

**Episode Quality Improvement Program  
(EQIP)  
Track Implementation Protocol**

**January 2025 – December 2025**

**Hospital Name:** \_\_\_\_\_

**Submission Date:** \_\_\_\_\_

## A. Introduction

The Episode Quality Improvement Program (EQIP) is a track under the Care Redesign Program (CRP) designed to allow physicians statewide to sign a Care Partner Arrangement with a hospital under a CRP Participation Agreement and receive Incentive Payments for improvements on cost and quality in an episode of care. Maryland modeled EQIP on bundled payment programs available through CMS and other private-payer bundled payment programs.

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 participating physicians will achieve this through better care management during episodes, eliminating unnecessary care, and reducing emergency department visits, unnecessary hospital admissions and readmissions. EQIP will provide Incentive Payments to Care Partners (physicians) that help achieve these goals.

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 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.

## B. CRP Entity Role and Responsibilities

A hospital participating in the CRP Participation Agreement will act as the "CRP Entity" for EQIP. In this role the CRP Entity will be responsible for administrative functions including aggregating Care Partner Arrangements and distributing Incentive Payments among Care Partners.

**(1) Engagement of Care Partners.** The HSCRC will invite eligible Care Partners to participate in EQIP. In accordance with the PA and the CRP Calendar, the CRP Entity, with assistance from the HSCRC, must vet prospective Care Partners with CMS and submit 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.

**(2) Reporting and Monitoring.** The State will conduct ongoing monitoring according to the CRP Calendar schedule by tracking and reporting various measures of performance improvement efforts and operational metrics. These measures will include aggregate performance on Allowable Interventions, the number of Care Partners participating in EQIP, and any Incentive Payment amounts made to Care Partners. The CRP Entity must attest that incentives will be paid in accordance with the Participation Agreement and approved Track Implementation Protocol.

**(3) EQIP Incentive Payments to Care Partners.** HSCRC will calculate the Incentive Payments to Care Partners according to Section D. The hospital 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 Care Partner to the final target price for those episodes (subject to adjustments based on quality performance). Reconciliation will occur at the participant level across all episodes. The EQIP payment from CMS would be in the form of a positive adjustment to the CRP Entity's Medicare Performance Adjustment (MPA) Efficiency Component— separate from, and additive to, the Traditional MPA adjustment (and excluded from calculating the MPA adjustment in future years). The CRP Entity will then distribute the full amount to Care Partners based on the HSCRC calculation.

### **C. Care Partner Role and Responsibilities**

The "Care Partners," or physicians, will sign Care Partner Arrangements with the CRP entity and shall select the clinical episodes for which they be held accountable and must put into effect the core components of EQIP: (1) implementing Allowable EQIP Interventions (e.g., care delivery enhancements such as reengineered care pathways using evidence-based medicine, standardized care pathways); (2) using CEHRT; (3) notifying patients about the program; (4) submitting the required reporting; and (5) Pass CMS vetting and certification. Care Partners are paid separately from the CRP entity for their Medicare services and may be eligible for Incentive Payments based on participation in EQIP and performance of Allowable EQIP Interventions. EQIP Care Partners are limited to General or specialist physician.

**(1) Allowable EQIP Interventions.** Allowable EQIP Interventions in the CRP are activities and processes the Care Partner may select and implement to improve care and lower costs under EQIP. The table below shows Allowable EQIP Interventions, which will be selected by physicians for annual participation. The CRP Entity's Track Implementation Protocol will be included in its submission to HSCRC for approval by HSCRC and CMS. It is anticipated that after Track Implementation Protocol submission by the CRP Entity, physicians may need up to one quarter for planning prior to implementation and performance year start, and this may be reflected in associated reporting for that first quarter after protocol submission. However, after this grace period, physicians must implement interventions and annually submit intervention elections to the CRP Entity and HSCRC in order to qualify for Care Partner incentive payments.

### Allowable EQIP Interventions

Intervention Category	Intervention
<b>Clinical Care/ Care Redesign</b>	<ul style="list-style-type: none"> <li>• Standardized, evidence-based protocols are implemented, for example for discharge planning and follow-up care.</li> </ul>
	<ul style="list-style-type: none"> <li>• Implementation of enhanced coordination with post-acute care providers.</li> </ul>
	<ul style="list-style-type: none"> <li>• Interdisciplinary team meetings address patients’ needs and progress.</li> </ul>
<b>Beneficiary/ Caregiver Engagement</b>	<ul style="list-style-type: none"> <li>• Patient education is provided pre-admission and addresses post-discharge options.</li> </ul>
	<ul style="list-style-type: none"> <li>• Shared decision-making processes and/or tools are implemented to help patients assess treatment options.</li> </ul>
	<ul style="list-style-type: none"> <li>• Methods for fostering "health literacy" in patient/family education are implemented.</li> </ul>
	<ul style="list-style-type: none"> <li>• Patient supports, items, and/or services are furnished to beneficiaries.</li> </ul>
<b>Care Coordination and Care Transitions</b>	<ul style="list-style-type: none"> <li>• Patient risk assessment/stratification is used to target services.</li> </ul>
	<ul style="list-style-type: none"> <li>• Assignment of a care manager/ coordinator/ navigator to follow patient across care settings (e.g., to help coordinate follow-up appointments and to connect patient to needed community resources).</li> </ul>
	<ul style="list-style-type: none"> <li>• Performance of medication reconciliation.</li> </ul>
	<ul style="list-style-type: none"> <li>• Elimination of duplicative or low value services</li> </ul>
	<ul style="list-style-type: none"> <li>• Remote patient consultation monitoring.</li> </ul>

**(2) Health Information Technology (HIT).** Use of CEHRT is a required program element for Care Partners to document and communicate clinical care with patients and other health care professionals. HIT will enable quality measurement, reporting and feedback, and use of electronic health records (EHRs) as a part of care redesign across treating health care providers.

**(3) Patient Notification.** A CRP Entity participating in EQIP will ensure that its Care Partners inform all Medicare patients receiving care from a participating EQIP Care Partner are given notice stating that the Care Partner and its medical staff are participating in CRP. A CRP Entity must ensure that a Care Partner’s notice indicates 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.

**(4) Monitoring and Reporting.** The State will measure and monitor care in Care Partners' selected EQIP episodes to ensure that objectives are met in redesigning care, achieving quality measure thresholds, and demonstrating improved care coordination. As described in Appendix A, the State will adjust a CRP Entity's reconciliation amounts based on the CRP Entity's quality performance on applicable quality measures. The State will also produce additional metrics to evaluate the overall performance of EQIP, as relevant.

The CRP Entity shall ensure that the Care Partner provides it and the State with ongoing monitoring information according to the CRP Calendar schedule (via "CRP Care Partner Reports") by tracking and reporting various measures of performance improvement efforts and operational metrics, including individual performance on Allowable Interventions in accordance with the Care Partner Arrangement. It is anticipated that Care Partners will be able to report experience within two annual quarters of joining EQIP or selecting new episodes (that is, after a one-quarter grace period for intervention planning and data collection).

The interventions, targets, and conditions of payment included in CRP Care Partner Reports must be consistent with the Allowable CRP Interventions and measures indicated by the CRP Entity in the supplemental information submitted as compliment to their Implementation Protocol, up to one quarter post submission but prior to the start of the Performance Year. Care Partners must report their performance on conditions of payment for each episode in which they participate. Care Partners will be paid Incentive Payments in accordance with the Participation Agreement and Track Implementation Protocol and, thus, will not receive Incentive Payments unless the Conditions of Payment are met and reported in the CRP Care Partner Report.

If hospitals wish to make changes to their interventions or measures during the performance period, they must first request approval by emailing [care.redesign@crisphealth.org](mailto:care.redesign@crisphealth.org) and formally amend their Implementation Protocol accordingly.

**(5) CMS Vetting and Certification.** Each potential Care Partner must meet, at a minimum, the following Care Partner Qualifications specific to EQIP in addition to the Care Partner requirements described in the Participation Agreement:

- I. A clinician must have a National Provider Identifier (NPI) and a facility must have a Taxpayer Identification Number (TIN);
- II. The provider must participate in the Medicare program;
- III. The provider must be licensed;
- IV. The provider must use CEHRT and CRISP, Maryland's health information exchange; and
- V. The provider will be subject to a federal program integrity screening process; while participants can opt to engage Care Partners at the physician group practice level, all members of the group must be screened individually.

Care Partners must sign a Care Partner Arrangement with the CRP entity and comply with all applicable requirements under the Participation Agreement.

EQIP Care Partners who meet the requirements of the Maryland Primary Care Program (MDPCP) are not prohibited from participating in both MDPCP and EQIP.

#### **D. Incentive Payment Methodology: Incentive Payment Pool Development, Care Partner Incentive Payments**

EQIP Incentive Payments will be paid to Care Partners on an annual basis based on a comparison of performance period episode costs to a prospective Target Price. EQIP payments will be paid to the CRP Entity through the MPA's Efficiency Component. To enable more timely distribution to Care Partners, the CRP entity may choose to pay incentives to Care Partners out of the hospital's global budget, ahead of receiving payment through the MPA, in accordance with the terms of this Track Implementation Protocol.

The following steps form the conceptual basis for EQIP Incentive Payments to Care Partners. The CRP Entity will complete this Track Implementation Protocol to provide detailed information to CMS on Incentive Payment process.

##### **(1) Establishing Care Partner Target Prices**

- a. Episode Triggers and Construction.** EQIP Clinical Episodes are identified via a trigger, defined by a primary ICD-10 or CPT / HCPCS code indicating qualifying diagnosis or procedure. Services and costs relevant to the trigger diagnosis or procedures are grouped together to include the index stay or event during which the initial care was performed, a specified look back period to capture pre-event workup and an episode duration for which to count all costs related to the trigger. CRP beneficiaries are identified as those with a qualifying trigger as defined in the grouper assignment rules..
- b. Relevant Costs to the Trigger.** After identification of a trigger, lookback and episode duration, all relevant costs will be captured and aggregated to create an Episode Cost. Relevant costs to the trigger may be identified via a diagnosis or procedure code that has been clinically determined to be related to the specific episode in question.
- c. Baseline Data for Episode Construction.** After identifying Episode Triggers and Relevant Costs to the Trigger, for all claim payments across all settings using the steps described above, the standardized, updated payment amounts will sum at the clinical episode level to create a baseline period episode. This baseline period episode will be trended forward, with GBR payments standardized, to create a final episode Target Price to compare performance period clinical episodes. The baseline period will be set to include the most recent, complete data available prior to Care Partner entrance into the program and claims runout.

- d. **Inflation Factor.** The baseline data used to construct episodes will be trended forward to the performance period utilizing annual fee schedules and HSCRC rate Update Factors. This will update baseline episode charges Care Partners would receive when accounting for inflation, market basket updates, or pertinent policy changes between the baseline period and the performance period.
- e. **Target Price.** After baseline episodes are trended forward to reflect the relevant costs in the Performance Year, the HSCRC will establish a Target Price for each episode of participation and Care Partner. Target Prices will be established prior to the start of the performance year and utilized to determine episode-level savings achieved or dissavings created.

**(2) Reconciliation and PAU Savings Measurement**

- a. **PAU Savings and Dissavings Determination.** Once Target Prices are established, Performance year costs will be established in the same manner outlined above and episodes constructed. The performance year costs will be compared to the episode, Care Partner specific Target Price to determine the level of “potentially avoidable utilization” or PAU savings achieved. Performance year costs higher than the Target Price will indicate negative performance, or dissavings, and performance year costs less than the target price will indicate PAU savings or ‘savings’ and positive reconciliation performance. Each episode savings or dissavings will ultimately impact the aggregate Incentive Payment due to a Care Partner.
- b. **Minimum Savings Threshold.** In order to establish non-random, statistically significant cost savings to Medicare, any PAU savings created within an episode will be subject to a minimum savings threshold. This threshold will establish a percentage of savings which must first be achieved prior to being eligible for an Incentive Payment. After the threshold is met, the Care Partner will be eligible to receive first dollar savings below the established Target Price, subject to the Shared Savings Rate below.
- c. **Shared Savings Rate.** The Incentive Payment to a Care Partner will only be a portion of the calculated PAU Savings. The portion available to Care Partners will be tiered, based on the Care Partner’s relative “potentially avoidable utilization,” or PAU in that episode’s results in historical comparison to all physicians who may trigger the episode statewide, based on the most year of completed data. Higher Target Prices will result in a lower percentile ranking and lower Target Prices will result in a higher percentile ranking. The intent of a tiered shared savings rate is to provide low-cost, high efficiency Care Partners with an opportunity to keep more savings when episodes have already been relatively optimized and to provide high-cost Care Partners incentive to improve towards others’ efficiency

level in the state. For Care Partners' Target Price in each of the following percentiles of statewide performance in the episode, the following Shared Savings Rate will apply:

*Tercile 1:* Up to 33<sup>rd</sup> percentile: 50 percent savings paid to Care Partner / 50 percent savings paid to Medicare

*Tercile 2:* 34 - 66<sup>th</sup> percentile: 65 percent savings paid to Care Partner / 35 percent savings paid to Medicare

*Tercile 3:* 67 - 99<sup>th</sup> percentile: 80 percent savings paid to Care Partner / 20 percent savings paid to Medicare

- d. Composite Quality Score (CQS) Adjustment.** After the Shared Savings are determined for each Care Partner, the resulting positive results, or savings, will be subject to a quality adjustment known as the CQS adjustment. By tying payment to performance on quality measures, EQIP will incentivize providers to improve quality of care while improving efficiency. For each clinical episode Care Partner, up to seven quality measures will be weighted to calculate a Composite Quality Score (CQS), which will then be applied to any positive total reconciliation or savings to result in an Incentive Payment due to the Care Partner.

**(3) Eligibility for EQIP Incentive Payment.** The Care Partner will receive an EQIP Payment if the Reconciliation is positive. Reconciliation is determined the sum of:

- i. Positive amounts by which Medicare expenditures for selected clinical episodes are below the Target Prices of those episodes
- ii. Negative amounts by which Medicare expenditures for selected clinical episodes are above the benchmark Target Prices for those episodes
- iii. Dissavings from the Prior Performance year or aggregate Negative amounts by which Medicare expenditures for selected episodes are above the benchmark prices for those episodes exceeding any positive amounts

**(4) Maximum Eligible Payment to Care Partners.** The CRP Entity will indicate their intention to distribute Incentive Payments to qualifying Care Partners based on the HSCRC's performance determination outlined in throughout Section D. A Care Partner's reconciliation is determined by the net sum of their actual performance against their episode Target Price, tiered shared savings rate, quality performance and dissavings accountability (Section D.3.).

**(5) Episode Attribution to Care Partners.** During the performance year, the HSCRC will attribute each individual clinical episode to a single Care Partner. Episodes that overlap within the program will be attributed based on a hierarchy of Care Partners and Episodes.

**(6) Incentive Payment Cap.** The Incentive Payment is then capped at the stop-gain limit for Care Partners to arrive at the final Incentive Payment. The State will ensure the Physician Incentive Payment Cap as determined by CMS, in accordance with the CRP Participation Agreement, is upheld. Per the Participation Agreement, the Physician Incentive Payment Cap is twenty-five



percent (25%) of the Average Care Partner Physician Fee Schedule (PFS) Expenditures for the preceding calendar year.

**(7) Incentive Payment Pool Development and Application.** The EQIP Incentive Payment Pool, established by the HSCRC and approved by CMS, will serve as a limit on the aggregate incentive amount that the CRP entity can distribute to participating Care Partners based on performance in a reconciliation period. The HSCRC will set the Incentive Payment Pool and specific Care Partner distributions that the CRP entity must pay to Care Partners. The EQIP Incentive Payment Pool is calculated after each annual performance period.

Once the State determines each participant's reconciliation for the performance period, it will calculate each care partner's aggregate Incentive Payment due for all clinical episode categories of participation and distribute the sum to the CRP Entity via the MPA Efficiency Component.

EQIP's Incentive Payment Pool is based on only those clinical episode categories in which the Care Partners achieved savings (yielded a positive reconciliation amount). A Care Partner's EQIP Incentive Payment is the sum of the savings achieved in such clinical episode categories (that is, its savings in Potentially Avoidable Utilization, or PAU Savings), adjusted by the Quality Adjustment Score, net of any prior performance year dissavings (negative reconciliation amount), in accordance with the State's agreement with CMS.

The State will ensure aggregate incentives paid to Care Partners do not exceed the EQIP Incentive Payment Pool.

**(8) Removal from the Program.** If in any period the Care Partner's Target Price for the episode is in the lower two terciles of the Tiered Shared Savings Rate (0-65<sup>th</sup> percentile of Statewide Target Prices) and the provider had dissavings in the immediately previous performance period, a second consecutive year of dissavings will result in removal from the program (subject to HSCRC review).

Additionally, if the PY performance rate for the EQIP Entity is below the 20<sup>th</sup> percentile benchmark threshold, the EQIP Entity will receive zero points for that measure AND will be on probation for the PY. Two consecutive PYs on probation will result in automatic exclusion from EQIP, as noted in Section 7. The second year will be evaluated based on quality performance during the first two calendar quarters of the program year to be eligible to continue participating in EQIP.

Finally, failure to maintain vetting and certification from CMS and/or failure to provide care or compliance in conjunction with this document and the CRP Participation Agreement will result in Care Partner removal from the program.

# Track Implementation Protocol Instructions

Please complete all required sections of this Track Implementation Protocol.

**Section 1**, CRP Entity provides general information.

**Section 2**, CRP Entity provides a description of the key personnel and the CRP Committee responsible for EQIP.

**Section 3**, CRP Entity provides information on the model plan.

**Section 4**, CRP Entity commits plans to make Incentive Payments to Care Partners.

## 1. Hospital Information

**Date of Track Implementation Protocol Submission:**

**Organization Name and D/B/A:**

**TIN:**

**CMS cert #(s) for organization:**

**Point of Contact:**

	Hospital
Name:	
Title:	
Street Address:	
City, State, Zip:	
Telephone:	
Fax:	
Email:	

**Name the key personnel and describe the function of the key management personnel for EQIP:**

Key Personnel	Title	Program Role/Responsibilities

## 2. CRP Committee

Provide the names of the CRP Committee members. During each performance period, at least one CRP Committee member must be a Medicare FFS beneficiary living in the hospital's service area.

Name, Credentials	Job Title and Organization, if applicable	Check if Care Partner Rep	Check if Medicare Bene Rep
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

### Provide an explanation of the following.

Please answer the following questions about how the CRP Entity's CRP Committee will provide oversight, guidance, and management for EQIP.	
1. How often will the CRP Committee meet? (monthly, bi-monthly, quarterly, bi-annually)	
2. How often will the CRP Committee receive progress/ dashboard reports on program performance? (monthly, bi-monthly, quarterly, bi-annually, annually)	
3. How will the CRP Committee assist Care Partners in selecting the allowable clinical episodes?	
4. How will the CRP Committee assist Care Partners in selecting the Allowable EQIP Interventions?	
5. How will the CRP Committee provide a forum for sharing ideas, identifying problems, for its Care Partners?	
6. How will the CRP Committee offer the internal leadership to ensure the integrity of and opportunity for success of the	

Please answer the following questions about how the CRP Entity's CRP Committee will provide oversight, guidance, and management for EQIP.	
CRP and each CRP Track in which the Hospital is participating?	
7. How will the CRP Committee conduct a qualitative analysis on the status of the Allowable EQIP Interventions and offer suggestions to the hospital on how implementation could be improved?	

### 3. EQIP Model Plan

Please briefly explain how the elements listed below will be executed.

Category	Changes to Current Care Model	Describe Program at a High Level (≤ 200 words)
<b>Infrastructure and HIT</b>	Please describe your process for engaging Care Partners.	
	How will you use CEHRT to document and communicate clinical care with patients and other health care professionals?	
	How will use of Electronic Health Records (EHRs) as a part of care redesign across treating health care providers help ensure coordination of care across settings?	
	How will use of HIT enable quality measurement, reporting and feedback?	
<b>Data</b>	Please describe how your hospital will utilize monthly CMS data files in the care redesign program.	
	Please describe how data will be used to support Incentive Payments and processes.	
<b>Care Redesign Processes</b>	Please describe how Care Partners will identify opportunities for improvement.	
	Please describe the monitoring and reporting process.	
	Please describe processes for communicating and educating physicians and clinical staff regarding EQIP.	
	Please describe how feedback from Care Partners will be used in order to improve Allowable EQIP Interventions.	

Define your process and frequency for monitoring a Care Partner’s completion of the Allowable EQIP Interventions. How will you ensure that medically necessary care is not reduced in an effort to reduce Medicare FFS expenditures?

How will you communicate Incentive Payment results to Care Partners?


#### **4. Incentive Payments**

The HSCRC will assist the hospital in providing a list of Care Partner’s participating in EQIP and episode elections to CMS.

Do you attest that Incentive Payments to Care Partners will be paid in accordance with the Participation Agreement and Track Implementation Protocol?

Yes       No

Please describe the process by which you will distribute the Incentive Payments to Care Partners, including the timing and periodicity of payments, the entities issuing the payments, the method for distributing payments to Care Partners, form of payments, the documentation of payments, etc.



**5. EQIPC Primary Care (EQIP PC)**

The EQIP track template will be revised to reflect EQIP PC policy at a later date.

## Appendix A: Clinical Episode Category List

The following table contains the episode participation opportunities for 2025. Care Partners will be able to elect episodes they would like to participate in and will not be required to participate in a set number or list so long as they meet episode thresholds for participation.

Acute CHF/Pulmonary Edema	Knee Arthroscopy	ED- Abdominal Pain & Gastrointestinal Symptoms
Acute Myocardial Infarction	Knee Replacement & Knee	ED- Asthma/COPD
Allergic Rhinitis/Chronic Sinusitis	Low Back Pain	ED- Atrial Fibrillation
Asthma	Lumbar Laminectomy	ED- Chest Pain
CABG and/or Valve Procedures	Lumbar Spine Fusion	ED- Deep Vein Thrombosis
Cataract Surgery	Musculoskeletal	ED- Dehydration & Electrolyte Derangements
Cellulitis, Skin Infection	Osteoarthritis	ED- Diverticulitis
Cholecystectomy	Pacemaker/Defibrillator	ED- Fatigue or Weakness
Chronic Anxiety	Percutaneous cardiac intervention	ED- Fever
Colectomy	Pneumonia	ED- Hyperglycemia
Colonoscopy	Prostatectomy	ED- Nephrolithiasis
COPD	Recurrent Depression	ED- Pneumonia
Decubitus Ulcer	Rheumatoid Arthritis	ED- Shortness of Breath
Dermatitis, Urticaria	Rotator cuff repair	ED- Skin & Soft Tissue Infection
Endoscopy	Sepsis	ED- Syncope
Glaucoma	Shoulder total arthroplasty	ED- Urinary Tract Infection
Gu device/catheter complications	TURP	
Hip Replacement & Hip Revision	UTI	
Hip/Pelvic Fracture		

## Appendix B: Example of Incentive Payment Methodology

The Hospital will distribute incentive payments to its Care Partners based on their savings relative to the target price. An example of that calculation is shown below.

- Baseline period Care Partner episode costs:
  - Episode A: \$15,000 (35<sup>th</sup> percentile in State)
  - Episode B: \$10,000 (67<sup>th</sup> percentile in State)
- Episode Target Prices:
  - Episode A: \$15,000 (\$15,000 x 100%)
  - Episode B: \$10,000 (\$10,000 x 100%)

- Aggregate actual performance (savings/dissavings) year episode payments:
  - Episode A: \$14,300 across 25 episodes ( $\$14,300 \times 25 = \$357,500$ )
  - Episode B: \$9,500 across 50 episodes ( $\$9,500 \times 50 = \$475,000$ )
- PAU Savings achieved
  - Episode A: \$15,000 - \$14,300 across 25 episodes ( $\$700 \times 25 = \$17,500$ )
  - Episode B: \$10,000 - \$9,500 across 50 episodes ( $\$500 \times 50 = \$25,000$ )
- Tiered shared savings rate applied:
  - Episode A: \$17,500 (savings)  $\times 0.65$  (66<sup>th</sup> pct. tier) = \$11,375
  - Episode B: \$25,000 (savings)  $\times 0.80$  (99<sup>th</sup> pct. tier) = \$20,000
- Total EQIP incentive payment
  - Shared Savings: \$31,375 ( $\$11,375 + \$20,000$ )
    - Less dissavings from prior year (if any)
    - Adjusted for Quality performance score (+/- 10 percent)