maryland
health services
cost review commission

EQIP Subgroup

March Meeting

03/20/2026

Agenda

- Introduction of New Program Analyst
- Quality Measures Overview (including the addition of a new Outcome Measure for current program year)
- Episode Development for PY6
- PY4 & PY5 Data Release Timeline
- Collecting W9/Payment information
- Resources, Tools and Support

New Program Analyst

New Program Analyst

Introduction

Please welcome Angelica Rego, CRISP's new EQIP Program Analyst. She brings a unique perspective to this group, including firsthand user-side experience with this program from her time as an admin proxy at an EQIP entity.

Quality Measures

Advance Care Plan (MIPS #047)

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.

- **NOTE:** We are no longer using the 99-series codes to count for this measure.

**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.*

Documentation of Current Medications in the Medical Record (MIPS #130)

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 Performance Met). reviewed (

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)

What is it?

BMI documented during the current or past 12 months. Normal range is 18.5-24.9 kg/m^2

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.

Unplanned Readmissions

Based on MIPS 2026 All-Cause, Unplanned Hospital-Wide Readmission (HWR) Measure

What is it?

- Rate of unplanned readmissions to a hospital within 30 days of an eligible inpatient stay
- Includes Medicare FFS beneficiaries aged 65 or older
- Calculated using claims data
- Risk-standardized

Why?

- Care coordination across the episode of care can reduce readmission rates
- Encourages effective discharge planning and care transitions
- Unplanned readmissions often reflect a poor beneficiary experience
- Readmissions are costly

How You Are Scored

Denominator

- Medicare FFS Beneficiaries discharged alive from an acute inpatient stay
- Excludes in-hospital deaths, transfers, discharges against medical advice, cancer hospitals and admissions, and admissions for psychiatric disease or for rehabilitation

Numerator

- Unplanned inpatient readmissions to a short-stay acute-care or critical access hospital within 30 days of discharge
- Planned readmissions excluded

Notes

- Applies to eligible EQIP specialty categories.
- See Measure Information Form and accompanying Specifications for details, including detailed exclusion criteria

Risk Adjustment

- Five specialty cohort regression models estimated using prior-year comorbidities and clinical factors (estimated using only Maryland Medicare FFS claims)
- Standardized readmission ratios (SRRs) calculated as observed-to-expected ratios of readmissions for each entity & specialty cohort
- Single summary score calculated by aggregating entity-cohorts to entities using a weighted average of SRRs, and multiplying the entity ratio by the average observed readmission rate in Maryland

Data Release Schedule

EEP - Tentative Release Date Schedule

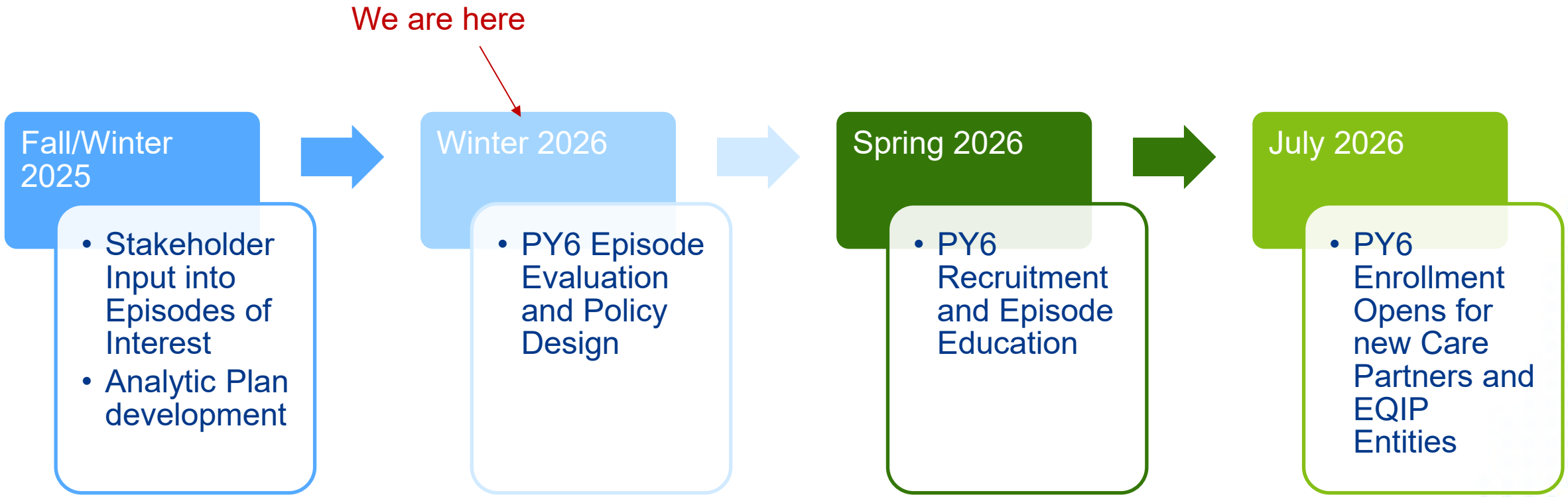
PY4 Data	Proposed Release Date (2nd Cycle)
Episodes Ending August	January 2026
Episodes Ending September	February 2026
Episodes Ending October	March 2026
Episodes Ending November	April 2026
Episodes Ending December	May 2026

PY5 Data	Proposed Release Date (2nd Cycle)
Baseline PY5	April 2026
PY5 – Episodes Ending January	June 2026
PY5 – Episodes Ending February	July 2026
PY5 – Episodes Ending March	Aug 2026
PY5 – Episodes Ending April	Sep 2026

Note: All release dates are proposed and subject to change

PY6 Episode Development

Performance Year Five (CY2026) Episode Development Process



PY6 Episode Development

- 47 New PACES Episodes of Interest
- Assess new episode requests to ensure they meet volume requirements and align with EQIP Program goals.
- We will update you on all the new episodes for PY6, once that assessment has been finalized.

Payment Information/W9 Collection

Collection of Payment information and W9s

Collection of Payment Information:

- Meritus will send emails to each entity enrolled in PY5
- Emails will come from EQIP.Finance@meritushealth.com
- Estimated timing: April.

Actions Required:

- Access the registration site using the step-by-step instructions included in the email sent by Meritus.
- Download and complete the IRS Form W9
- Upload the completed W-9 to the registration site
- Provide banking information for ACH payments
    - PY 5 savings payments will be made via ACH rather than check

Important Notes:

- EQIP team will send a reminder email before the Meritus emails go out.
- Please watch for communication and share internally with your finance teams.

Resources

Resources

- CRISP's EQIP Website
- EQIP Curriculum
- EQIP Episode Playbook PY5
- EQIP Policy Documentation PY5
- EQIP Specifications and Methodology PY5

CMS Ambulatory Specialty Model (ASM)

Starts January 2027 | Mandatory CMS Model

- **What Is ASM?**
  - A mandatory, NPI-level, episode-based payment model for specialists with national peer comparison and significant financial risk.

- **Who Is Impacted**
  - **Episodes:** Low Back Pain, Heart Failure (20+ attributed patients required)

  - **Specialties:**
    - *Low Back Pain:* Anesthesia/Pain, Orthopedic Surgery, Pain Management, PM&R, Sports Medicine
    - *Heart Failure:* Cardiology

- **ASM Update (Geographic Mandatory areas)**
  - ASM Mandatory Geographies.eml
  - ASM Mandatory Geographic Areas_12_23_25.xlsx
  - ASM Mandatory Geographic Areas_12_23_25.xlsx

Thank you!