EQIP Episode Quality Improvement Program

EQIP DICTIONARY

Term	Definition
Administrative Proxy	An **Administrative Proxy** could be a practice manager, an external consultant, or whoever the EQIP Entity would like to engage to help them manage participation and monitor performance in the program through the EQIP Entity Portal (EEP).
Advance Care Plan (ACP)	**Advance Care Plan (ACP)** is an EQIP quality measure that evaluates the percentage of patients aged 65 and older who have either (1) an advance care plan or a surrogate decision maker documented in their medical record, or (2) documentation of a discussion about advance care planning, even if the patient declined or was unable to provide a plan.
Advanced Alternative Payment Model (AAPM)	**Advanced Alternative Payment Models (AAPMs)** are one track of the Quality Payment Program that offer incentives to healthcare practitioners that deliver high-quality and cost-effective care.
Aggregate Episode Payments	An EQIP Entity's **aggregate episode payments** are equal to the sum of the total relevant episode costs across all selected Clinical Episode Categories for all participating Care Partners in an EQIP Entity during the Performance Year.
Aggregate Target Price (ATP)	An EQIP Entity's **aggregate target price (ATP)** is equal to the preliminary target price multiplied by the total volume of episodes in the performance period.
APM Qualifying Participants (QPs)	**APM Qualifying Participants (QPs)** are practitioners who meet the participation thresholds in an Advanced Alternative Payment Model (AAPM) under the Quality Payment Program (QPP). EQIP Participants are considered QPs.
Attributed Episode	An **attributed episode** is assigned to an individual Care Partner's NPI based on eligible, non-denied, professional Medicare claims that (a) have the required trigger diagnosis or procedure codes and (b) are within the trigger window, defined as +/- two days from the beginning date of service on the trigger claim. If more than one Care Partner could have triggered the episode, the NPI with the highest allowed amount is attributed the episode.
Baseline Costs	An EQIP Entity's **baseline costs** are equal to the Medicare Parts A and B claim payments for services that are rendered during the baseline period and defined as relevant according to the PACES episode grouper across all selected Clinical Episode Categories for all participating Care Partners in the EQIP Entity.

Baseline Volume	An EQIP Entity's **baseline volume** is equal to the number of EQIP Episodes attributed to the EQIP Entity's Care Partners during the baseline period.
Baseline Period	The **baseline period** is the Calendar Year EQIP uses to determine eligibility and assign target prices for EQIP Entities. The baseline period is Calendar Year 2019 for PY1-PY5. (*ED Episodes ONLY will use Calendar Year 2023 for the baseline period in PY5.)*
Care Partner (CP)	**Care Partners (CPs)** are general practitioners, specialists, or other CMS-approved practitioners who participate in an EQIP Entity.
Care Partner Arrangement (CPA)	A **Care Partner Arrangement (CPA)** is a standard agreement that each Care Partner must sign and return to finalize enrollment.
Care Redesign Program (CRP) Entity	The **Care Redesign Program (CRP) Entity** will administer the Care Partner Agreements and incentive payments.
Catastrophic Quality Performance	**Catastrophic quality performance** occurs when 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.
Center for Medicare & Medicaid Innovation (CMMI)	The **Center for Medicare & Medicaid Innovation (CMMI)** is established under the Affordable Care Act (ACA) to test new payments and service delivery models designed to improve patient care, lower costs, and better align payment systems to promote patient-centered practices.
Centers for Medicare & Medicaid Services (CMS)	The **Centers for Medicare & Medicaid Services (CMS)** is the federal agency that oversees Medicare, Medicaid, Children's Health Insurance Program and Health Insurance Marketplace.

Certified Electronic Health Record Technology (CEHRT)	**Certified Electronic Health Record Technology (CEHRT)** refers to electronic health records that meet established standards and other criteria set by CMS.
Chesapeake Regional Information System for our Patients (CRISP)	**Chesapeake Regional Information System for our Patients (CRISP)** is the State Designated Health Information Exchange (HIE) and Health Data Utility (HDU) for Maryland. CRISP is a program administrator for EQIP.
Close Period	The **close period** is the period following the triggering event, during which all costs related to the trigger are counted.
CMS Vetting	**CMS vetting** refers to the evaluation process conducted by CMS to determine whether a practitioner meets the eligibility criteria for participation in EQIP. CMS Vetting ensures Medicare PECOS is up to date and correct and verifies CMS program integrity.
Composite Quality Score (CQS)	An EQIP Entity's **composite quality score (CQS)** is a weighted calculation to determine the amount of the incentive payment the EQIP Entity has earned back for quality performance.
Current Procedural Terminology (CPT) Code	**Current Procedural Terminology (CPT) codes** are the numerical codes used to identify medical services and procedures furnished by qualified healthcare professionals.
CRISP Participation Agreement (PA)	The **CRISP Participation Agreement (PA)** is a signed agreement between CRISP, each data-contributing "participants" and all other provider and payer organizations that access data. The agreement includes specific provisions governing the use of data and includes a business associate agreement.
CRISP Reporting Services (CRS)	**CRISP Reporting Services (CRS)** provides secure access to Maryland health care data and related analytics tools to assist health care organizations in improving patient care throughout the State.
Dissavings	A clinical episode category generates **dissavings** if the total relevant episode costs exceed the aggregate target price for that clinical episode category.

Documentation of Current Medications in the Medical Record	**Documentation of Current Medication in the Medical Records** is an EQIP quality measure that measures the Percentage of visits for patients 18 years and older for which a clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.
Earned Quality Adjustment	The **earned quality adjustment** is the amount of the incentive payment (i.e., shared savings) earned back for quality performance.
Eligibility Audits	**Eligibility audits** will be conducted by the EQIP Administrative Team and CMS to review and verify whether Care Partners and EQIP Entities meet the required criteria to participate in the program.
Episode Grouper	An **episode grouper** is a public software program that organizes claims data by episodes of care.
Episode Quality Improvement Program (EQIP)	**The Episode Quality Improvement Program (EQIP)** is a voluntary program that engages non-hospital Medicare providers and suppliers in care transformation and value-based payments through an episode-based approach.
EQIP Beneficiary	An **EQIP beneficiary** is a Medicare Patient who receives care related to an EQIP Episode.
EQIP Entity	An **EQIP Entity** is an individual Care Partner or a group of Care Partners that enroll and participate in EQIP together
EQIP Entity Portal (EEP)	The **EQIP Entity Portal (EEP)** is used for EQIP enrollment and provides both EQIP baseline and performance year data.
EQIP Episode	An **EQIP episode** is a defined period of care for a specific medical condition, procedure, or treatment under EQIP.
EQIP Care Intervention	Each EQIP Entity is required to select at least one **EQIP care intervention** for each episode category it selects. The three EQIP Care Interventions are Clinical Care Redesign and Quality Improvement, Beneficiary/Caregiver Engagement, and Care Coordination and Care Transitions.

EQIP Subgroup	MedChi hosts the **EQIP Subgroup** meeting on the third Friday of every other month at 9:00 AM Eastern Time. The meeting is open to all EQIP stakeholders.
Fee-for-Service (FFS)	**Fee-for-service (FFS)** is a payment model in which practitioners are reimbursed based on the volume of services provided.
Final Shared Savings Total	The **final shared savings total** is equivalent to the incentive payment due to the EQIP Entity.
HCPCS code	The **Healthcare Common Procedure Coding System (HCPCS)** is a standardized coding system for classifications of healthcare procedures, supplies and services billed under Medicare and Medicaid.
Health Information Exchange (HIE)	**Health information exchange (HIE)** refers to the electronic sharing of health-related information among different healthcare organizations, providers, and systems.
Health Services Cost Review Commission (HSCRC)	**Health Services Cost Review Commission (HSCRC)** is an independent state agency that aims to ensure all Marylanders have access to high-value and affordable healthcare.
ICD-10-CM Code	The **International Classification of Disease-Tenth Revision-Clinical Modification (ICD-10-CM) code** is a standardized coding system to classify healthcare diagnoses, symptoms and procedures.
Incentive Payment Cap	The **incentive payment cap** for a Care Partner's incentive payment is calculated by CMS for a given program year based on the average Physician Fee Schedule (PFS) payments made to the Care Partner in the prior year.
Lead Care Partner (LCP)	A **Lead Care Partner (LCP)** is a practitioner who initiates the creation of an EQIP entity.
Look-Back Period	The **look-back period** is the period prior to the triggering event, during which all costs related to the trigger are counted.

MedChi, The Maryland State Medical Society	**MedChi, The Maryland State Medical Society** is the statewide professional association for licensed medical doctors and doctors of osteopathy. MedChi's mission is to serve as Maryland's foremost advocate and resource for physicians, their patients and the public health.
Medicare Provider Enrollment, Chain, and Ownership System (PECOS)	The **Medicare Provider, Enrollment, Chain, and Ownership System (PECOS)** is a online platform managed by CMS that facilitates the enrollment process for Medicare providers and suppliers.
Merit-based Incentive Payment System (MIPS)	The **Merit-Based Incentive Payment System (MIPS)** is one track of the Quality Payment Program (QPP) which provides performance-based payment adjustments for the services provided to Medicare patients.
Minimum Savings Threshold (MST)	A **minimum saving threshold** helps ensure that the state awards incentive payments based on actual transformation, rather than on normal, random fluctuations in cost and clinical experience over time. The Minimum Savings Threshold for EQIP is 3%.
National Provider Identifier (NPI)	An **National Provider Identifier (NPI)** is a unique 10-digit identification number issued to healthcare providers in the United States.
PACES	**Patient Centered Episode System (PACES)** was incorporated in 2019, to further update and enhance earlier groupers developed for CMS in efforts to make them available to the market in a more transparent manner. The goal of PACES is to continue developing a clinically sound episode grouper in collaboration with the clinical community and stakeholders. EQIP began utilizing PACES as its episode grouper in PY4 (2025).
Payment Remission Recipient	Any earned incentive payments will be paid to the **payment remission recipient** indicated by the EQIP Entity in the EQIP Entity Portal during the enrollment period.
Performance Year (PY)	A **performance year** is a defined 12-month period in EQIP. PY1 of EQIP was 2022.
Potentially Avoidable Episode Complications (PAEC)	**Potentially avoidable episode complications (PAEC)** are diagnoses or complications during the patient's treatment that indicate the occurrence of a potentially avoidable complication during the episode period.

Preliminary Target Price	**Preliminary target price** is equal to the EQIP Entity's average episode costs during the baseline period, without risk-adjustment, standardized and inflated using data on CMS and HSCRC update factors for each setting of care available at the time of enrollment.
Preventative Care and Screening: Body Mass Index (BMI) and Follow-Up Plan	**The Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan** is an EQIP quality measure that identifies the percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if the most recent BMI was outside of normal parameters.
Qualifying APM Conversion Factor	Beginning in EQIP Performance Year 3 (Calendar Year 2024), QPs will receive a higher Medicare Physician Fee Schedule (PFS) update (**"Qualifying APM Conversion Factor"**) than non-QPs.
Quality Payment Program (QPP)	The **Quality Payment Program (QPP)** was created in 2017 to reward Medicare practitioners who provide high-quality and patient-centered care
Shared Savings Tercile	An EQIP Entity's **shared savings tercile** determines the percent of savings due to the EQIP Entity, and the percent of savings retained by Medicare. *Tier 1: 1st – 33rd percentiles, 50% to EQIP Entity and 50% to Medicare* *Tier 2: 34th – 66th percentiles, 65% to EQIP Entity and 35% to Medicare* *Tier 3: 67th – 100th percentiles, 80% to EQIP Entity and 20% to Medicare*
Trigger	A **trigger**, such as an index hospital stay or procedure during which the initial care was performed, is defined by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code for procedural episodes or International Classification of Diseases-Tenth Revision-Clinical Modification (ICD-10-CM) diagnosis code for acute episodes.
Value-based Care (VBC)	**Value-based care (VBC)** is a healthcare delivery model where providers are reimbursed based on the quality of care they deliver rather than the volume of services they provide.