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

March 13, 2020

HSCRC
Health Services Cost Review Commission

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.*

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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+)

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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

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* 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

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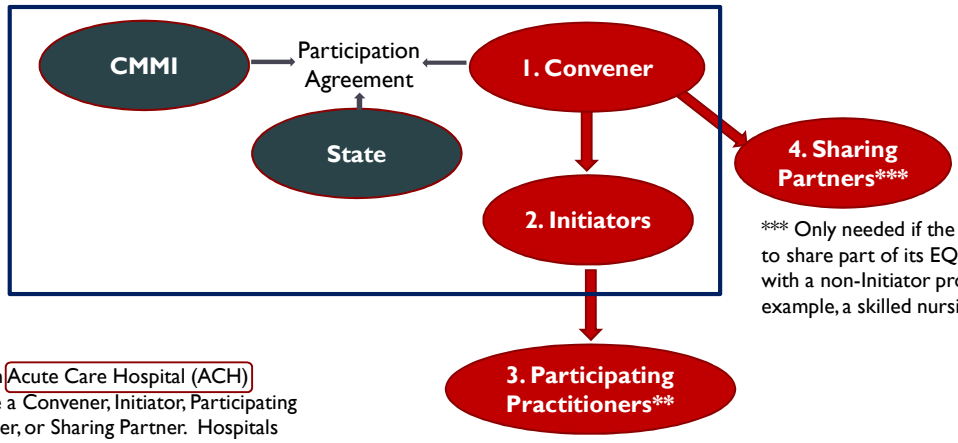
EQIP's Types of "Participants"*

* 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).

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.

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

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EQIP's Types of Participants: 1. Conveners

1. **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

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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

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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)

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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

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* 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.**

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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

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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

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EQIP outpatient-triggered episodes for Y1*

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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

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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

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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

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* See Appendix for CPT triggers by category

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 Replacement/Revision	2,077	$10.3 M	$4,977
Knee Arthroscopy	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

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1. Cost of trigger event and total cost of care during the 90-day episode window

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

1. Cost of trigger event and total cost of care during the 90-day episode window

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)

1. Cost of trigger event and total cost of care during the 90-day episode window

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
Asthma COPD	3,507	$11,187,606	$3,190
Atrial Fibrillation	1,856	$7,251,423	$3,907
Chest Pain	13,723	$50,043,046	$3,647
CHF	590	$3,222,577	$5,462

Primary Dx	FY18 Medicare FFS Episodes	FY18 Medicare FFS Spending	Average per Episode
DVT	771	$2,643,120	$3,428
Hyperglycemia	1,304	$3,802,997	$2,916
Pneumonia	2,116	$7,537,753	$3,562
Skin Infection	3,649	$9,088,625	$2,491
Syncope	5,263	$22,324,553	$4,242

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1. Cost of trigger event and total cost of care during the episode window. Episode window is 14 days for Efficient Admissions and 30 days for High-frequency ED Users. Subject to change based on ongoing analyses and discussions with CMMI

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)

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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)	✓*Baseline ends no later than the CY, 2 years before performance year**

So for a convener joining 1/1/21, baseline will end by 12/31/2019 but number of years in the baseline is TBD

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.	✓ *Only for small cell sizes*
	Peer data	Efficiency factors are used to align incentives for participation and avoid the potential for pre-determined winners based only on selection	✗

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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 99th and 1st 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%	

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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.	✓ *Actual history updated with trend and case mix to performance year and then discounted*
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	*Likely*
Reconciliation	One time	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	✓ *Run out period under consideration*
		Some models incorporate multiple iterations (e.g., OCM has three per performance period)	

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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	✓ *20% of the target price at the episode initiator level*
	Winsorize	Winsorization or other methods of reducing the impact of extreme outliers are a way of reducing risk	✓ *At 99th and 1st percentiles*

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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	*Under consideration*
Factors	Demographic	Age and gender	✓
	Diagnosis / Event	For example: APR-DRG, chronic condition status, hip fracture	✓
	Eligibility category	Dual enrollees, for example	*Under consideration*

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Savings Strategy and Relative Impact: Hypothetical Examples

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**

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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	Episdoes				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)	= m * 0.35	$767		$767	
	o	**Per Episode Savings (Dissavings)**	= m - n	**$1,425**	**-$303**	**$1,122**	
	p	**Total Savings (Dissavings) to Convener before quality adjustment (7)**	=o * e	**$14,253**	**-$3,032**	**$11,221**	

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.

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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

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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)

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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

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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

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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.

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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.

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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

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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

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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

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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

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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

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*Certain exclusions are applied including: patients with ICU or OR costs, patients with prior ED visits, and patients with certain secondary diagnosis codes

Appendix 2: Info from nationally experienced episode conveners/contractors

Fusion5
Premier
Signify

Fusion 5

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FUSION5

Fusion5

A Convener Option

FUSION5

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 Annually[1]**

1. Forecasted based on current contracted customer episode volume

Fusion5 manages the largest musculoskeletal bundled payment network in the US

FUSION5

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

- Bundled Payments
- Provider Management
- VBC Strategy Development
- TCOC[1] Design & Admin
- Private/Public Initiatives
- ACO[2] Integration
- Extended Care Management

Supported Procedures

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

1. Total Cost of Care
2. Accountable Care Organization

FUSION5

Fusion5 – Pioneering the Value-Based Experience

Leading the Way – Addressing Specific Client Goals and Objectives

CMS BPCI Classic & Advanced
- Thought leader CMS/CMMI BPCI-A collaborator
- Program structure & analytics refinement
- Gainshare contracting and solutions
- Risk-sharing CMS BPCI-A Convener

Care Management
- 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

High Performance Networks
- Afford payers ability to control rising costs
- Address low-value/wasteful spending
- Outcome-driven care/high patient satisfaction

Chronic-Complex Care Management
- Structured recording of patient health info
- Self-management education & support
- Managing transitions of care
- Maintaining electronic health plan

Market Insight & Expertise
- Proven results in markets nationwide
- Library of best practice solutions
- Maximize hospital and physician practice realized value in bundled payments
- Delivering scale and transparency

eFusion
- Care management
- Data Analytics – transparent & actionable
- Highly configurable
- Data integration, exchange, & reporting

Maternity Care
- Enhanced care coordination across duration of pregnancy
- Supports healthy pregnancies & reduces risks of complications

Specialty Care Networks
- Musculoskeletal
- Post-acute care
- Cardiac
- Bariatric
- Major medical

FUSION5

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
Spend Managed

>200,000
Episodes Managed[1]

$190M
Cost Reductions[2]

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

FUSION5

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

Care Management Solutions	• 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
Integrated Data Analytics	• 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
Detailed Operational Reporting	• Real-time and historical Reporting Capabilities • Interactive Reports that provide direct links to eFusion Tools • Download & Export in multiple formats
Secure & Interoperable Interfaces	• 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

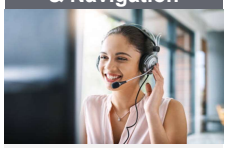
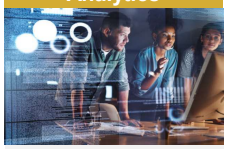
FUSION5

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

Fusion5 Solution Scope

VBC Service Lines

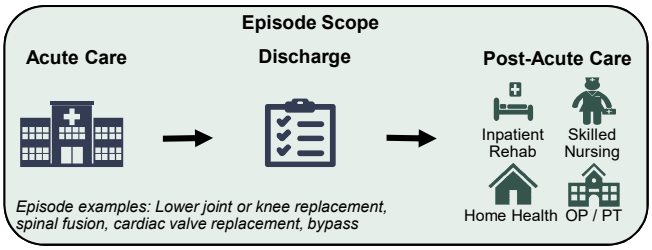
- Bundled Payments
- VBC Services
- VBC Strategy Development

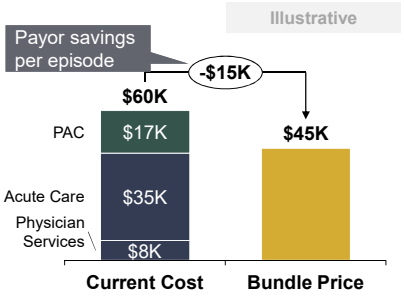
Program Design & Admin.	Care Coordination & Navigation	Technology & Analytics
		
• Contracting • Network development and ongoing management • Program services scoping and pricing	• Risk assessments and care pathway redesign • Ongoing patient engagement, interventions, and care management	• Patient / Employee care journey IT platform • Patient cost and quality outcomes

FUSION5

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

Example Bundle Program Design





Payment Model	Care Improvement Levers	Cost Reduction Levers
• 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	• 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	• Cost effective discharge decisions and clinical pathways • Improved outcomes in the post-acute setting • Reduced readmissions driven by patient engagement and care management

FUSION5

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

FUSION5

Contacts

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Jerry Rupp	Chief Innovation Officer	Jerry.rupp@fusion5.us
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Premier

Premier Performance Partners Capabilities

Premier helps members build and sustain essential capabilities

Supply Chain
- Med/Surg supplies
- Supply chain operations
- Purchased services
- Capital and construction
- Pharmacy
- High value implants

Physician Enterprise
- Workflow optimization
- Technology optimization
- Clinical space allocation
- Staffing/skill mix
- Revenue enhancement

Clinical Delivery Optimization
- Procedure/testing utilization
- Level of Care
- Length of Stay
- Interdisciplinary rounds
- Discharge management

Workforce Management
- Skill mix
- Span of control
- Productivity
- Workflow
- Workforce expense
- Benefits

Quality Improvement
- Value based purchasing
- Clinical documentation improvement
- Compliance, regulatory and accreditation
- Utilization / denials management

Clinical Transformation
- Continuum of care strategy/ integration
- Care Management model re-design to support value-based payer contracts (bundles)
- Complex and Chronic care model development

Throughput and Capacity
- Readmission prevention
- Post-acute assessment and strategy
- Network development, design, launch, and implementation

Population Health & Strategy
- 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

Premier Performance Partners – Service Lines

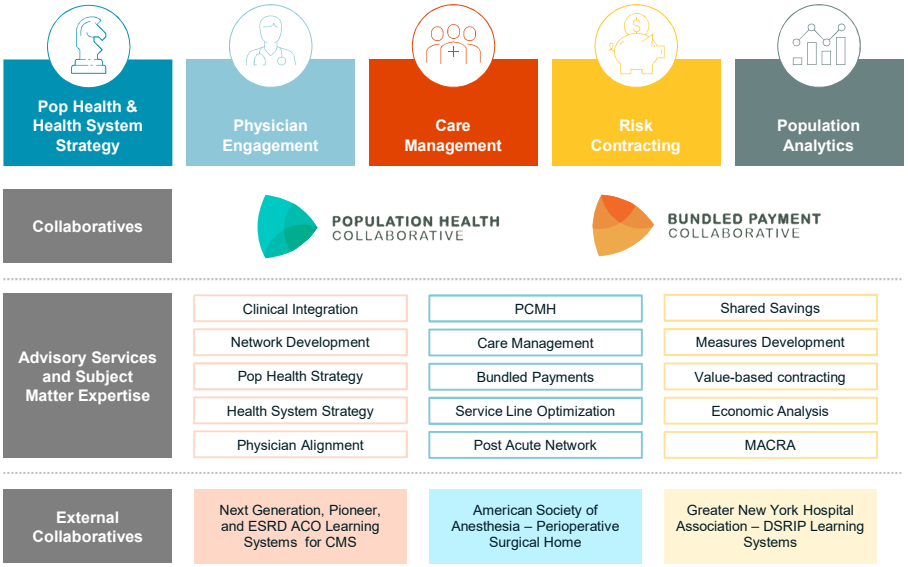
Our mission is to provide innovative services and tools to help organizations successfully transition to value-based care and value-based payment.

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

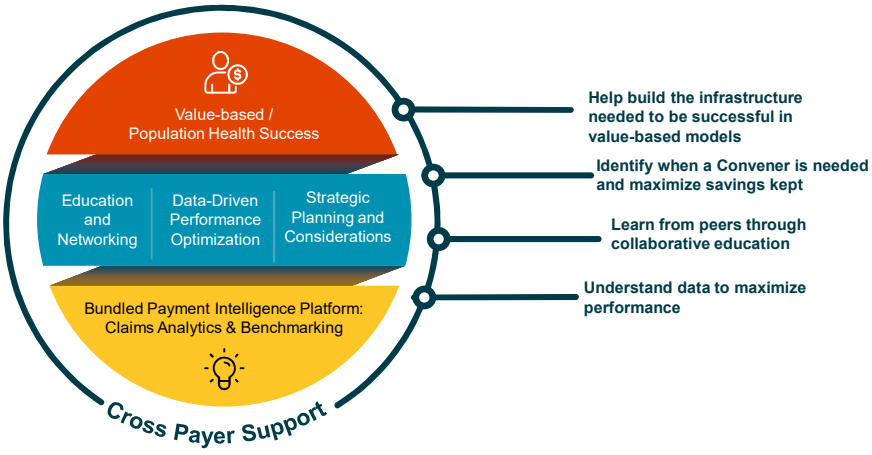
Control Tower Advisory
- Regulatory
- High Reliability Medicine
- Clinical Performance Partners
- Clinical Delivery Optimization
- Service Line Analytics and Integrated Technology
- Operational Performance Partners

Premier's Population Health (SIPH)

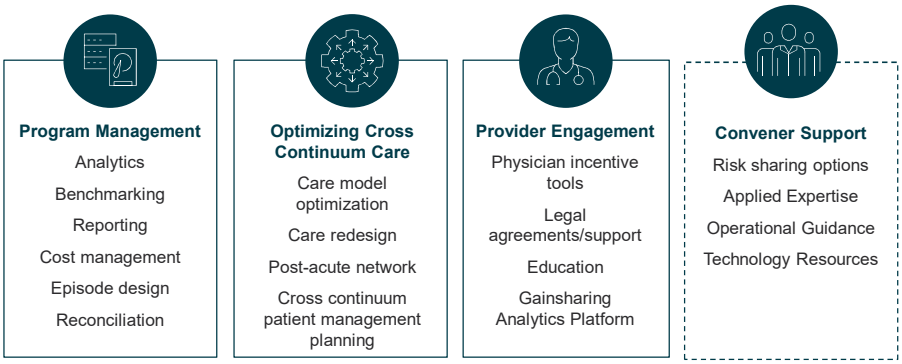


Population Health Framework

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



Bundled Payment Services



Premier's Population Health Support in Maryland

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	**Health System Convener** • 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).	**Partner Convener** • 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	**PGP Convener** • 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.	**Premier Convener** • 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.

Premier EQIP Contact Information

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Signify
(formerly known as Remedy)

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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

signifyhealth

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

Product Offerings				
In-Home Evaluative Services	**Episode of Care Management**	**Complex Care Management**	**Social Determinants of Health**	**Emerging Value-Based Services**
In-home visits to assess health conditions and risk and provide clinical services	Software and services to organize, execute, and finance against bundled payment programs	Managing high-risk patients post-discharge from an acute event or with chronic conditions	Curated network of community based organizations enabled to address social needs	In-home services to facilitate value-based pharma programs (e.g., first dose observations)
Driving care gap closure and revenue for at-risk members	Reduced readmissions, utilization, and post acute spend	Improved MLR, reduced readmission and utilization rates	Reduced readmissions, utilization, and spend linked to social issues	Driving value-based outcomes for pharma & life sciences
Representative Customers				
aetna, Humana, OPTUM, Anthem	Ascension, Memorial Hermann, Intermountain Healthcare, AdventHealth	aetna, HCSC	Catholic Health Initiatives, BaylorScott&White, Ascension, Humana	NOVARTIS, Celgene

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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

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Episode Of Care Solutions

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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

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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 Heath: 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.

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Signify Surrounds Providers With Support

People/Processes/Technology/Information

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Inquiries and questions

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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

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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

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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)

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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

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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

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