maryland health services cost review commission

Episode Quality Improvement Program (EQIP) Technical Review

Program Year 3

2024

Overview

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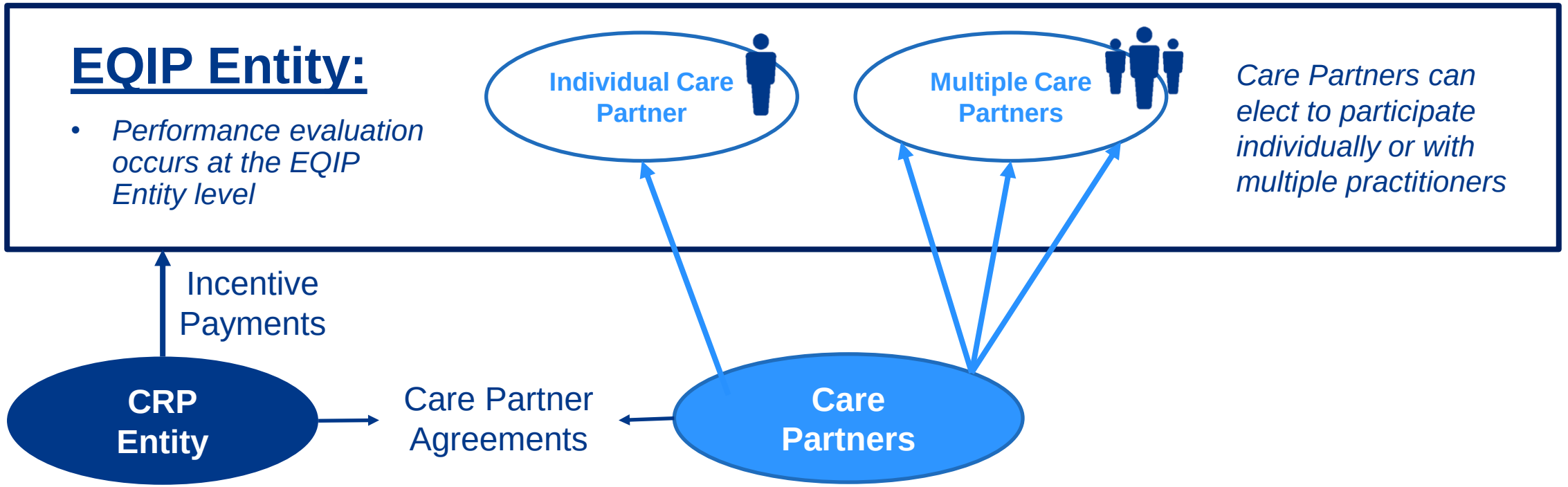
EQIP Overview

EQIP Roles and Definitions



- *Care Partners are the individual Practitioner /NPI participating in EQIP*
- *Care Partners triggers episodes in EQIP*

Administrative Proxies: *EQIP Entities can delegate management of their program administration. This contractual arrangement, if any, will be determined between Administrative Proxy and Participant outside of Care Partner Arrangements*.

Care Partners

General and specialty physicians, or other approved practitioners licensed and enrolled in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

Required to sign a Care Partner Arrangement Agreement (**CPA**) indicating they will:

- Implement allowed interventions
- Use Certified Electronic Health Record Technology (CEHRT) as required by CMS
- Notify patients about EQIP

Must pass CMS vetting for eligibility based on:

- A check that Medicare PECOS is up-to-date and correct
- CMS program integrity verification
- Law enforcement review

EQIP Entity

An individual Care Partner or a group of Care Partners.

- Professional affiliations with other legal entities do not prohibit Care Partners from participating in an EQIP Entity.
- Incentive payments are based on the EQIP Entity's aggregate performance - i.e., improved financial performance and quality of care.
- EQIP Entity determines the distribution of earned incentive payments among its Care Partners.

EQIP Entities face upside-only risk

- Not expected to repay CMS because of inadequate performance.
- Financial performance is assessed approximately 6 months after the program year ends.

Care Redesign Program (CRP) Entity

Aggregates CPAs and issues incentive payments to the payment remission source indicated by EQIP Entity.

- CPA with the CRP Entity certifies a Care Partner's participation and Qualifying Advanced Alternative Payment Model (APM) Participant status.
- Care Partners can opt out of Merit-based Incentive Payment System (MIPS) in exchange for EQIP participation.
- The University of Maryland Medical Center is the CRP Entity for the third program year (PY3).

EQIP Entity Portal (EEP)

Providers use the EEP to enroll in EQIP, view data, and access resources available to EQIP Entities.

- EQIP Entities must enroll with CRISP to utilize the EEP and participate in EQIP.
- Contact **EQIP@crisphealth.org** for EQIP application assistance or refer to the CRISP Onboarding Instructions for EQIP and the EEP User Guide for technical assistance.

CRISP Onboarding Instructions for EQIP:
https://hscrc.maryland.gov/Documents/EQIP%20Onboarding%20One%20Pager%20Final%20(2).pdf

EEP User Guide, version 1.0:
https://hscrc.maryland.gov/Documents/EEPUserGuide_20210708105643.pdf

EQIP Program Year Cycle

June	• Recruitment and EQIP Outreach
July 1	• EQIP Entity Portal (EEP) opens for enrollment
September 1	• EEP deadline for submission of Care Partners (NPIs) for CMS vetting • CRP Entity contracting and episode selection process begins
October 1	• CMS Vetting Results Available in EEP • Care Partner Agreement arrangement (contracting) begins
December 31	• Care Partner Agreement arrangement (contracting) ends • EQIP Entity participation and rosters final
January 1	• Episode elections are final • EQIP program year begins

Clinical Episode Construction

Data Source

EQIP episodes are constructed from the Maryland All-Payer Model (MDAPM) Claim and Claim Line Feed (CCLF) data.

- Medicare final action claims for all Part A and Part B services received by Maryland residents, regardless of service location.

***Excluded* Beneficiaries:**

- Non-Maryland residents
- Managed care enrollees
- ESRD patients

***Excluded* Claims:**

- Non-final Action
- Unpaid/Denied
- Substance Abuse and Mental Health Service Association (SAMHSA)

Clinical Episode Categories

49 clinical episode categories spanning 8 clinical specialty categories

- EQIP Entities can participate in one or more clinical episode categories across one or more specialty areas.
- 33 clinical episode categories constructed using the proprietary **Prometheus episode grouper** (see link for more information).
- 16 “non-Prometheus” clinical episode categories constructed using HSCRC’s methodology (refer to the *CTI Policy Guide* for more information).

Change Healthcare – Prometheus Analytics, Deeper Dive: http://prometheusanalytics.net/deeper-dive

Prometheus Clinical Episode Categories

Allergy

- Allergic Rhinitis/Chronic Sinusitus
- Asthma
- COPD
- Pneumonia
- Sepsis

Gastroenterology

- Colonoscopy
- Colorectal Resection
- Gall Bladder Surgery
- Upper GI Endoscopy

Urology

- Catheter Associated UTIs
- Prostatectomy
- Transurethral Resection Prostate
- Urinary Tract Infection

Dermatology

- Cellulitis, Skin Infection
- Decubitus Ulcer
- Dermatitis, Urticaria

Ophthalmology

- Cataract Surgery
- Glaucoma

Orthopedics

- Accidental Falls
- Hip Replacement & Hip Revision
- Hip/Pelvic Fracture
- Knee Arthroscopy
- Knee Replacement / Revision
- Low Back Pain
- Lumbar Laminectomy
- Lumbar Spine Fusion
- Osteoarthritis
- Shoulder Replacement

Cardiology

- Acute CHF/Pulmonary Edema
- Acute Myocardial Infarction
- CABG and/or Valve Procedures
- Coronary Angioplasty
- Pacemaker/Defibrillator

Non-Prometheus Clinical Episode Categories

Emergency Department

- Abdominal Pain & Gastrointestinal Symptoms
- Asthma/COPD
- Atrial Fibrillation
- Chest Pain
- Deep Vein Thrombosis
- Dehydration & Electrolyte Derangements
- Diverticulitis
- Fever, Fatigue or Weakness
- Hyperglycemia
- Nephrolithiasis
- Pneumonia
- Shortness of Breath
- Skin & Soft Tissue Infection
- Syncope
- Urinary Tract Infection

Orthopedics

- Musculoskeletal

Trigger Codes and Diagnoses

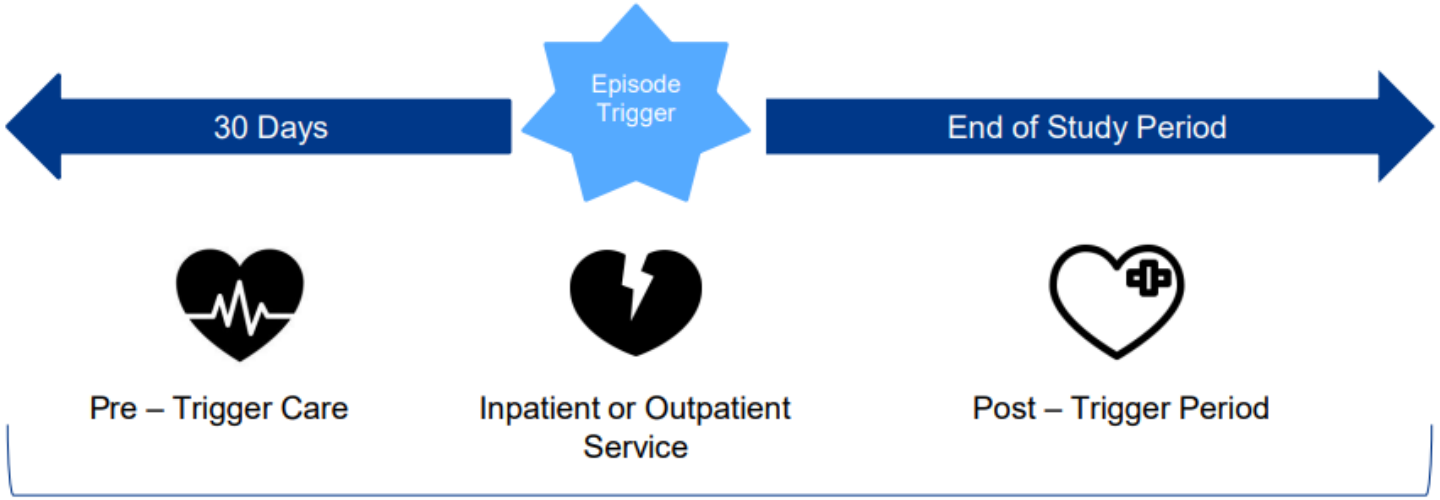
Trigger Code

Codes that, when coupled with a trigger diagnosis and meet trigger criteria, indicate and episode exists.

Trigger Diagnosis

Descriptive diagnoses codes that must be present on the claim with a ‘Trigger Code’ for an episode to initiate.

Episode Window



Total Episode Cost = All expected services and complication costs associated from index service until the end of the post-trigger window.

Episode windows include:

- **Pre-trigger window** – a period prior to the triggering event during which to count costs related to the triggering event.
- **Post-trigger window** – a period following the triggering event during which to count costs related to the triggering event.
- Durations depend on the clinical episode category – the EQIP Episode Playbook outlines the episode window specifications for each of the clinical episode categories.

Relevant Services and Costs for Prometheus Episodes

Prometheus assigns relevant costs to each clinical episode based on episode definitions.

Relevant costs include payments for claims with one or more relevant diagnosis or procedures codes.

Typical/Routine	• Diagnoses for routine and typical care during an episode, including signs and symptoms related to the episode, aftercare, and similar conditions, as well as status codes and family history codes.
Potentially Avoidable Complications	• Diagnoses that indicate the occurrence of a potentially avoidable complication during the episode window. Help to determine unexplainable variation in total costs of care that could be reasonably attributed to complications under the control of Care Partners.

Information on relevant diagnoses and procedures are available in the EQIP Episode Playbook.

- Cost and rates of incidence of potentially avoidable complications are available.

Prometheus Episode Leveling and Payment Aggregation

Prometheus episode grouper contains a proprietary relationship methodology that combines clinical episodes in different clinical categories, but associated with each other, into the most clinically relevant category.

- Assigns each clinical episode category a level at which relevant episode costs will no longer be aggregated.

Episode Associations for Prometheus Episode Categories

Level 1	• All episodes are triggered, and service assignments occur. **Complication** episodes are triggered and assembled only at Level 1.
Level 2	• Used to merge typical/routine associations within an episode family (e.g., cardiac, GI) and category (i.e., Procedural or Acute). For example, Colonoscopy following Colon Resection. Both are in the same clinical family and type of episode.
Level 3	• Used to complete **Procedural** episodes, including all potentially avoidable complication associations and all remaining typical/routine associations.
Level 4	• Used to complete **Acute** episodes, including all potentially avoidable complication associations and all remaining typical/routine associations.
Level 5	• Used to complete **Condition/Chronic** episodes, including all potentially avoidable complication associations and all remaining typical/routine associations.

Calculate Total Relevant Episode Costs for Prometheus Episodes

Split Costs – when applicable, the cost of a single service is apportioned to more than one episode, so that the total cost assigned to a higher-level episode is the same as the beneficiary's actual claims paid.

- Costs of a single service are apportioned equally across related lower-level episodes (e.g., 2 episodes are each assigned 1/2 the cost, 3 episodes are each assigned 1/3 the cost, etc.)

Total relevant episode costs are derived as follows:

1) Total relevant costs for a single episode include all Medicare Part A & B claim payments for the beneficiary for relevant services rendered during the episode window.
2) Paid claims for relevant services rendered during the episode window are split and "leveled." (Denied claims and Medicare Part D expenditures are excluded.)
3) Total split costs are summed to calculate total relevant episode costs.

Total Episode Costs for Non-Prometheus Episodes

Total cost of care during the episode window is calculated for non-Prometheus clinical episodes, following the methodology described in the *CTI Policy Guide*.

General Episode Criteria

Maryland Resident	• Beneficiaries must reside in Maryland at the time the episode is triggered, throughout the episode window, and throughout the time window for identifying prior healthcare utilization or previous medical encounters.
Medicare Parts A and B Enrollment	• Beneficiaries must be enrolled in both Medicare Parts A and B at the time the episode is triggered, throughout the episode window, and throughout the time window for identifying prior healthcare utilization or previous medical encounters.
Medicare as Primary Payer	• Episodes are excluded if there is one or more claims (of any type) during episode window on which Medicare was not the primary payer.
No ESRD Treatment	• Episodes are excluded if the beneficiary ever received treatment for end-stage renal disease (ESRD) during the calendar year in which they were discharged from the index hospitalization.
Patient Alive at the End of the Episode	• Episodes are excluded if the beneficiary died during the episode window (including the final day of the episode).

EQIP Episode Filters

Low or High Age	• Episode is dropped if beneficiary is less than 18 years old or greater than 120 years old.
Low or High Cost	• Episodes in the lowest 5 percent of costs or the top 95 percent of costs in their clinical episode category are excluded.
Coverage Gap	• Episodes > 90 days with a gap in coverage greater than 32 days are dropped. • Episodes ≤ 90 days with a one-day or longer gap in coverage are dropped.
Incomplete	• Episodes are dropped if there is not enough data, claims, or accompanying information to compare the episode to other episodes.
Outpatient Only Episode	• Upper GI endoscopy (EGD) and colonoscopy (COLOS) episodes performed in the inpatient setting are dropped from the final data output. These procedures are almost always performed in the outpatient setting and when performed inpatient are too different from the typical care to be included in episode performance.

Attribution of Episodes to Providers

Episodes are attributed to an individual NPI of a Care Partner based on the ‘Rendering NPI’ field on Professional Medicare claims that:

- Have the required trigger diagnosis or procedure codes, and
- Are within the trigger window, defined as +/- two days from trigger claim date of service start date.

If more than one Care Partner/NPI could have triggered the episode, the Care Partner with the highest Allowed Amount is attributed the episode.

- EQIP episodes must be assigned to individual eligible clinicians.
- If a group NPI is used to populate the rendering provider field on a claim and an individual NPI is available in the ‘Referring NPI’ field, the episode is assigned using the individual NPI.

Minimum Episode Volume Threshold

An EQIP Entity must meet 3 minimum episode volume thresholds during the baseline period (CY 2019) to be eligible to participate in the clinical episode categories they choose:

- 75% of the NPIs comprising the EQIP Entity have at least one claim with a beneficiary who triggered a clinical episode in each clinical episode category chosen.
  - The claim threshold is 50% for EQIP Entities with 10 or fewer Care Partners.
  - EQIP Entity will be required to remove NPIs until the claim threshold is met.
  - Care Partners with zero claims during the baseline period will be in probationary status during the program year. Probationary Care Partners must have one or more claims during the first half of the program year to be eligible to continue participating in EQIP.
- Attributed 11 or more clinical episodes in each clinical episode category chosen.
  - Reporting will not be available for a clinical episode category if this threshold isn't met.
- Attributed 50 or more clinical episodes across *all* clinical episode categories chosen.
  - EQIP Entity will be excluded from participating in EQIP if this threshold is not met.

Example 1: Meeting the Minimum Volume Thresholds

Clinical Episode Category	Selected	Clinical Episode Volume During 2019	Eligible for Episode Category?	Total Clinical Episode Count
Pacemaker / Defibrillator	**No**	**10**	No	Category not selected: *Excluded from the EQIP Entity's total episode count.*
Acute Myocardial Infarction	**Yes**	**8**	No	Insufficient episode volume: EQIP Entity is ineligible to participate in this category; Excluded from the total episode count.
CABG &/or Valve Procedures	**Yes**	**36**	**Yes**	EQIP Entity is eligible to participate in these two clinical episode categories because they were attributed ≥50 episodes during 2019.
Coronary Angioplasty	**Yes**	**28**	**Yes**	

Example 2: Meeting the Minimum Volume Thresholds

Clinical Episode Category	Selected	Clinical Episode Volume During 2019	Eligible for Episode Category?	Total Clinical Episode Count
Pacemaker / Defibrillator	**Yes**	**8**	**No**	Insufficient episode volume: Entity is ineligible to participate in this category; Excluded from the total episode count.
Acute Myocardial Infarction	**Yes**	**10**	**No**	Insufficient episode volume: Entity is ineligible to participate in this category; Excluded from the total episode count.
CABG &/or Valve Procedures	**Yes**	**40**	**Yes**	Entity is eligible to participate in this category, but ineligible to participate in EQIP because they were not attributed ≥50 episodes during 2019
Coronary Angioplasty	**No**	**15**	**Yes**	Entity should consider adding this episode type to meet the total episode threshold.

Target Price Methodology

Target Price Methodology Overview

An EQIP Entity's incentive payments are determined by comparing the total relevant episode costs for each EQIP episode attributed to its Care Partners against a target price calculated for the Entity.

- Calculated using the CY 2019 baseline period.
- **Adjusted for inflation** between the baseline and performance periods.
- Regulated payments (IPPS & OPPS for MD regulated hospitals) are **standardized** using CMS methodology for standardized allowed amounts.
- **Not adjusted for changes in Care Partners' patient mix** between the baseline and performance periods.
- **Do not vary across care settings** (e.g., inpatient, outpatient, post-acute care, physician office).
  - Setting neutrality allows for savings generated by shifting low-acuity services to lower-cost settings.

Target Price Calculation

Target Prices are calculated separately for each EQIP Entity and Clinical Episode Category:

1) Sum the total relevant episode costs for all participating Care Partners to calculate a single *Entity Aggregate Episode Cost*.
2) Divide the *Entity Aggregate Episode Cost* by the total baseline episode volume of participating Care Partners to calculate the **Entity Average Episode Cost** (i.e., the weighted average of episode-level costs across all attributed episodes).

$$Target\ Price = Entity\ Average\ Episode\ Cost$$

Standardization of Regulated Payments

- All regulated payments are standardized using the CMS methodology for standardized allowed amounts to avoid feedback effects from Global Budget Revenue.
- After standardization, regulated payments are converted back to real dollars using the ratio of actual to standardized payments.
  - The ratio is based on total regulated payments for each provider over full program years.
  - The same ratio is used to calculate target prices and determine reconciliation.

Inflation Adjustments

All claims are inflated to performance period dollars prior to constructing episodes and calculating reconciliation amounts. All payments for a given period displayed in EQIP reports (baseline and performance) are displayed in same-year dollars for comparability.

- Non-regulated payments are inflated based on CMS' PPS-specific market basket update factors.
- Regulated payments are inflated based on HSCRC update factors.
- A special adjustment is made to account for overpayments in the SNF PPS due to CMS policy change beginning in 2019.
- Additional adjustments account for unique policy scenarios (e.g., suspension of sequestration during the Covid-19 PHE) or changes in policy during the program year.

Inflation Process – Unregulated Payments

- Actual regulation market basket update data used by CMS for prospective payment system (PPS) values are used to inflate the unregulated Medicare fee-for-service payments used for assessing EQIP episodes.
  - Data files and methodology are available from the CMS.gov research, statistics, data, and systems site (URL below)
- For each PPS claim type, the full market basket update less productivity adjustment is taken for each intervening period to be inflated over and cumulatively applied to each claim payment.
- Only general CMS inflation update policy is applied. The inflation process does not and is not intended to replicate any program-specific inflation policies from other CMS initiatives (e.g., MIPS), as these may vary from program to program.

* *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata*

Inflation Process – Unregulated Payments

Simplified example of an episode with 2 claims:

SNF PPS	FY2018	FY2019	FY2020	FY21	FY22
Actual Regulation Market Basket Update	2.0	2.0	2.4	2.2	2.0

Actual baseline 2017 claim payment total: $100
Cumulated SNF Inflation Factor = 1.02 * 1.02 * 1.024 * 1.022 * 1.02 = 1.11058
Inflated claim payment total = $100 * 1.11058 = $111.05

HHA PPS	FY2018	FY2019	FY2020	FY21	FY22
Actual Regulation Market Basket Update	1.9	2.2	2.6	2.0	2.6

Actual baseline 2017 claim payment total: $50
Cumulated HHA Inflation Factor = 1.019 * 1.022 * 1.026 * 1.02 * 1.026 = 1.1182
Inflated claim payment total = $50 * 1.1182 = $55.91

Uninflated “episode” total = $100.00 + $50.00 = $150
Inflated “episode” total = $111.05 + $55.91 = $166.97

Inflation Process - Regulated Payments

- All regulated setting payments (IPPS and hospital OPPS for MD regulated hospitals) are standardized, inflated, and renormalized to derive an inflation adjusted amount that eliminates any GBR fluctuations or payment policy from influencing or penalizing payment evaluation.
- All regulated payments are first standardized using the CMS standardization methodology for allowed amount at the claim level.
- A hospital-specific Standardization Ratio is then calculated as the ratio of actual paid to standardized paid over the entire Program Baseline Period.
  - Formula is (Actual Paid Amount) / (Standardized Payment Amount)
  - Example: if actual Maryland charges are $100 in the program baseline period and standardized payments are $60, then the Standardization Ratio is 100 / 60 = 1.66.
- For each period, a cumulative HSCRC inflation factor is calculated as the cumulative HSCRC inflation for the prior year multiplied by (1 + the current year update factor).
  - The program baseline period cumulative HSCRC inflation factor is equal 1.0.
  - The HSCRC provides update factors for each period based on the actual Maryland policy for that time window.
  - This process is otherwise similar to the inflation factor cumulation example shown previously.

Inflation Process - Regulated Payments

- The standardized amounts are then multiplied by the cumulated inflation factor for the given performance period to arrive at a standardized, inflated amount.
- The standardized, inflated amount is then converted to an inflation-adjusted actual amount by multiplying by the standardization ratio for that hospital.

$$\boldsymbol{Final\ Inflated\ Regulated\ Claim\ Payment\ Amount} = \boldsymbol{Standardized\ Payment} * \boldsymbol{Inflation_{Period}} * \boldsymbol{Standardization\ Ratio_{Participant}}$$

Preliminary Versus Final Target Prices

Preliminary Target Prices

- Calculated for each EQIP Entity in each clinical episode category elected.
- Available in the EEP performance dashboard once the program year begins.
- Based on CMS and HSCRC update factors available at the time of enrollment.

Final Target Prices

- Based on the final CMS and HSCRC update factors for each setting of care.
- HSCRC will adjust target prices to account for CMS or HSCRC policy changes, e.g., sequestration adjustments or changes in the SNF and home health fee schedules.
- *Not* adjusted for changes in patient mix, geographic variation, or peer comparison.

Baseline Period Updates

- Because of substantial COVID volumes, 2020–2022 does not represent an actuarially stable period with which to predict future costs.
- The HSCRC anticipates that 2023 will be a suitable baseline for EQIP participants starting in 2025 but PY3 will use a 2019 baseline period.
- Updates to the baseline will be discussed with stakeholders and developed for future program years.

Reconciliation

From Reconciliation to Incentive Payments

1. Determine total program year savings.
   - **Dissaving policy** applies if dissavings are generated.
2. Subtract total dissavings from the previous program year from the total program year savings, if applicable.
3. Check if the **Minimum Savings Threshold** was met.
4. Determine the **Shared Savings Amount**.
5. Apply the **Composite Quality Score Adjustment** to the Shared Savings Amount.
6. Determine the final incentive payment.

Calculate Total Episode Savings

An EQIP Entity generates program year savings if the sum of the following three elements is positive:

- Positive amounts by which the aggregate performance period costs for each clinical episode category are below the Final Target Price, across all clinical episode categories.
- Negative amounts by which aggregate performance period costs for each clinical episode category are above the Final Target Prices, across all clinical episode categories.
- Dissavings from the prior program year, i.e., an aggregate negative sum from the prior year's reconciliation.

An EQIP Entity will receive an incentive payment if its program year savings meets or exceeds the *Minimum Savings Threshold.*

Dissavings Policy

EQIP Entities are held accountable for year-over-year dissavings to incentivize efficiency and quality improvement.

- **Annual Accountability**: EQIP Entities who generate dissaving in a program year will be required to offset that dissaving in the following program year, before earning an incentive payment.
- **Removal Accountability**: An EQIP Entity will be removed from EQIP if it generates dissaving in two consecutive program years and its baseline-period performance across all clinical episode categories in which it participates ranks in the lower two terciles of the *Tiered Shared Savings Rate*.

Minimum Savings Threshold

The Minimum Savings Threshold for EQIP is **3%**.

- An EQIP Entity's program year savings must meet or exceed 3% of its *Aggregated Target Price* before it is eligible to receive incentive payments.

An EQIP Entity's program year savings is evaluated across all its clinical episode categories, as follows:

1) **Aggregated Target Price**. For each clinical episode category in which an EQIP Entity participates, multiply the EQIP Entity's final target price by the number of clinical episodes it was attributed during the program year. Sum across all categories.
2) **Program Year Costs**. Sum the program year costs for all clinical episodes calculated across all clinical episode categories in which the EQIP Entity participates.
3) **Program Year Savings**. Subtract program year costs (2) from the Aggregated Target Price (1).

Tiered Shared Savings Rate

Tiered Shared Savings Rate Overview

Incentive payments are a “tiered portion” of an EQIP Entity’s reconciliation amount.

- Based on an Entity’s efficiency in the clinical episode category compared to baseline data on the same clinical episodes triggered statewide.
- Allows lower-cost, higher efficiency Entities to keep more savings; incentivizes higher-cost, lower-efficiency Entities to improve efficiency.
- Allows EQIP Entities and Medicare to share savings generated.

Tiered Shared Savings Rate: Statewide Ranking Methodology

Statewide ranking of an EQIP Entity's overall performance is determined prior to the program year, based on baseline data.

- *For each clinical episode category*, the EQIP Entity's total episode costs during the baseline period will be ranked among all other providers in the State that triggered the same clinical episodes.
- An EQIP Entity receives a "blended" ranking based on its total episode costs across all clinical episode categories in which it participates. Higher costs result in a lower percentile ranking.

Statewide Ranking Methodology – **Step 1**

Within each clinical episode category, determine each individual Care Partner's statewide ranking with respect to average episode cost.

a. Using statewide data (i.e., all individual NPIs in the state) from the baseline year, remove NPIs with <11 episodes to ensure estimates are based on providers with sufficient volume for a stabile distribution.

b. Calculate each NPI's average episode cost during 2019 (i.e., total episode costs divided by the NPI's episode volume).

c. Create a distribution of average episode costs across NPIs by setting the bottom of the distribution (0^{th} percentile) equal to the highest average episode cost and the top of the distribution (100^{th} percentile) equal to the lowest average episode cost.

d. Establish each Care Partner's percentile rank between the highest and lowest cost providers.

Statewide Ranking Methodology – **Step 2**

For all NPIs (including those with fewer than 11 episodes), define their **NPI Rank Clinical Category** as their percentile rank in the distribution established in Step 1.

a. If an NPI's average episode cost is *higher* than the 0th percentile of average episode costs, set their percentile to 0. If an NPI's average episode cost is *lower* than the 100th percentile of average episode costs, set their percentile to 100.

b. If the NPI had fewer than 11 episodes, and their average episode cost falls between two percentile values in the established distribution, use linear interpolation between the two values to determine their exact *NPI Rank Clinical Category*.

Statewide Ranking Methodology – **Step 3**

Within each clinical episode category, define an **EQIP Entity Rank Clinical Category** as the weighted average of its Care Partners' NPI Rank Clinical Categories.

a. Multiply each Care Partner's episode volume by their NPI Rank Clinical Category, then sum the values.

b. Sum the total episode volume across all the EQIP Entity's Care Partners for that clinical episode category.

c. Divide (a) by (b) to determine the EQIP Entity Rank Clinical Category.

Example: If an EQIP Entity consists of 3 Care Partners, $NPI_A^{50th\ pctl}$, $NPI_B^{75th\ pctl}$, and $NPI_C^{45th\ pctl}$ with 100, 200, and 300 episodes, respectively, then the EQIP Entity Rank Clinical Category is **56**, because

$$\frac{(50*100)+(75*200)+(45*300)}{600} = 55.8$$

Statewide Ranking Methodology – **Step 4**

Calculate the **EQIP Entity Rank Percentile** across all clinical episode categories in which an EQIP Entity participates, weighted by episode volume:

a. For each clinical episode category, multiply the *EQIP Entity Rank Clinical Category* by the total episode volume determined in Step 3(b).

b. Sum the result from (a) across all clinical episode categories in which the EQIP Entity participates.

c. Sum the result from Step 3(b) across all clinical episode categories in which the EQIP Entity participates.

d. Divide the result from (b) by the result from (c) to obtain the final EQIP Entity Rank Percentile (percentiles will be rounded to two decimal points to determine tercile rank).

Tiered Shared Savings Rate

The following Shared Savings Rates will be applied to EQIP Entities' incentive payments based on the their *EQIP Entity Rank Percentile* (from Step 4):

	EQIP Entity Rank Percentile	Savings Paid to EQIP Entity	Savings Retained by Medicare
Tier 1	1st – 33rd percentiles	**50%**	50%
Tier 2	34th – 66th percentiles	**65%**	35%
Tier 3	67th – 100th percentiles	**80%**	20%

Updating the Tiered Shared Savings Rate Rankings

EQIP Entities will be re-ranked each program year based on baseline year (CY 2019) data but adjusted to their current list of Care Partners.

Program Year (PY)	EQIP Entity A (Joined in PY1)	EQIP Entity B (Joined in PY2)	EQIP Entity C (Joined in PY3)
2022 (PY1)	**Ranking Year = 2019**	n/a	n/a
2023 (PY2)	**Ranking Year = 2019**		n/a
2024 (PY3)	**Ranking Year = 2019**		

Composite Quality Score Adjustment

Composite Quality Score Adjustment Overview

Incentive Payments to an EQIP Entity is subject to the Composite Quality Score adjustment.

- Quality adjustment is required as a part of EQIP's APM status.

EQIP includes a 5% "earn-back" adjustment on incentive payments.

- **The final shared savings amount is reduced 5%, then 0-100% of that 5% withholding is returned to the EQIP Entity based on its quality performance (measured as a percentage).**
- For each clinical episode category in which the EQIP Entity participates, 3 quality measures are weighted to calculate a Composite Quality Score, which determines the amount of the incentive payment earned back for quality performance.

Composite Quality Score Adjustment

For each attributed episode, regardless of category, the HSCRC assesses whether 3 measures were performed, *by any physician*, within 364 days *preceding* the end of the episode:

- **Advance Care Plan (NQF #326)**

  https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2023_Measure_047_MedicarePartBClaims.pdf

- **Documentation of Current Medications in the Medical Record (NQF #419)**

  https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_130_MIPSCQM.pdf

- **Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (MIPS #128)**

  https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_128_MIPSCQM.pdf

Quality Measures Applied to all Clinical Episode Categories

Measure	Description	CPT/HCPCS Codes
Advance Care Plan (NQF #326)	Percentage of patients, 65 years and older, who have an advance care plan (ACP) or surrogate decision maker documented in the medical record, **or** documentation in the medical record that an ACP was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an ACP.	**99497**, **99498**, **1123F-1124F** (tracking codes, non-billable)
Documentation of Current Medications in the Medical Record (NQF #419)	Percentage of visits for patients aged 18 years and older for which a clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.	**G8427**, **G8430**, **1159F** (tracking code, non-billable)
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (MIPS #128)	Percentage of patients, 18 years and older, with a documented BMI during the encounter or during the previous twelve months **and,** when the BMI is outside of normal parameters, a follow-up plan documented during the encounter or during the previous twelve months of the encounter.	**G8422**, **G8938***

* The denominator of the BMI measure is adjusted downward to account for documented exceptions (i.e., CPT Code G8438). The numerator will also exclude these instances.

Composite Quality Score Performance Measurement

Score by Quality Measure: Each quality measure will be “scored” at the EQIP Entity level and will be worth up to 10 points.

Determine Aggregate Measure Score: An EQIP Entity can receive up to 30 points (3 measures * 10 points each).

Convert Aggregate Score to Percentile:

- The Composite Quality Score will be calculated at the EQIP Entity level and will be expressed as a percentage ranging from 0 to 100.
- Equal to the sum of the points earned on all applicable quality measures for the program year, divided by the maximum number of points available for the program year.

Quality Performance Thresholds

- The process of assigning quality points to each quality measure, will be based on the EQIP Entity's quality performance during the program year, *relative to set thresholds.*
- Quality performance thresholds are determined using data on baseline (2019) EQIP episodes.
  - Thresholds will be re-calculated each program year based on baseline year (2019) data but adjusted to the current list of EQIP Care Partners.

Quality Performance Threshold Calculation – **Step 1**

Determine each Care Partner's baseline performance rate for each measure:

a) Limit data to baseline episodes attributed to Care Partners (NPIs).

b) For each clinical episode, use the beneficiary's carrier and outpatient claims with service dates on or between the episode end date and 364 days prior to the episode end date to flag CPT/HCPCS codes associated with each quality measure (Slide 56).

c) For each clinical episode and quality measure, set the *Quality Measure Flag* equal to one if one or more quality measure-specific CPT/HCPCS were flagged.

- Beneficiaries may initiate more than one episode during baseline and their episode windows can overlap. A Quality Measure Flag is created for each episode and each episode is included in the performance rate calculation.

d) Calculate each Care Partner's baseline performance rate, for each quality measure:

$$Performance\ Rate_{Care\ Partner} = \left(\frac{Total\ Count\ of\ Quality\ Measure\ Flags}{Total\ Count\ of\ Episodes}\right) \times 100$$

Quality Performance Threshold Calculation **– Step 2**

The distribution of baseline performance rates for all Care Partners will be used to determine the performance thresholds *specific to each quality measure*.

- EQIP Entities who receive performance scores below the 20th percentile will be on probation. Two consecutive years of probation will result in automatic exclusion from EQIP.
- Program year scores equal to or higher than the 20th percentile benchmark and lower than the 35th percentile benchmark will receive zero points, but they will NOT constitute grounds for probation.

Quality Performance Threshold Calculation – **Step 2**

Quality Performance Rate (PR)	Program Year Points Assigned	Quality Probation Initiated
PR < 20th Percentile	**0**	**YES**
20th Percentile ≤ PR < 35th Percentile	0	NO
35th Percentile ≤ PR < 40th Percentile	1	NO
40th Percentile ≤ PR < 45th Percentile	2	NO
45th Percentile ≤ PR < 50th Percentile	3	NO
50th Percentile ≤ PR < 55th Percentile	4	NO
55th Percentile ≤ PR < 60th Percentile	5	NO
60th Percentile ≤ PR < 65th Percentile	6	NO
65th Percentile ≤ PR < 70th Percentile	7	NO
70th Percentile ≤ PR < 75th Percentile	8	NO
75th Percentile ≤ PR < 80th Percentile	9	NO
80th Percentile ≤ PR	10	NO

Program Year Scoring

Use the same steps to calculate each EQIP Entity's performance rate, for each measure, using CCLF and Episode data from the program year.

$$Performance\ Rate_{EQIP\ Entity} = \left(\frac{\sum_{Care\ Partners} Total\ Count\ of\ Quality\ Measure\ Flags}{\sum_{Care\ Partners} Total\ Count\ of\ Episodes}\right) \times 100$$

EQIP Entity Program Year Score:

Compare each quality measure performance rate (ACP Performance Rate, Medicine Performance Rate, BMI Performance Rate) with the performance thresholds (see table on Slide 61) to derive *Total Points ACP Performance*, *Total Points Medicine Performance*, and *Total Points BMI Performance*.

Final Composite Quality Score Determination

An EQIP Entity's Composite Quality Score will equal the total performance points earned across the three quality measures divided by the maximum (30 points) possible points for the program year.

The Composite Quality Score (CQS) is calculated as:

$$CQS_{EQIP\ Entity} = \frac{Total\ Points\ ACP\ + Total\ Points\ Medication\ + Total\ Points\ BMI}{30}$$

$$Incentive\ Payment = (Shared\ Savings * .95) + \left(Shared\ Savings * .05 * CQS_{EQIP\ Entity}\right)$$

Incentive Payment Cap, Calculation, and Distribution

Incentive Payment Cap (Stop Gain Amount)

- After the Composite Quality Score adjustment, the incentive payment will be assessed for a stop-gain amount, or Incentive Payment Cap.
- The cap for a Care Partner's incentive payments is calculated by CMS for a given program year based on the average Physician Fee Schedule (PFS) payments made to the Care Partner in the previous year.
- Per the Participation Agreement, the Care Partner Incentive Payment Cap is **25%** of the Average Care Partner PFS Expenditures for the preceding calendar year.

Incentive Payment Cap

CMS Calculates an EQIP Entity's Incentive Payment Cap as follows:

1. Sum all Medicare PFS payments made during the previous calendar year for Part B covered services provided by all Care Partners in the EQIP Entity during the performance period.
2. Divide the amount in (1) by the total number of Care Partners in the EQIP Entity.

If *Incentive Payment > Incentive Payment Cap*, the EQIP Entity will only receive the cap amount for the program year for each Care Partner.

Example

Incentive Payment Cap Calculation

- EQIP Entity has 3 Care Partners
- Care Partners' PFS Expenditures during the previous calendar year totaled $100, $200, and $300, respectively.
- Maximum incentive payment for each Care Partner is:

$$\frac{(\$100 + \$200 + \$300)}{3} * 0.25 = \$50$$

Final Incentive Payment Calculation and Distribution

- The Incentive Payment will be paid in total to the EQIP Entity no later than six months after the end of the performance period.
- The Incentive Payment will be paid to the payment remission recipient indicated by the EQIP Entity in the EEP.

Removal From the Program

Removal From the Program

- EQIP Entities require an initial CPA and annual consent to participate, thereafter.
- EQIP Entities are expected to maintain updated Care Partner documentation in the EEP.
- Should a Care Partner wish to be removed from an EQIP Entity, or an EQIP Entity no longer wishes to participate in EQIP, they will be required to update the HSCRC via the EEP within the annual enrollment window (July 1 – December 31).
- Care Partners and EQIP Entities cannot be removed from the program during a program year.

Involuntary Removal From EQIP

Circumstances where an EQIP Entity or Care Partner will be involuntarily removed from the program:

- Failure to maintain vetting and certification from CMS.
- Failure to provide care or compliance in conjunction with the CPA.
- The EQIP Entity's Rank Percentile is in the lower two terciles of the tiered Shared Savings Rate *and* the EQIP Entity experienced 2 consecutive years of dissavings.
- **Catastrophic quality performance –** If the program year performance for the EQIP Entity is below the 20th percentile benchmark threshold of a single quality measure, the Entity will receive zero points for that measure *and* will be on probation for the program year. Two consecutive program years on probation will result in automatic exclusion from EQIP.