EQIP Program Reports - User Guide

Version 1.2

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hMetrix

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1 Welcome to the EQIP Program Reports

The EQIP Program Reports present a detailed analysis of the claims data that is provided to EQIP participants – both the baseline data issued at the start of every program year and performance data during the year via quarterly updates as new data becomes available. The intent is that they will enable EQIP participants to make informed decisions that can help to achieve positive results in the program.

This user guide provides instructions on accessing and using the Program Reports as well as an overview of all the individual dashboards and information contained within the reporting suite. For data questions, technical issues, or other support, reach out to the CRISP EQIP team at eqip@crisphealth.org.

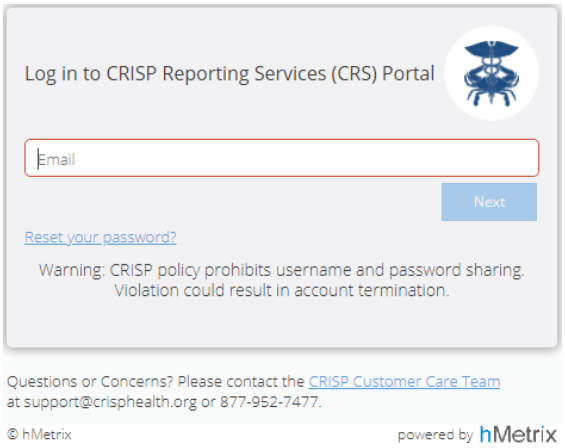
1.1 Software Requirements

The EQIP Enrollment Portal and all associated reports are web-based applications accessible through a modern browser. To ensure correct functioning and an optimal user experience, please use an up-to-date version of Google Chrome, Firefox, Safari, or Microsoft Edge to access the application.

1.2 Accessing the EQIP Program Reports

All EQIP Program Reports are available via the EQIP Enrollment Portal. If you require and do not have access to the EQIP Enrollment Portal, contact the CRISP EQIP Team at eqip@crisphealth.org. Note that most of the functionality requires both PHI access and the appropriate EQIP program role.

To access the EQIP Program Reports, first navigate to the Care Redesign Program (CRP) login page at https://crp.crisphealth.org. You will be prompted to enter your username and password, followed by the multi-factor authentication prompt you selected during the CRISP credentialling process. Log in using your CRISP Reporting Services (CRS) credentials, as shown below.



Users familiar with CRS services will also find a link to the EQIP Enrollment Portal under the Medicare Population pane of the CRS Landing Page. The reports can also be accessed by launching this link, as shown below.

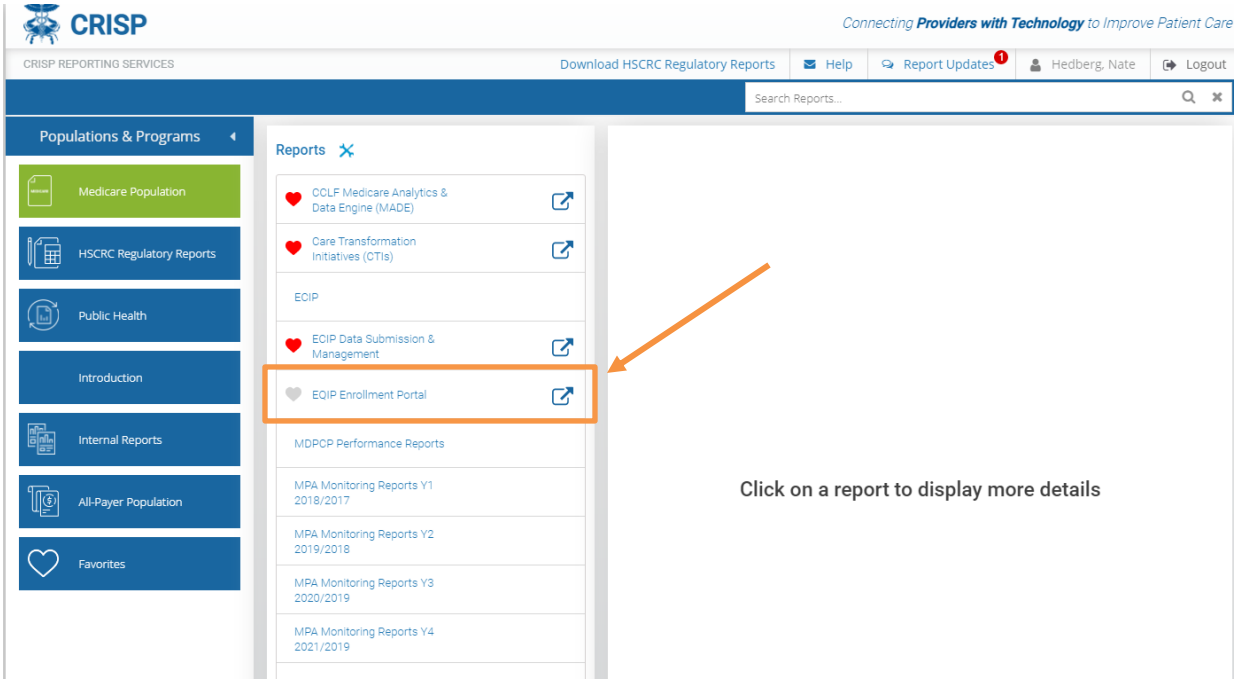


Figure 1 - Launching EEP from the CRS Landing Page

1.3 Data Sources & Availability

EQIP program reporting and evaluation are based on the Maryland Claim and Claim Line Feed (CCLF) data extract received by the State from CMS on a monthly basis in the same manner as ECIP, CTI, and other Maryland Care Redesign Programs. Episodes are generated using the PROMETHEUS episode grouper logic, and the resulting extract is used in all EQIP reports and evaluation materials. For more details on EQIP program policy, data sources, and data availability, please see the EQIP program policy user guide made available by the HSCRC at https://hscrc.maryland.gov/Pages/Episode-Quality-Improvement-Program.aspx .

Baseline data will be made available to participants during the enrollment period for an upcoming performance year when enrollment begins, and a final baseline dataset based on actual Care Partner and episode selection will be generated to populate the EQIP Program Reports by the first day of each performance period.

All reports will be updated on a quarterly basis as new claims data completes and is made available. Note that it takes some time for claims to be processed and made available by CMS, so there will be a lag of approximately seven months before performance data is fully available. Only data on complete episodes (those whose global period have ended and sufficient claims run-out is collected to ensure the completeness of the claims data) will be displayed in the EQIP Program Reports.

1.4 Common Functions

There are a number of common functions available in all reports in the reporting suite. These are available from the task bar at the top of each report. Each of these functions is described below, the order in which they appear from left to right.

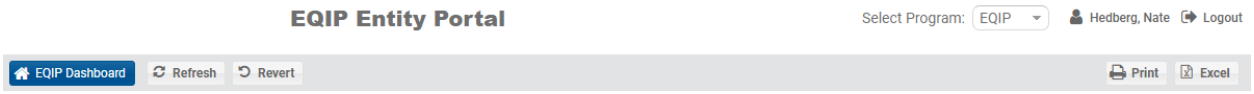


Figure 2 - Common Report Functions & Taskbar

Clicking the **Dashboard** button takes the user back to EEP Landing Page.

The **Refresh** button will fetch the most recent data from the database. Typically this won't be needed, but can resolve browser cache issues if the application appears to be displaying incorrecy or out-of-date information.

The **Revert** button will return the displayed report to its original format, removing any filters or selections and retrieving the most recently available data in the application.

The **Print** option allows users to download a PDF copy of the dashboard view they are accessing at that time. Note that any PHI exported from the site must be handled and treated accordingly.

The **Excel** option allows users to download the data in excel format. Users can only download the data they are accessing at the point of download. Graphs will not be displayed in the downloaded excel file; the data contained in graphs will, however, be presented in table format in the export. As with the PDF export, we would note that any PHI exported from the site must be handled and treated accordingly.

If you are participating in or have access to both ECIP and EQIP program data, a drop-down selector **Select Program** will appear allowing you to navigate between the ECIP Management Interface and EQIP Enrollment Portal. This control will not appear for users who only have access to EEP.

Use the **Logout** button to safely terminate your session once you are done working. This will log you out of all CRS applications in the current browser window.

2 EQIP Performance & Savings Summary

An aggregate, non-PHI program summary dashboard presenting information on all enrolled EQIP entities is available for any program participant to view. If you would like access to this report but do not have access, contact CRS Support and ask to be provisioned with the role 'EQIP Viewer.' If you are a Lead Care Partner or Administrative Proxy for an EQIP Entity, you will already have the access you need to view this report.

This dashboard can be accessed by using the 'View Performance / Savings Summary' link on the EEP Landing Page as shown below. Note that if you only have Viewer access, all other functionality will be greyed out, as these require additional program privileges to access.

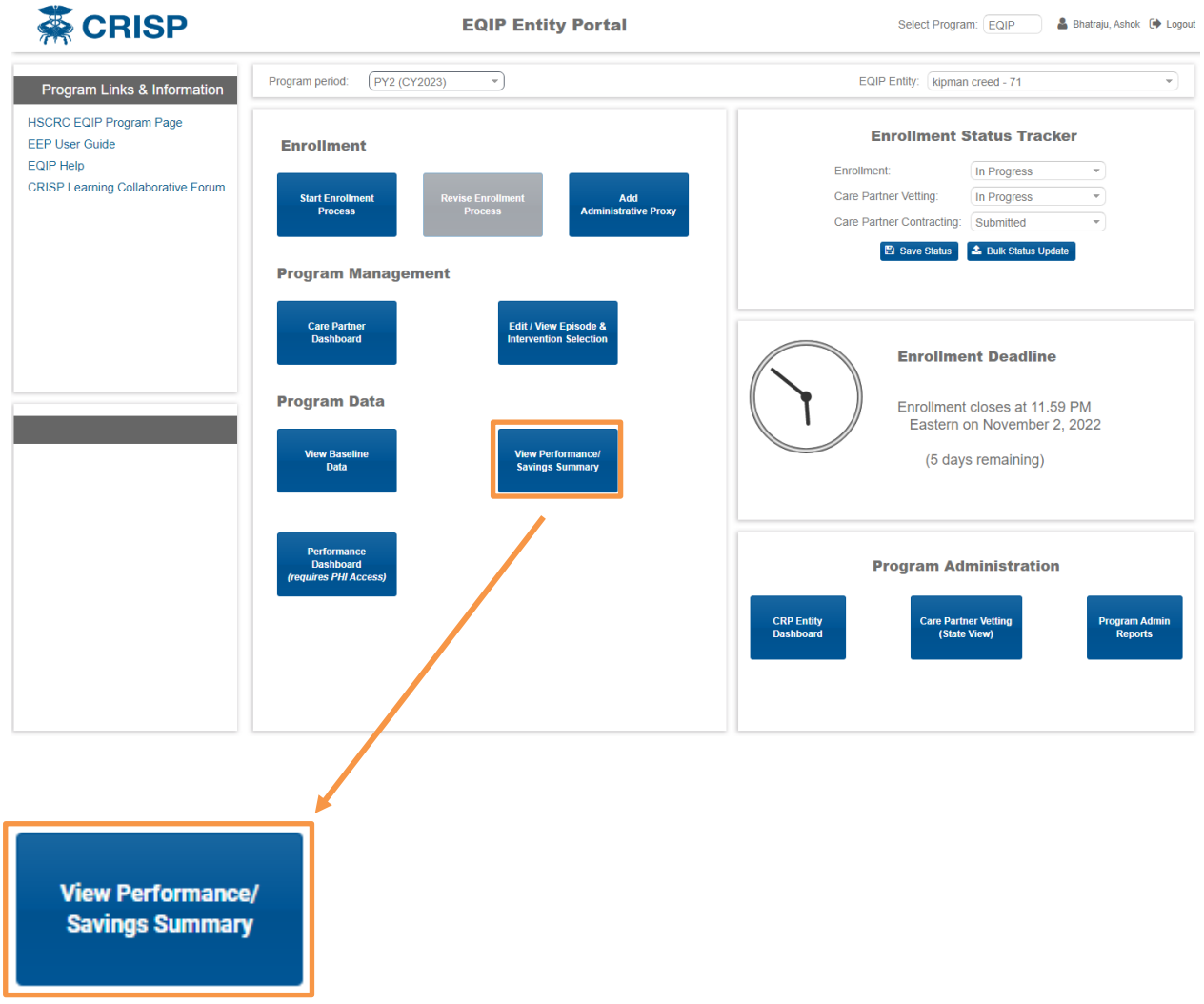


Figure 3 - Accessing the Performance & Savings Summary Report

This Performance & Savings Summary Report displays a list of all EQIP Entities participating in the selected performance year, the list of episodes each Entity is participating in, and the associated episode volume, target price, and aggregate payments associated with those episodes. Payment amounts, target prices, and episode definitions are generated as described in the appropriate EQIP Performance Year Policy User Guide available at https://hscrc.maryland.gov/Pages/Episode-Quality-Improvement-Program.aspx.

At the beginning of a given performance period, only the baseline data for that period will display. The report will be updated with new performance period data quarterly as the claims data associated with the episodes is submitted, processed, and made available.

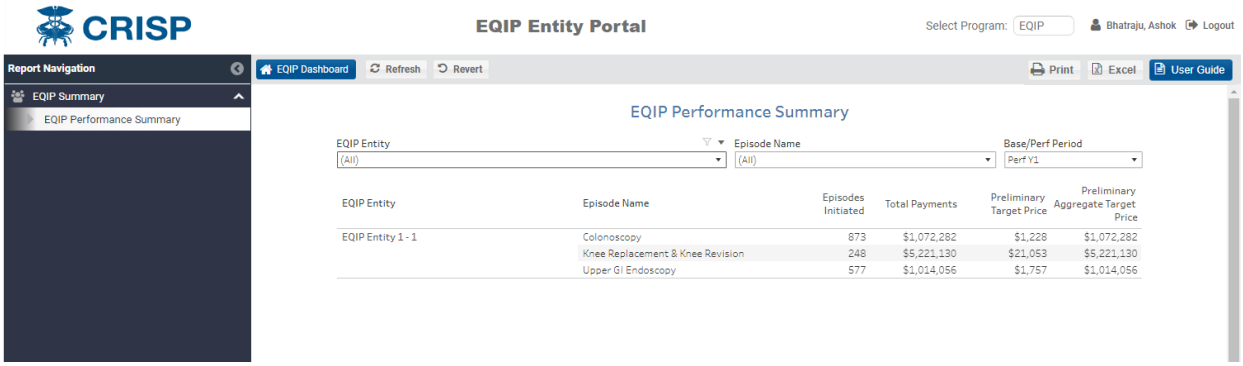


Figure 4 - EQIP Performance & Savings Summary Report

Filters are available at the top of the page to narrow the displayed data to a subset of EQIP Entities, episode categories, or performance years. Performance and baseline time period filters can be used to navigate between baseline and performance year data.

Data Element	Description
Episodes Initiated	Total number of episodes triggered meeting program criteria for the given row for the selected time period.
Total Payments	Total Medicare FFS payments associated with the episodes triggered, following the program payment analysis policy. Note that payments are assigned to an episode following the PROMETHEUS episode grouper logic, certain limited payment categories excluded, and an adjustment to account for regulated payments under GBR are applied, so these amounts may not exactly match the sum of the raw claim totals for the associated episode.
Preliminary Target Price	Target price per episode assigned to the EQIP Entity / episode category based on the average episode payment amount during the baseline period. All dollar amounts are inflated and adjusted to reflect real, equivalent dollars in the performance period.
Preliminary Aggregate Target Price	Number of episodes initiated multiplied by the preliminary target price, giving the total target for the EQIP Entity / episode category in question. During evaluation, the final aggregate target price will be compared to the total payments during the performance period to determine if and the amount of any savings achieved.

3 EQIP Performance Dashboard

Lead Care Partners and Administrative Proxies for EQIP Entities who have been certified and provisioned with PHI access for the program additionally have access to detailed program reports specific to the EQIP Entities they are affiliated with.

To access this reporting suite, click on the Performance Dashboard button on the EEP Landing Page as shown below.

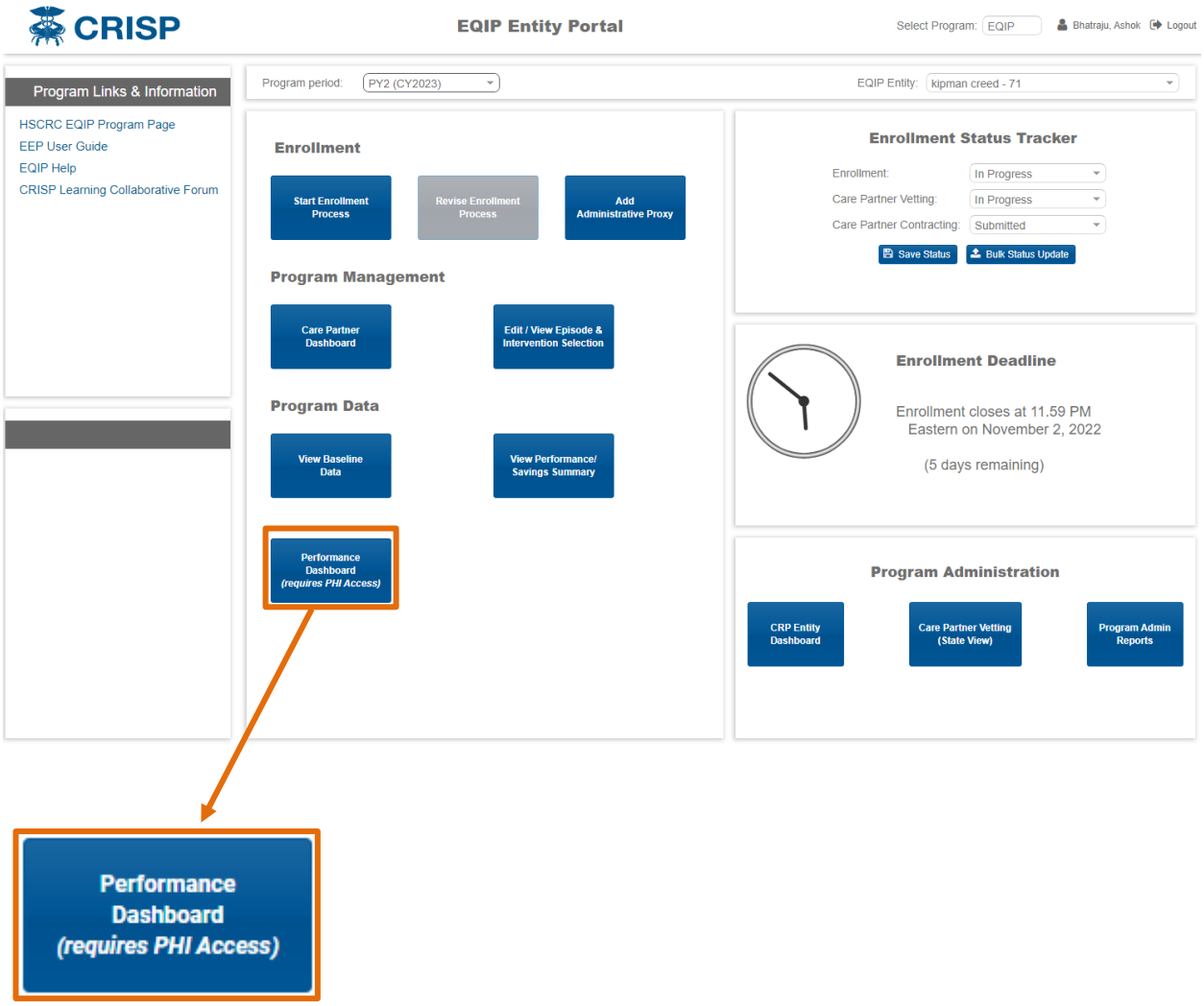


Figure 5 - Accessing the EQIP Performance Dashboard

Upon clicking the link, you will be directed to EQIP reporting suite and the first dashboard, the Target Price Summary, will open, which should appear as below.

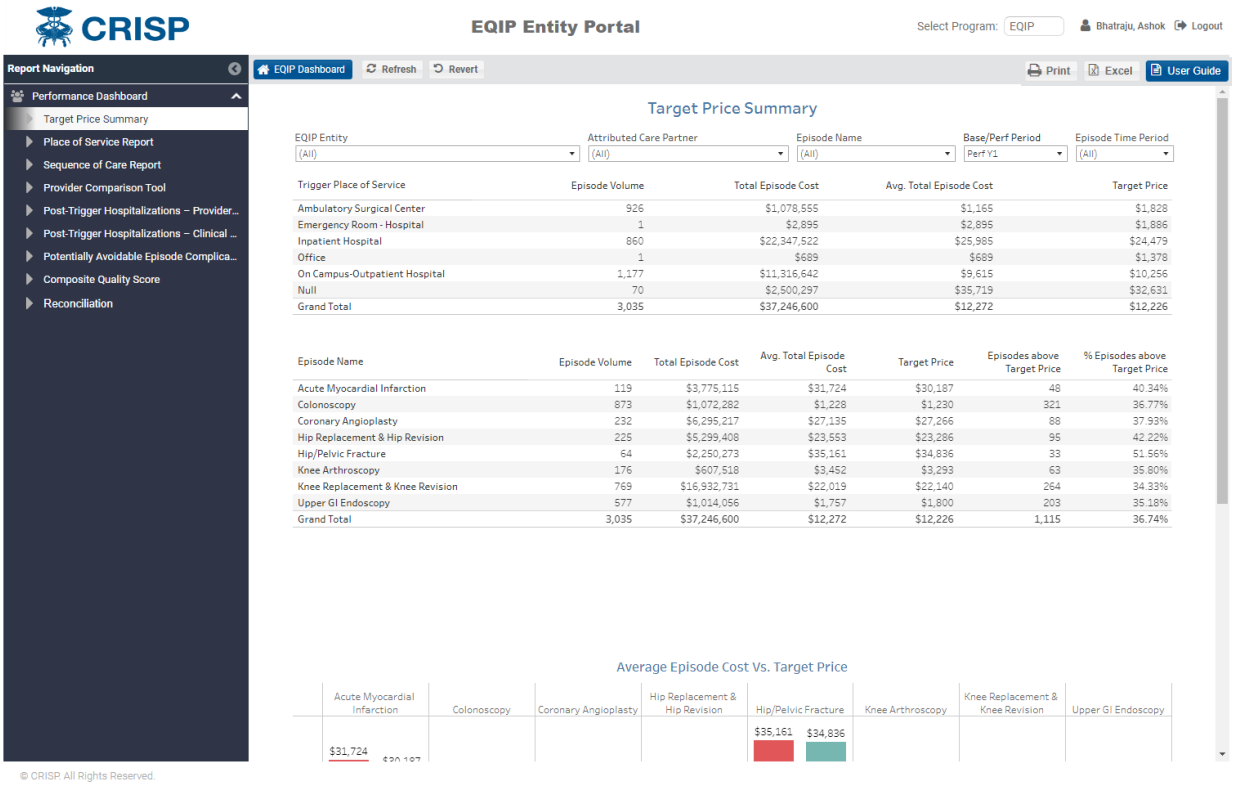


Figure 6 – Opening the EQIP Performance Dashboard – Target Price Summary View

3.1 EQIP Performance Dashboards Workflow

The EQIP Performance Dashboards suite consists of nine individual reports, listed in the diagram below, that have been designed to present users with the information most needed to evaluate EQIP participation and monitor performance. These reports are ordered in the left-hand navigation bar in such a way to guide new users through the data in an intuitive fashion. For your first time through, we recommend moving through the workflow in this order. Then, in subsequent sessions you can return and navigate directly to the reports of greatest interest. Each of these reports is described in detail in the sections that follow.

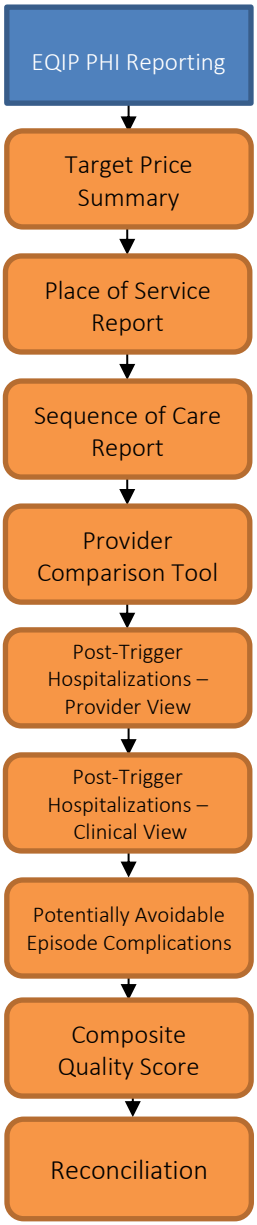


Figure 7 - EQIP Performance Dashboard Workflow

3.2 Report Filters

Each of the reports includes four top-level filters that users can apply to narrow the data displayed in the application, as described below:

EQIP Entity – If a user is an Administrative Proxy for multiple EQIP Entities, this allows the user to select which entity to view data for. All other users will only see / be able to select the single EQIP Entity they are affiliated with. Note that if you are exporting data via the PDF or Excel export option, it is recommended to select a single EQIP Entity before doing so.

Attributed Care Partner – This filter allows the user to select individual Care Partner(s) within the selected EQIP Entity and view data on the episodes attributed to them.

Episode Name – This filter allows the user to narrow the presented data down to specific clinical episode category or categories to more easily compare and view data for a specific clinical domain for EQIP Entities that may be participating in a broad range of episodes.

Base / Perf Period – This filter allows the user to navigate between base year data and performance period data. Baseline and performance period values will be added to this filter as data becomes available for new periods.

Episode Time Period – This filter allows the user to select and view data for specific time periods. This filter applies to the month of the episode trigger date – e.g. selecting April 2019 will display data for episodes triggered in April of 2019. Once performance year data is available, this filter also allows to to select between viewing program baseline data and performance period data.

Figure 8 - Top Level Filters

3.3 Target Price Summary

The first report, the **Target Price Summary**, provides an overview of the episode volume, payments and resulting target price for each episode category in which the selected EQIP Entity is participating.

These data are displayed in two ways in the tables at the top of the page – by triggering site of service, and by clinical episode category. Note that if the Episode Name filter includes multiple different episode categories, there will appear do be a difference between the average episode payments and target price even in the baseline due to the fact that this table is showing (blending) data for multiple different episode categories, each of which has its own separate target price.

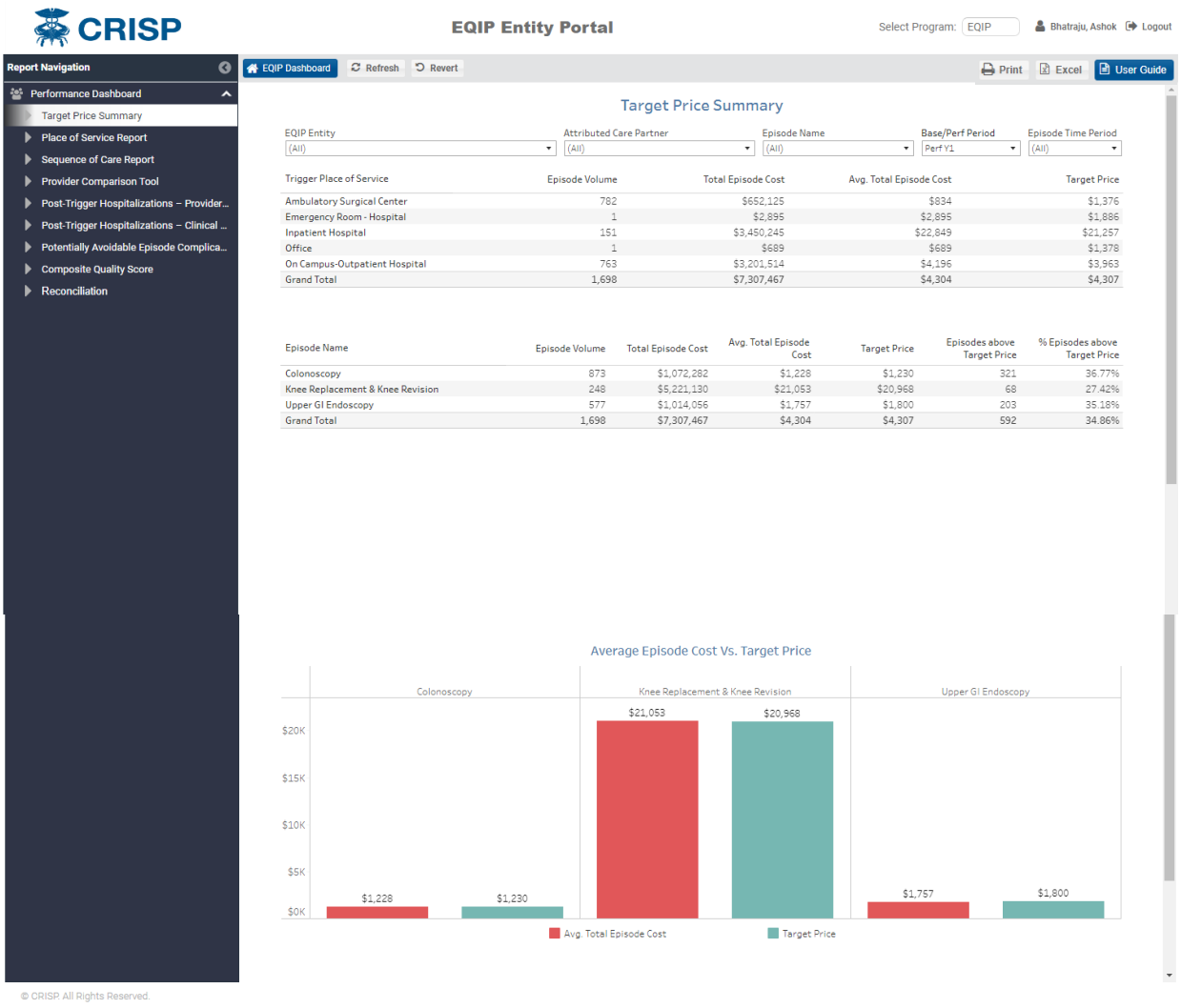


Figure 9 - Target Price Dashboard

At the bottom of the report you will find a chart comparing the target price to average payments for the selected episodes. When only baseline data is displayed, these values will be equal, but once performance period data is posted this can be used to easily view which episode categories are meeting or exceeding the target price.

Data Element	Description
Episodes Initiated	Total number of episodes triggered meeting program criteria for the given row for the selected time period.
Total Payments	Total Medicare FFS payments associated with the episodes triggered, following the program payment analysis policy. Note that payments are assigned to an episode following the PROMETHEUS episode grouper logic, certain limited payment categories excluded, and an adjustment to account for regulated payments under GBR are applied, so these amounts may not exactly match the sum of the raw claim totals for the associated episode.
Preliminary Target Price	Target price per episode assigned to the EQIP Entity / episode category based on the average episode payment amount during the baseline period. All dollar amounts are inflated and adjusted to reflect real, equivalent dollars in the performance period.
Preliminary Aggregate Target Price	Number of episodes initiated multiplied by the preliminary target price, giving the total target for the EQIP Entity / episode category in question. During evaluation, the final aggregate target price will be compared to the total payments during the performance period to determine if and the amount of any savings achieved.
Episodes Above Target Price	Number of episodes which exceed the target price established by EQIP policy.
% Episodes Above Target Price	Percent of episodes which exceed the target price established by EQIP policy.

3.4 Place Of Service Report

The **Place of Service Report** provides insights into the distribution of episode volume, total episode payments and average episode cost by the triggering place of service, and first post-trigger place of service.

Clicking on any of the 'Trigger Place of Service' rows in the top table will display the information related to that particular place of service separately in a table below it, along with a chart comparing average cost by first post-trigger setting.

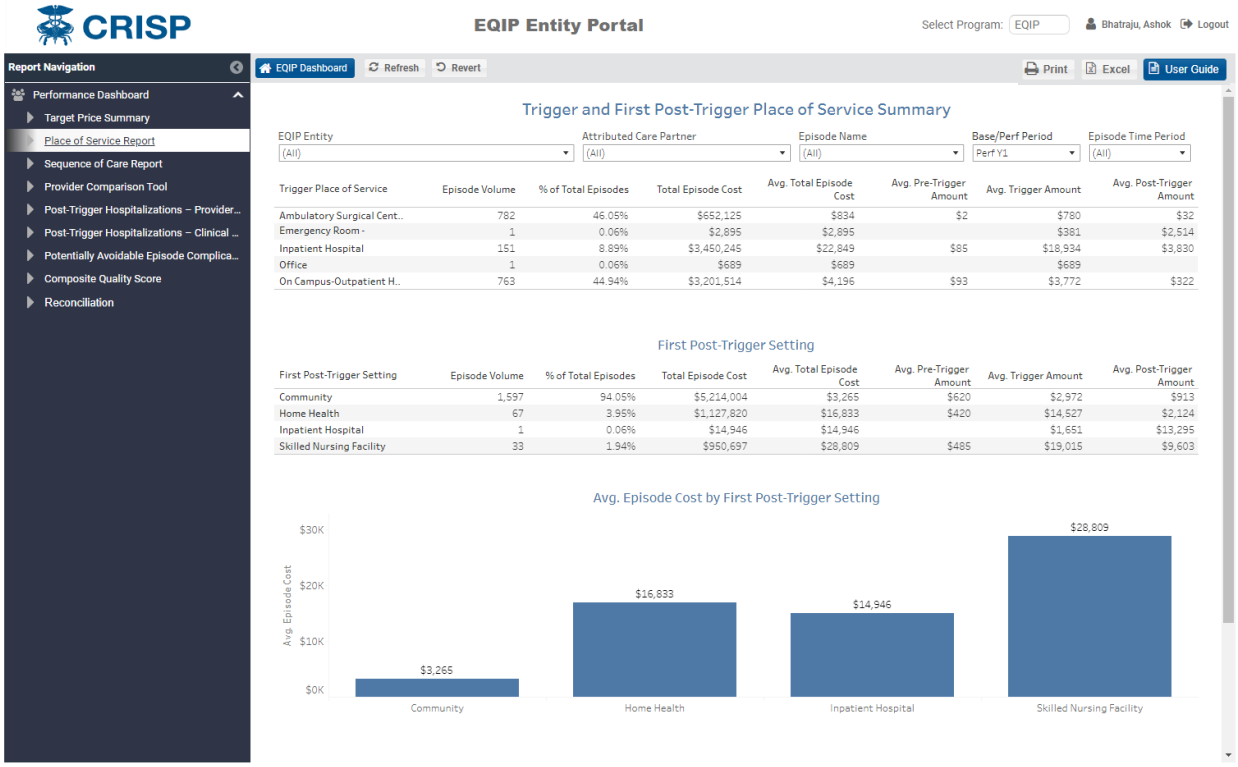


Figure 10 - Place of Service Report

Data Element	Description
Episode Volume	Number of episodes that triggered in the listed Place of Service (for 'Trigger Place of Service') or number of episodes in which a beneficiary first transitioned to the listed Place of Service following the trigger event (for 'First Post-Trigger Setting). Place of Services is determined using the Medicare POS codes on the claims used for analysis.
% of Total Episodes	Proportion of episodes triggering in ('Trigger Place of Service') or transitioning to ('First Post-Trigger Setting) the listed place of services, out of all episodes triggered.

Data Element	Description
Average Pre-Trigger Amount	Total attributed episode payments incurred in the episode global period prior to the episode trigger event.
Average Trigger Amount	Total attributed episode payments incurred during the episode trigger event.
Average Post-Trigger Amount	Total attributed episode payments incurred in the episode global period following the episode trigger event.

3.5 Sequence Of Care Report

The **Sequence of Care Report** is designed to provide users with a clear view of the services beneficiaries receive following the trigger event all the way through to the end of the episode.

The first column in the table displays the triggering place of service. The second column shows the episode sequence, with a series of letters representing different care types. A key at the bottom of the page provides the site of services associated with each letter. For example, a sequence of care simply represented by the letter 'C' indicates the beneficiary was seen in an outpatient setting followed by a return home after the trigger procedure, with no additional follow-up. The sequence 'A-H' indicates an inpatient hospitalization followed by home health care followup.

The remaining columns in the table detail the volume and costs associated with all episodes following the listed sequence of care.

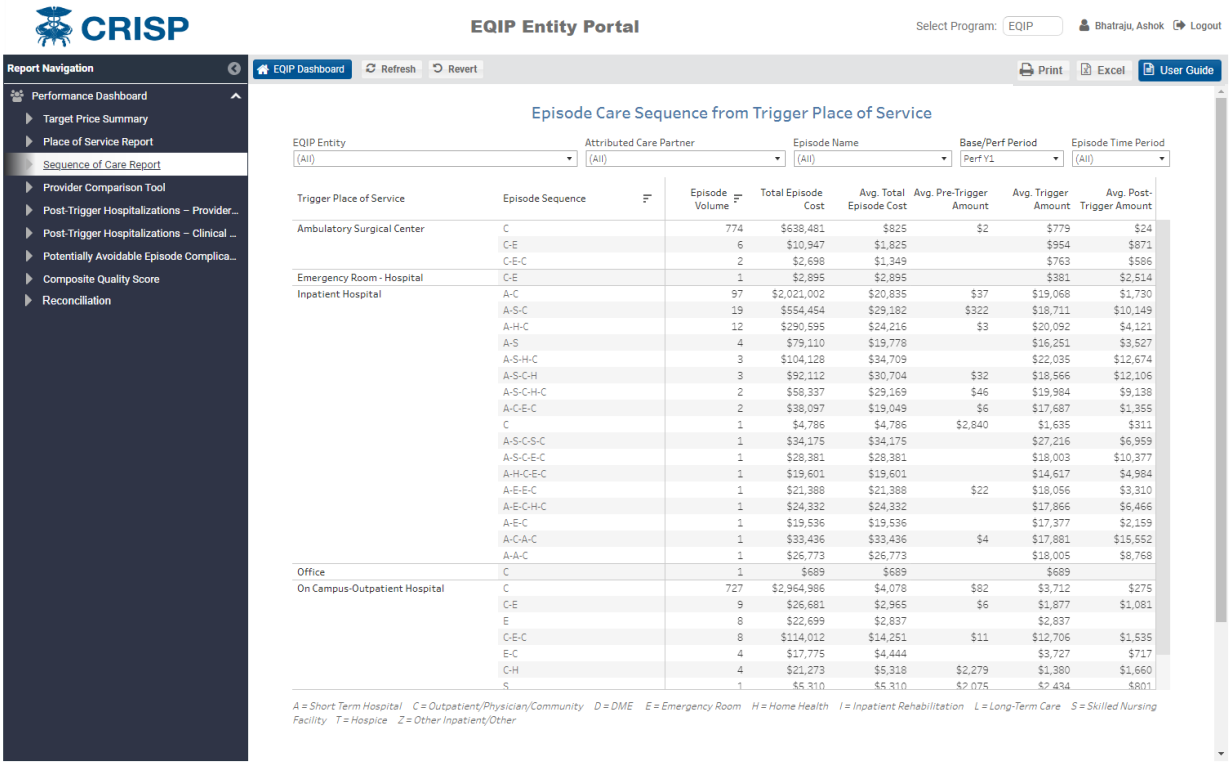


Figure 11 – Episode Sequence of Care

Data Element	Description
Total Episode Cost	Total payments attributed to the episodes under the PROMETHEUS grouper logic following a given sequence of care.
Avg. Total Episode Cost	Average total payments assigned to each episode following a given sequence of care.
Average Pre-Trigger Amount	Total attributed episode payments incurred in the episode global period prior to the episode trigger event.
Average Trigger Amount	Total attributed episode payments incurred during the episode trigger event.
Average Post-Trigger Amount	Total attributed episode payments incurred in the episode global period following the episode trigger event.

3.6 Provider Comparison Tool

The **Provider Comparison Tool** is a utility that can be used to understand how individual care partners are performing in comparison to the EQIP Entity as a whole. The dashboard displays two sets of charts and tables side-by-side, providing details on the selected episode by triggering place of service and first post-trigger setting.

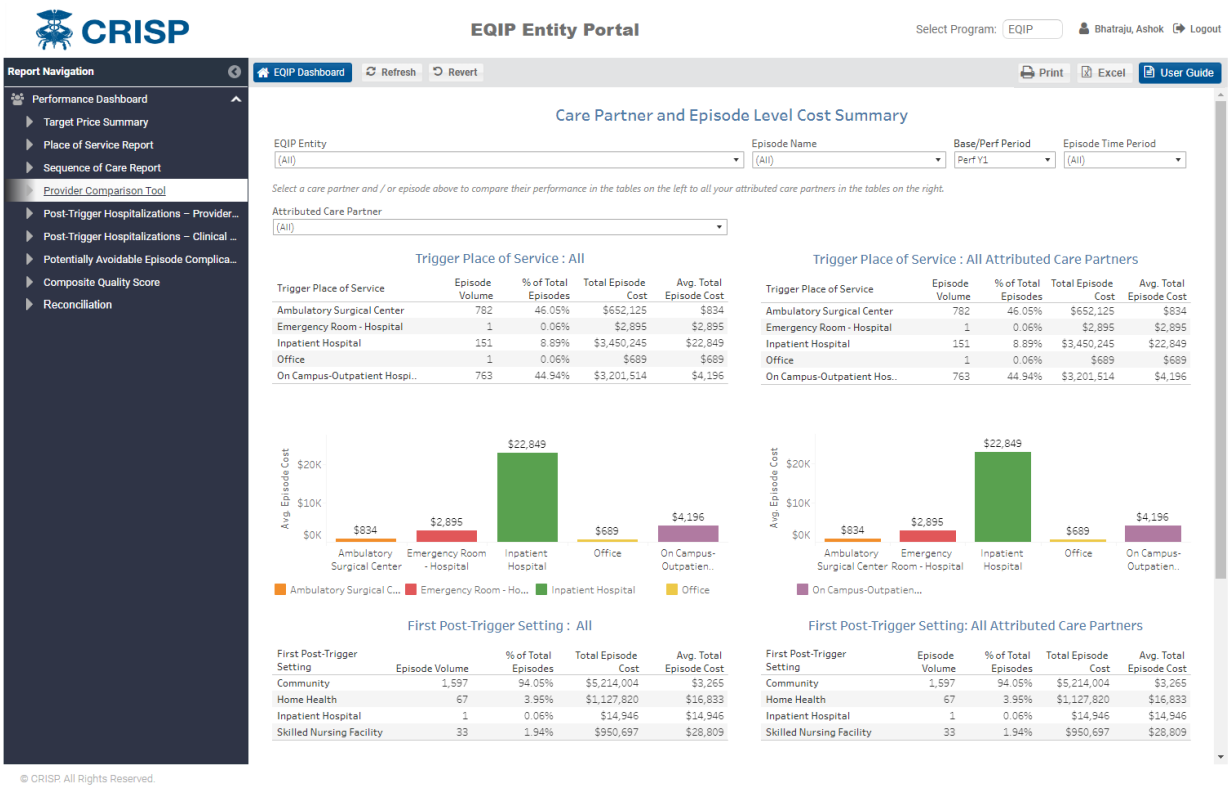


Figure 12 - Provider Comparison (Overview)

After selecting a Care Partner using the filter drop-down at the top of the page, the tables and graphs on the left-hand side of the report will update to display data on the episodes attributed to that specific care partner, while the charts and tables on the right continue to display information on the EQIP Entity as a whole.

If a clinical episode category or time period is selected, the charts and tables on both sides will update to reflect this (allowing for a Care Partner's performance in a single episode category or time period to be compared to the equivalent values for the EQIP Entity as a whole).

An example of this is shown below.

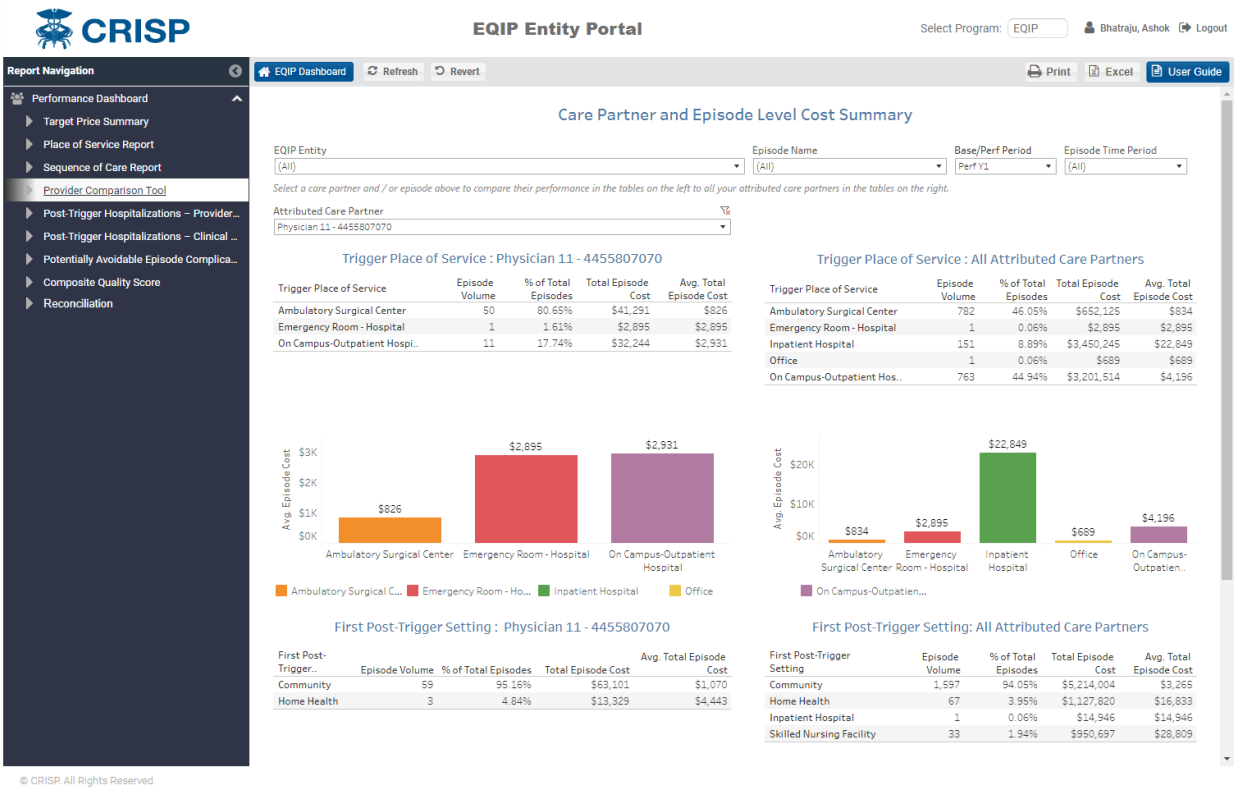


Figure 13 - Care Partner Comparison

3.7 Post-Trigger Hospitalizations - Provider View

The **'Post-Trigger Hospitalizations - Provider'** dashboard provides information on inpatient hospitalizations occurring during episode global periods after the trigger event. For episodes triggered exclusively by an inpatient hospitalization, this can be thought of as essentially a readmissions report. However, it also includes data on such events that occur after an outpatient episode trigger, which is why the term 'post-trigger hospitalizations' is used rather than readmissions.

This particular dashboard is intended to help understand the providers involved in these events. The top table displays the setting of care in which the episode trigger event occurred, highlighting the relative number of post-trigger hospitalizations by triffering setting of care.

The second table displays the same data elements for each individual Care Partner associated with the selected EQIP entity, allowing for comparisons in the rate of post-trigger hospitalizations by triggering physician.

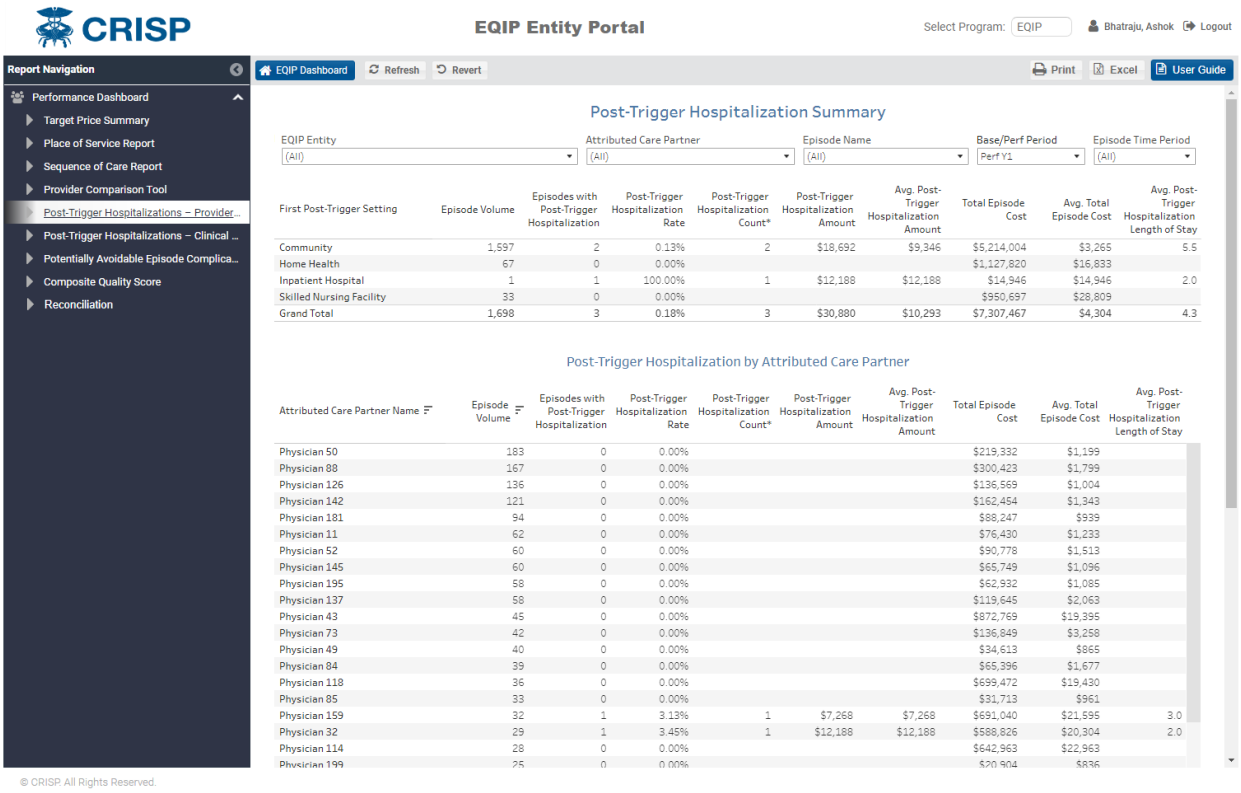


Figure 14 – Post-Trigger Hospitalizations - Provider View

Data Element	Description
Episodes with Post-Trigger Hospitalizations	Number of episodes with at least one post-trigger inpatient hospital admission during the episode global period.
Post-Trigger Hospitalization Rate	Percent of all episodes with a post-trigger inpatient hospital admission.
Post-Trigger Hospitalization Count	Count of individual post-trigger hospitalizations. Note that a single beneficiary / episode can have multiple hospitalizations, so this number will typically be higher than the post-trigger hospitalization rate.
Post-Trigger Hospitalization Amount	Total dollar value of payments made during the episode global period attributed to inpatient hospitalization stays occurring after the trigger event.
Avg. Post-Trigger Hospitalization Amount	Average dollar amount per episode of payments associated with inpatient hospitalizations occurring after the trigger event during the episode global period.
Total Episode Cost	Total payments attributed to the episodes in the view or row in question.
Avg. Total Episode Cost Avg. Post-Trigger Hospitalization Length of Stay	Average inpatient admission length of stay for hospitalizations that occur during the episode global period after the trigger event.

3.8 Post-Trigger Hospitalizations - Clinical View

The **'Post-Trigger Hospitalizations - Clinical View'** dashboard provides similar information to the 'Post-Trigger Hospitalizations – Provider View' described in section 3.7 above, but pivots the data for easy analysis by episode category and the admission DRG for the post-trigger hospitalization. The data elements displayed in this report are otherwise the same as those described in Section 3.7 above.

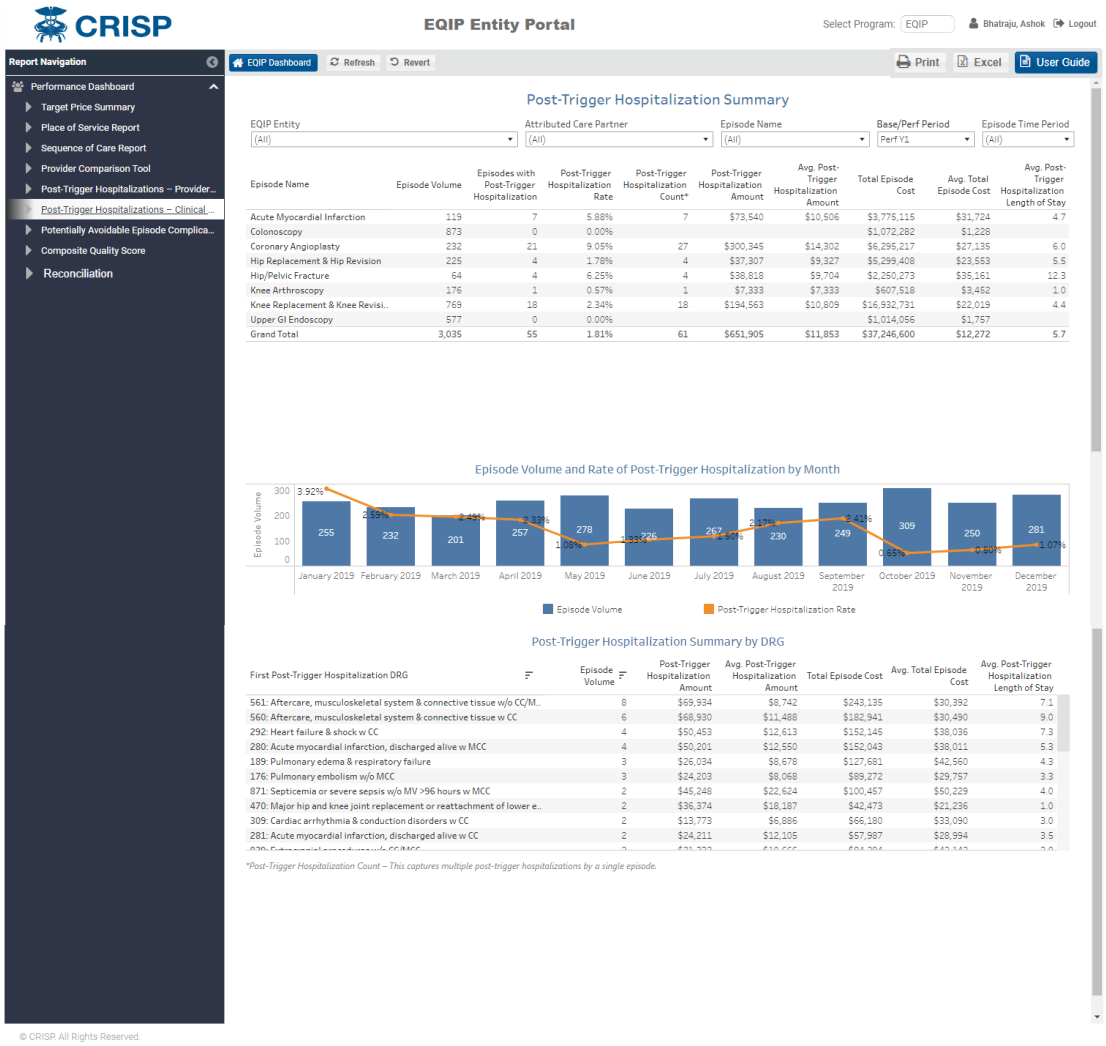


Figure 15 – Post-Trigger Hospitalizations - Clinical View

3.9 Potentially Avoidable Episode Complications

The **Potential Avoidable Episode Complications** dashboard insights into potentially avoidable complications occurring during EQIP episodes and the costs associated with these events. Note that this logic is only available for episodes generated using the PROMETHEUS grouper logic. Any episodes created by the HSCRC at participant request outside of this grouper will have null values for these data elements.

The top table provides an aggregate summary of potentially avoidable episode complications and costs by clinical episode category. The bottom table goes into further detail, enumerating the specific complication groups these PAECs fall into and the relative number of each type of complication identified.

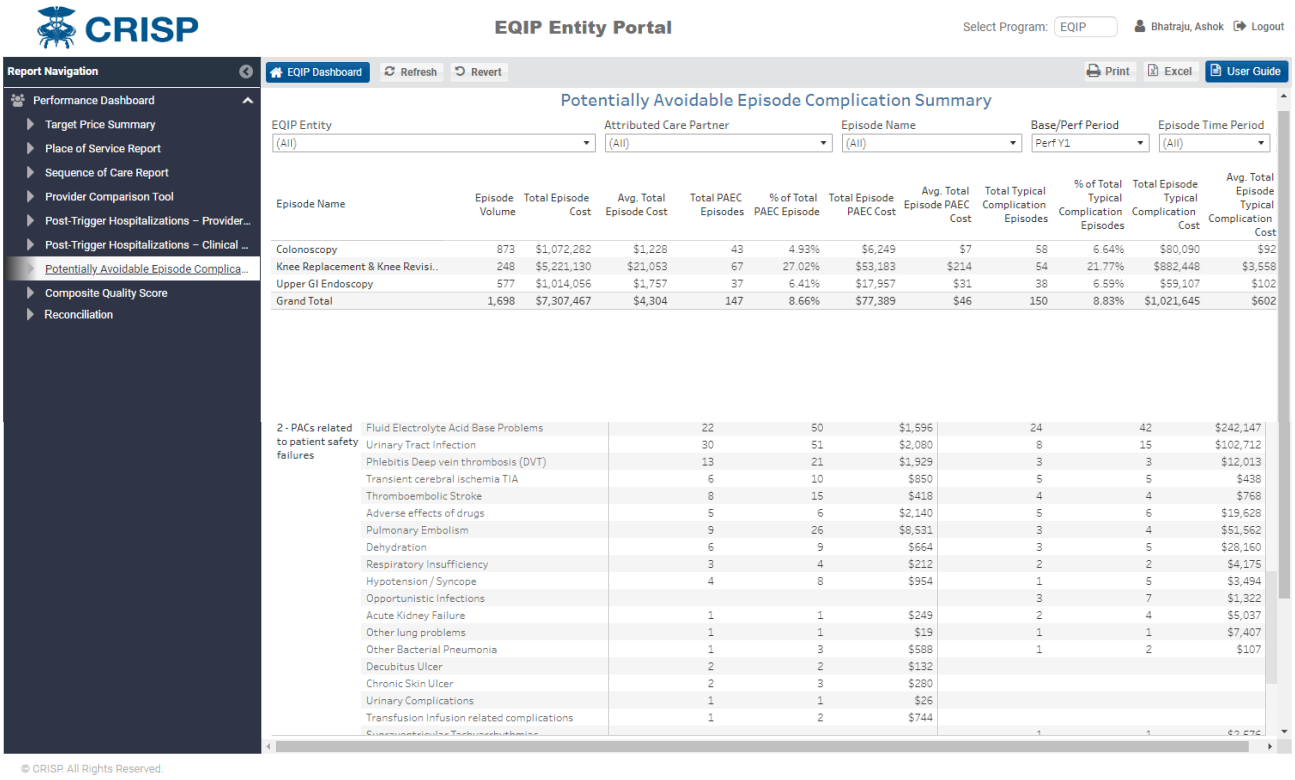


Figure 16 - Potentially Avoidable Complications

Data Element	Description
Total PAEC Episodes	Total number of triggered EQIP episodes identified as having potentially avoidable episode complication (PAEC) events
% of Total PAEC Episodes	Percent of episodes identified as having PAEC events
Total Episode PAEC Cost	Total payments attributed to PAEC events according to the PROMETHEUS episode grouper logic

Data Element	Description
Avg. Total Episode PAEC Cost	Average total payments per episode attributed to PAEC events
Total Typical Complication Episodes	Total number of triggered EQIP episodes identified as having 'Typical Complication' events (see TypicalWithComplication description below).
% of Total Typical Complication Episodes	Percent of episodes identified as having Typical Complication events
Total Episode Typical Complication Cost	Total payments attributed to Typical Complication events according to the PROMETHEUS episode grouper logic
Avg. Total Episode Typical Complication Cost	Average total payments per episode attributed to Typical Complication events
Complication Type	General type of complication, as defined by the PROMETHEUS episode grouper logic. Broken into two broad categories – (1) PACS related to the index stay(s) and (2) PACS related to patient safety failures.
Complication Group	Specific complication group assignment in which the adverse event occurred, as defined by the PROMETHEUS episode grouper logic.
PAC / PAEC	Potentially Avoidable Complication / Potentially Avoidable Episode Complication. Interchangeable, but generally PAEC is used in the application to avoid confusion with PAC as 'post-acute care.'
TypicalWithComplication	Because of the manner in which the claims are coded and the episode grouper logic works, there are certain diagnoses specifically associated with inpatient claims that the grouper cannot absolutely assign as a PAEC vs typical event. Such events are included in the TypicalWithComplication category. These merit review, as clinical input is required to determine whether the event was truly a complication, but are included for informational purposes here.
Episode Volume	Total number of episodes triggered meeting the EQIP inclusion criteria for the currently displayed selection or row.
PAEC Claim Count	Number of claims attributed to an episode which included PAEC events.
PAEC Cost	Total attributed episode payments associated with PAEC events.

3.10 Composite Quality Score

The **Composite Quality Score** Report can be used to track performance on the EQIP quality measures. For Performance Years 1 and 2, for example, EQIP Entities will be evaluated on three quality metrics – Advance Care Planning, Documentation of Current Medications, and BMI Screening.

The report provides the raw performance rate, score, numerator, and denominator for each measure included in the performance year, as well as the resulting Composite Quality Score calculated by combining the individual measure quality scores as described in the Program Policy User Guide. Each individual measure is scored on a 0 – 10 scale, with the CQS being presented as a percentile score. Again, the full logic for all measure and calculation of the CQS can be found in the EQIP Program Policy User Guide available on the HSCRC website.

Note that while users can filter the tables by episode name and Care Partner to see the values for those specific subsets of episodes, the actual Composite Quality Score is only calculated and evaluated at the EQIP Entity Level. Any other level of data display is for informational purposes only.

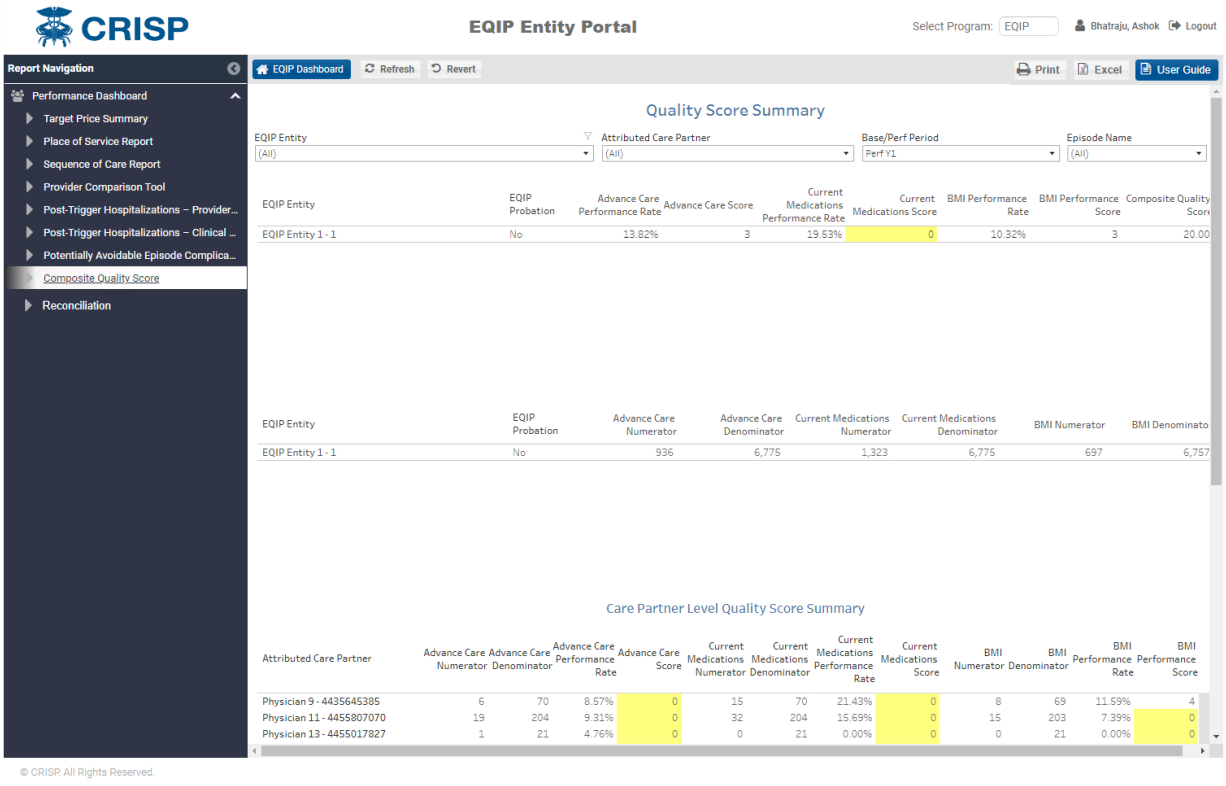


Figure 17 - Quality Score Summary

Below the summary tables at the top of the page is a Care Partner Level Quality Summary that displays each individual Care Partner's contributions to the EQIP Entity's quality score. The same data elements are displayed for each Care Partner as for the EQIP Entity as a whole above; however keep in mind that the quality measures are only actually scored and evaluated at the EQIP Entity level.

Data Element	Description
EQIP Probation	EQIP Entity probation status. EQIP Entities are placed on probation if their performance rate is in the bottom 20th percentile for any quality measure. Two consecutive years of probation will result in removal from the program.
[Measure Name] Performance Rate	Raw performance rate for the named measure, as calculated per the measure specifications in the EQIP Policy User Manual.
[Measure Name] Score	Number of points assigned to the EQIP Entity for the named measure, based on their raw performance rate relative to the statewide percentile distribution thresholds.
[Measure Name] Numerator	Number of episodes contributing the the named measure numerator.
[Measure Name] Denominator	Number of episodes contributing to the named measure denominator.
Composite Quality Score	Final composite quality score (on a scale of 0 to 100), calculated by combining the individual measure scores as described in the EQIP Policy User Guide.

3.11 Reconciliation

The Reconciliation Report displays the components of the EQIP Program reconciliation calculation for each performance period, as of the most recent data available. **Note that until the final reconciliation is calculated at the end of the performance period, all values displayed in this report are preliminary and may change as additional data accrues.**

A clinical episode category generates savings if the total performance period payments across all clinical episode categories in which an EQIP Entity is participating are less than the total aggregate target price across those episode categories. Savings are calculated at the EQIP Entity level, and are not scored for individual clinical episode categories. If total performance period payments exceed the aggregate target price, the EQIP Entity is considered to have generated dissavings, which will be deducted from any future performance period shared savings amounts.

The tables on this report walk the user through the various calculation steps of the reconciliation, including calculation of the EQIP Entity's savings share, quality adjustments, dissavings application, the minimum savings threshold calculation, and incentive payment cap generation. For full details on each of these steps, see the EQIP Program Policy Guide available on the HSCRC program website.

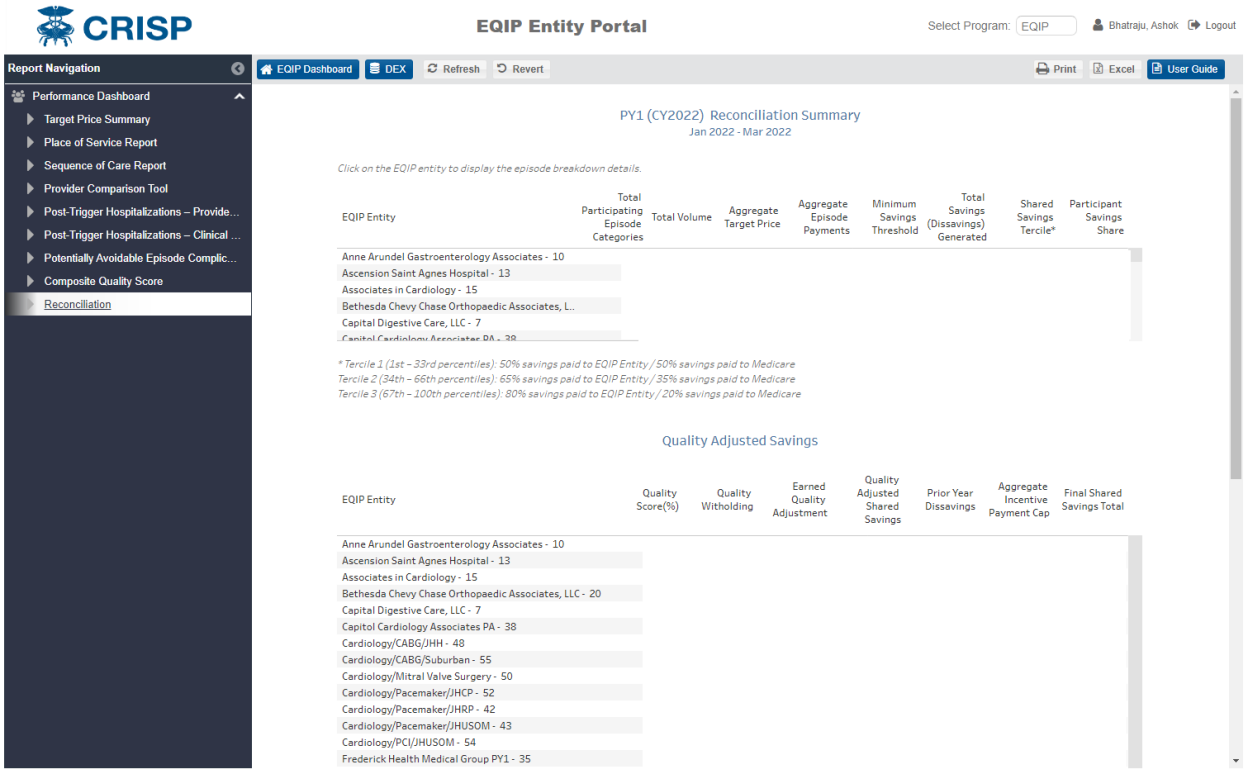


Figure 18 – Reconciliation Summary

Data Element	Description
Aggregate Target Price	The total aggregate target price for an EQIP Entity for the selected performance period is equal to the number of episodes triggered by that Entity's Care Partners in each clinical episode category by the target price for that clinical episode category, summed across all clinical episode categories in which the EQIP Entity is participating for that period.
Aggregate Episode Payments	Sum the total payments associated with all clinical episodes in all clinical episode categories in which the selected EQIP Entity is participating for the selected performance year.
Minimum Savings Threshold	The minimum savings an EQIP Entity must achieve in order to earn a shared savings payment, equal to 3% of the aggregate target price for the selected performance period.
Total Savings (Dissavings)	Total dissavings generated by the EQIP Entity for the selected performance period, calculated as the aggregate target price less aggregate episode payments. Any dissavings accrued from the final reconciliation for a performance year will be applied to shared savings from the following year, per EQIP program policy.
Shared Savings Tercile	The Shared Savings Terciile to which the EQIP Entity has been assigned for the performance period, based on their efficiency relative to the rest of the state (based on average baseline episode cost). The Shared Savings Tercile determines the proportion of shared savings that is allocated to CMS. Refer to EQIP Program Policy Guide to understand how Savings Terciles are calculated.
Participant Savings Share	EQIP Entity's allocation of the total savings share, determined based on the shared savings tercile to which they belong to.
Quality Withholding	Total amount of the participant savings share held at risk and earned back based on the EQIP Entity's Composite Quality Score for the period. Equal to 5% of the Participant Savings Share.
Earned Quality Adjustments	Proportion of the quality withholding amount the EQIP Entity has earned back for the period, based on their Composite Quality Score for the quality measures for that performance period.
Quality Adjusted Shared Savings	The total quality-adjusted shared savings earned by the EQIP Entity after the earned quality adjustment is added to the participant savings share.
Prior Year Dissavings	Amount of any prior year dissavings to be deducted from the EQIP Entity's quality adjusted shared savings total. Zero for the first year in which an EQIP Entity participates in the program.
Incentive Payment Cap	Maximum incentive payments that can be made to an EQIP Entity's Care Partners for the selected performance period, equal to 25% of the total of all payments made for Medicare FFS Part B services provided by those care partners in the prior year. This is a preliminary value that will be updated with the final incentive cap after CMS calculates and provides the State with the official value prior to final reconciliation.
Final Shared Savings Total	The final shared savings amount (if any) that the EQIP Entity has earned for the selected period. This amount must be greater than the Minimum Savings Threshold (described above) and includes any quality offsets, previous year dissavings offsets, and CMS' savings share deduction, all as described above.