EQIP Episode Quality Improvement Program

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EQIP Specialty Series – PY5 Ophthalmology

A Value-Based Medicare Incentive Payment Opportunity for Maryland Practitioners

June 2025

Welcome to the EQIP Specialty Series

The EQIP Specialty Webinars will provide an overview of EQIP and introduce the Clinical Episode Categories available for Performance Year 5 (Calendar Year 2026).

- Each webinar will follow a consistent format.
- Please register for upcoming webinars that may be of interest to you.

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EQIP Specialty Webinars:

- ~~Overview of PY5 Episodes – 6/5, 12:30 PM ET~~
- **Ophthalmology Episodes** – 6/13, 12:30 PM ET
- Orthopedics & Musculoskeletal (MSK) Episodes – 6/20, 12:30 PM ET
- Gastroenterology Episodes – 6/27, 12:30 PM ET
- Cardiology/Vascular Episodes – 6/30, 12:30 PM ET

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Understanding the Opportunity

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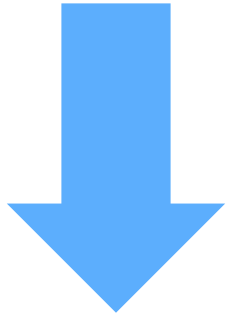
- Maryland practitioners largely remain on fee-for-service reimbursement incentives.
- As a result of the Total Cost of Care Model, Maryland practitioners are left out of national, Medicare value-based payment programs.
- There is a need for new value-based reimbursement opportunities to ensure cost containment in non-hospital settings.



The Health Services Cost Review Commission (HSCRC) created a voluntary, episodic incentive payment program for practitioners in Medicare, EQIP, starting in 2022. Calendar year 2026 will be the fifth performance year of EQIP.

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What is Maryland's Episode Quality Improvement Program (EQIP)?

- EQIP is a voluntary, Advanced Alternative Payment Model (AAPM) for Maryland generalists, specialists, or other CMS-approved practitioners.
- EQIP engages practitioners who treat Maryland Medicare beneficiaries in care transformation and value-based payment through an episode-based approach.
- EQIP will hold participants accountable for achieving **cost** and **quality** targets for one or more Clinical Episodes.

EQIP Episode Quality Improvement Program

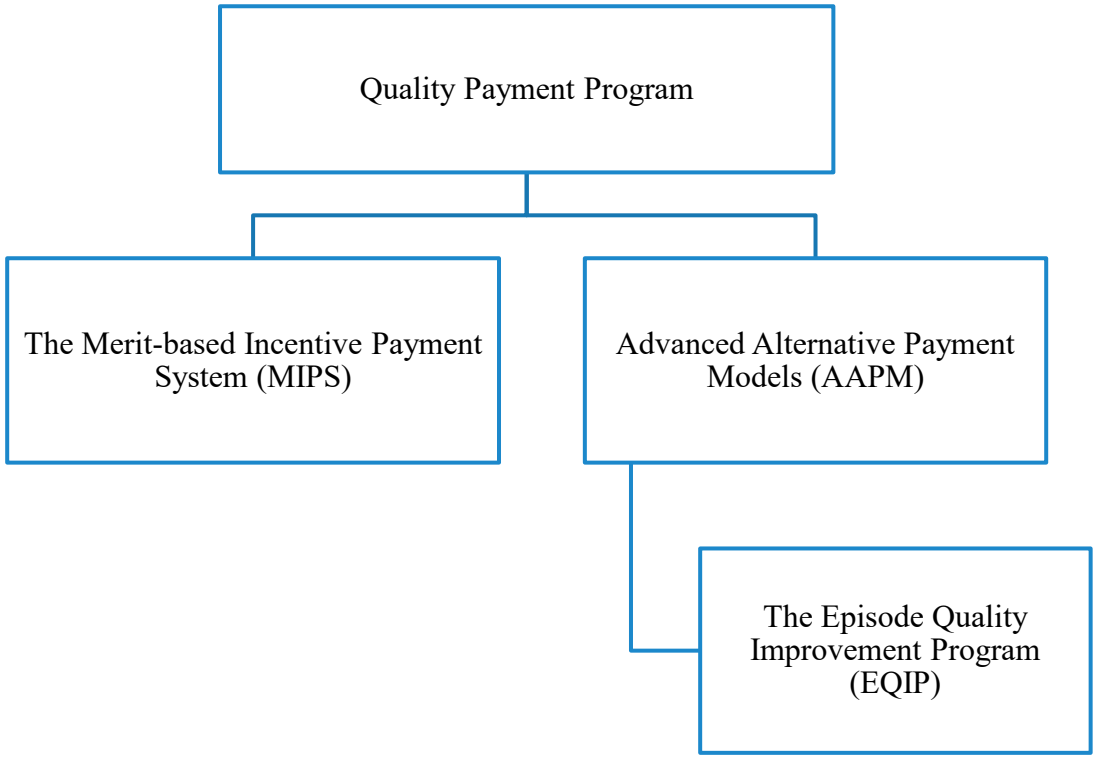
EQIP Emphasizes:

EQIP as an Advanced Alternative Payment Model (AAPM)

Practitioners participating in EQIP are on the AAPM track of the QPP and considered Qualifying APM Participants (QPs).

QPs will:

- **Be exempt from MIPS reporting and MIPS payment adjustments.**
- **Receive a higher Medicare Physician Fee Schedule (PFS) update than non-QPs.**
  - Payment rates under the Medicare PFS for covered professional services furnished by the QPs will be updated annually by the **0.75 percent qualifying APM conversion factor**.



How Does EQIP Work?

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Annual Enrollment Opportunity

- Practitioners decide to enroll in EQIP during July through August of each year.
- One or more practitioners enroll in an EQIP Entity.
- EQIP Entities select Clinical Episodes that will trigger when a specific Medicare beneficiary or procedure is performed.

Target Price is Set

- Costs from Episodes triggered in the baseline year are aggregated for each EQIP Entity.
- Entities are assigned a per episode average cost or unique Target Price per episode it has selected.

Performance Assessed

- EQIP uses claims data to assess cost and quality performance
- Performance year Episode costs are compared to the Target Price and savings are aggregated.
- Any earned incentive payments are due to the EQIP Entity.

EQIP Episodes

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During the enrollment period, EQIP Entities enroll in clinical episodes based on their episode volume in the baseline period.

Each episode will consist of the following:

Trigger	ICD-10 codes, CPT, or HCPCS codes that initiate an episode. These codes indicate that a patient has a particular condition or underwent a particular procedure.
Lookback Window	The time period prior to the trigger during which to count all costs related to the trigger.
Close Period Window	The time period after the trigger during which to count all costs related to the trigger.

Performance Year 5 (CY2026) Episodes

PY5 will offer 123 episodes from the following clinical categories.

- Allergy / ENT
- Behavioral Health
- Cardiology / Vascular
- Dermatology
- Emergency Department
- Endocrinology
- Gastroenterology
- General Surgery / Wound Care
- Hematology / Oncology
- Infectious Disease
- Nephrology
- Neurology
- Ophthalmology
- Orthopedics / MSK
- Pulmonology / Critical Care
- Rheumatology
- Urology

While EQIP Episodes are organized by clinical category, there is no limitation to the type of practitioner that wishes to enroll in EQIP under these episodes.

PY5 Ophthalmology Episodes

- Cataract Surgery
- Glaucoma
- Vitrectomy*
- Retinal Tear*
- Macular Hole*
- Glaucoma Surgery*
- Macular Pucker*
- Macular Degeneration*

*New for PY5

Example - macular degeneration

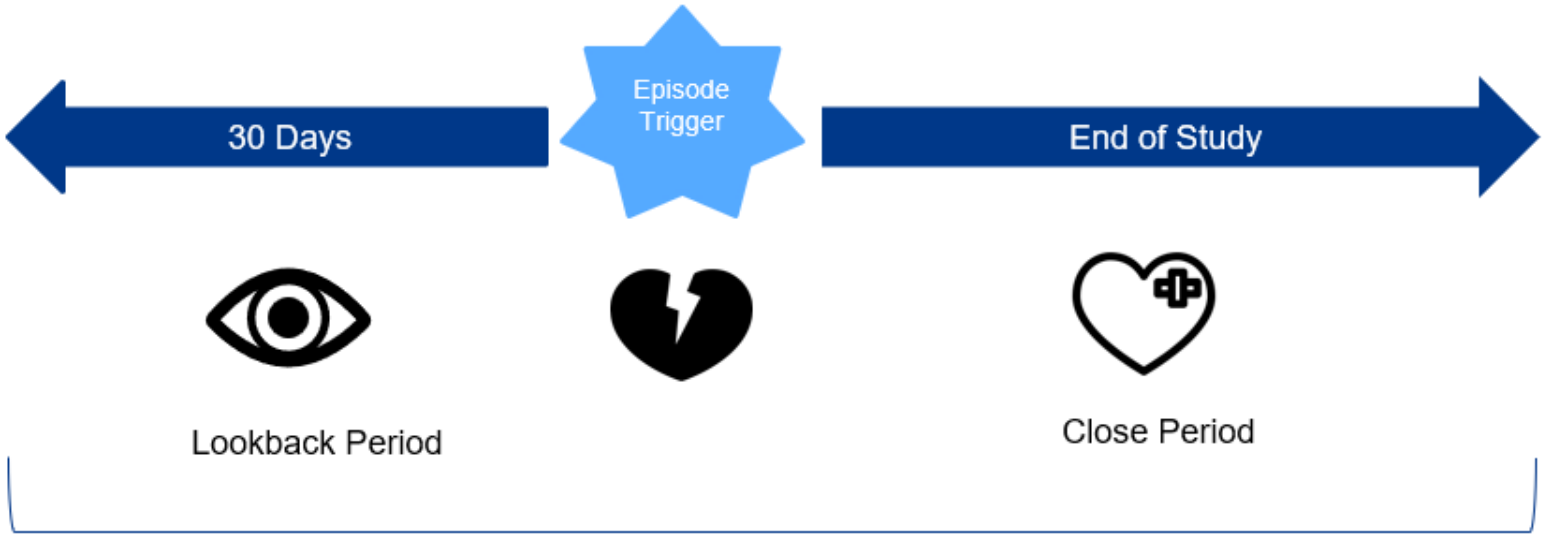
The following ICD-10 codes indicate that a Medicare patient has macular degeneration and initiates the start of an episode.

PACES Episode	Code Type	Code			
macular degeneration	ICD10	H3532	H353191	H353124	H353211
		H3530	H353192	H353230	H353212
		H3531	H353133	H353231	H353213
		H353120	H353134	H353232	H353290
		H353113	H353130	H353233	H353291
		H353114	H353131	H353222	H353292
		H353110	H353132	H353223	H353293
		H353111	H353121	H353220	
		H353112	H353122	H353221	
		H353190	H353123	H353210	

Example - macular degeneration

Once a macular degeneration episode has been initiated, the following episode length will be used to determine the total episode cost.

Episode Length – macular degeneration



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

Episode Costs

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Total relevant costs for a single episode include all Medicare Parts A and B claim payments for the beneficiary for services that are rendered during the episode period and linked to the episode.

Relevant costs are services and costs that are clinically associated with the condition or treatment of the Episode (regardless of who provides them). Including:

- Inpatient stays
- Outpatient visits
- Imaging
- Labs
- Part B drugs
- Physician services
- DME (Durable Medical Equipment), if applicable

*Episode triggers and episode-relevant costs are derived from Medicare fee-for-service claims. There are no additional reporting requirements for EQIP participants. EQIP utilizes claims data as part of the standard billing practices.

Target Price

Each EQIP Entity will be assigned its own unique Target Price per episode it has selected.

- An EQIP Entity's target price for a given clinical episode category equals the average total relevant episode costs among all clinical episodes attributed to its Care Partners during the baseline period.
  - EQIP's baseline period is 2019.
  - PY5 ED episodes only will use 2023 for the baseline period.

Preliminary target prices are available at the start of the program year. Final target will be made available at end of the program year after inflation adjustments and standardization have been applied.

Performance year Episode costs will be compared to the Target Price to determine if the EQIP Entity generates savings.

Quality Metrics

Each EQIP Entity is subject to a Quality Score adjustment, as required as a part of EQIP's Advanced APM status.

PY5 Quality Metrics:

- Advance Care Plan (NQF #326)
- Documentation of Current Medications in the Medical Record (NQF #419)
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (MIPS #128)

For each attributed episode, the HSCRC will assess whether the three quality measures were performed, by any practitioner, within the year preceding the end of the episode.

- The EQIP quality metrics are measured ONLY through claims data.
- The quality measures only needs to be billed once by any practitioner to receive credit.

Advance Care Plan (NQF #326)

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What is it?

This quality measure evaluates the percentage of patients aged 65 and older who have:

- An **advance care plan** or a **surrogate decision maker** documented in their medical record, or
- Documentation of a discussion about advance care planning, even if the patient declined or was unable to provide a plan.

Why?

- Helps establish medical treatment preferences prior to incapacity, reducing decision-making uncertainty.
- Enhances care coordination, reduces errors, and aligns treatment with patient goals.

How You Are Scored

Denominator:

- Patients aged 65+ with specific eligible encounters (CPT/HCPCS codes).

Numerator:

- Patients with documented plans, surrogates, or discussions.

Submission Codes

1123F:

- An advance care plan or a surrogate decision maker is documented in the medical record.

1124F:

- An Advanced care plan was discussed but patient did not wish or was not able to provide an advanced care plan or a surrogate decision maker.

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

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What is it?

Measures the percentage of visits for patients aged 18+ where clinicians document a complete medication list.

Includes prescriptions, over-the-counter drugs, herbals, vitamins, and dietary supplements with the name, dosage, frequency, and route of administration.

Why?

Accurate medication lists are critical for reducing adverse drug events (ADEs) and promoting patient safety.

Minimizes risks of medication errors, especially for older adults and those with chronic conditions.

How You Are Scored

Denominator: All visits for patients aged 18+ with eligible encounter codes (e.g., CPT, HCPCS).

Numerator:

- Documented, updated, or reviewed medication list at the time of the encounter.
- Includes medications reported by patients, caregivers, or other sources.

Submission Codes

G8427: Medication list documented, updated, or reviewed (Performance Met).

G8430: Patient not eligible (e.g., emergent situation) (Denominator Exception).

G8428: Medication list not documented, reason not given (Performance Not Met).

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

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What is it?

BMI documented during the current or past 12 months. Normal range is 18.5-24.9 kg/m²

Follow up plan recorded if BMI is outside normal parameters.

- Nutrition counseling.
- Referral to specialists (e.g., dietitians, exercise physiologists).
- Pharmacological interventions or dietary supplements.
- Behavioral or exercise therapy.

Why?

Addresses obesity and underweight issues to prevent related complications like diabetes, cardiovascular diseases, and malnutrition.

Supports the goal of population health improvement and healthcare cost reduction through preventive care.

How You Are Scored

Denominator:

- Patients aged 18+ with an eligible encounter during the measurement period (specific CPT/HCPCS codes).
- Exclusions:
  - Patients in hospice or palliative care.
  - Pregnant patients.

Numerator:

- BMI documented as:
  - **Normal**: No follow-up plan required.
  - **Above or Below Normal**: Follow-up plan documented for the current or prior 12 mons

Submission Codes

Performance Met Codes:

- **G8420**: BMI within normal range, no follow-up needed.
- **G8417**: BMI above normal, follow-up documented.
- **G8418**: BMI below normal, follow-up documented.

Exceptions and Non-Compliance:

- **G2181**: BMI not documented due to patient refusal or medical reasons.
- **G8419**: BMI outside normal range, no follow-up documented, no reason given.

Incentive Payment Methodology

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1. Performance Period Results

- The total performance year Episode Costs are less than the Target Price across all episodes in which the EQIP Entity participates.
- At least three percent of savings are achieved (EQIP Entity's Performance Year savings must meet or exceed 3% of its Aggregated Target Price).
- Dissavings from prior year (if any) are offset

2. Shared Savings

- Each Care Partner's Target Price will be compared to the statewide experience and annually ranked based on relative efficiency. Lower cost practitioners will be in a higher tier and vice versa.
- The Shared Savings split with Medicare will be based on the Care Partner's Target Price rank

Target Price Rank	% of Savings to due EQIP Entity
Up to 33rd percentile	50 percent
34th – 66th percentile	65 percent
66th + percentile	80 percent

3. Clinical Quality Score

- 5% of the incentive payment achieved will be withheld for quality assessment
- The EQIP Entity's quality performance will indicate the portion of this withholding that is 'earned back'

4. Incentive Payment Cap

- The Care Partner Incentive Payment Cap is 25% of the Average Care Partner PFS Expenditures for the preceding calendar year.

5. Final Incentive Payment

- Paid directly to the payment remission source indicated by the EQIP Entity*
- Paid in full, 9 - 12 months after the end of the performance year

**The EQIP entity can direct the payment remission source to distribute payments to individual Care Partners however it desires.*

Removal from EQIP

There are several circumstances where a Care Partner or an EQIP Entity 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 Agreement
- **Dissavings Policy: The EQIP Entity's Rank Percentile is in the lower two terciles of the tiered Shared Savings Rate (i.e., 0-65th percentile of statewide target prices) and the EQIP Entity experienced two 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 EQIP Entity will receive zero points for that measure and will be on probation for the program year. Two consecutive program years on probation results in automatic exclusion from EQIP.**

Upcoming Enrollment Opportunity

Enrollment for PY5 (CY2026) will open July 1, 2025 through August 29, 2025.

EQIP Open Enrollment Webinar – June 18 at 12:00 PM.

- Register here

Please reach out to eqip@crisphealth.org for more information.