maryland
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Introduction to Episode Quality Improvement Program (EQIP)

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Introduction

The Episode Quality Improvement Program (EQIP) is operated by Maryland's Health Services Cost Review Commission (HSCRC) as a track under the Total Cost of Care (TCOC) Model, Care Redesign Program (CRP). 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.[1]

The methodology for constructing most EQIP episodes closely reflects the Patient-Centered Episode System (PACES) episode grouper (https://www.pacescenter.org), which uses proprietary algorithms and clinical information to identify and group services related to an episode of care. PACES episodes of care costs include Medicare Parts A and B spending that PACES defines as relevant to the specific type of clinical episode category. EQIP episodes not based on the PACES episode grouper are constructed by the HSCRC, using Medicare claims to identify when episodes begin (or, are "triggered"), and a pre-defined number of days when they end. Non-PACES episode costs include all Medicare Parts A and B spending between the episode's beginning and end dates. To date, EQIP includes 105 PACES clinical episode categories spanning 16 clinical specialty categories and 18 non-PACES clinical episode categories spanning two clinical specialty categories.[2]

General or specialist physicians and other approved practitioners licensed and enrolled in Medicare are eligible to participate in EQIP as a Care Partner. Care Partners can participate individually as an EQIP Entity, or they may join other Care Partners to participate together as one EQIP Entity. Care Partners can participate in an EQIP Entity regardless of their affiliation with other organizations. For example, individual practitioners in a multi-specialty group practice could split up to participate in one or more clinical episode categories aligned with their own clinical specialty.

EQIP participation involves upside-only risk for EQIP Entities. An EQIP Entity generates savings in a clinical episode category if total episode costs are less than the aggregate target price established for that EQIP Entity and clinical episode category. The HSCRC uses a four-step process to determine the EQIP Entity's incentive payment: (1) calculate total program year savings as the cumulative savings across all clinical episode categories it selected, subtracting total dissaving's (if applicable) from the previous program year; (2) check if EQIP's Minimum Savings Threshold is met; (3) determine the Shared Savings amount, and (4) apply a Composite Quality Score Adjustment to that shared savings amount. The EQIP Entity's incentive payment is then assessed for a stop-gain amount, or Incentive Payment Cap. Incentive payments are paid, in total, to EQIP Entities between 9 and 12 months after the end of the program year.

This policy guide provides a high-level overview of EQIP and its objectives and describes the process to reconcile and reward savings. It reflects EQIP policy for Program Year (PY) 5. More detail on EQIP methodology is available here: **EQIP Specifications and Methodology**.

Background

The HSCRC developed the EQIP Program as an episode-based incentive payment model for physicians and other practitioners to increase participation in Advanced Alternative Payment Models (APM) within the State and allow them to align with hospitals under the TCOC Model. By providing incentive payments to participating practitioners based on both financial and quality performance, EQIP aims to:

- Increase physicians' accountability for improving quality of care and reducing healthcare spending related to episodes of care.
- Support and encourage physicians interested in continuously transforming care to align with value-based payment policies and Maryland hospital Global Budget Revenues (GBR).

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[1] For more information on the Episode Quality Improvement Program, please visit our website: https://hscrc.maryland.gov/Pages/Episode-Quality-Improvement-Program.aspx.

[2] In this document, the term "episode of care" refers to a single instance of a type of episode whereas "clinical episode category" refers to the type of episode. For example, a patient's hip replacement on January 4 is an episode of care whereas Hip Replacement is a clinical episode category.

- Reduce episode costs by eliminating unnecessary or low-value care, shifting care to lower-cost settings where clinically appropriate, increasing care coordination, and fostering quality improvement.
- Shift towards physician-focused, value-based care reimbursement to create environments that stimulate rapid development and deployment of new evidence-based knowledge.
- Increase the likelihood of better health at lower cost through patient education and ongoing communication throughout the clinical episode.

EQIP involves three parties: Care Partners, EQIP Entities, and the CRP Entity.

- **Care Partners** are general physicians, specialists, or other CMS-approved practitioners who trigger EQIP episodes.
- **EQIP Entities** consist of an individual Care Partner or a group of Care Partners for whom performance is assessed and to whom incentive payments are issued. Incentive payments are based on the aggregate performance of an EQIP Entity's Care Partners and the EQIP Entity determines the distribution of earned incentive payments among its Care Partners.[3]
- **The CRP Entity** for EQIP, the University of Maryland Medical Center, aggregates Care Partner Agreements and issues incentive payments to the payment remission source indicated by the EQIP Entity. Providers must sign a Care Partner Agreement with the CRP Entity to participate.

The **EQIP Specifications and Methodology** document provides additional information about Care Partners' eligibility for EQIP and the relationship between Care Partners, EQIP Entities, and CRP Entities.

Clinical Episode Categories

The methodology for EQIP episode construction closely reflects the PACES episode grouper, which uses algorithms and clinical information to identify and group services related to a clinical episode. Other aspects of EQIP are determined by CMS and HSCRC policy and the HSCRC's actuarial analysis of historical Medicare claims data. The overall methodology has been tailored to meet the goals of the TCOC Model; requirements of the CRP; and the State of Maryland's needs, unique payment structure, and technical capacity.

EQIP includes 105 PACES clinical episode categories spanning 16 clinical specialty categories (allergy/ENT, behavioral health, cardiology / vascular, dermatology, endocrinology, infectious disease, gastroenterology, general surgery / wound care, hematology / oncology, nephrology, neurology, ophthalmology, orthopedics / musculoskeletal, pulmonology / critical care, rheumatology, and urology) and 18 non-PACES clinical episode categories spanning two clinical specialty categories (emergency department and musculoskeletal). A detailed list of clinical episode categories is included in the detailed methodology document linked above and the EQIP Episode Playbook.[4] Section 3 of the EQIP Specifications and Methodology document provides an overview of the PACES approach to constructing clinical episodes, including a description of the PACES approach to associating procedures, conditions, and sequalae episodes of care and aggregating relative services and payments. HSCRC constructs non-PACES clinical episodes based on HSCRC definitions described in the EQIP Episode Playbook. HSCRC calculates TCOC (as opposed to relevant costs) incurred during non-PACES clinical episodes following the methodology described in Appendix B of the **EQIP Specifications and Methodology** document.

EQIP Entities can choose to participate in one or more clinical episode categories within one specialty area, or multiple clinical episode categories across more than one specialty area. However, EQIP Entities

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[3] CRISP serves as the program administrator for EQIP and developed the EQIP Entity Portal (EEP) for providers to enroll in EQIP, view data, and access resources available to EQIP Entities. EQIP Entities must enroll with CRISP to use the EEP and participate in EQIP. Contact EQIP@crisphealth.org for EQIP application assistance or refer to the CRISP Onboarding Instructions for EQIP (https://www.crisphealth.org/onboarding-training-materials) and the EEP User Guide (accessed through the "help" button in the EEP) for technical assistance.

[4] https://www.crisphealth.org/wp-content/uploads/2025/01/PY4-EQIP-Episode-Playbook-1.2.2025.pdf

must meet a minimum clinical episode volume threshold to be eligible to participate in each type of EQIP episode, as discussed in the next section.

Minimum Episode Volume Thresholds

The HSCRC requires each EQIP Entity to meet three minimum episode volume thresholds **during the baseline period** to ensure they have a sufficient volume of clinical episodes necessary to calculate reliable target prices for each EQIP Entity and clinical episode category. The baseline for PY5 is 2019, except for Emergency Department Episodes which will use 2023. To be eligible to participate in the clinical episode categories they choose:

- Of the NPIs that make up the EQIP Entity, 75% must have at least one claim with a non-excluded beneficiary who triggered a clinical episode in each clinical episode category chosen. *This claim threshold is 50% for EQIP Entities with 10 or fewer Care Partners.*
    - Care Partners who do not have at least one claim during the baseline period will be in probationary status during the program year. Probationary Care Partners are required to have at least one claim during the first two calendar quarters of the program year to be eligible to continue participating in EQIP.
- The EQIP Entity must be attributed 11 or more clinical episodes within each selected clinical episode category (e.g., 11 or more hip replacements during 2019).
- The EQIP Entity must be attributed 50 or more clinical episodes across all clinical episode categories chosen.

If an EQIP Entity does not meet the 75% (or 50%) NPI threshold, then it is required to remove NPIs until they meet that threshold. EQIP Entities that do not meet the 11 minimum episode-volume threshold for a clinical episode category will be excluded from subsequent reporting for those types of episodes during the PY. EQIP Entities that do not meet the overall 50 minimum episode-volume threshold are excluded from participating in EQIP during the PY.

EQIP Methodology

An EQIP Entity's incentive payment is based on its total savings across all clinical episodes attributed to its Care Partners during the program year. Its incentive payment is calculated as its cumulative savings after subtracting total dissavings (if applicable) from the previous program year, and after applying a Minimum Savings Threshold (Step 2), a Shared Savings Rate (Step 3), and adjusting for the EQIP Entity's Composite Quality Score (Step 4). Incentive payments are calculated in accordance with Maryland's agreement with CMS.

Step 1: Reconcile Total Program Year Savings

HSCRC establishes a single target price for each EQIP Entity and clinical episode category. An EQIP Entity generates savings in a clinical episode category if total episode costs are less than the aggregate target price established for that EQIP Entity and clinical episode category. A clinical episode category generates dissavings if the total relevant episode costs exceed the aggregate target price for that clinical episode category. EQIP Entities receive an incentive payment if the sum of the following three amounts positive:

- Positive amounts by which the aggregate performance period costs for each clinical episode category are below the final target price, across all clinical episode categories.
- Negative amounts by which aggregate performance period costs for each clinical episode category are above the final target prices, across all clinical episode categories.
- Dissavings from the prior program year; that is, an aggregate negative sum from the prior year's reconciliation.

Target Price Calculation

The target price is based on the combined total relevant episode costs for each clinical episode attributed to the EQIP Entity's Care Partners during the baseline period (2019 for PY5). An EQIP Entity's target price *for a given clinical episode category* equals the average of total relevant episode costs among all clinical episodes attributed to its Care Partners during the baseline period. Target prices are not adjusted for changes in patient case-mix, geographic variation, or peer comparison.

HSCRC calculates preliminary target prices for each EQIP Entity in each clinical episode category it elects. Preliminary target prices are standardized and inflated using the existing data on CMS and HSCRC update factors for each setting of care. They are available to be viewed in the EQIP Entity Portal (EEP) once the program year begins. Final target prices are calculated at reconciliation; standardized and adjusted for inflation based on the *final* CMS and HSCRC update factors for each setting of care.

Dissavings Policy

The HSCRC will not incorporate downside risk in EQIP because it does not have the ability to directly adjust physician fee-for-service payments. However, to ensure EQIP drives meaningful improvements in cost efficiency and quality and maintains fidelity to CMS Quality Payment Program standards, EQIP Entities are held accountable for dissavings, year over year, to incentivize efficiency and quality improvement:

- **Annual Accountability:** EQIP Entities that generate dissavings in a PY are required to offset that dissavings in the following PY, prior to earning an incentive payment.
- **Removal Accountability:** 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 it elects ranks in the lower two terciles of the tiered Shared Savings Rate (described below).

Step 2: Minimum Savings Threshold

A Minimum Savings Threshold helps ensure that the State awards incentive payments based on actual care transformation, rather than on normal, random fluctuations in costs and clinical experience over time. The Minimum Savings Threshold for EQIP establishes the percentage of savings that an EQIP Entity must first achieve before that EQIP Entity is eligible to receive incentive payments. If the Minimum Savings Threshold is met, then the total amount that the EQIP Entity saved during the program year is counted when calculating its incentive payment. **The Minimum Savings Threshold for EQIP is 3%.** Meaning that an EQIP Entity's PY savings must meet or exceed 3% of its Aggregated Target Price – the total volume of clinical episodes it was attributed in each clinical episode multiplied by its final target price for each category, summed over all clinical episode categories – before it is eligible to receive incentive payments.

Step 3: Tiered Shared Savings Rate

EQIP Entities and Medicare share the savings generated during the PY. The incentive payment to an EQIP Entity is a tiered portion of its total savings, based on the Entity's efficiency compared to baseline data on the same type of clinical episodes triggered statewide. The tiered shared savings provides low-cost, high-efficiency EQIP Entities with an opportunity to keep more savings when episodes have already been optimized, while providing high-cost, low-efficiency EQIP Entities with an incentive to improve relative to the efficiency of its peers.

For each clinical episode category, the EQIP Entity's total episode costs during the baseline period will be ranked among all other practitioners in the State that triggered the same types of episodes. The EQIP Entity will receive a single "blended" ranking based on its total costs across all clinical episode categories in which it participates, during the baseline period. Higher costs result in a lower percentile ranking, and lower costs result in a higher percentile ranking. EQIP Entities will be re-ranked each program year based on baseline year (2019) data but adjusted to their current list of Care Partners.

The Shared Savings Rates in Exhibit 1 is applied based on the tercile in which an EQIP Entity's blended performance falls (percentiles will be rounded to two decimal points to determine percentile rank). HSCRC provides a detailed description of its statewide ranking methodology in Section 6.1 of the EQIP Specifications and Methodology document.

Exhibit 1. Shared Savings Rates, by EQIP Entity Rank Percentile

	EQIP Entity Rank Percentile	Savings Paid to EQIP Entity	Savings Retained by Medicare
Tier 1	1st – 33rd percentiles	**50%**	50%
Tier 2	34th – 66th percentiles	**65%**	35%
Tier 3	67th – 100th percentiles	**80%**	20%

Step 4: Composite Quality Score Adjustment

After the Shared Savings Rates are determined for each EQIP Entity, the resulting savings paid to the EQIP Entities is subject to the Composite Quality Score adjustment. Quality adjustment is required as a part of EQIP's Advanced APM status. By tying payment to performance on quality measures, EQIP incentivizes providers to improve quality of care while also improving efficiency.

EQIP includes a 5% "earn-back" adjustment on incentive payments. The final Shared Savings Amount is reduced 5%, and 0 to 100% of that 5% withholding is returned to the EQIP Entity based on its quality performance (which is measured as a percentage). For each clinical episode category in which the EQIP Entity participates, three quality measures are weighted to calculate a Composite Quality Score, which determines the amount of the incentive payment (i.e., shared savings) earned back for quality performance.

For each attributed episode, regardless of clinical episode category, the HSCRC assesses whether the following three measures were performed, *by any physician*, within 364 days *preceding* the end of the episode:

- ***Advance Care Plan*** **(NQF #326)[5]**
- ***Documentation of Current Medications in the Medical Record*** **(NQF #419)[6]**
- ***Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*** **(MIPS #128)[7]**

The Composite Quality Score adjustment is calculated as follows:

1. **Score by Quality Measure.** Each quality measure is scored at the EQIP Entity level and worth up to 10 points.

[5] CMS QPP Quality Measures Specification, Claims Registry Measures, Quality ID #47 (NQF 0326), Advance Care Plan, https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2024_Measure_047_MedicarePartBClaims.pdf

[6] CMS QPP Quality Measures Specification, CQM Measures, Quality ID #130, Documentation of Current Medications in the Medical Record, https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2024_Measure_130_MIPSCQM.pdf

[7] CMS QPP Quality Measures Specification, CQM Measures, Quality ID #128, Preventive Care and Screening, Body Mass Index (BMI) Screening and Follow-Up Plan, https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2024_Measure_128_MIPSCQM.pdf

2. **Determine Aggregate Measure Score.** An EQIP Entity can receive up to 30 points (three measures, 10 points each).
3. **Convert Aggregate Score to Percentile.** The Composite Quality Score equals the sum of points earned on all three quality measures, divided by the maximum number of points available for the program year (30 points). The Composite Quality Score is calculated at the EQIP Entity level and expressed as a percentage ranging from 0 to 100.

The process of assigning quality points to each quality measure, called "scoring," is based on the EQIP Entity's quality performance during the program year, relative to set thresholds. HSCRC provides a detailed description of this process in Section 7.3 of the EQIP Specifications document.

The EQIP Entity's incentive payment will equal 95% to 100% of its calculated Shared Savings Amount, depending on its Composite Quality Score ($CQS_{EQIP\ Entity}$):

$$\boldsymbol{Incentive\ Payment} = (\boldsymbol{Shared\ Savings} * .\mathbf{95}) + \left(\boldsymbol{Shared\ Savings} *.\mathbf{05} * \boldsymbol{CQS_{EQIP\ Entity}}\right)$$

Incentive Payments

The Incentive Payment after the Composite Quality Score adjustment is assessed for a stop-gain amount, or Incentive Payment Cap. The cap for a Care Partner's incentive payments 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. Per the Participation Agreement, **the Care Partner Incentive Payment Cap is 25% of the Average Care Partner PFS Expenditures for the preceding calendar year**.

CMS calculates the Average Care Partner PFS Expenditures as follows:

- **Step 1:** Sum all Medicare PFS payments made during the previous calendar year (CY) for Part B covered services provided by all Care Partners in the EQIP Entity during the preceding CY.
- **Step 2:** Divide the amount in Step 1 by the total number of Care Partners in the EQIP Entity.

The EQIP Entity's Incentive Payment Cap is equal to the Average Care Partner PFS Expenditures multiplied by 0.25, then multiplied by the number of Care Partners in the EQIP Entity. If the EQIP Entity's incentive payment due exceeds its Incentive Payment Cap, the EQIP Entity will receive only the capped amount for the program year.

After reconciliation of total savings, application of the tiered Shared Savings Rate, Composite Quality Score adjustment, and comparison of the incentive payment amount to the Incentive Payment Cap, the final incentive payment due to the EQIP Entity is determined. The Incentive Payment will be paid in total to the EQIP Entity between 9 and 12 months after the completion of the program year. The incentive payment will be paid to the payment remission recipient indicated by the EQIP Entity in the EEP.

Removal from EQIP

EQIP is a voluntary program that requires an initial Agreement and annual consent to participate thereafter. EQIP Entities are expected to maintain updated Care Partner documentation in the EEP. Should a Care Partner wish to be removed from an EQIP Entity, or an EQIP Entity no longer wishes to participate in EQIP altogether, it will be required to update the HSCRC via the EEP within the annual enrollment window, from July 1 through December 31. EQIP Entities cannot be removed from the program during a program year.

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 (Section 1.2.1 of EQIP Specifications document).

- Failure to provide care or compliance in conjunction with the Agreement (Section 1.2.1 of EQIP Specifications document).
- The EQIP Entity's Rank Percentile (Section 6 of EQIP Specifications document) 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 (Section 7 of EQIP Specifications and Methodology document), 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. The second year will be evaluated based on quality performance during the first two calendar quarters of the program year to be eligible to continue participating in EQIP.

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