EQIP Request for Information Responses

Overview

- The HSCRC released a Request for Information (RFI) in March of 2020 to seek feedback from stakeholders and potential participants in the newly proposed Episode Quality Improvement Program (EQIP)
  - RFI Responses were shared in full with the subgroup with materials for this meeting.
  - EQIP is targeted to begin in 2022 now due to COVID-19. A number of RFI respondents indicated this would be preferred as well.
- The HSCRC received and reviewed seven responses to the RFI from the following organizations:
  - American Society for Radiation Oncology (ASTRO)
  - CareFirst BlueCross BlueShield (CareFirst BCBS) – Payment Transformation Team
  - Fusion5
  - Johns Hopkins Health System (JHHS) – Office of Provider/Payer Transformation
  - Maryland Hospital Association (MHA)
  - The Maryland State Medical Society (MedChi)
  - Signify Health, LLC
- The following discussion represents a summary of these responses sorted by topical area. Responses only indicate the initial viewpoint of the HSCRC and do not indicate CMS agreement or permanent program changes.

CPT Code Updates and Performance Year Two Episodes

	Comment	HSCRC Response

CPT Code Updates	• A number of respondents indicated changes necessary to the CPT codes that the HSCRC released with initial episode modeling. These changes include:
	  • Additions/Deletions to account for updates to the CPT system
	  • Codes that are inpatient or outpatient dependent
		• The HSCRC is doing a validation and complete review with our design contractor to ensure CPT codes utilized for episodes are as up-to-date as possible.
		• Some CPT codes included in the initial listing may have included inpatient episodes, though analytics did not include them in outputs for the outpatient only triggered approach.
		• In the future, the HSCRC and staff will work with this subgroup to define initial episodes and make updates annually.

Performance Year 2 Episodes	• A number of respondents had suggestions for future program year episodes, including:
	  • Chronic disease episodes (PACES Model)
	  • Coronary artery bypass surgery
	  • Bariatric Surgery
	  • Ocular Episodes
	  • Oncology and Combined radiation-oncology episodes
	  • Additional episodes in PY1 specialty areas
	  • Inpatient-triggered episodes
		• Given the delay of EQIP for COVID-19, the HSCRC will explore additional episode categories for PY1.
		• Focus will first be on:
		  • Inpatient-triggered episodes,
		  • Episode expansions in PY1 specialty areas; and,
		  • Episodes that align with other payers/programs.
		• As discussions with CMMI continue, the HSCRC will vet and update new episodes with this subgroup.

Changes to Episode Design from RFI

- Nearly all respondents indicated desired changes to episode design and structure. All individual comments to episode design will be considered and the following represents a summary of planned analytics and additions to accommodate.

Comment	HSCRC Development Plan
Episode Lengths	• Plan is to explore episode-specific lengths utilizing published standards, unless stakeholder or other reasons arise.
Episode Overlaps	• A methodology will be developed to create a hierarchical framework of EQIP episodes to be discussed with stakeholders and clinical experts. • Overlaps between programs (EQIP, CTI, ECIP) will also be address with a separate, hierarchical framework.
Minimum Volumes	• There will be a minimum episode volume threshold established at the episode initiator level.
Cost Exclusions	• EQIP will use BPCI-A and CTI cost exclusion methodologies as its baseline, any additions or changes will be vetted through the EQIP subgroup. • Under the Maryland Model inclusion of total cost of care in the episode is standard. An ICD-10-based cost limitation has not been established for any episodes. However, CMS and the State have discussed applying a related costs approach on an episode-specific basis. • There will be winsorized levels at which catastrophic outliers are addressed.
Bene Exclusions	• EQIP will use BPCI-A and CTI methodologies as its baseline, any additions or changes will be vetted.
Quality Measures	• The HSCRC intends to vet all quality measures with relevant clinical experts and the EQIP subgroup. • Current analytics are focused on finding measures with reliable data, that are nationally standardized and fulfill the standards of Advanced Alternative Payment Model (AAPM) qualification.

Baseline Period for Episodes

	Comment	HSCRC Response
CareFirst BCBS	• A multi-year baseline should be included to account for single year variation	• Intent is to develop episodes using a two-year, fixed baseline based on participation initiation. • With COVID-19, there may be a need to omit 2020 data from the program, thus a gap between baseline and performance may not be necessary. • The HSCRC intends to include protections against exogenous factors in EQIP.
Fusion5	• A multi-year baseline should be included to account for single year variation • There should also be a gap between baseline and performance years	
Signify	• The impact of COVID-19 on the baseline should be mitigated through establishing corridors around the Target Prices	
ASTRO	• There should be protections/adjustments to protect against exogenous issues that may impact both baseline and performance spending	

Target Price Methodology

	Target Price Comments	HSCRC Response
CareFirst BCBS	• Target pricing should include Part D costs on an episode-specific basis	• The HSCRC agrees Part D costs may be appropriate for some episodes, though more analysis should be performed prior to including in EQIP due to only some Medicare beneficiaries having this coverage. • The stop loss/stop gain limits at 20% should help to mitigate the need for a cost floor on total costs of care. • The current methodology only compares episode initiators to their own historic performance within one episode. • DRG-specific target pricing is not supported in EQIP. Target prices must remain episode specific, some may cross DRGs and some may never. This also remains a lesser issue so long as inpatient remains precluded in PY1. • Setting neutral target prices will be discussed in the following slides and in future EQIP subgroups.
Fusion5	• Consider a cost floor where after which care transformation and patient-centered care can no longer reduce total costs • Requested clarity on if episode initiators be compared to their own target price or an episode/convener-wide approach? • Consider DRG-specific target prices as opposed to blended within one episode	
MHA	• Setting neutral neutral target prices should be thoroughly examined and established to align with the goals of the TCOC model to ensure balanced shifts. This is especially important given the impacts of COVID-19.	

Discount Factor and GBR Effects

	Comment	HSCRC Response
MedChi	• The 3% discount is more than what is required in hospital programs and will deter participation • Regulated savings discount seems high and the State should consider private payer models that do not utilize it	• The State must guarantee CMS a savings rate similar to BPCI-A (3%) in order to justify EQIP. • The Regulated Savings Discount is a function of the Maryland model and part of the program as defined with CMS. As an offset EQIP is creating site-neutral Target Prices to support site of service shifting. An opportunity not afforded in BPCI-A. In many cases, this approach will increase the Target Price, and thus savings available for outpatient episodes. Initially the HSCRC had stated that savings from shifting site of service would be factored into the target price after one year (thereby limiting the savings to one-time), the HSCRC is evaluating that further based on the concerns raised in responses. • The Regulated Savings Discount is based on payer regulated revenue mix statewide, which is fairly stable and does not fluctuate based on higher costs or overhead settings. • The HSCRC intends to move forward with the outlined levels of risk and inpatient savings discount. However, the HSCRC would be interested in hearing if stakeholders would prefer separated, setting-specific target prices as opposed to blended.
Signify	• To incent participation, the discount rate for CMS should be phased in • Actual IP utilization shifts should be used to adjust the GBR savings discount retrospectively	
JHHS	• Considering the additional risks (from BPCI-A) Maryland providers would assume due to the lack of full credit for reductions in regulated utilization and costs, participation in the program may be enhanced if providers were permitted to assume less risk	
CareFirst BCBS	• Would like more detail on the regulated savings discount and its mechanics	
Fusion5	• The regulated savings discount is a negative incentive to participation and the 3% discount rate is applied to total cost, without the savings discount, which further disincentives.	
ASTRO	• The regulated savings discount should take into account its impact on higher overhead cost centers and suggests a graduated reduction in the discount based on settings' fixed cost ratios	

Savings Strategy and Relative Impact: Hypothetical Examples, GBR 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	Target Price	$1,000	$1,000	$1,000	$1,000
	Performance Period Cost	$650	$650	$650	$650
Savings Calculation	Net Unregulated Savings (Dissavings)	$350	$0	$0	($650)
	Net Regulated Savings (Dissavings)	$0	$350	$350	$1,000
	GBR Discount (35% of net regulated savings)	$0	($122)	($122)	($350)
	Net Savings, Per Case	**$350**	**$228**	**$228**	**$0**

Comparison of ECIP to BCPI-A Advanced, OP Hospital to ASC (Example of 4th scenario on prior slide)

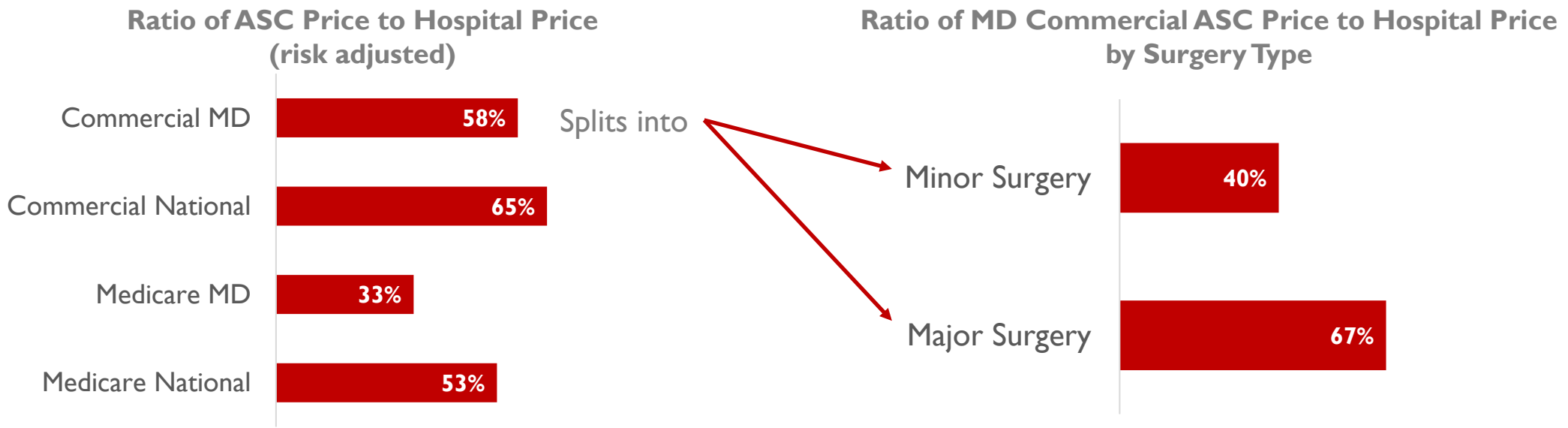
Scenario	Program	EQIP		EQIP`		BPCI-A	
	Savings Strategy	Shift OP Hospital to ASC, ASC <65% of OP Hospital Cost		Shift OP Hospital to ASC, ASC >65% of OP Hospital Cost		Shift OP Hospital to ASC, ASC >65% of OP Hospital Cost	
Target Price		Hosp OP	ASC	Hosp OP	ASC	Hosp OP	ASC
	Historic Volume	50	50	50	50	50	50
	Historic Price	$1,300	$700	$1,200	$800	$1,300	$700
	Target Price	$1,000		$1,000		$1,300	$700
Perf. Period	Performance Volume	0	100	0	100	0	100
	Performance Cost		$700		$800		$700
	Blended Performance Period Cost	$700		$800			$700
Savings per Case	Net Unregulated Savings (Dissavings)	($700)		($800)		$0	$0
	Net Regulated Savings (Dissavings)	$1,300		$1,200		$0	$0
	GBR Discount (35% of net regulated savings)	($455)		($420)		$0	$0
	Net Savings per Case	**$145**		**($20)**		**$0**	

As long as unregulated POS costs are less than 65% of regulated costs shifting services to unregulated will drive savings under ECIP.

Under BPCI-A no savings were available due to site of service specific targets.

Maryland Outpatient Surgery Prices vs Ambulatory Surgery Centers

- The price gap between ASC and Hospital is significantly larger under the Medicare fee schedule than under commercial, particularly in Maryland.
- Splitting Maryland commercial claims data into major and minor surgery shows the largest gap between hospital and ASC in minor surgery.



Commercial data derived from Maryland MCDB and benchmarking data. Medicare data based estimates of Maryland and national pricing

Risk Adjustment Methodology

	Target Price Comments	HSCRC Response
CareFirst BCBS	• Consider beyond DRGs and look at length of stay in post-acute facilities • EQIP should use Prometheus definitions to reduce the need to case-mix	• The HSCRC plans to evaluate optimal risk adjustment methods with its design contractor and the EQIP subgroup. • HCCs utilize a lookback of two-years, which is ideal for risk adjustment. • Initial modeling indicates some combination of DRGs and HCCs will be sufficient to risk adjust, but the HSCRC is analyzing all appropriate factors (such as demographics or length of stay) as data is available.
Fusion5	• If EQIP uses HCCs, utilize a lookback for 1 year (not 90 days because it doesn't capture PCP coding)	
ASTRO	• Adjustment for socioeconomics would be preferred	
Signify	• EQIP should consider beyond DRG, Demographic and HCC risk adjustment	

Reconciliation Payment Timing and Runout

	Comment	HSCRC Response
ASTRO	• The BPCI-A standard is too long and hurts provider margins and a six month reconciliation with a true-up at 12 months should be used.	• The HSCRC is considering a number of approaches to claims runout and reconciliation payment timing, which will likely diverge from BPCI-A and converge with other HSCRC policies (CTI, ECIP etc.). • The goal is to have as timely and accurate payments as possible to help incentivize providers in the program and ensure data is actionable year over year.
Fusion5	• Annual reconciliation works, claims run out should be no more than 4 months and anything more is a burden	
Signify	• Recommends a two phased approach with initial reconciliation and true-up with completed claims	
CareFirst BCBS	• Recommends a three month runout	

Convener Eligibility

	Comment	HSCRC Response
Signify	• Conveners should be vetted to guarantee they can manage the capital, risk, support for episode initiators and data capabilities necessitated by EQIP	• CMS will perform regular vetting and approval of program participants after applications are received, the State expects this process to be sufficient for ensuring viable entities. • Regulated Maryland hospitals, health systems and affiliated organizations may participate as a Convener, if they establish a separate legal entity from the regulated hospital business. • The HSCRC would like more background on the concern surrounding out of state conveners, the current plan is to allow them to participate.
ASTRO	• Requested clarity on whether regulated Maryland hospital entities (such as outpatient departments) could participate as a convener and/or an initiator • Concerns that out of state conveners could cherry pick/upend participation without having a significant stake in the State	
JHHS	• Requested clarity on health systems participating as a convener	

Waivers from CMS Regulation for EQIP Participation

	Comment	HSCRC Response

Fusion5	• Telehealth, post discharge home health and general fraud and abuse waivers should be in place	• EQIP will have the necessary payment policy and fraud and abuse waivers available to participants on a conditional basis.
		• Dependent on episode needs, participants will have the opportunity to elect waivers for each episode in their participation documents.
		• The HSCRC plans to explore the following waivers :
		  • Telehealth Payment Policy Waiver – potentially a statewide conversation
		  • 3-Day Skilled Nursing Facility Rule Payment Policy Waiver
		  • Post-Discharge Home Visits Payment Policy Waiver – potentially a statewide conversation

Hopkins	• Telehealth, post discharge home visits and three-day skilled nursing discharge waivers should be in place	