maryland
health services
cost review commission

EQIP Q&A Session and Reporting Webinar

October 25, 2024

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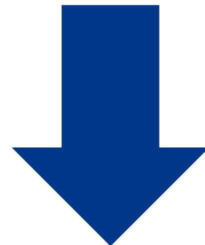
EQIP Overview

EQIP Background

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 HSCRC created a voluntary, episodic incentive payment program for practitioners in Medicare, EQIP, starting in 2022. Calendar year 2025 is the fourth performance year.

What is the Episode Quality Improvement Program?

EQIP is a voluntary program that engages non-hospital Medicare practitioners and suppliers in care transformation and value-based payment through an episode-based approach. EQIP emphasizes:

EQIP will provide incentive payments to practitioners who improve the quality of care and reduce the cost of care they provide to Maryland Medicare patients.

- There is an **upside-only** risk for EQIP Entities.
- Participating Care Partners bill CMS and receive reimbursement for their services as **normal**.
- Financial performance is assessed approximately **six months** after the program year ends.

Participation Requirements

Qualify as a Care Partner with CMS

- Must be licensed and enrolled in the **Medicare** Provider Enrollment, Chain, and Ownership System (**PECOS**)
- Must use **CEHRT and CRISP**, Maryland's health information exchange

Enroll in EQIP

- Establish **EQIP Entity** with **multiple Care Partners**
- **Select Episodes and Interventions** and agree to quality metrics
- Each Care Partner Signs a **Care Partner Arrangement**
- Determine **Payment Remission Recipient**

Meet Episode Thresholds

- Provide care in **Maryland**
- For a **single episode, threshold = 11** episodes in the baseline
- Across **all episodes of participation, threshold = 50** episodes in the baseline

PY4 EQIP Episodes

- EQIP will utilize the Patient-Centered Episodes of Care System (PACES) to define a clinical 'episode'.

Allergy Allergic Rhinitis, Asthma	**Orthopedics** Accidental Falls, Hip Replacement & Hip Revision, Hip/Pelvic Fracture, Knee Arthroscopy, Knee Replacement & Knee Revision, Low Back Pain, Lumbar Laminectomy, Lumbar Spine Fusion, Osteoarthritis, Rotator Cuff, Shoulder Replacement, Musculoskeletal Disorders
Behavioral Health Chronic Anxiety, Recurrent Depression	
Cardiology Pacemaker / Defibrillator, Acute Myocardial Infarction, CABG &/or Valve Procedures, Coronary Angioplasty	**Pulmonary / Critical Care** Acute CHF / Pulmonary Edema, Chronic Obstructive Pulmonary Disease, Deep Vein Thrombosis / Pulmonary Embolism, Pneumonia, Sepsi
Dermatology Cellulitis, Decubitus Ulcer, Dermatitis	**Rheumatology** Rheumatoid Arthritis
Gastroenterology Colonoscopy, Colorectal Resection, Gall Bladder Surgery, Upper GI Endoscopy	**Urology** Catheter Associated UTIs, Prostatectomy, Transurethral Resection Prostate, UTI
Ophthalmology Cataract, Glaucoma	**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

Episodic Value Based Payment

- Signed Agreement with a CRP Entity
- Enroll in clinical episodes that will Trigger when a specific Medicare beneficiary or procedure is performed

- Costs from episodes triggered in the baseline year are aggregated
- A per episode average cost or Target Price is set

- Performance year episode costs are compared to the Target Price
- Savings are aggregated to determine the Incentive Payment due to the practitioner

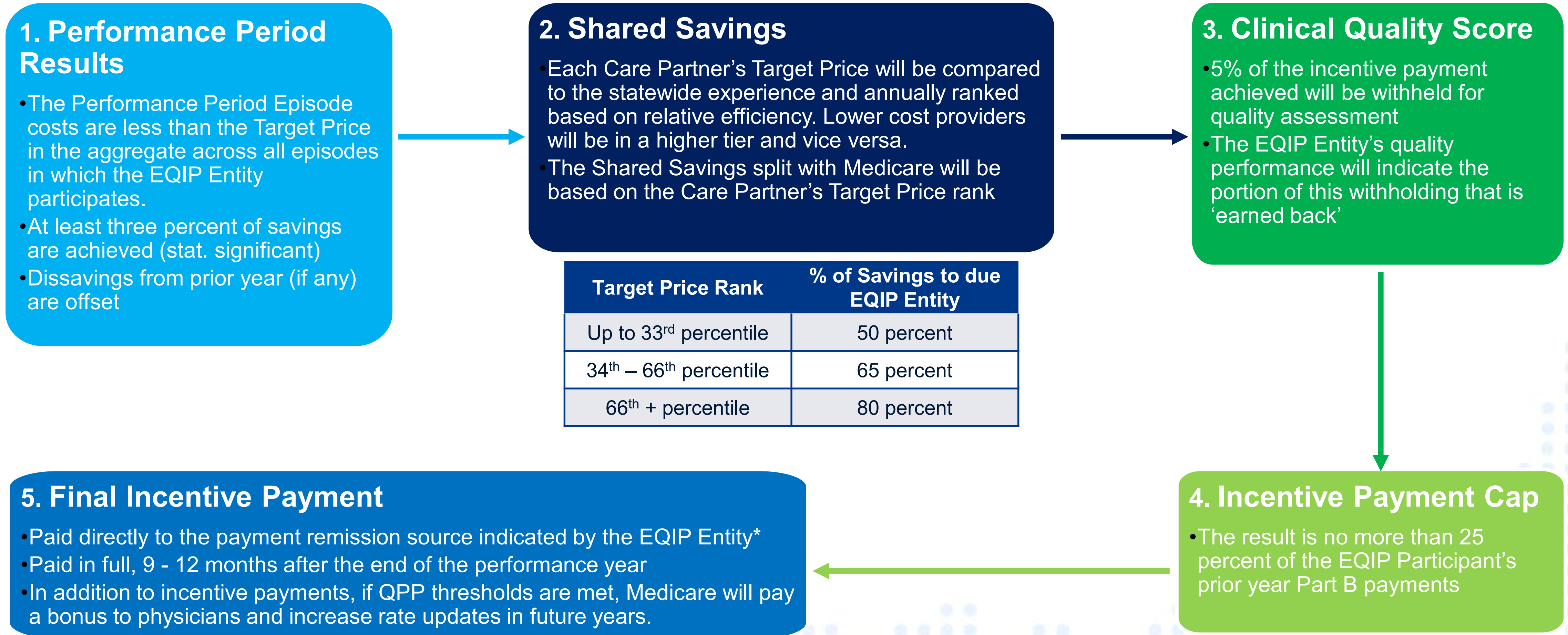
Quality Metrics

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

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

Incentive Payment Methodology

***Incentive Payments** will be direct checks made from the CRP Entity to the EQIP Entity for aggregate positive performance after a minimum savings threshold, shared savings split, and quality adjustment are applied.*



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

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

EQIP Timeline

- Care Partner participation opportunity will be annual

July – August	Enrollment Period for Upcoming PY
September – December	CMS Vetting, Eligibility Auditing, and Contracting
January 1st	Performance Year Begins
December 31st	Performance Year Ends
9-12 Months After Performance Year Ends	Incentive Payments (if earned) Distributed

Q&A Session

Key Players

- **What is a Care Partner?**
  - Care Partners are general practitioners, specialists, or other CMS-approved practitioners who are enrolled in EQIP.
- **What is an EQIP Entity?**
  - An EQIP Entity is an individual Care Partner or a group of Care Partners that have enrolled and will be participating together in EQIP.
- **What is an Administrative Proxy?**
  - An Administrative Proxy could be a practice manager, an external consultant, or whoever the entities would like to engage to help them manage participation and monitor performance in the program.
- **What is a Care Redesign Program (CRP) Entity?**
  - The CRP Entity is responsible for aggregating Care Partner Agreements and issuing incentive payments to the payment remission source indicated by the EQIP Entity. The CRP Entity for EQIP is the University of Maryland Medical Center (UMMC).
- **What is the difference between HSCRC/MedChi/CRISP; how are they all related and what are their roles?**
  - The HSCRC and CRISP are the EQIP program administrators. They will facilitate enrollment, calculate episodes, monitor performance, maintain reporting requirements, and determine incentive payments. MedChi works closely with HSCRC/CRISP to support EQIP and its participants. MedChi has helped create EQIP Entities, specifically for practitioners who may be ineligible to participate on their own and serves as an Administrative Proxy to them.

PACES Episode Grouper

- **What is PACES?**
  - The Patient-Centered Episode System (PACES) is the episode grouper for EQIP beginning in PY4 (CY2025). PACES consists of 1,090 episodes grouped into clinically relevant areas: Procedural, Chronic Condition, and Acute Condition.
- **Why did EQIP switch to PACES from Prometheus?**
  - While many PACES episodes are undergoing final clinical review and updates, the system offers much more complete coverage than PROMETHEUS and paves the way for easier, more seamless program expansion in future years. Current EQIP episode categories are well-covered by finalized PACES categories and overall, a high degree of alignment has been found for episodes currently available under EQIP.
  - The PACES Center is committed to transparency of the value sets that define each episode and the business rules that determine how those episode definitions are applied. In contrast commercially available groupers are “black boxes” (i.e., the underlying codes and rules are not available to users), which undermines users’ and stakeholders’ ability to understand what drove results.
- **What is the process to add new EQIP Episodes?**
  - A list of available PACES episodes will be circulated. Stakeholders can reach out to eqip@crisphealth.org to request a new episode.
- **Where can I find more information on PACES?**
  - https://www.pacescenter.org/

Methodology

- **What data is used for EQIP?**
  - EQIP episodes are constructed from the Claim and Claim Line Feed (CCLF) data provided by CMS to the State of Maryland. This data file contains Medicare final action claims for all Part A and Part B services received by beneficiaries who reside in Maryland, regardless of where services were rendered. The file also contains claims information on all Medicare-covered services furnished within Maryland to non-residents; however, non-residents are excluded from EQIP episode construction. The data do not include certain substance abuse claims excluded from the dataset under rules promulgated by the Substance Abuse and Mental Health Services) Administration (i.e., SAMHSA claims).
- **How does my data get into EQIP and hence get to Medicare?**
  - 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.
- **How are EQIP episodes triggered?**
  - Each episode has a different definition that uses clinically validated codes. EQIP episodes are triggered by the submission of a claim for a specified, relevant procedure and/or diagnosis through a qualifying primary ICD-10-CM code, CPT code, or HCPCS code. To view specific trigger codes for each episode, please see the PY4 Episode Playbook.
- **What costs are included in EQIP episodes?**
  - 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 defined as relevant according to the PACES episode grouper.
- **How is the target price calculated?**
  - An EQIP Entity’s target price is calculated by determining the average total relevant episode costs among all clinical episodes attributed to its Care Partners during the baseline period for each enrolled clinical episode category. 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.

Methodology Continued

- **If there is a patient that is seen by an EQIP-participating provider that is eligible for two enrolled episodes which episode will their care be attributed to?**
  - Within PACES, services assignment follow a pre-established hierarchical order. Procedure episodes are considered 1st priority followed by acute episodes and then chronic.
  - In the case where both episodes fall other the same category, PACES will decide the episode based on the service type and other rules they have in place.
- **If a doctor in a different entity submits a claim for a patient, triggering an episode, and we see the patient for the same diagnosis 2 weeks later, is that episode only attributed to the doctor who first saw the patient? Or is our entity now involved in the episode?**
  - For procedure and acute episodes, the attribution is assigned to the practitioner who first opened the episode.
    - Subsequent visits would be included in the relevant costs of that episode.
  - For chronic episodes, attribution is determined at the end of the year based on the plurality of all E/M visits.

Quality Metrics

- What CPT codes are required for each quality metric?
  - Advance Care Plan
  - Current Medications
  - Body Mass Index
- When doing these quality measures, do they need done each time the patient comes in or at least "Once" a year?
  - 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 period. The quality metrics only need to be billed once to get credit.
- Do the quality CPT codes need to be submitted at the same time the qualifying trigger code is billed? Can the quality CPT codes be submitted with any claim in 2024? Does the triggering practitioner have to be the one billing for the quality metrics? Can the quality CPT codes be submitted by any practitioner? Do they have to be in EQIP at all?
  - See above
- What if I typically record quality metrics in other ways?
  - EQIP quality metrics are measured through claims data only. Other methods of quality reporting will not satisfy EQIP requirements.

Incentive Payment

- **Is the incentive payment a lump sum payment?**
  - Yes. Incentive payments will be paid in full directly to the payment remission source indicated by the EQIP Entity.
- **When would I get my incentive payment?**
  - Incentive payments are distributed 9 - 12 months after the end of the performance year.
  - Incentive payments for PY4 (CY2025) should be expected around Fall 2026.

Dissavings

- **How would dissavings affect my practice?**
  - EQIP Entities that generate dissavings in a program year are required to offset that dissavings in the following program year, prior to earning an incentive payment.
  - An EQIP Entity is removed from EQIP if it generates dissavings 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.
- **If my entity is removed from the program for two consecutive years of dissavings, can my entity re-enroll in future performance years?**
  - The NPIs associated with an EQIP Entity's two consecutive years of dissavings will be required to leave EQIP for one performance year. After one year, those NPIs are eligible to re-enroll in the program.

Removal from EQIP

- **Why would an EQIP entity involuntarily be removed from EQIP?**
  - Failure to maintain vetting and certification from CMS
  - Failure to provide care or compliance in conjunction with the Agreement
  - The EQIP Entity's Rank Percentile is in the lower two terciles of the tiered Shared Savings Rate and the EQIP Entity experienced two consecutive years of dissavings.
  - 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.
- **Can Care Partners withdraw from EQIP during the performance year?**
  - No, EQIP Entities or Care Partners cannot withdraw during a program year. Please contact eqip@crisphealth.org if you have any questions or concerns.

MIPS

- **Am I exempt from reporting MIPS if I am in EQIP? What if not everyone in my practice is in EQIP? Do they still have to report?**
  - Practitioners enrolled in EQIP are considered Qualifying APM Participants (QP) and therefore, are exempt from reporting MIPS for the calendar year(s) they are engaged in EQIP. Exemption is at an individual/NPI level not practice level. Any practitioners not in EQIP, may still be required to report.
- **Are there negative consequences to reporting MIPS while being in EQIP?**
  - Reporting MIPS while being in EQIP will not have a positive or negative impact on practitioners. Practitioners in EQIP will not benefit from MIPS.
- **How can I check my QPP Status?**
  - QPP Participation Lookup

Live Questions

- Please ask any additional clarifying questions.

Reporting Webinar