EQIP Episode Quality Improvement Program

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Maryland's Episode Quality Improvement Program (EQIP)

Performance Year 6 (Calendar Year 2027)

Why Consider EQIP?

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Qualifying APM Participant (QP) Status

- Be exempt from MIPS
- Benefit from APM conversion factor updates on Medicare payments

Lump-Sum Incentive Payment Opportunity

Earn a portion of the savings you create as a lump-sum incentive payment.

Claims-Based Reporting

Already bill Medicare?
No additional reporting or extra work involved.

EQIP's Impact

EQIP continues to demonstrate success, reducing Medicare costs while delivering meaningful financial incentives to participants.

Medicare Total Cost-of-Care Savings

- Performance Year 1 (CY2022): ***$20.0M***
- Performance Year 2 (CY2023): ***$36.7M***
- Performance Year 3 (CY2024): ***$62.6M***

Incentives Distributed to Participants

- Performance Year 1 (CY2022): ***$13.0M***
- Performance Year 2 (CY2023): ***$23.1M***
- Performance Year 3 (CY2024): ***$29.1M***

Enrollment Summary

- Performance Year 1 (CY2022):
  - ***50 entities, 1,979 practitioners***
- Performance Year 2 (CY2023):
  - ***62 entities, 2,787 practitioners***
- Performance Year 3 (CY2024):
  - ***116 entities, 3,203 practitioners***
- Performance Year 4 (CY2025):
  - ***128 entities, 3,362 practitioners***
- Performance Year 5 (CY2026):
  - ***207 entities, 5,369 practitioners***

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What is EQIP?

The **Episode Quality Improvement Program** is a value-based Medicare incentive payment opportunity for Maryland practitioners.

- A voluntary, **Advanced Alternative Payment Model** (AAPM).
- Engages practitioners who treat **Maryland Medicare fee-for-service** beneficiaries.
- Supports care transformation and value-based payment through an **episode-based approach**.

EQIP Episode Quality Improvement Program

How Does EQIP Work?

- EQIP Entities are held accountable for achieving **cost** and **quality** targets for one or more Clinical Episodes.

- Entities have an opportunity to earn a portion of the savings they create in their selected Clinical Episode(s) as a **lump-sum incentive payment**.

EQIP Entity

One or more practitioners who enroll and participate in EQIP together. EQIP performance is evaluated at the **entity level**.

Clinical Episodes

A defined period of care for a specific medical **condition**, **procedure**, or **treatment** under EQIP.

Clinical Episodes

An ***EQIP Episode*** is a defined period of care for a specific medical condition, procedure, or treatment under EQIP.

Each episode consists of three parts:

Lookback Window
A specific time **prior** to the triggering event in which all costs related to the trigger will be counted.

Episode Trigger
An index hospital stay or procedure **during** which the initial care was performed.

Close Period
A specific time **after** the triggering event in which all costs related to the trigger will be counted.

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PY6 Episode Categories

Performance Year 6 (CY2027) will offer **over 140 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
Obstetrics/ Gynecology	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 as long as they meet eligibility requirements.*

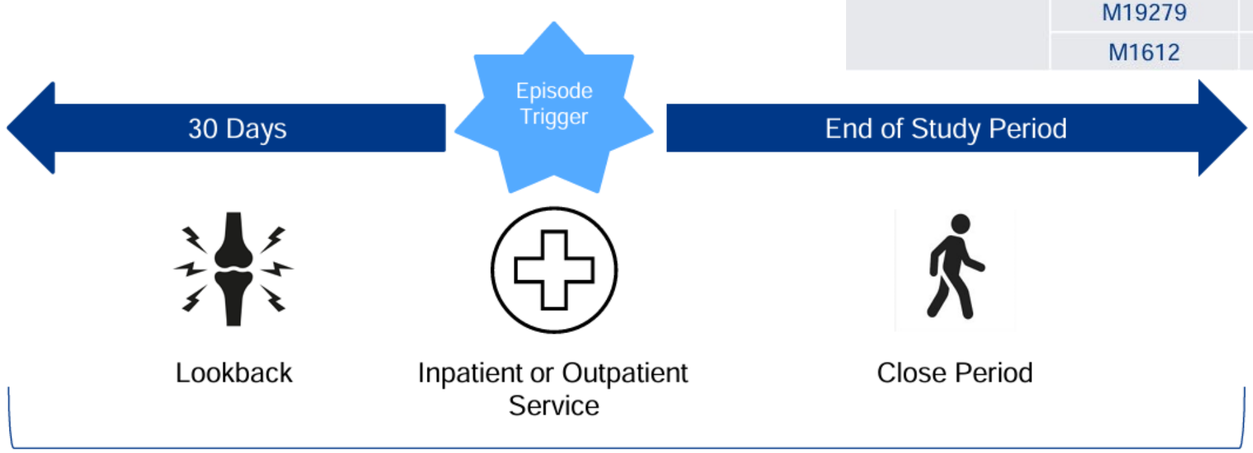
Please note the PY6 Episode Playbook is coming soon and will be available with episode definitions.

Example: Chronic Episode

Osteoarthritis

Trigger Codes

Code Type	Code					
ICD10	M19211	M1611	M1652	M166	M179	M19079
	M19212	M1610	M1711	M169	M180	M19111
	M19219	M1631	M1710	M151	M19011	M19112
	M19221	M1630	M1712	M152	M19012	M19119
	M19222	M1632	M1730	M150	M19019	M19121
	M19229	M1812	M1732	M153	M19021	M19122
	M19231	M1811	M1731	M154	M19022	M19129
	M19232	M1810	M1929	M159	M19029	M19131
	M19239	M1832	M1990	M158	M19031	M19132
	M19241	M1831	M1992	M184	M19032	M19139
	M19242	M1830	M1991	M182	M19039	M19141
	M19249	M1851	M1993	M189	M19041	M19142
	M19271	M1850	M160	M172	M19042	M19149
	M19272	M1852	M164	M170	M19049	M19171
	M19279	M1651	M162	M175	M19071	M19172
	M1612	M1650	M167	M174	M19072	M19179



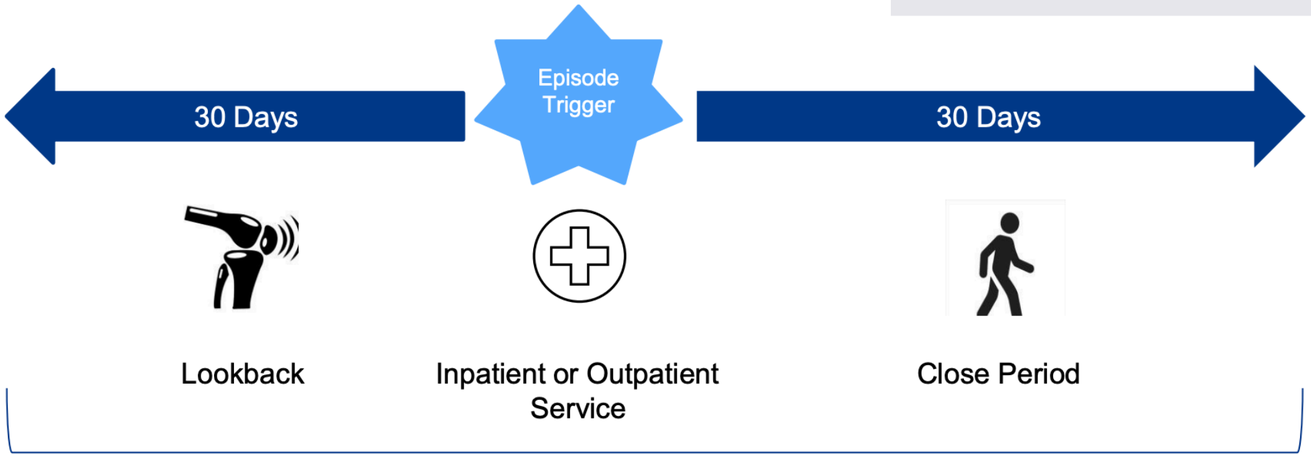
Episode Length

Example: Procedural Episode

Knee Arthroscopy

Trigger Codes

Code Type	Code	
CPT	G0289	29888
	29876	29889
	29877	29884
	29879	29885
	29873	29886
	29874	29887
	29875	29866
	29880	29867
	29881	29868
	29882	29870
	29883	29871



Episode Length

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Episode Costs

Episodes are triggered, and related costs are identified, based on traditional **Medicare fee-for-service claims**.

Total relevant ***costs*** for a single episode include all Medicare Part A & B payments for services that are clinically related to the episode and occur within the episode timeframe, regardless of who provides them.

Episode costs may include:

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

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Episode Costs Cont.

Performance Year episode ***costs*** are compared to a **Target Price**.

- Each Entity receives a unique Target Price for *every episode* it selects.
- Calculated based on the Entity's average episode costs during the **baseline period (CY2019).**

PY Episode Costs < Target Price = Savings/Cost Target Achieved

Note: Baseline dollar amounts are inflated and adjusted to reflect equivalent dollars in the Performance Year.

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Quality Measures

Quality measures must be completed for each attributed episode:

- **Advance Care Plan**
- **Documentation of Current Medications in the Medical Record**
- **Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan**
- **Unplanned Readmissions** (if applicable)

To receive credit, the measures* must be:

✓Submitted through **claims** using the CPT II or G-codes.

✓Performed **at least once by any practitioner** who sees the patient.

✓Completed within **one year** prior to the end of the episode.

**Please note this applies to Advance Care Plan, Medication Reconciliation, and BMI only.*

Quality Measures Cont.

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Advance Care Plan

What is it?

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.

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.

Medication Reconciliation

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.

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).

BMI Screening and Follow-Up Plan

What is it?

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

Submission Codes:

- **G8420**: BMI within normal range, no follow-up needed (Performance Met).
- **G8417:** BMI above normal, follow-up documented (Performance Met).
- **G8418:** BMI below normal, follow-up documented (Performance Met).
- **G2181:** BMI not documented due to patient refusal or medical reasons (Exceptions / Non-Compliance).
- **G8419:** BMI outside normal range, no follow-up documented, no reason given (Exception / Non-Compliance).

Unplanned Readmissions

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.

Submission Codes:

- N/A

Performance Evaluation

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Determine Performance Period Results

- The total performance year episode costs are compared to the Target Price across all episodes in which the EQIP Entity participates.
- **To be eligible for Shared Savings:**
  - ✓ The total PY episode costs are less than the Target Price across all episodes.
  - ✓ PY savings ≥ 3% of Entity's Aggregated Target Price.
  - ✓ Dissavings from prior year (if any) are offset.

Split Shared Savings with Medicare

- The entity's Target Price will be compared to the statewide experience and annually ranked based on relative efficiency.

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

Make Quality Score Adjustment

- 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'.

Final ***incentive payments*** are paid in full approximately 9-12 months after end of Performance Year.

- **Paid directly to the payment remission source indicated by the EQIP Entity.**

What if My Entity is Unsuccessful?

EQIP Entities are ***not expected*** to repay CMS as the result of inadequate performance.

However, the HSCRC has created the following policies to ensure that EQIP drives meaningful improvements in cost efficiency and quality:

Dissavings Removal Accountability:

An EQIP Entity is removed from EQIP if it generates dissavings in two consecutive program years *and* is in the lower two terciles of the tiered Shared Savings Rate.

Catastrophic Quality Performance

An EQIP Entity is removed from EQIP if the entity is below the 20th percentile benchmark threshold of a single quality measure for two consecutive program years.

Am I Eligible to Participate?

To be eligible for EQIP, practitioners must meet the following criteria:

- ✓ Be a licensed general practitioner, specialist, or other CMS-approved practitioner in ***Maryland***.
- ✓ Be enrolled in the ***Medicare Provider Enrollment, Chain, and Ownership System (PECOS)***.
- ✓ Use ***Certified Electronic Health Record Technology (CEHRT)***.
- ✓ Be onboarded with ***CRISP***, Maryland's Health Information Exchange.
- ✓ Meet EQIP ***volume thresholds*** in baseline period.
  - ≥11 episodes per selected episode.
  - ≥50 total episodes across all selected episodes.
  - ≥75% of NPIs in entity must contribute to volume.

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Get Started with EQIP Today

Open enrollment for Performance Year 6 (CY2027) will take place from June 29 - August 21, 2026.

Next Steps:

- ❑ New EQIP Entities must complete the **Pre-Enrollment Form** **by August 7, 2026.**
- ❑ Submit **Baseline Volume Report** to determine opportunity to participate.
- ❑ Complete official **EQIP Application** in the EQIP Entity Portal (EEP) **by August 21, 2026**.
- ❑ Register **here** for upcoming **EQIP Open Enrollment Webinar** on **June 23, at 12:00 PM**.

Need Assistance?

Contact the CRISP EQIP Team at **EQIP@crisphealth.org**

Additional Resources

Plan for CMS Vetting

- Ensure practitioners have an active PECOS record and is in good standing with CMS.
- Log into **PECOS Portal** to manage records, revalidate info and monitor for compliance issues.
- Log into **NPPES** and ensure info is accurate.

Visit the EQIP Curriculum

- Explore comprehensive learning modules and deepen your understanding of EQIP.
- Start learning **here**.

Join the EQIP Subgroup for regular EQIP updates

- The EQIP Subgroup meets on the third Friday of every other month at 9:00 AM ET
- To be added to distribution list, email: **MedChiEQIP@medchi.org**
- Prior recordings can be found **here**.

Need Additional Support? Schedule an individual meeting with the MedChi or CRISP Team!

- MedChi Team: **MedChiEQIP@medchi.org**
- CRISP Team: **EQIP@crisphealth.org**