergency Department (ED) visits and hospital readmissions. ECIP provides hospitals with the opportunity to provide incentive payments to care partners that help achieve these goals.

year equates to the approved hospital global budget. Rates are initially set based on projected volumes and then adjusted during the year as volumes fluctuate.

This system results in two phenomena: (1) as hospitals adjust unit rates to meet the approved global budget through the year, rates for individual services fluctuate; and (2) if a hospital experiences increasing or decreasing utilization during the year that is likely to result in volume for the full year not meeting projected amounts, the hospital will adjust unit rates to offset the volume changes. As a result, a decline in utilization due to the shifting of a service to an unregulated setting will be effectively offset under the hospital’s GBR by an increase in all other rates to maintain a constant global budget. The impact of these two phenomena on EQIP financing are addressed in Section II.B.

In addition, the HSCRC maintains a number of methodologies that adjust for related phenomena like volume shifting between hospitals and the planned deregulation of a service by a hospital. These mechanisms complicate the calculation described above but do not change the fundamental mechanics whereby changing volumes leads to offsetting changes in unit rates.

Regulated services generally reflect all services provided on a hospital campus, although there are allowances in this definition for specific nuances. Regulated services are billed under a specific list of NPIs using specific bill types on the CMS UB billing form. Therefore, it is relatively easy to identify regulated services within a claims data set.

C. Operations and Timing

CMS and the State will jointly administer EQIP. CMS will annually release the EQIP Request for Applications (“RFA”) for Convener consideration and response. Selected participants will be required to submit a preliminary Downstream Participants list during the RFA process so that CMS may begin vetting potential Downstream Participants. Once RFA responses have been submitted, CMS and the State will issue guidance to selected participants. The State and CMS will issue preliminary target prices to Convener applicants after RFA submission and prior to Participation Agreement signing. Conveners will also be required to submit a Track Implementation Protocol, based on a template developed by the State and approved by CMS, indicating how the Convener and its Downstream Participants will implement EQIP. Finally, Conveners will enter into a Participation Agreement with the State and CMS prior to 12/31 of their first year of participation; amendments and updates to the Participation Agreement may be required in following years.

The table below contains an overview of anticipated timing for PY1 participation, subject to change.

Date	Event
Fall 2020	<ul style="list-style-type: none"> <li data-bbox="613 1717 1333 1850">Request for Applications (RFA), along with template of potential Episode Initiators (EIs) et al. for vetting and for State to produce preliminary target prices due

Winter 2021	<ul style="list-style-type: none"> • RFA submitted by Conveners • HSCRC provides data flat file, including preliminary Target Prices
Spring 2021	<ul style="list-style-type: none"> • Participation Agreement (PA) available • Implementation Protocol (IP) Template available, including Certified EI template
Summer 2021	<ul style="list-style-type: none"> • Signed PA submitted by Conveners • IP and Certified EIs submitted

- Attachment 1: PY1 Episodes and Codes
- Attachment 2: Episode Development Overview (Marth 13th, 2020 EQIP Subgroup Slides)
- Attachment 3: State-wide Episode Costs by Place of Service

Attachment 1: PY1 Episodes and Codes

Episode	CPT Triggers
Orthopedic Episodes	
Knee Arthroscopy	29866, 29867, 29868, 29870, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29888, 29889
Knee Replacement & Knee Revision	27446, 27447, 27486, 27487
Lumbar Laminectomy	63005, 63011, 63012, 63017, 63030, 63035, 63042, 63044, 63047, 63056, 63057, S2350, S2351
Shoulder Replacement	23470, 23472, 23473, 23474
Cardiology Episodes	
Coronary Angioplasty	92920, 92921, 92924, 92925, 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, 92944, 92973, 92980, 92981, 92982, 92984, 92995, 92996, C9600, C9601, C9602, C9603, C9604, C9605, C9606, C9607, C9608, G0290, G0291
Pacemaker / Defibrillator	0319T, 0321T, 0387T, 33206, 33207, 33208, 33212, 33213, 33214, 33221, 33224, 33225, 33227, 33228, 33229, 33230, 33231, 33240, 33249, 33262, 33263, 33264, 33270, 33271, 71090, C1721, C1722, C1785, C1786, C1882, C2619, C2620, C2621, G0448
Gastrointestinal	

Colonoscopy	CPT: 44388, 44389, 44392, 44394, 44403, 44404, 45330, 45331, 45333, 45335, 45338, 45378, 45380, 45381, 45384, 45385, 45390, G0104, G0105, G0106, G0120, G0121, G0122
Gall Bladder Surgery	CPT: 47562, 47563, 47564, 47600, 47605, 47610, 47612, 47620
Upper GI Endoscopy	CPT: 43200, 43201, 43202, 43204, 43205, 43206, 43211, 43212, 43213, 43214, 43215, 43216, 43217, 43219, 43220, 43226, 43227, 43228, 43229, 43231, 43232, 43233, 43234, 43235, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43252, 43253, 43254, 43255, 43256, 43257, 43258, 43259, 43266, 43270
Emergency Department	
High-Frequency ED Users (four distinct triggers per beneficiary)	CPT: 99281, 99282, 99283, 99284, 99285 Revenue Code: 045X
Efficient Admissions (first trigger)	CPT: 99281, 99282, 99283, 99284, 99285 Revenue Code: 045X
Efficient Admissions (second trigger)	
Chest Pain	R07.1, R07.2, R07.9, R07.81, R07.89
Syncope	R55, T67.1XXA, G90.01
CHF	I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
Skin & Soft Tissue Infection	L08.0, L08.1, L08.81, L08.82, L08.89, L08.9, K12.2, L03.011, L03.012, L03.019, L03.031, L03.032, L03.111, L03.112, L03.113, L03.114, L03.115, L03.116, L03.119, L03.211, L03.213, L03.221, L03.311, L03.312, L03.313, L03.314, L03.315, L03.316, L03.317, L03.319, L03.811, L03.90, N48.22, H05.011, N61.0, N61.1, L01.00, L01.03, L02.01, L02.11, L02.211, L02.212, L02.213, L02.214, L02.215, L02.219, L02.223, L02.31, L02.411, L02.412, L02.413, L02.414, L02.415, L02.416, L02.419, L02.423, L02.424, L02.511, L02.611, L02.612, L02.619, L02.811, L02.831, L02.91, L02.92
Asthma/COPD	J44.0, J44.1, J44.9, J45.20, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.51, J45.52, J45.90, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

Deep Vein Thrombosis	I82.401, I82.402, I82.403, I82.409, I82.411, I82.412, I82.413, I82.419, I82.421, I82.422, I82.423, I82.429, I82.431, I82.432, I82.433, I82.439, I82.441, I82.442, I82.443, I82.449, I82.451, I82.452, I82.453, I82.459, I82.461, I82.462, I82.463, I82.469, I82.491, I82.492, I82.493, I82.499, I82.4Y1, I82.4Y2, I82.4Y3, I82.4Y9, I82.4Z1, I82.4Z2, I82.4Z3, I82.4Z9, I82.501, I82.502, I82.503, I82.509, I82.511, I82.512, I82.513, I82.519, I82.521, I82.522, I82.523, I82.529, I82.531, I82.532, I82.533, I82.539, I82.541, I82.542, I82.543, I82.549, I82.551, I82.552, I82.553, I82.559, I82.561, I82.562, I82.563, I82.569, I82.591, I82.592, I82.593, I82.599, I82.5Y1, I82.5Y2, I82.5Y3, I82.5Y9, I82.5Z1, I82.5Z2, I82.5Z3, I82.5Z9, I82.601, I82.602, I82.603, I82.609, I82.611, I82.612, I82.613, I82.619, I82.621, I82.622, I82.623, I82.629, I82.701, I82.702, I82.703, I82.709, I82.711, I82.712, I82.713, I82.719, I82.721, I82.722, I82.723, I82.729, I82.A11, I82.A12, I82.A13, I82.A19, I82.A21, I82.A22, I82.A23, I82.A29, I82.B11, I82.B12, I82.B13, I82.B19, I82.B21, I82.B22, I82.B23, I82.B29, I82.C11, I82.C12, I82.C13, I82.C19, I82.C21, I82.C22, I82.C23, I82.C29, I82.811, I82.812, I82.813, I82.819, I82.890, I82.891, I82.90, I82.91
Pneumonia	J18.0, J18.1, J18.2, J18.8, J18.9, B96.1, J10.00, J10.08, J11.00, J11.08, J12.2, J12.9, J13., J15.1, J15.212, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8
Atrial Fibrillation	I48.0, I48.11, I48.19, I48.20, I48.21, I48.3, I48.4, I48.91, I48.92
Hyperglycemia with Diabetes Mellitus	E10.65, E11.65, E13.65, E09.65, E08.65, R73.9



Episode Quality Improvement Program (EQIP): New Program Designed for Specialists

March 13, 2020

Agenda

- ▶ Update on EQIP design
- ▶ EQIP schedule
- ▶ EQIP outpatient-triggered episodes for Y1 (2021)
 - ▶ Orthopedics
 - ▶ Cardiology
 - ▶ Gastroenterology
 - ▶ Emergency Department
- ▶ Appendix 1. Glossary and CPT Codes
- ▶ Appendix 2. Info from nationally experienced episode conveners/contractors
- ▶ Appendix 3. Overlaps and FAQs

** State is currently in discussions/negotiations with CMMI on EQIP, thus everything is subject to change.*

Update on EQIP Design*

* State is currently in discussions/negotiations with CMMI on EQIP,
thus everything is subject to change.



Bad News: For years, CMMI has excluded Maryland from many of their models or limited take-up

- ▶ Bundled Payments for Care Improvement Advanced (BPCI Advanced)
- ▶ Oncology Care Model (OCM)
- ▶ New Radiation Oncology (RO) Model [proposed]
- ▶ Comprehensive Primary Care Plus (CPC+)

Good News: Maryland Model* now permits developing our own versions

- ▶ Maryland Primary Care Program (MDPCP started January 2019)
- ▶ **Episode Quality Improvement Program (EQIP)**
 - ▶ Expected RFA in Spring 2020
 - ▶ Expected start date January 2021
- ▶ Also, CMMI permitting Maryland providers into newest proposed kidney models (ETC [proposed], KCF, CKCC)
- ▶ CMMI will permit Maryland providers' participation in their models IF hospitals are not a substantial source of savings
 - ▶ CMMI can't calculate actual Medicare savings in hospitals because of hospitals' Global Budget Revenue (GBR)
 - ▶ For EQIP and similar programs, the State will calculate the savings obtained using a methodology approved by CMS

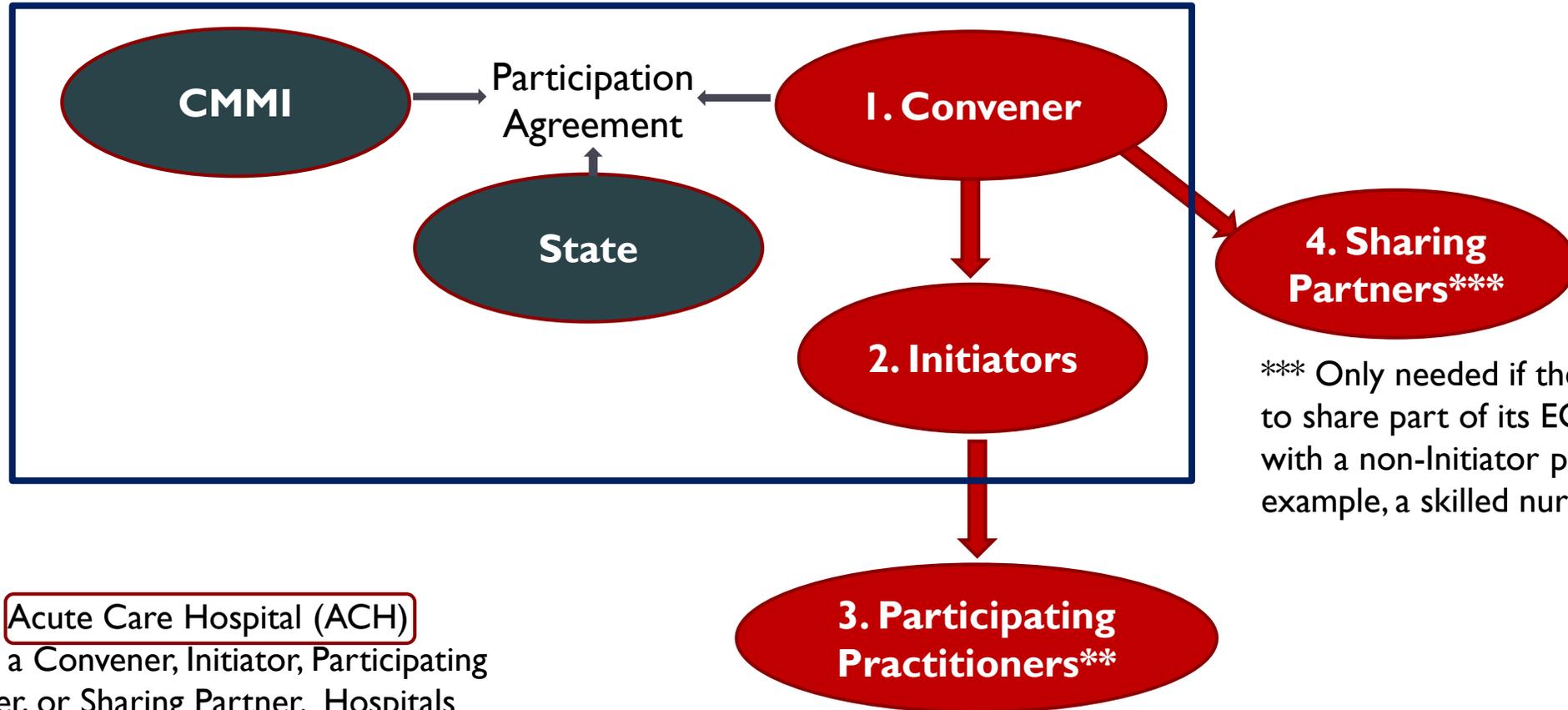
▶ 5 * Sometimes referred to as the All-Payer Model, the Total Cost of Care (TCOC) Model, or "the Waiver." Of these alternatives, TCOC Model is most accurate. Generically we just say "Maryland Model."

Episode Quality Improvement Program (EQIP): Overview and goals

- ▶ EQIP is an episode-based payment program for non-hospital providers designed to:
 - ▶ Help the State meet the financial targets of TCOC Model
 - ▶ Include more providers in a value-based payment framework (that is, to have responsibility and share in rewards for reducing Medicare TCOC spending)
 - ▶ Encourage multi-payer alignment in a value-based payment framework
 - ▶ Include more episodes than in CMMI models
 - ▶ Broaden access to Medicare's 5% Advanced APM (AAPM) MACRA opportunity
- ▶ As with almost all Maryland Model programs, participants (Conveners in EQIP context) **must accept more-than-nominal downside risk**
 - ▶ Episode Initiators (e.g., physician partners) can participate through a Convener and agree on risk/reward arrangement
- ▶ Targeted start date of January 2021, with RFA Spring 2020
 - ▶ EQIP Conveners, episode initiators, etc., can sign up or withdraw annually

EQIP's Types of "Participants"*

* Some attorneys prefer that the term "participants" only refers to those signing the Participation Agreement (PA). In EQIP, that would be only Conveners, plus CMMI and the State.



*** Only needed if the Convener wishes to share part of its EQIP risk/rewards with a non-Initiator provider – for example, a skilled nursing facility (SNF).

3. Participating Practitioners**

** Only needed if (1) the Initiator is a PGP or Facility, and (2) that Initiator wants to share payments with their practitioners.

NOTE: An **Acute Care Hospital (ACH)** cannot be a Convener, Initiator, Participating Practitioner, or Sharing Partner. Hospitals can benefit from EQIP through retaining savings in the GBR for utilization reduction.

EQIP's Types of Participants: 1. Conveners

I. Episode Convener

- ▶ Entity that bears the risk (to CMMI an “Advanced APM Entity”)
- ▶ Legal entity like an ACO, CTO, PGP, or a Participant in BPCI-Advanced
- ▶ Respond to Request for Applications (RFA), sign Participation Agreement (PA), and submit Implementation Protocol (IP)
- ▶ Expecting no more than a dozen Episode Conveners (but no State/Federal restriction on number)
- ▶ Enter into agreement with Episode Initiators (EIs)
- ▶ Provide their Episode Initiators with resources and support, for example:
 - Technical assistance, outreach and education, enrollment support
 - Care management resources
 - Episode management and analytics

EQIP's Types of "Participants": 2. Initiators

2. Episode Initiators

- ▶ Do not sign PA with CMMI and State
- ▶ Medicare suppliers and providers (e.g., doctors) that:
 - Initiate clinical episodes,
 - Implement care intervention plans,
 - Treat patients
- ▶ Enter into agreement with Convener
 - CMMI and State not a party
- ▶ NPIs like those on:
 - ACO list,
 - MDPCP practice roster, or
 - CRP Certified Care Partner list
- ▶ NPIs must be submitted by potential Conveners to CMMI for vetting (program integrity). Once approved through vetting, can participate with ONE Convener

EQIP's Types of "Participants": 3. Participating Practitioners 4. Sharing Partners

3. Participating Practitioners

- ▶ If the Initiator is a PGP or a non-ACH facility, they may want to share payments with their individual downstream practitioners

4. Sharing Partners

- ▶ The Convener may want to share incentive payments with non-Initiator organizations (e.g., with a PAC facility that is helping reduce readmissions and TCOC but is not an Initiator)

EQIP: Simplified example

- ▶ Convener elects to take responsibility for Medicare TCOC for:
 - ▶ Triggered by [CPT code(s)]
 - ▶ For spending over [90] days
- ▶ The Convener's average Medicare TCOC is \$10,000 per beneficiary
 - ▶ CMS wants its 3% savings: Discount Factor → \$9,700 Target Price
 - ▶ Across the Convener's patients, if the Convener's average per beneficiary spending falls below \$9,700 (on risk-adjusted basis, assuming certain quality metrics are met), Convener receives payment from Medicare
 - ▶ On the other hand, average Medicare TCOC above \$9,700* will require a payment from the Convener
- ▶ Because Maryland hospitals operate under global budgets, reductions in Medicare hospital utilization do not produce a one-for-one savings to Medicare
 - ▶ **For net reductions in hospital spending, Conveners will get partial credit of 65%**
- ▶ BPCI Advanced has stop-loss/stop-gain of 20% of sum of Target Prices at the Episode Initiator level

▶ || * Consistent with CMMI's BPCI Advanced, which is the primary model for EQIP
Note: Care management fees, aka MEOS payments, not part of BPCI Advanced

HSCRC will be releasing a Request for Information (RFI) on EQIP episode design

- ▶ RFI likely to be released early next week
 - ▶ Want to take into account comments from today's meeting
- ▶ Seeking comments on episode design in four Y1 outpatient-triggered categories:
 - ▶ Orthopedics
 - ▶ Cardiology
 - ▶ Gastroenterology
 - ▶ Emergency Department
- ▶ Also seeking initial input on priorities and design of Y2 episodes
- ▶ Content of RFI will be similar to today's slides
- ▶ **Due date for comments will be Friday, April 17**

* State is currently in discussions/negotiations with CMMI on EQIP, thus everything is subject to change. Input may not be taken into account. **We will not be including any other Y1 episode categories besides ortho, cardio, GI, and ED.**

EQIP Schedule*

* State is currently in discussions/negotiations with CMMI on EQIP, thus everything is subject to change.



EQIP Documents

▶ **State/CMMI provide:**

1. Request for [Convener] Application (RFA) – along with attachment/template for vetting potential Episode Initiators, Participating Practitioners, and Sharing Partners
2. Participation Agreement (PA)
3. Implementation Protocol (IP) template – along with attachment/template for final certified Episode Initiators, Participating Practitioners, and Sharing Partners

▶ **Every Convener submits:**

1. Completed Application, including attachment for vetting list of potential Episode Initiators, Participating Practitioners, and Sharing Partners
2. Signed PA
3. Completed Implementation Protocol, including attachment for final certified Episode Initiators, Participating Practitioners, and Sharing Partners

D R A F T – “Aiming for” EQIP dates

BPCI-A vs. EQIP: Key documents with Conveners

BPCI-A (for effective date of 1/1/20)		EQIP (for effective date of 1/1/21)	
Request for Application (RFA) along with template for potential Episode Initiators (EIs) for vetting and for CMMI to produce preliminary target prices	4/18/19	RFA along with template potential Episode Initiators (EIs) et al. for vetting and for State to produce preliminary target prices	Spring 2020
• Application submitted by Participants	Due 6/24/19	• Application submitted by Conveners	Due Summer
CMS provides preliminary Target Prices	September 2019	HSCRC provides data flat file, including preliminary Target Prices (next slide)	Summer 2020
Participation Agreement (PA) available	Sept. 2019	PA available	Fall 2020
• Signed PA submitted by Participants	Nov. 2019	• Signed PA submitted by Conveners	Winter 2020
Participant Profile template, Care Redesign Plan template, Financial Arrangement list	TBD	Implementation Protocol (IP) Template available, including Certified EI template	Fall 2020
• Participant Profile, Care Redesign Plan, and Financial Arrangement list submitted	Nov. 2019	• IP and Certified EIs submitted	Winter 2020

EQIP outpatient-triggered episodes for Y1*

* State is currently in discussions/negotiations with CMMI on EQIP,
thus everything is subject to change.



Episode Categories for Y1: Limited to Outpatient Triggers

- ▶ Episode categories from BPCI Advanced where CMMI excluded Maryland:
 - ▶ Orthopedics
 - ▶ Cardiology
 - ▶ Gastrointestinal (GI)
- ▶ Emergency Department (ED) triggered

Proposed Episode Triggers for Y1

Orthopedics	Gastrointestinal (GI)	Cardiology	Emergency Department (ED) Triggered*
Knee Replacement & Knee Revision	Colonoscopy	Coronary Angioplasty	Efficient Admissions
Knee Arthroscopy	Gall Bladder Surgery	Pacemaker / Defibrillator	High-Frequency ED Users
Lumbar Laminectomy	Upper GI Endoscopy		
Shoulder Replacement			

* Efficient admissions triggers include ED visits for one of 9 conditions: Chest pain, Syncope, Congestive heart failure, Skin & soft tissue infections, Asthma/COPD, Deep vein thrombosis, Pneumonia, Atrial fibrillation, Hyperglycemia with diabetes mellitus. These may be subsequently split into a greater number of diagnosis-based episodes. High frequency ED use trigger is 4th ED visit within a 12-month period.

Note: CMS will not permit inpatient-triggered episodes to be included in Y1, though they may be included in 2022 and beyond



Current Methodology (HSCRC continuing validation)

- ▶ Data: Medicare Claim and Claim Line Feed (CCLF; i.e., Medicare-only claims) for the period July 2017-June 2018
- ▶ CPT trigger codes will be based upon publicly available definitions
- ▶ Each episode was identified using a CPT trigger from the *outpatient* claims*
 - ▶ Following a given outpatient CPT trigger, any facility claim (inpatient, outpatient, ASC, etc.) within the episode window was included
 - ▶ Episode windows are all currently 90 days except ED episodes, which are 14 days for Efficient Admissions and 30 days for High Utilizer
 - ▶ When multiple triggers were observed during the episode window for a single beneficiary, the first trigger was the winning episode (all other costs included but no new episodes triggered)
 - ▶ Episodes lacking a corresponding facility claim (“orphan claims”) were dropped
 - ▶ Part D prescription drug expenditures were not included
 - ▶ To calculate the average payments per episode, all applicable payments during the episode window were totaled, then divided by the total episodes

Potential Orthopedic Episodes & Maryland Spending

Outpatient
Orthopedic
Episodes planned
for EQIP Year 1

Episode	FY18 Medicare FFS Episodes	FY18 Medicare FFS Spending ¹	Average per 90-Day Episode ¹
Knee Arthroscopy	2,077	\$10.3 M	\$4,977
Knee Replacement/Revision	1,305	\$23.8 M	\$18,222
Lumbar Laminectomy	1,122	\$12.9 M	\$11,490
Shoulder Replacement	145	\$3.2 M	\$21,963
Total	4,649	\$50.2 M	\$10,797

Potential Inpatient
Orthopedic
Episodes for EQIP
Year 2 pending
CMS sign-off

Episode	FY18 Medicare FFS Episodes	FY18 Medicare FFS Spending ¹	Average per 90-Day Episode ¹
Knee Replacement/Revision	4,981	\$151.6 M	\$30,445
Lumbar Laminectomy	1,862	\$96.9 M	\$52,027
Shoulder Replacement	951	\$32.1 M	\$33,799
Hip Replacement	3,576	\$119.7 M	\$33,482
Lumbar Spine Fusion	530	\$35.7 M	\$67,324
Total	11,900	\$436.1 M	\$36,645

Chronic & Other
Potential Y2
Episodes

- Lower Back Pain
- Anterior cervical discectomy and fusion (ACDF)
- Osteoarthritis



Potential GI Episodes & Maryland Spending

Outpatient GI Episodes planned for EQIP Year 1

Episode	FY18 Medicare FFS Episodes	FY18 Medicare FFS Spending ¹	Average per 90-Day Episode ¹
Colonoscopy	50,928	\$231.6 M	\$4,547
Gall Bladder Surgery	1,172	\$11.0 M	\$9,396
Upper GI Endoscopy	18,184	\$123.3 M	\$6,780
Total	70,284	\$365.9 M	\$5,206

Potential Inpatient GI Episodes for EQIP Year 2 pending CMS sign-off

Episode	FY18 Medicare FFS Episodes	FY18 Medicare FFS Spending ¹	Average per 90-Day Episode ¹
Colonoscopy	2,762	\$119.0 M	\$43,092
Gall Bladder Surgery	997	\$33.6 M	\$33,672
Upper GI Endoscopy	5,511	\$330.6 M	\$59,985
Colorectal Resection	835	\$52.3 M	\$62,665
Total	10,105	\$535.5 M	\$52,993

Chronic & Other Potential Y2 Episodes

- Bariatric Surgery
- Crohn's Disease
- Diverticulitis
- Gastro-Esophageal Reflux Disease
- GI Bleed
- Intestinal Obstruction
- Pancreatitis
- Ulcerative Colitis



Potential Cardiac Episodes & Maryland Spending

Outpatient
Cardiac
Episodes
planned for
EQIP Year 1

Episode	FY18 Medicare FFS Episodes	FY18 Medicare FFS Spending ¹	Average per 90-Day Episode ¹
Coronary Angioplasty	1,505	\$28.5 M	\$18,925
Pacemaker / Defibrillator	2,472	\$56.8 M	\$22,970
Total	3,977	\$85.3 M	\$21,439

Potential
Inpatient
Cardiac
Episodes for
EQIP Year 2
pending CMS
sign-off

Episode	FY18 Medicare FFS Episodes	FY18 Medicare FFS Spending ¹	Average per 90-Day Episode ¹
Coronary Angioplasty	2,218	\$94.8 M	\$42,719
Pacemaker / Defibrillator	1,438	\$75.6 M	\$52,547
CABG &/Or Valve Procedures	1,716	\$142.5 M	\$83,038
Total	5,372	\$312.8 M	\$58,229

Chronic & Other Potential Y2 Episodes

- Acute Congestive Heart Failure
- Acute Myocardial Infarction
- Arrhythmia / Heart Block / Conduction Disorders
- Heart Failure
- Shock / Cardiac Arrest (SRF)



Potential ED Episodes & Maryland Spending

Outpatient ED Episodes planned for EQIP Year 1	Episode	FY18 Medicare FFS Episodes	FY18 Medicare FFS Spending ¹	Average per Episode ¹
	Efficient Admissions	32,779	\$117.1 M	\$3,572
	High-Frequency ED Users	17,470	\$109.0 M	\$6,242
	Total	50,249	\$226.1 M	\$4,500

Breakout of Efficient ED Episodes by Primary Dx, Episode may be split up on this basis

Primary Dx	FY18 Medicare FFS Episodes	FY18 Medicare FFS Spending	Average per Episode	Primary Dx	FY18 Medicare FFS Episodes	FY18 Medicare FFS Spending	Average per Episode
Asthma COPD	3,507	\$11,187,606	\$3,190	DVT	771	\$2,643,120	\$3,428
Atrial Fibrillation	1,856	\$7,251,423	\$3,907	Hyperglycemia	1,304	\$3,802,997	\$2,916
Chest Pain	13,723	\$50,043,046	\$3,647	Pneumonia	2,116	\$7,537,753	\$3,562
CHF	590	\$3,222,577	\$5,462	Skin Infection	3,649	\$9,088,625	\$2,491
				Syncope	5,263	\$22,324,553	\$4,242



Overview of Episode Design Parameters

- ▶ **EQIP Benchmarking and Target Pricing Overview for Year 1: How Maryland's proposed approach compares to other CMMI model options**
- ▶ **Key Elements and Maryland Approach**
 - ▶ Payments
 - ▶ Benchmarks, Adjustments and Target Prices
 - ▶ Assuming and Mitigating Risk
- ▶ **EQIP Participants' Potential Savings Strategies**
- ▶ **Other issues (quality measures, data and reporting, Y2 options)**

EQIP Episode Model Elements: Y1 Payments

Element	Potential Approach	Description	Maryland Approach
Service Payments	Traditional FFS	Pay through traditional claims method	✓
	Benchmark / capitated	Participants can only bill for the benchmark rate or receive a capitated payment	✗
Performance Payments	Financial performance	Compare target price versus actual payments	✓
	Quality adjustment	Based on performance on quality measures or for specific outcomes	✓
Enhanced Payments	Flat fee / enhanced	CMMI employs population-based payments, enhanced service payments, and flat fee approaches.	✗

EQIP Model Elements: Y1 Benchmark Methods

Element	Potential Approach	Description	Maryland Approach
Historical Baseline	1-2 years of Medicare FFS claims	Generally 2-3 years for CMMI models	✓
Episode Costs	Total cost of care	Either targeted episodes or total cost of care	✓
	Exclusions	Exclusions may be applied based on beneficiary characteristics, e.g., require full Part A and Part B eligibility	✓
Trend	Medicare FFS payment rate changes	Use information from published price schedules	✓
	GBR / MD-HSCRC	Apply separate trend accounting for MD hospital payments	✓
	Regional / peer date	Base part of trend on regional values or peer groups	✗
	Data Refresh	The baseline can be recalculated using more up to date information to address the lag between the available data and the start of a new model (e.g., new and costlier treatments may become more common)	✓ <i>Baseline ends no later than the CY, 2 years before performance year*</i>



EQIP Model Elements: Y1 Adjustments

Element	Potential Approach	Description	Maryland Approach
Discount Factor	Percentage (3%)	CMS sets a percentage of the benchmark that will not be available to participants	✓
Withhold	None	CMS may hold back a percentage of the payment rather than attempting to take back some amount in the future, if necessary	✗
		If participants do not owe money, then these funds will be released as part of the reconciliation process	
Historical Experience	Participant	A participant's own historical experience may be used to adjust the benchmark either as part of a blended rating system (e.g. CJR) or for a specific time period	✓
	MD beneficiaries	Regional experience may be employed as well.	✓ <i>Only for small cell sizes</i>
	Peer data	Efficiency factors are used to align incentives for participation and avoid the potential for pre-determined winners based only on selection	✗



EQIP Model Elements: Y1 Adjustments Continued

Element	Potential Approach	Description	Maryland Approach
Geography	Actual	Payment rates based on actual claims history	✓
	Standardized	Standardized FFS claims can offset comparisons, but the data will need to be adjusted to reflect actual payment conditions	✗
Outliers	Winsorize	Average episode expenditures can be skewed by a few very high or very low cost outliers	✓
		Winsorization is used to cap very high expenditures and place a floor on very low expenditures so as to not skew the results; often set at 99 th and 1 st percentiles	
Other	Accounting for GBR feedback	Because global budgeting, reductions in Medicare hospital utilization do not produce a one-for-one savings to Medicare	✓
		Episode savings associated with lower hospital spending will be discounted by 35%	

EQIP Model Elements: Y1 Target Prices

Element	Potential Approach	Description	Maryland Approach
Target Prices	Target prices will be compared against actual expenditures	Establish a basis for comparison for actual expenditures during a model; calculate actual performance relative to target price, with quality adjustments.	✓ <i>Actual history updated with trend and case mix to performance year and then discounted</i>
Price Cells	Classify payments into subsets based on setting, diagnosis, etc.	Price cells are related to case mix adjustment as their values should be set to capture important differences in expected costs	<i>Likely</i>
Reconciliation	One time	<p>The reconciliation process compares actual expenditures versus the target amounts and determines potential participant outlays and payments based on the model rules including quality adjustments</p> <p>Some models incorporate multiple iterations (e.g., OCM has three per performance period)</p>	✓ <i>Run out period under consideration</i>



EQIP Model Elements: Y1 Risk Sharing & Mitigation

Element	Potential Approach	Description	Maryland Approach
Risk sharing	One sided	Participants share in savings (upside only) but do not reimburse losses	✗
	Two sided	Participants share savings as well as potential losses (downside risk)	✓
		Advanced Alternative Payment Models require two sided risk	
Mitigation	Voluntary	Voluntary participation lets eligible participants choose whether to take-on or avoid risk on an annual basis	✓
	Stop-loss / stop-gain	Provisions that set a threshold beyond which participant exposure (stop-loss) and performance payments (stop-gain) are capped	✓ <i>20% of the target price at the episode initiator level</i>
	Winsorize	WinsORIZATION or other methods of reducing the impact of extreme outliers are a way of reducing risk	✓ <i>At 99th and 1st percentiles</i>

EQIP Model Elements: Y1 Case Mix Adjustment

Element	Potential Approach	Description	Maryland Approach
Methods	Rate cells	Intended to bucket beneficiaries with similar costs into the general categories	✓
	Risk scores	HCC scores or HCC score categories can be employed to the extent that they predict expenditures well for subsets of beneficiaries.	✓
	Regression	Regression models are employed for OCM, BPCI-A and the proposed Radiation Oncology model	<i>Under consideration</i>
Factors	Demographic	Age and gender	✓
	Diagnosis / Event	For example: APR-DRG, chronic condition status, hip fracture	✓
	Eligibility category	Dual enrollees, for example	<i>Under consideration</i>



Savings Strategy and Relative Impact: Hypothetical Examples Before CMS Discount

Scenario	Type of Spend	Unregulated	Regulated	Regulated	Regulated
	Savings Strategy	Eliminate	Eliminate	Shift to Cheaper Regulated Setting	Shift to Cheaper Unregulated Setting
	Cost Offset Type	None	None	Regulated	Unregulated
Inputs	Gross Savings before Offset	\$1,000	\$1,000	\$1,000	\$1,000
	Cost Offset Amount	\$0	\$0	\$800	\$650
Savings Calculation	Net Unregulated Savings (Dissavings)	\$1,000	\$0	\$0	(\$650)
	Net Regulated Savings (Dissavings)	\$0	\$1,000	\$200	\$1,000
	GBR Discount (35% of net regulated savings)	\$0	(\$350)	(\$70)	(\$350)
Net Savings		\$1,000	\$650	\$130	\$0

Example Savings Calculation by Cost Bucket

				Regulated Costs	Unregulated Costs	Total	Case Mix
Baseline Costs	a	Baseline Period Total Costs (1)		\$100,000	\$50,000	\$150,000	
	b	Episodes				10	
	c	Baseline Period Cost per Episode	=a / b	\$10,000	\$5,000	\$15,000	1.00
Performance Period Costs	d	Performance Period Total Costs (1)(2)		\$80,000	\$55,000	\$135,000	
	e	Episodes				10	
	f	Performance Period Cost per Episode	=d / e	\$8,000	\$5,500	\$13,500	1.01
Target Price Calculation	g	Average Annual Trend (3)		2.0%	3.0%		
	h	Trend Periods in Years (4)		2	2		
	i	Trended Baseline Costs	= c * (1+g) ^ h	\$10,404	\$5,305	\$15,709	
	j	Case Mix Adjusted Trended Baseline Costs (5)	= i * f / c	\$10,508	\$5,358	\$15,866	
	k	Target Discount		3.0%	3.0%	3.0%	
l	Case Mix Adjusted Target Price	= j * (1-k)	\$10,193	\$5,197	\$15,390		
Savings Calculation	m	Per Episode Savings (Dissavings) before GBR feedback	= l - f	\$2,193	-\$303	\$1,890	
	n	GBR Discount (Regulated Only)(6)	= (j - f) * 0.35	\$878		\$878	
	o	Per Episode Savings (Dissavings)	= m - n	\$1,315	-\$303	\$1,012	
	p	Total Savings (Dissavings) to Convener before quality adjustment (7)	=o * e	\$13,150	-\$3,032	\$10,118	

1. Based on one year \$ paid by Medicare after winsORIZATION
2. Assumes increase in unregulated is driven by shifts in site of service
3. Actual trends determined annually based on HSCRC GBR update and CMS inflation factors on individual unregulated cost components
4. Assumes baseline period is CY2019 and performance period is CY2021
5. Based on ratio of case mix values. More complex case mix adjustment methodologies are under consideration.
6. GBR discount has no impact on Unregulated savings
7. Final payments from CMS would be adjusted based on the quality results.



Quality Measures

- ▶ To qualify as an Advanced Alternative Payment Model and qualify participants for potential MACRA bonuses, EQIP will need to include quality measures
- ▶ Convener Reconciliation Payments will be adjusted for quality performance based on individual EI performance weighted on episode volume
- ▶ Measures will be applied at two levels:
 - ▶ For all episodes regardless of specialty area
 - ▶ Potential MIPS measures: Advance Care Plan (#47), Closing the Referral Loop Receipt of Specialist Report (#374) and Documentation of Current Medications (#130)
 - ▶ Episode-specific
 - ▶ TBD. State will aim to align with priority areas for TCOC Model and ongoing quality programs
 - ▶ E.g., THA/TKA Surgical Complications measure (NQF #1550)
- ▶ State plans to vet and discuss potential measures as a part of EQIP subgroup

Proposed Approach for Y2 and Beyond

- ▶ Add Inpatient-triggered episodes
- ▶ Add Chronic episodes
- ▶ For Y1 participants, target prices will not be reset (except for normal adjustments for trend and case mix) for at least the first 3 years, except HSCRC may:
 - ▶ Adjust for shifts in place of service (eliminating pure shift savings after a more limited period)
 - ▶ For participants starting after Y1, set targets based on their start date (for example if the start date is 1/1/22, CY20 would be considered for target setting)

Data and Reporting Schedule

- ▶ **Summer 2020: Preliminary Descriptive Analytics**
 - ▶ Based on the list of potential EIs submitted as part of the RFA, the State will be calculating and providing to potential Conveners a flat file with preliminary target prices and many other variables (e.g. spend by place of service)
 - ▶ File will not include PHI but will include enough information for potential Conveners to do analyses and make decisions
 - ▶ File will mirror table shells used by CMS for this purpose
- ▶ **After Convener Signs Participation Agreement (late 2020): Claims Detail File**
 - ▶ Conveners with a signed participation agreement will be able to regularly download detail data about historic and current beneficiary episodes for their participating EIs
- ▶ **Spring 2021: CRISP Reporting Tool**
 - ▶ Reporting on completed episodes at a summary level will be available through CRISP Reporting Services. This reporting will also calculate participant savings or dissaving and will reflect official results that will populate CMS payment adjustments

Next Steps

- ▶ The State is releasing a Request for Information (RFI) specific input requested includes:
 - i. Episode design (see appendix and separate handout on trigger CPT codes)
 - ii. Payment windows and methodologies
 - i. Trade-off of complete run out versus more timely payment
 - ii. Trade-off of reconciliation window versus earlier payment finalization
 - iii. Episodes to include in Y2 (prioritization)
- ▶ Future EQIP Subgroup will be devoted to discussing:
 - ▶ Potential EQIP episodes for Oncology and Radiation-Oncology
 - ▶ Episode-specific Quality Measures
 - ▶ Methodology and RFI feedback

Appendix 1: Glossary and CPT Codes



Glossary of Terms

- ▶ **ACO** – Accountable Care Organizations, or those participating in the CMMI Model.
- ▶ **Annual Medicare Savings** - the annual Medicare TCOC savings per Maryland Medicare Beneficiary as defined in the Agreement.
- ▶ **Benchmark Price** - A metric used by the State, together with the Discount Factor, to calculate an Episode Initiator-specific Target Price for each Clinical Episode. The Benchmark Price is calculated based on a combination of historical Medicare FFS spending, adjusted to reflect the Episode Initiator's efficiency relative to its peers, along with adjustments for patient characteristics and regional spending trends.
- ▶ **Clinical Episode** – The defined period of time triggered by the provision of a designated trigger service or procedure by an Episode Initiator to an EQIP Beneficiary, during which all Medicare FFS expenditures for all non-excluded items and services furnished to a EQIP Beneficiary are bundled together as a unit for purposes of calculating the Target Price and for purposes of Reconciliation.
- ▶ **Convener-Initiator Arrangement** - An arrangement between an Episode Convener and an Episode Initiator that is in writing and satisfies the applicable requirements of the EQIP Participation Agreement. Pursuant to the Convener-Initiator Arrangement, the Episode Convener may: (1) share the NPRA and, if applicable, CIPs paid by CMS to the Episode Convener with the Episode Initiator; and/or (2) apportion to the Episode Initiator some or all of a Repayment Amount owed to CMS by the Episode Convener .
- ▶ **Discount Factor** —A set percentage by which CMS reduces the Benchmark Price in order to calculate the Target Price.
- ▶ **Downstream Participant** – An Episode Initiator, Participating Practitioner, Sharing Partner, or Sharing Partner Participating Practitioner
- ▶ **Episode Care Improvement Program** – “ECIP” is a Track in the Maryland Care Redesign Program which includes inpatient bundles for Hospital accountability, similar to those included in CMMI's Bundled Care Improvement Program- Advanced.
- ▶ **Episode Convener** – An entity that brings together at least two downstream Episode Initiators to participate in EQIP, facilitates coordination among them, and bears full financial risk to CMS under the Program. An Episode Convener may be an entity that is either a Medicare-enrolled provider or supplier or an entity that is not enrolled in Medicare. An Episode Convener may not be a Regulated Maryland Hospital.
- ▶ **Episode Initiator (EI)** – A Medicare provider or supplier that has entered into a Convener-Initiator Arrangement with an Episode Convener and that initiates Clinical Episodes through the provision of a designated triggering service or procedure.
- ▶ **EQIP** or **Program** - the Episode Quality Improvement Program under the Maryland Total Cost of Care Model.
- ▶ **EQIP Track Implementation Protocol Template** – A form that has been approved by CMS, that is designed to be completed by the Episode Convener and to set forth the Episode Convener's plan for participating in an EQIP Track selected by the Episode Convener.
- ▶ **EQIP Beneficiary** – A Maryland Medicare FFS Beneficiary on whose behalf an Episode Initiator submits a trigger claim to Medicare FFS. The term EQIP Beneficiary specifically excludes: (1) Medicare beneficiaries covered under United Mine Workers or managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations); (2) beneficiaries eligible for Medicare on the basis of end-stage renal disease (ESRD); (3) Medicare beneficiaries for whom Medicare is not the primary payer; and (4) Medicare beneficiaries who enter hospice during the Clinical Episode.

Glossary of Terms, Cont.

- ▶ **Maryland Medicare FFS Beneficiary** -- An individual enrolled in Medicare Part A or Part B but who is not enrolled in Medicare Part C (Medicare Advantage), and who resides in Maryland.
- ▶ **Medicare Fee-for-Service (FFS)** – Medicare Parts A and B, and does not include Part C (Medicare Advantage) or Part D.
- ▶ **Net Payment Reconciliation Amount (NPRA)** –the amount paid to the Episode Convener by CMS, if the summed total of Negative Total Reconciliation Amounts and Adjusted Positive Total Reconciliation Amounts for the Episode Convener’s Episode Initiators is positive, as specified in the Reconciliation Report.
- ▶ **Performance Year** – The 12-month period beginning on January 1 of each calendar year during the EQIP in which one or more EQIP Tracks is in effect.
- ▶ **PGP** – Physician Group Practice which may participate as an Episode Initiator and submit a list of their physicians who constitute their Participating Practitioners.
- ▶ **Reconciliation** – The annual process of comparing the aggregate Medicare FFS expenditures for all items and services included in a Clinical Episode attributed to an Episode Initiator against the Target Price for that Clinical Episode to determine whether the Episode Initiator is eligible to receive an NPRA payment from CMS, or is required to pay a Repayment Amount to CMS.
- ▶ **Repayment Amount** – Monies owed to CMS by the Episode Convener, as determined during Reconciliation.
- ▶ **RFI** – Request for Information, i.e. solicitation of stakeholders for formal design input and feedback to the State.
- ▶ **Sharing Partner** - A physician group practice (PGP), accountable care organization (ACO), or a post-acute care (PAC) provider (skilled nursing facility, inpatient rehabilitation facility, or a home health agency) that is not an Episode Initiator; that participates in EQIP Activities; and with whom an Episode Convener has executed a Sharing Partner Arrangement.
- ▶ **Target Price** – The Benchmark Price reduced by the Discount Factor.

CPT trigger codes used for orthopedics episodes

Episode	CPT Triggers
Hip Replacement & Hip Revision	27125, 27130, 27132, 27134, 27137, 27138, S2118
Knee Arthroscopy	29866, 29867, 29868, 29870, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29888, 29889
Knee Replacement & Knee Revision	27446, 27447, 27486, 27487
Lumbar Laminectomy	63005, 63011, 63012, 63017, 63030, 63035, 63042, 63044, 63047, 63056, 63057, S2350, S2351
Lumbar Spine Fusion	22533, 22558, 22612, 22630, 22633, 22800
Shoulder Replacement	23470, 23472, 23473, 23474



CPT trigger codes used for GI episodes

Episode	CPT Triggers
Colonoscopy	44388, 44389, 44392, 44394, 44403, 44404, 45330, 45331, 45333, 45335, 45338, 45378, 45380, 45381, 45384, 45385, 45390, G0104, G0105, G0106, G0120, G0121, G0122
Colorectal Resection	44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45123, 45126, 45160, 45170, 45171, 45172, 45395, 45397
Gall Bladder Surgery	47562, 47563, 47564, 47600, 47605, 47610, 47612, 47620
Upper GI Endoscopy	43200, 43201, 43202, 43204, 43205, 43206, 43211, 43212, 43213, 43214, 43215, 43216, 43217, 43219, 43220, 43226, 43227, 43228, 43229, 43231, 43232, 43233, 43234, 43235, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43252, 43253, 43254, 43255, 43256, 43257, 43258, 43259, 43266, 43270

CPT trigger codes used for cardiology episodes

Episode	CPT Triggers
CABG &/or Valve Procedures	33400, 33401, 33403, 33405, 33406, 33410, 33411, 33412, 33413, 33414, 33415, 33416, 33417, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33472, 33474, 33475, 33476, 33478, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33860, 33861, 33863, 33864, 33870
Coronary Angioplasty	92920, 92921, 92924, 92925, 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, 92944, 92973, 92980, 92981, 92982, 92984, 92995, 92996, C9600, C9601, C9602, C9603, C9604, C9605, C9606, C9607, C9608, G0290, G0291
Pacemaker / Defibrillator	0319T, 0321T, 0387T, 33206, 33207, 33208, 33212, 33213, 33214, 33221, 33224, 33225, 33227, 33228, 33229, 33230, 33231, 33240, 33249, 33262, 33263, 33264, 33270, 33271, 71090, C1721, C1722, C1785, C1786, C1882, C2619, C2620, C2621, G0448



Trigger codes used for ED episodes

- ▶ The following codes are used to trigger both the “Efficient Admissions” episode and “High-Frequency ED Users” episode:

Code Type	Triggers
CPT	99281, 99282, 99283, 99284, 99285
Revenue Code	045X

ICD-10 trigger codes used for ED episodes*

- ▶ The following codes are further used to determine if a patient in the “Efficient Admissions” episode has a qualifying diagnosis:

Episode	ICD-10 Triggers
Chest Pain	R07.1, R07.2, R07.9, R07.81, R07.89
Syncope	R55, T67.1XXA, G90.01
CHF	I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
Skin & Soft Tissue Infection	L08.0, L08.1, L08.81, L08.82, L08.89, L08.9, K12.2, L03.011, L03.012, L03.019, L03.031, L03.032, L03.111, L03.112, L03.113, L03.114, L03.115, L03.116, L03.119, L03.211, L03.213, L03.221, L03.311, L03.312, L03.313, L03.314, L03.315, L03.316, L03.317, L03.319, L03.811, L03.90, N48.22, H05.011, N61.0, N61.1, L01.00, L01.03, L02.01, L02.11, L02.211, L02.212, L02.213, L02.214, L02.215, L02.219, L02.223, L02.31, L02.411, L02.412, L02.413, L02.414, L02.415, L02.416, L02.419, L02.423, L02.424, L02.511, L02.611, L02.612, L02.619, L02.811, L02.831, L02.91, L02.92
Asthma/COPD	J44.0, J44.1, J44.9, J45.20, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.51, J45.52, J45.90, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
Deep Vein Thrombosis	I82.401, I82.402, I82.403, I82.409, I82.411, I82.412, I82.413, I82.419, I82.421, I82.422, I82.423, I82.429, I82.431, I82.432, I82.433, I82.439, I82.441, I82.442, I82.443, I82.449, I82.451, I82.452, I82.453, I82.459, I82.461, I82.462, I82.463, I82.469, I82.491, I82.492, I82.493, I82.499, I82.4Y1, I82.4Y2, I82.4Y3, I82.4Y9, I82.4Z1, I82.4Z2, I82.4Z3, I82.4Z9, I82.501, I82.502, I82.503, I82.509, I82.511, I82.512, I82.513, I82.519, I82.521, I82.522, I82.523, I82.529, I82.531, I82.532, I82.533, I82.539, I82.541, I82.542, I82.543, I82.549, I82.551, I82.552, I82.553, I82.559, I82.561, I82.562, I82.563, I82.569, I82.591, I82.592, I82.593, I82.599, I82.5Y1, I82.5Y2, I82.5Y3, I82.5Y9, I82.5Z1, I82.5Z2, I82.5Z3, I82.5Z9, I82.601, I82.602, I82.603, I82.609, I82.611, I82.612, I82.613, I82.619, I82.621, I82.622, I82.623, I82.629, I82.701, I82.702, I82.703, I82.709, I82.711, I82.712, I82.713, I82.719, I82.721, I82.722, I82.723, I82.729, I82.A11, I82.A12, I82.A13, I82.A19, I82.A21, I82.A22, I82.A23, I82.A29, I82.B11, I82.B12, I82.B13, I82.B19, I82.B21, I82.B22, I82.B23, I82.B29, I82.C11, I82.C12, I82.C13, I82.C19, I82.C21, I82.C22, I82.C23, I82.C29, I82.811, I82.812, I82.813, I82.819, I82.890, I82.891, I82.90, I82.91
Pneumonia	J18.0, J18.1, J18.2, J18.8, J18.9, B96.1, J10.00, J10.08, J11.00, J11.08, J12.2, J12.9, J13., J15.1, J15.212, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8
Atrial Fibrillation	I48.0, I48.11, I48.19, I48.20, I48.21, I48.3, I48.4, I48.91, I48.92
Hyperglycemia with Diabetes Mellitus	E10.65, E11.65, E13.65, E09.65, E08.65, R73.9



Appendix 2: Info from nationally experienced episode conveners / contractors

Fusion5
Premier
Signify



Fusion 5

Fusion5

A Convener Option

Fusion5 was founded to help providers achieve success in the shift from FFS to value-based care

Fusion5 builds partnerships to maximize value-based payment model opportunities by simplifying complexity and creating sustainable solutions that enhance the ability to improve outcomes in the evolving healthcare landscape



Operations in 40 states



Top 2 Bundled Payment Convener



>3,000 Physician Partners



100 Hospital/Physician Group Engagements



50,000 Episodes of Care Managed Annually¹

1. Forecasted based on current contracted customer episode volume

Fusion5 manages the largest musculoskeletal bundled payment network in the US

Fusion5's broad range of solutions and capabilities provide a path to operationalize value-based care (VBC) opportunities

Not Exhaustive

Fusion5 Attributes

- Flexibility
- Experience
- Market Insight
- Actionable Insights
- Quality
- Technology
- Performance

Solutions & Opportunities



Supported Procedures

- Orthopedics
- Bariatrics
- Maternity
- Spine
- Cardiology
- Other Medical

1. Total Cost of Care
 2. Accountable Care Organization

Fusion5 – Pioneering the Value-Based Experience

Leading the Way – Addressing Specific Client Goals and Objectives

<p>CMS BPCI Classic & Advanced</p>	<ul style="list-style-type: none"> • Thought leader CMS/CMMI BPCI-A collaborator • Program structure & analytics refinement • Gainshare contracting and solutions • Risk-sharing CMS BPCI-A Convener 	<p>Market Insight & Expertise</p>	<ul style="list-style-type: none"> • Proven results in markets nationwide • Library of best practice solutions • Maximize hospital and physician practice realized value in bundled payments • Delivering scale and transparency
<p>Care Management</p>	<ul style="list-style-type: none"> • Care redesign & pathways tied to continuous quality & outcome improvement • Evidence-based clinical decision-making • Standard transition of care protocols • Care coordination across multiple treatment settings 	<p>eFusion</p>	<ul style="list-style-type: none"> • Care management • Data Analytics – transparent & actionable • Highly configurable • Data integration, exchange, & reporting
<p>High Performance Networks</p>	<ul style="list-style-type: none"> • Afford payers ability to control rising costs • Address low-value/wasteful spending • Outcome-driven care/high patient satisfaction 	<p>Maternity Care</p>	<ul style="list-style-type: none"> • Enhanced care coordination across duration of pregnancy • Supports healthy pregnancies & reduces risks of complications
<p>Chronic-Complex Care Management</p>	<ul style="list-style-type: none"> • Structured recording of patient health info • Self-management education & support • Managing transitions of care • Maintaining electronic health plan 	<p>Specialty Care Networks</p>	<ul style="list-style-type: none"> • Musculoskeletal • Post-acute care • Cardiac • Bariatric • Major medical

The F5 Leadership Team has a history of delivering clinical and financial success in Bundled Payments

Reduced

- ✓ Medical cost ratio (MCR) to **68%**
- ✓ 30-day readmission by **>15%**
- ✓ Surgical site infection by **>40%**
- ✓ Acute MI within 7 days by **>20%**
- ✓ Urinary tract infection by **>20%**



\$950M
Spended Managed

>200,000
Episodes Managed¹

\$190M
Cost Reductions²

98%+
Patient Satisfaction

Source: CMS BPCI-A Program baseline data received June 2018 for Providers included on the F5 2018 submission; Fusion5 Analysis
(1) Represents cumulative total episode volume over the BPCI Classic program
(2) Cumulative savings generated over a 3 year period

The eFusion platform is our proprietary cloud-based fully integrated Care Management & Analytics Solution

<p>Care Management Solutions</p>	<ul style="list-style-type: none"> • Highly Configurable for Bundled Programs & Episodes • Efficient Clinical Workflow & Patient Stratification Tools • Easily View & Manage Multiple Staffing Models • 200+ Comprehensive Assessments & Predictive Risk Tools • Patient Portal & Provider Education Tools
<p>Integrated Data Analytics</p>	<ul style="list-style-type: none"> • Guided discovery to provide the right data, at the right time to make informed strategic decisions • Interactive Experience with Population Based Graphs • Episode and Patient Review with Detailed Drill-down Capabilities • Real-time Data Access & Reporting Capabilities
<p>Detailed Operational Reporting</p>	<ul style="list-style-type: none"> • Real-time and historical Reporting Capabilities • Interactive Reports that provide direct links to eFusion Tools • Download & Export in multiple formats
<p>Secure & Interoperable Interfaces</p>	<ul style="list-style-type: none"> • Secure Cloud Based MFA Technology • Interface with Physician Group Practices and Hospitals via HL7, ANSI X12 and Custom Formats • Real-Time Data Exchange with many EHRs such as EPIC, NextGen, Centricity, CareTracker, Allscripts, eClinicalWorks etc.

Simplify Process of Care Navigation and Data Analysis

State-of-the-Art Platform Design and Functionality

Fully Integrated Care Management and Analytics

Provide Program Support for Continuous Process Improvement

Fusion5 provides services and solutions that deliver improved outcomes in non-traditional payment models

Fusion5 Solution Scope

VBC Service Lines

Bundled Payments

VBC Services

VBC Strategy Development

Program Design & Admin.



- Contracting
- Network development and ongoing management
- Program services scoping and pricing

Care Coordination & Navigation



- Risk assessments and care pathway redesign
- Ongoing patient engagement, interventions, and care management

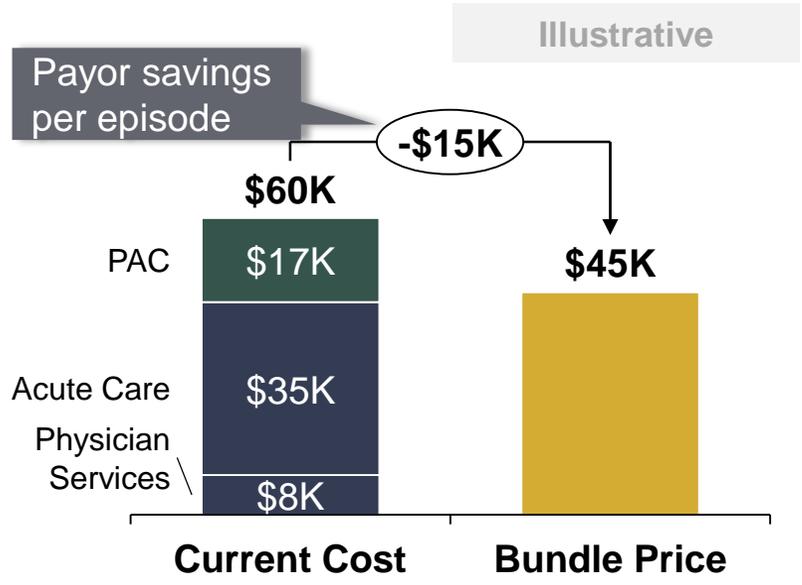
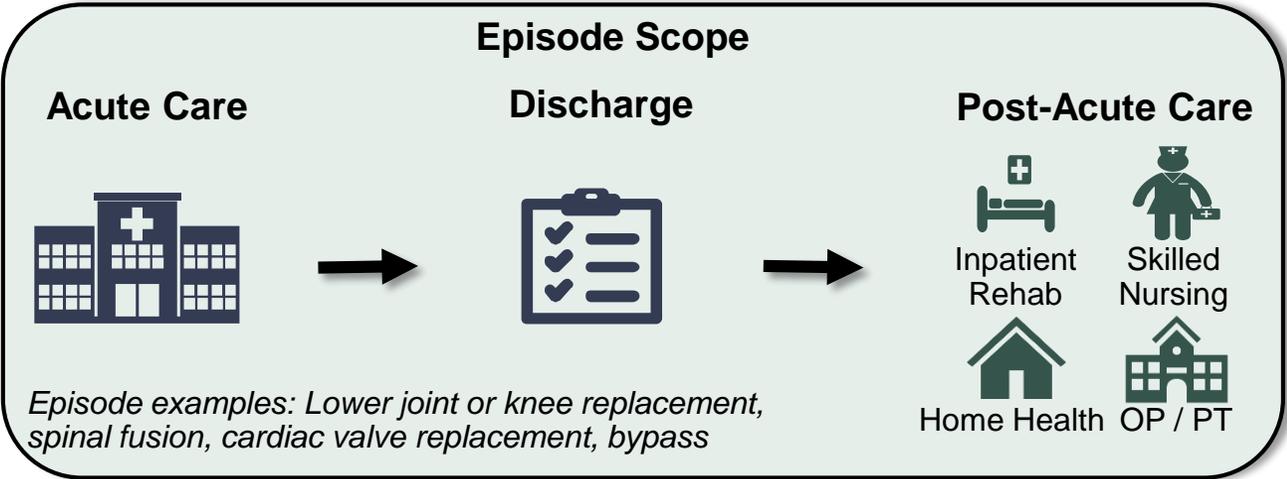
Technology & Analytics



- Patient / Employee care journey IT platform
- Patient cost and quality outcomes

How do bundled payments drive quality care improvement and cost reduction?

Example Bundle Program Design



Payment Model	Care Improvement Levers	Cost Reduction Levers
<ul style="list-style-type: none"> • Single “target” payment that covers care for a defined period • Target set below current average cost • Providers are responsible for any costs incurred over target price 	<ul style="list-style-type: none"> • Elite acute care physicians • Preferred post acute care network comprised of cost-effective high-quality providers • Care management and ongoing patient engagement from episode start to finish 	<ul style="list-style-type: none"> • Cost effective discharge decisions and clinical pathways • Improved outcomes in the post-acute setting • Reduced readmissions driven by patient engagement and care management

Fusion5 is flexible –our solutions are designed for the specific needs of payer partners

		FUSION5 Edge
 Flexibility	▶	Healthcare is local – our solutions are flexible and designed to address the specific needs of each employer patient population
 Experience	▶	Our team has expertise across provider & payor settings with proven track record in improving outcomes and reducing costs in value-based payment arrangements
 Provider Management	▶	We deploy a service model designed to support both the clinical and business elements of VBC payment arrangements
 Provider Network	▶	Access to national network of specialist actively engaged in value based care initiatives – available for participation in commercial bundles
 Technology	▶	Intelligent and actionable analytics powering clinical decision making, care management, and patient engagement tools

Contacts

Name	Title	E-Mail
Jerry Rupp	Chief Innovation Officer	Jerry.rupp@fusion5.us
Ryan Dillon	VP of Operations	Ryan.dillon@fusion5.us

Premier



Premier Performance Partners Capabilities

Premier helps members build and sustain essential capabilities

 <p>Supply Chain</p> <ul style="list-style-type: none"> • Med/Surg supplies • Supply chain operations • Purchased services • Capital and construction • Pharmacy • High value implants 	 <p>Physician Enterprise</p> <ul style="list-style-type: none"> • Workflow optimization • Technology optimization • Clinical space allocation • Staffing/skill mix • Revenue enhancement 	 <p>Clinical Delivery Optimization</p> <ul style="list-style-type: none"> • Procedure/testing utilization • Level of Care • Length of Stay • Interdisciplinary rounds • Discharge management 	 <p>Workforce Management</p> <ul style="list-style-type: none"> • Skill mix • Span of control • Productivity • Workflow • Workforce expense • Benefits
 <p>Quality Improvement</p> <ul style="list-style-type: none"> • Value based purchasing • Clinical documentation improvement • Compliance, regulatory and accreditation • Utilization / denials management 	 <p>Clinical Transformation</p> <ul style="list-style-type: none"> • Continuum of care strategy/ integration • Care Management model re-design to support value-based payer contracts (bundles) • Complex and Chronic care model development 	 <p>Throughput and Capacity</p> <ul style="list-style-type: none"> • Readmission prevention • Post-acute assessment and strategy • Network development, design, launch, and implementation 	 <p>Population Health & Strategy</p> <ul style="list-style-type: none"> • Value-based strategy and PI • CIN development • Physician alignment • Payer contracting • System integration • Service line rationalization • Merger/Acquisition

Capabilities offered as individual solutions or in combination



Collaboratives

- Population Health
- Bundled Payment
- QUEST
- Physician Enterprise

Our mission is to provide innovative services and tools to help organizations successfully transition to value-based care and value-based payment.



Supply Chain and Enterprise Value Optimization Advisory

- Non-labor Expense Reduction
- Supply Chain Operations
- Supply Chain Co-Management
- High Value Implants
- Pharmacy
- Enterprise Value Optimization



Strategy Innovation and Population Health Advisory

- Population Health
- **Bundled Payment**
- Innovative Consulting
- Advisory Services
- Pop Health Strategy
- Physician Enterprise
- Collaboratives



Control Tower Advisory

- Regulatory
- High Reliability Medicine
- Clinical Performance Partners
- Clinical Delivery Optimization
- Service Line Analytics and Integrated Technology
- Operational Performance Partners



Premier's Population Health (SIPH)



Collaboratives



POPULATION HEALTH COLLABORATIVE



BUNDLED PAYMENT COLLABORATIVE

Advisory Services and Subject Matter Expertise

Clinical Integration	PCMH	Shared Savings
Network Development	Care Management	Measures Development
Pop Health Strategy	Bundled Payments	Value-based contracting
Health System Strategy	Service Line Optimization	Economic Analysis
Physician Alignment	Post Acute Network	MACRA

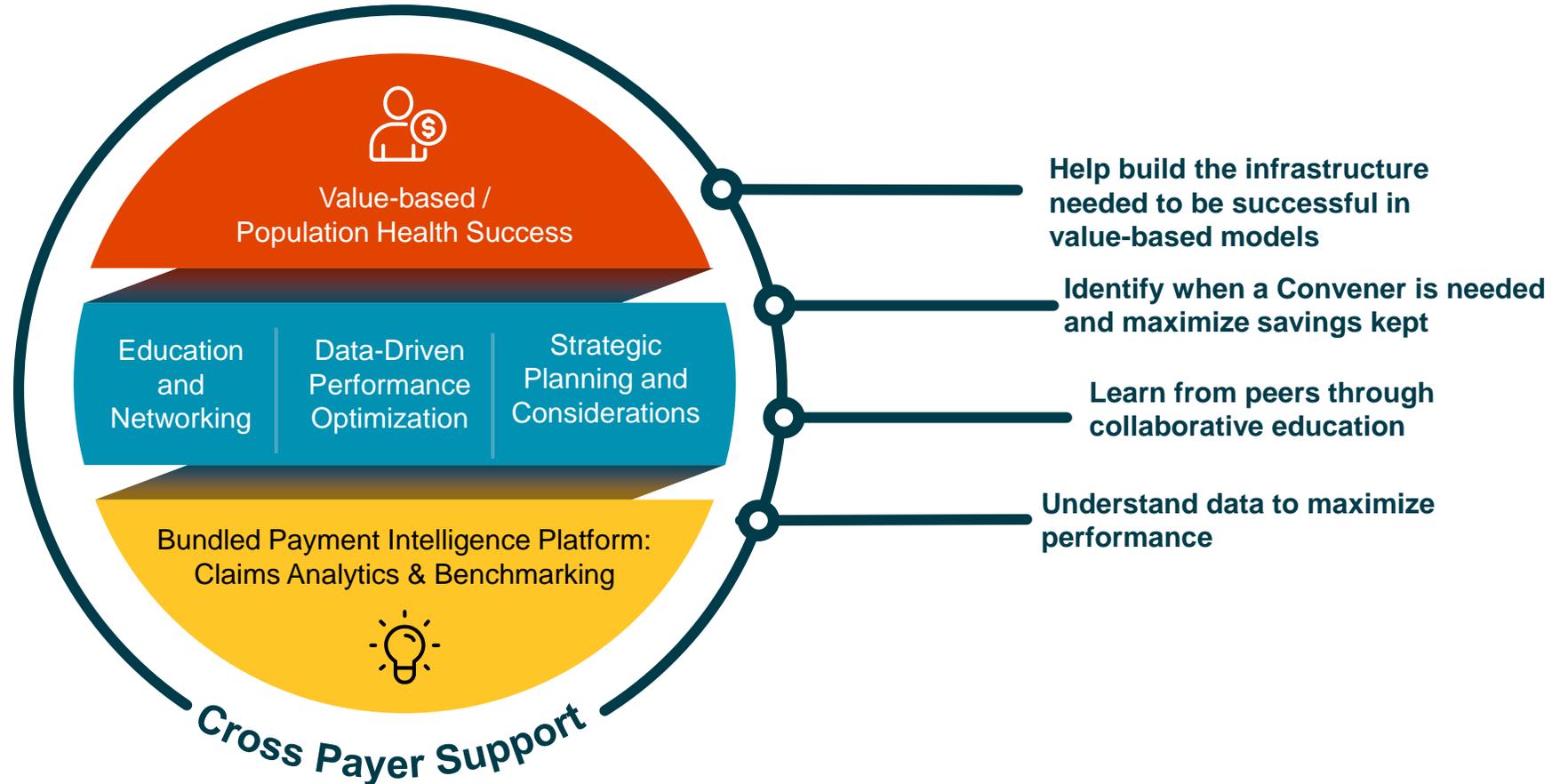
External Collaboratives

Next Generation, Pioneer, and ESRD ACO Learning Systems for CMS	American Society of Anesthesia – Perioperative Surgical Home	Greater New York Hospital Association – DSRIP Learning Systems
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Population Health Framework

Premier's framework provides robust, holistic, value-based services across all payers



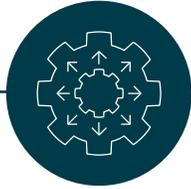


Bundled Payment Services



Program Management

- Analytics
- Benchmarking
- Reporting
- Cost management
- Episode design
- Reconciliation



Optimizing Cross Continuum Care

- Care model optimization
- Care redesign
- Post-acute network
- Cross continuum patient management planning



Provider Engagement

- Physician incentive tools
- Legal agreements/support
- Education
- Gainsharing
- Analytics Platform



Convener Support

- Risk sharing options
- Applied Expertise
- Operational Guidance
- Technology Resources



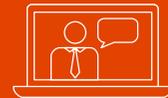
1:1 Coaching & Onsite Assessments



National Meetings



Advocacy and Administrative Support



Live and Recorded Educational Webinars, Tools/Resources via PremierConnect®



Dedicated Partner & SME Access



Analytics and Performance Monitoring

Population Health Management (PHM) Collaborative provides support for TCOC and all Maryland programs beyond MSSP

- PHM Collaborative currently supports members through:
 - ***Maryland Affinity Group***
 - ***On-site strategy sessions***
 - ***Monthly Dedicated Partner calls and quarterly data 1:1 calls***



Four Ways Premier Can Support

	Premier Does Not Share Risk	Premier Shares Risk
Health System Shares Risk	<p><u>Health System Convener</u></p> <ul style="list-style-type: none"> • Health System takes on risk and is the Convening Entity for PGPs with underlying support from Premier • Premier provides education and analytics support through the Bundled Payment Collaborative (BPC). 	<p><u>Partner Convener</u></p> <ul style="list-style-type: none"> • Premier and Health System share Convener responsibilities and risk with joint program support. • Premier and Health System will mutually develop PGP evaluation criteria to determine which PGPs would be appropriate for a Partner Convener model. • Analytics and education are provided through Premier’s BPC and Premier will take an active role in program management.
Health System Does Not Share Risk	<p><u>PGP Convener</u></p> <ul style="list-style-type: none"> • PGPs are their own Conveners with Health System messaging Premier Collaborative support • Health System will connect these PGPs with Premier’s BPC and analytics support, • Premier and Health System do not take an active role in program administration or risk sharing. 	<p><u>Premier Convener</u></p> <ul style="list-style-type: none"> • Premier will evaluate Convener option on behalf of PGPs without the direct support of the Health System • Premier will work with PGPs on direct management of the model and share risk based on their respective contributions to model success. • Premier will develop PGP evaluation criteria to determine whether to move forward as a Convener on behalf of PGPs. • The level of direct management and risk sharing will be determined on a case-by-case basis contingent upon the PGPs’ readiness for EQIP.

For questions about how Premier can provide EQIP support, please contact Justin_Rock@premierinc.com.



Beth Ireton, RN, MS

Principal, Strategy Innovation and Population Health

Beth_Ireton@Premierinc.com

Premier, Inc.

Justin Rock, MBA

Director, Performance Partners

Justin_Rock@Premierinc.com

Premier, Inc.

Signify
(formerly known as Remedy)

We Implement Episode of Care Programs At Scale

Signify Manages \$8 Billion Worth of Episodes Annually

- Largest operator of episodes of care payment programs in the U.S.; working with payers, providers, and employers – including two Blue plans, large Medicaid plan, regional health plans and the State of Connecticut
- Deepest and broadest pool of experts in episode of care payments and benefits programs in the U.S.
- Flexible administrative platform to manage prospective and retrospective programs
- Systematic improvement in clinical and financial outcomes – readmission and complication reductions – as well as social determinants of health

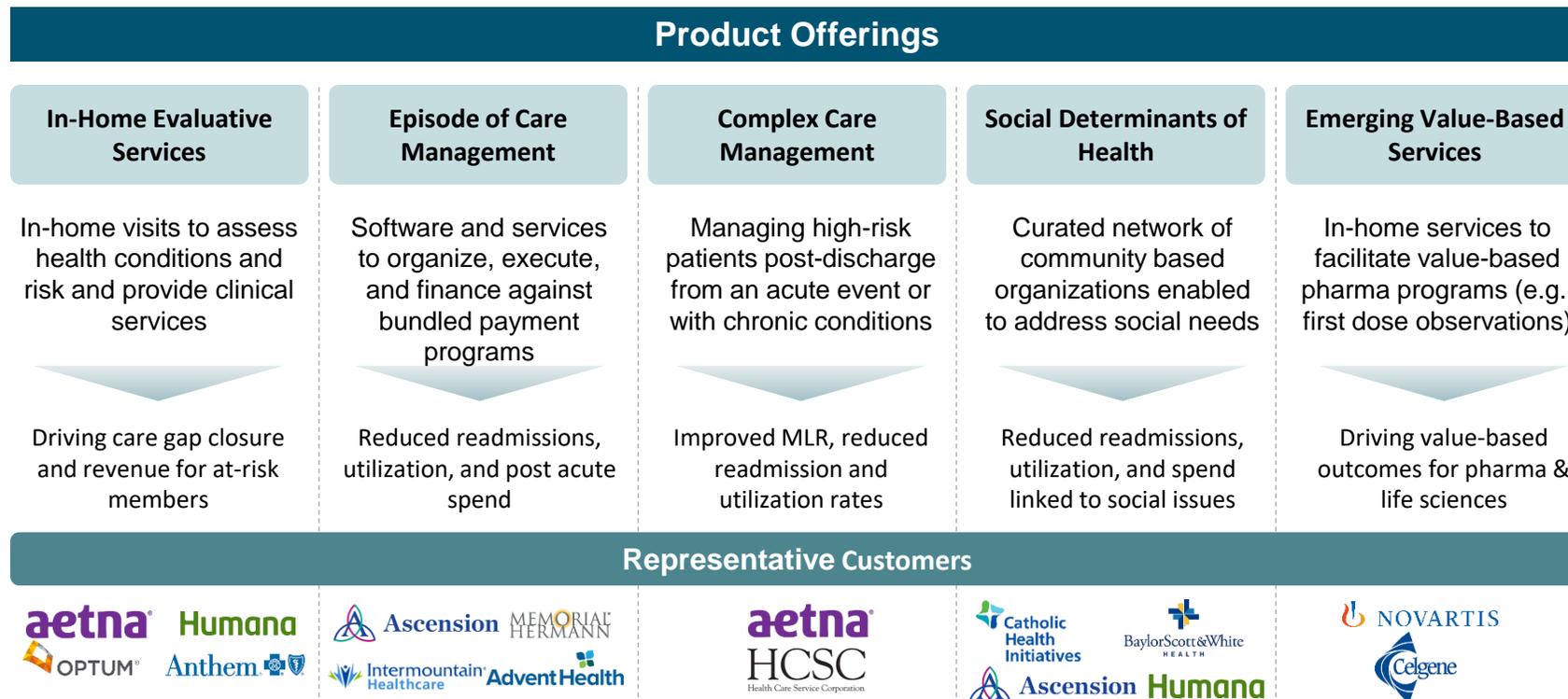
Fully scalable episode program covering up to 70% of medical spend

Comprehensive network of providers already taking risk on Medicare priced episodes

Full provider engagement suite integrated into EMRs

Our goal is to create a market that will deliver high value healthcare every day to everyone

Our Suite Of Technology-Enabled Services Help Our Partners Better Manage Patients and Improve Outcomes



We Provide Support In Any Number Of Ways

We'll take your lead

- ✓ Provider network contracting strategy
- ✓ Episodes of care contracting
- ✓ Target pricing
- ✓ Provider support & reporting
- ✓ ASO customer engagement
- ✓ Program reports & evaluation



Episode Of Care Solutions

Why Episodes Of Care?

It's an essential component of the VBP tapestry for MA or Commercial plans

- PCP-based programs help manage upstream care
- ACO-based programs help focus on total costs of care
- Consumer activism works on discretionary services
- Episodes of care extend the PCP's reach to specialists
- Episodes of care optimize ACOs by reducing the impact of leakage
- Episodes create comprehensive price transparency

Episodes of Care from Signify

Principles & Ingredients

- Full transparency on information/analytics to create trust with providers and employers
- Guaranteed value improvement – Signify guarantees the target price, which is essential to employers, and can include mandatory quality gates depending on program design
- Warranty period on each episode, procedural or condition
- Ability to manage a member within multiple Episodes simultaneously – which is essential to engage specialists
- Ability to risk-adjust at scale, ensuring fairness in pricing
- Sophisticated network tiering based on quality and cost, adapted to Humana needs
- Broad scope of episodes covering more than 50% of all medical spend

Scope of EOC Payment Programs

We Can Use And Leverage All Episode Definitions For Your EOC Program

Procedures

Cardiology: PCIs, Pacemaker-Defibrillator, CABG/Cardiac Valve

GI: Bariatric, Gall Bladder, Colonoscopy, Upper GI Endoscopy, Colorectal Resection

Ortho: Hip Replacement, Knee Replacement, Knee Arthroscopy, Shoulder Replacement, Lumbar Laminectomy, Lumbar Spine Fusion

Ophthalmology: Cataract Surgery

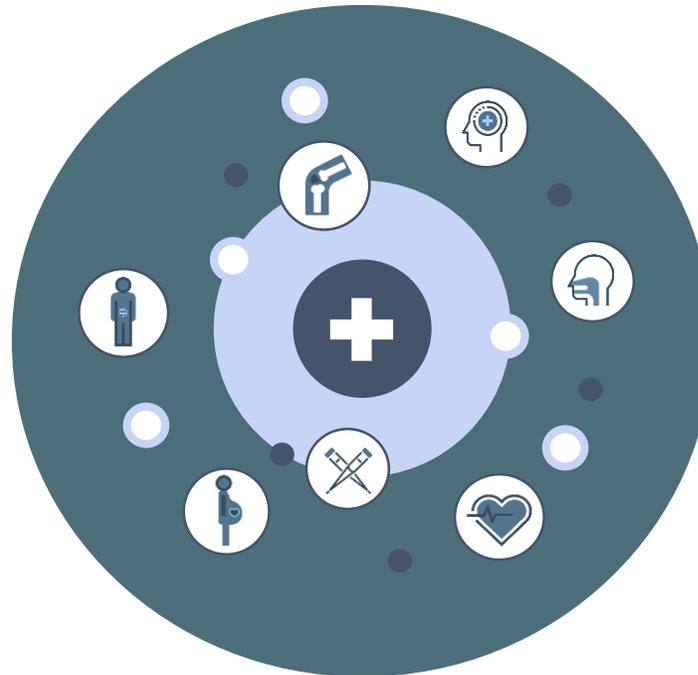
Women's Health: Hysterectomy, Mastectomy, Breast Biopsy

Men's Health: Prostatectomy, TURP

Maternity:

Mother: Pregnancy, C-Section and Vaginal Delivery

Baby: Newborn



Chronic Conditions

Major Chronic Conditions: Asthma, COPD, Diabetes, CAD, Hypertension, CHF, Arrhythmias/Heart Block, GERD, Crohn's Disease, Diverticulitis

Ortho: Low Back Pain, Osteoarthritis

Behavioral Health: Substance Use Disorders, Depression, PTSD, Bipolar, Schizophrenia

Oncology: Breast Cancer, Colon Cancer, Rectal Cancer, Lung Cancer, Prostate Cancer, Gynecologic Cancer

Instead of paying all the claims costs, w/o regard to appropriateness, Episodes redefine the unit of service to pay one "target price" for the entire duration of care appropriate to each Episode, plus a warranty period.

Signify Surrounds Providers With Support

People/Processes/Technology/Information



Inquiries and questions

Joe Miralles

Senior Director Business Development

jmiralles@remedypartners.com

Appendix 3: Overlaps and FAQs*

* State is currently in discussions/negotiations with CMMI on EQIP, thus everything is subject to change.



ECIP vs EQIP-Y1 (2021): No overlaps in episodes

	ECIP	EQIP-Y1
Who convenes/controls?	Hospitals	Non-hospital conveners (but could be hospital-established entity)
Episode triggers	Hospital inpatient	HOPD and non-hospital setting
Medicare costs included	All FFS Parts A&B 90 days post discharge. Excludes hospital costs	All FFS Parts A&B – maybe some D in future. Generally 90 days. Includes hospital costs
Accounting for GBR feedback effects	Not applicable	Conveners given only partial credit (~65%) for savings from hospital utilization
Advanced APM (for MACRA purposes)?	Yes. Generous QP calculation	Yes. Standard QP calculation
Downside financial risk?	Indirectly borne by hospitals via global budgets and MPA – and paid for by all hospitals via MPA lever	Directly borne by conveners
Payments from CMS	Via MPA lever	Directly to/from conveners
Optional incentive payments with partners	Hospital can share upside payments with downstream partners	Convener can share upside and downside payments to/from downstream partners



ECIP vs. EQIP-Y2+

- ▶ EQIP may include inpatient-triggered episodes beginning in 2022
- ▶ HSCRC staff have previously noted that ECIP could be modified to include:
 - ▶ Episodes triggered outside of inpatient setting, and
 - ▶ Spending occurring within hospitals
- ▶ In federal BPCI-Advanced, both hospitals and physicians can participate
 - ▶ When an episode occurs at a participating hospital triggered by physicians participating on their own (separate from hospital participation), then the physician “wins” the episode
- ▶ State’s expectation is that ECIP/EQIP overlap policy would reflect BPCI-A:
 - ▶ ECIP hospital signs up for particular episodes and is responsible for them unless:
 - ▶ An Episode Initiator (EI) is signed up with an EQIP Convener that participates in that exact same episode triggered in that hospital. In this case, EQIP “wins” the episode

FAQs answered by State (CMMI may disagree and their determination will be binding)

- ▶ **Can an Initiator/partner participate in both ECIP and EQIP?**
 - ▶ Yes. For 2021, there is no overlap between episodes. ECIP Hospitals may partner with Care Partners for inpatient-triggered episodes. EQIP Conveners may sign up those same providers for the outpatient-triggered episodes
 - ▶ In 2022+, if there is an overlapping episode, EQIP will “win”
 - ▶ If the ECIP Hospital has chosen an episode and, for a particular beneficiary, the initiating doctor is in EQIP, then the EQIP Convener will win that particular episode
 - ▶ If the ECIP hospital has chosen an episode and, for a particular beneficiary, the initiating doctor is NOT in EQIP, then the ECIP Hospital will win that particular episode
- ▶ **Any policies for ACO/EQIP overlaps?**
 - ▶ Current thought: EQIP will exclude all prospectively attributed ACO beneficiaries
 - ▶ State will need CMMI to provide the ACO lists in order to effectuate
 - ▶ State not very concerned if CMMI does not provide lists (see next slide)

FAQs answered by State (CMMI may disagree and their determination will be binding), p. 2

- ▶ **If EQIP payments are made for the same beneficiaries for which an ACO received a payment, isn't there concern about double payments?**
 - ▶ Maybe, but that will be on the State to manage
 - ▶ Under the Maryland Model, CMMI is guaranteed certain levels of Medicare savings statewide in exchange for the flexibility and levers provided to the State
 - ▶ The State seeks to encourage broad participation in Advanced Alternative Payment Models
 - ▶ If widespread participation in both downside ACOs and EQIP leads to double payments on the same beneficiaries, it is not clear that this would increase Maryland's TCOC by more than the savings produced, given the savings guaranteed to Medicare
 - ▶ If those payments did increase Maryland's TCOC overall, the State could use other levers that did not directly penalize those organizations accepting downside risk

FAQs answered by State (CMMI may disagree and their determination will be binding), p. 3

- ▶ **Are EQIP payments taken into account for hospitals' Care Transformation Initiatives? Isn't CMMI worried about double payments?**
 - ▶ No. Any amounts paid for CTIs are offset from all hospitals and therefore do not affect net payments to/from Medicare
- ▶ **Will EQIP payments affect Maryland TCOC financial tests?**
 - ▶ Yes
 - ▶ Payments to Conveners will count as additional costs – but are only made if the Convener has beaten the 3% Discount for TCOC (guaranteed savings to Medicare)
 - ▶ Payments from Conveners will be counted as savings under the Model, because they are paying for the costs for which they did not beat the 3% Discount
 - ▶ Either way, EQIP is beneficial to the State and CMS (Medicare), at the price of Medicare paying Conveners for savings in excess of the 3% discount