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The Episode Quality Improvement Program

Care Partner Arrangement

Participation Year One, 2022

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Introduction – The Episode Quality Improvement Program (EQIP)

Maryland's Total Cost of Care Model includes a Care Redesign Program, which enables the State to create alignment with providers to provide more coordinated care to Medicare beneficiaries. Under the Care Redesign Program, the State of Maryland can share savings created from care improvement activities performed on Medicare Beneficiaries and incentivize improved quality of care. Maryland modeled EQIP on bundled payment programs available through the Centers for Medicare and Medicaid Services (CMS) and other private payer bundled payment programs.

Starting in January 2022, specialty physicians (Care Partners) in Maryland will be able to participate in the Episode Quality Improvement Program (EQIP) as an "EQIP Entity", either individually or with a multiple Care Partners as defined during enrollment. The first performance year (PY1) runs from January 1st, 2022, through December 31, 2021. Participation opportunity is annual and at the will of each Care Partner.

Episodic payment models bundle payments to health care providers for certain items and services furnished during an episode of care. EQIP's episodic payment approach creates incentives for physicians to coordinate across settings of care, generate savings to Medicare and improve quality. EQIP Care Partners will achieve this through better care management during episodes; eliminating unnecessary care; and reducing emergency department visits, unnecessary hospital admissions and readmissions. EQIP will enable the CRP Entity, the University of Maryland Medical Center, to provide Incentive Payments to EQIP entities that help achieve these goals.

EQIP runs through the Care Redesign Program (CRP), enabled by the Maryland Total Cost of Care Model Agreement (TCOC Model Agreement) and the Care Redesign Program Participation Agreement (CRP PA).[1] This Care Partner Arrangement and its parameters are outlined both in the CRP PA and TCOC Model Agreement and should satisfy all CMS requirements. Additionally, On December 14, 2018 the OIG and CMS jointly issued Fraud and Abuse waivers for specified arrangements entered into pursuant to the Maryland Total Cost of Care Model Care Redesign Program.[2] Signature of this Arrangement acknowledges the heretofore mentioned legal arrangements and the CMS waiver coverage of activities within the scope of EQIP.

EQIP promotes the following objectives:

- *Financial Accountability*: Create physician financial accountability for the outcomes of improved quality and reduced spending, in the context of acute and chronic episodes of care.
- *Care Redesign*: Support and encourage physicians who are interested in continuously transforming care to align with value-based payment policy.
- *Clinical Data Analysis and Feedback*: Decrease the cost of an episode by eliminating unnecessary or low-value care, shifting care to lower-cost settings, increasing care

[1] https://hscrc.maryland.gov/Documents/Care%20Redesign/CRP%20PP4%20Participation%20Agreement%20.docx , https://hscrc.maryland.gov/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf

[2] https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/md-tcoc-crp-waiver.pdf

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coordination, and fostering quality improvement.

- *Physician Engagement*: Create environments that stimulate rapid development of new evidence-based knowledge and shift towards physician-focused, value-based care reimbursement.
- *Patient and Caregiver Engagement:* Increase the likelihood of better health at lower cost through patient education and ongoing communication throughout the clinical episode

For purposes of this Care Partner Arrangement, the Care Partner is participating in an EQIP Entity named: [INSERT EQIP ENTITY NAME AND ID HERE]

EQIP Entities may choose one or more of 15 different clinical episodes to participate in. These episodes will be designed and measured by the Prometheus Episode Grouper algorithm. For purposes of this Care Partner Arrangement, the Care Partner is participating in an EQIP Entity that will participate in the following clinical episodes: [INSERT EPISODES HERE]

Clinical episodes are triggered by the submission of a claim for a specified, relevant procedure and/or diagnosis. Episodes contain a pre-trigger and post-trigger period that determine the time point for how far the relevant cost accounting looks backwards and forward to calculate relevant episode costs. EQIP will use a retrospective bundled payment approach where the usual fee-for-service (FFS) payments are made, and the total FFS payment for the clinical episode is then retrospectively reconciled against a Target Price set at baseline and trended forward for relevance to performance year costs.

Care Partner Eligibility

To be a care partner, you must continuously meet the Medicare provider enrollment requirements at 42 CFR 424.500 et seq., including having a valid and active National Provider Identifier (NPI) and reporting all changes to enrollment information to CMS consistent with 42 CFR 424.516. Any Medicare providers and suppliers are eligible to participate in EQIP if they are one of the following:

- General or specialist physician,
- Clinical nurse specialist or nurse practitioner, or,
- Physician assistant.

Care partners who sign this agreement are attesting that they take responsibility for either the overall management and coordination of patients who trigger an EQIP episode OR play a critical role in the patient's continuum of care during the EQIP episode.

Care Partners must also:

- **Use an Electronic Medical Record.** As with other CMS programs, the use of CMS secured, and certified, electronic health (medical) records (CEHRT) is required. Signature of this Arrangement attests that the signatory is utilizing CERHT in a manner that creates a summary record of care

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formatted according to the standard adopted at 45 CFR 170.205(a)(3) that includes, where applicable, the Common Clinical Data Set as defined by 45 CFR 170.102.

- **Use CRISP, Maryland's Health Information Exchange.** Your EQIP Entity's lead Care Partner or Administrative proxy, must upload a current roster of EQIP Care Partners into CRISP prior to 9/1 annually. In addition, your Entity's lead Care Partner or administrative proxies will be responsible for submitting the clinical episode categories and interventions you plan to participate in for each performance year prior to 12/31 annually. Signature of this Arrangement attests that the Care Partner will utilize CRISP to electronically transmit the summary record of care, upon request by the HSCRC or CMS, to CRISP when you transition or refer a patient to another setting of care.
- **Agree to the EQIP Methodology for Performance Year One.** This documentation is available on the HSCRC Website and may be updated to reflect program changes.[3] Signature of this Care Partner Arrangement indicates acknowledgement of EQIP methods and policy.

This EQIP Care Partner will be considered a part of the EQIP Entity once the following two conditions are met:

1. They pass CMS vetting in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)[4], and,
2. They sign this Care Partner Arrangement on, or prior to, December 31st, 2021.

CRP Entity Responsibilities – University of Maryland Medical Center (UMMC)

It is not required to have privileges, an active contract or relationship with UMMC beyond this Care Partner Arrangement to participate in EQIP. The HSCRC and CMS will maintain all policy decisions, calculation and reporting for EQIP through CRISP.

The University of Maryland Medical Center (UMMC) will sign and participate under the CRP Participation Agreement will act as the "CRP Entity" for EQIP. This partnership is required to qualify EQIP as an Advanced Alternative Payment Model (AAPM) with CMS, so that Care Partners may qualify for the Quality Payment Program. In this role, the CRP Entity will aggregate Care Partner Arrangements and distribute Incentive Payments to EQIP Entities. Any eligible Care Partner that practices in Maryland and meets program eligibility requirements will be eligible to participate in EQIP, regardless of prior, current or pending relationships with UMMC.

UMMC will maintain its two functions in the following manner:

(1) **Engagement and Contracting of Care Partners:** The HSCRC will invite eligible Care Partners to participate in EQIP, in accordance with the CRP PA and the CRP Calendar. The HSCRC must vet prospective Care Partners with CMS and indicate to UMMC which Care Partners should have an executed Care Partner Arrangement. The HSCRC will submit the final lists of certified Care Partners— i.e., those Care Partners that have signed Care Partner Arrangements—to CMS. Care Partners must be certified with CMS to be eligible to receive incentive payments. UMMC is responsible for executing Care Partner Arrangements prior to the start of the Performance Year.

[3] https://hscrc.maryland.gov/Documents/EQIP%20Year%201%20User%20Guide%20-%20V1_Published_7_9_21.pdf
[4] https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

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(2) **EQIP Incentive Payments to Care Partners:** HSCRC will calculate the Incentive Payments to Care Partners according to the most current EQIP policy for the performance year.[1] UMMC, the CRP Entity, must distribute incentives as per the HSCRC calculation. An annual reconciliation will compare actual Medicare fee-for-service (FFS) expenditures for all episodes triggered by the EQIP Entity to the final target price for those episodes (subject to adjustments based on quality performance). Reconciliation will occur at the EQIP Entity level, across all episodes. The CRP Entity will then distribute the full amount to Care Partners based on the HSCRC calculation as a lump-sum payment by July of the year following the Performance Year (July 2023).

The CRP Entity, UMMC, will not have access to PHI, EQIP Entity/Care Partner analytics or any proprietary information to the EQIP Entity and Care Partner's practice outside of what is required to operationalize EQIP under this Arrangement.

EQIP Incentive Payments

The EQIP Entity is eligible to earn a reconciliation payment based on the cost of all Medicare FFS expenditures for the clinical episodes for which the EQIP Entity elects to participate in. The HSCRC will compare the Medicare FFS expenditures to a target price, based on the episodes created from relevant costs as determined by the Prometheus Episode Grouper.

If, 1) the aggregate total Medicare FFS expenditures across all clinical episodes in the performance year is less than the aggregate target prices for those episodes from the baseline at the performance year volume, and 2) this amount is greater than three percent of the baseline aggregate, the EQIP Entity will receive a positive reconciliation amount.

The EQIP Entity will be eligible for a share of their savings, or positive reconciliation amount based on their statewide ranking of episode costs. The final Incentive Payment will be the positive reconciliation amount, adjusted for the EQIP Entity's quality performance, as calculated and reported by the HSCRC. Technical documentation for this process is available at the HSCRC Website.[1]

The EQIP Entity is responsible for distributing the Incentive Payments to individual Care Partners. This agreement will not oversee or dictate Incentive Payment distribution amongst multiple Care Partners who participate in the EQIP Entity. Incentive payments will be paid to the EQIP Entity 18 months after the start of the first Performance Year via check or direct money transfer. This Care Partner acknowledges the EQIP Entity has elected the following Payment Remission Recipient for their Incentive Payment distribution: [PAYMENT REMISSION SOURCE GOES HERE]

In order to earn an Incentive Payment from the CRP Entity, Care Partners agree to perform care redesign interventions for patients in an EQIP Episode. The care redesign interventions, as elected by the EQIP Entity in the EQIP Entity Portal are: [INSERT INTERVENTION ELECTIONS].

CMS prohibits the CRP Entity from making an Incentive Payment in excess of 25 percent of each Care Partners Medicare FFS revenue in the prior year. In the event that the Incentive Payment would otherwise exceed 25 percent of last year's FFS revenue, the Incentive Payment will be capped at that amount. EQIP Entities will be informed of their collective Incentive Payment caps annually, prior to Incentive Payment distribution.

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Dissavings Accountability

In lieu of collecting payments from EQIP Entities and Care Partners for negative performance against the Target Price in the performance year, the EQIP Entity will be subject to dissavings accountability. Accountability for dissavings, or exceeding the Target Price in the aggregate, is important to maintain in EQIP for AAPM status and program integrity.

The dissavings accountability will come in two main components of EQIP's policy:

1. If dissavings were created in the Prior Performance year, the HSCRC will deduct this amount from the next year's savings prior to calculating an incentive payment (if applicable).
2. If in any period the EQIP Entity's Target Price for the episode is in the lower two terciles of the Tiered Shared Savings Rate (0-66th percentile of Statewide Target Prices) and the EQIP Entity had dissavings in the immediately previous performance year, the second consecutive year of dissavings will result in removal from the program.

Quality Accountability

Quality adjustment is required as a part of EQIP's AAPM status. By tying payment to performance on quality measures, EQIP incentivizes providers to improve quality of care while also improving efficiency. Additionally, since EQIP will be an AAPM for CMS's Quality Payment Program, including a potential 5% Part B bonus and MIPS exclusion, it is imperative that the program has strict quality standards to ensure fidelity to the federal programs. Therefore, the HSCRC will monitor and potentially remove EQIP Entities who achieve minimal quality performance, that is:

- If the PY performance rate in any quality measure for that year, for the EQIP Entity, is **below the 20th percentile in the benchmark**, the EQIP Entity will receive zero points for that measure and will receive notice that they are on 'probation' for the following PY, and,
- **If an EQIP Entity has two consecutive PYs on probation, this will result in automatic removal of the Entity from EQIP.**

Care Partner Integrity

Providing high quality patient care remains our priority while we strive to continue to improve health outcomes and operate more efficiently. The following safeguards have been built directly into the EQIP to maintain our quality standards:

- **No Change in Your Discretion.** Care Partners retain the ability to make decisions in the best interest of their patients, including the selection of devices, supplies and treatments.
- **Your Participation Is Key.** Care Partners will provide direction to care management teams to ensure the best course of care for their patients.

Patient Rights

- Maryland Medicare Beneficiaries have the right to Medically Necessary services made available by their Care Partners.

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- Maryland Medicare Beneficiaries and their assignees can appeal claims determinations in accordance with 42 CFR part 405.
- Care Partners cannot avoid treating "at risk beneficiaries" (as defined at 42 CFR §425.20) or to target certain beneficiaries for any reason that could compromise the integrity of the CRP, the Maryland TCOC Model, the Medicare Program or other federal health programs, or the safety of Medicare beneficiaries.
- Care Partners cannot include CRP Interventions that discourage medically necessary services in the most appropriate setting.

Beneficiary Choice and Notice

Care Partners cannot obstruct the choice of Maryland Medicare Beneficiaries to obtain health services from providers outside from the participating CRP Entity, EQIP Entity or Care Partners.

Medicare beneficiaries receiving care from the EQIP Care Partner will be given notice stating that the Care Partner, the EQIP Entity and its medical staff are participating in EQIP. The Care Partner's notice will indicate that Care Partners may receive financial incentives when meeting specific performance goals of improving quality, streamlining care, and reducing spending. EQIP does not allow beneficiaries to "opt out" of the payment methodology. However, the initiative will not affect beneficiaries' freedom to choose their health care provider, meaning that beneficiaries may elect to see a provider or supplier that does not participate in EQIP. These notices may be requested by the HSCRC for verification and compliance purposes.

Care Redesign Program Committee

The State and HSCRC will work with the CRP Entity, the University of Maryland Medical Center, to maintain a Care Redesign Program Committee that ensures compliance with the Care Redesign Program requirements. The Care Redesign Program Committee will:

- Provide oversight on the implementation of the care redesign and quality improvement components of the Care Redesign Program(s), including options for the EQIP Entity's selection of Care Redesign Interventions,
- Provide a forum for sharing ideas, identifying problems, and developing solutions,
- Offer the internal framework and leadership to ensure the integrity of and opportunity for success of the Care Redesign Program(s), and,
- Monitor participation in the Care Redesign Program(s) to ensure compliance with applicable requirements of the participant CRP Entity's GBR Agreement and the All-Payer Model.

All Care Partners and EQIP Entities in EQIP are invited to participate in the Care Redesign Program Committee meetings.

Your feedback to the Program Committee is always welcome. If you have concerns about the implementation of the EQIP, or how the program is working for you and your patients, please contact Madeline Jackson-Fowl, Chief of Payment Reform at the Health Services Cost Review Commission [madeline.jackson@maryland.gov].

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State Reporting Requirements to CMS

In EQIP, the State is required to report certain data to CMS on behalf of Care Partners, including the number of Clinical Episode Categories and Care Redesign Interventions engaged in by EQIP Entities.

To ensure that then State can satisfy its obligations to CMS, you, your employees and contractors may be required to:

- Cooperate with the State and CMS in complying with the monitoring, reporting and auditing requirements associated with the Care Redesign Program. Current monitoring and reporting policy requires EQIP Entities to upload their Care Partner lists, select clinical episode categories for participation and indicate which care redesign interventions will be deployed.

- As applicable and/or requested, provide the State underlying data, and sufficient access to your records, information and data as necessary for purposes of satisfying the monitoring and reporting requirements associated with the Care Redesign Program.

- Maintain, for a period of ten (10) years from the expiration or termination of this Agreement, and, subject to applicable law, give the State and CMS the right to audit, inspect, investigate and evaluate any of your books, contracts, records, documents and other evidence that relates to (i) this Agreement or your compliance with the TCOC Model, and (ii) the quality or safety of services furnished under a Care Redesign Program.

Program Integrity

Performance under the Care Redesign Program will be monitored by the State and CMS to ensure the program encourages delivery of high-quality services to the participants and does not result in unintended consequences, including cost shifting or underutilization of services.

- State or CMS oversight of the program may result in the imposition of a Performance Improvement Plan (PIP) or corrective action plan for your EQIP Entity. You, the Care Partner, your employees and contractors will comply with the PIP or corrective action plan, as applicable. The State and CMS will provide you with all required information from any PIP or corrective action plan.

- If CMS or the State determines the EQIP Entity (i) has materially breached any Care Redesign Program requirements, (ii) has compromised the integrity of any of the CRP Entity's Care Redesign Program(s), or (iii) has past or present Medicare program integrity issues, then you, your employees and contractors will cooperate with CMS or the State with respect to any on-site visit, interviews or requests for information.

- The State or CMS may terminate an EQIP Entity or Care Partner due to failure to satisfy program requirements. In the event of EQIP termination, within 5 business days the HSCRC shall provide written notice of the effective date of the termination to the EQIP Entity or Care Partner.

The CRP Entity and State will collectively terminate this Care Partner Arrangement as required by CMS or the State if CMS or the State determines that you, the Care Partner,:

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- Have failed to comply with the terms of this Agreement or any other Medicare program requirement, rule or regulation,

- Have failed to comply with a PIP, corrective action plan or other remedial action or to demonstrate improved performance following the imposition of any such PIP, corrective action plan or other remedial action,

- Have failed to materially comply with any reporting, monitoring or auditing plan or requirements under this Agreement or a Care Redesign Program,

- Have taken any action that threatens the health or safety of a Medicare beneficiary or other patient,

- Have submitted false data in connection with any aspect of the TCOC Model,

- Are subject to sanctions or other actions of an accrediting organization or a federal, state or local government agency, including revocation of Medicare billing privileges, Medicare or Medicaid program exclusion or debarment, or,

- Are subject to action by the U.S. Department of Health and Human Services (including the Office of Inspector General and CMS) or the U.S. Department of Justice to redress an allegation of fraud or significant misconduct, including being subject to the filing of a complaint, filing of a criminal charge, being subject to an indictment, being named as a defendant in a False Claims Act qui tam matter in which the government has intervened, or similar action.

Effect of Termination

Upon termination of this Agreement, the CRP Entity will distribute any Incentive Payments owed to the EQIP Entity for episodes and Care Redesign Interventions performed prior to the termination of this Agreement, if applicable. Termination of the Care Partner Arrangement will not affect the rights and obligations of the Parties accrued prior to the effective date of the termination.

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Care Partner Arrangement Form

Care Partner participation in the EQIP is voluntary. You may decide not to participate and decline to sign this Arrangement, if so. If you do participate, you may withdraw during the annual enrollment window from July-September prior to the performance year annually.

If you do wish to participate in EQIP, you must sign and return this Care Partner Arrangement Form to the CRP Entity, UMMC. An EQIP Entity's Incentive Payments will not be calculated including a Care Partner's baseline or performance, without a current Care Partner Arrangement in place as evidenced by signature of the CRP Entity and Care Partner.

The CRP Entity shall provide a copy of the executed Care Partner Arrangement to each care partner and its EQIP Entity. A copy of the Care Redesign Program Participation Agreement between CMS and the CRP Entity is available for review on the HSCRC's website.[5]

By signing this form, I acknowledge the heretofore Care Partner Arrangement and consent to my participation in the Episode Quality Improvement Program. I acknowledge my participation is voluntary and will comply with the policy set forth by the Maryland Health Services Cost Review Commission and Centers for Medicaid and Medicare Services.

EQIP Entity Name:

Care Partner Name:

Care Partner Title:

Signature: **Date:**

Accepted on behalf of the CRP Entity, UMMC, by:

Name:

Title:

Signature: **Date:**

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5 https://hscrc.maryland.gov/Documents/Care%20Redesign/CRP%20PP4%20Participation%20Agreement%20.docx