

Episode Care Improvement Program (ECIP) Track Implementation Protocol

January 2026 – December 2026

Hospital Name: _____

Submission Date: _____

A. Introduction

The Episode Care Improvement Program (ECIP) is a voluntary track under the Care Redesign Program (CRP) designed to allow a hospital to link payments across providers during an episode of care. To participate in ECIP, hospitals must sign a CRP Participation Agreement with the State of Maryland and the Centers for Medicare and Medicaid Services (CMS). Maryland modeled ECIP on CMS's Bundled Payments for Care Improvement Advanced (BPCI Advanced) program. CRP provides fraud and abuse waivers—relating to Federal physician self-referral law and Federal anti-kickback statute—to a hospital that has signed a CRP Participation Agreement. The waivers enable the hospital to make incentive payments and/or provide intervention resources to the Care Partners certified under ECIP.

Episodic payment models bundle payments to health care providers for certain items and services furnished during an episode of care. ECIP's episodic payment approach aligns incentives across hospitals, physicians, post-acute care facilities, and other providers to generate savings and improve quality. Better care management during episodes has the potential to eliminate unnecessary care and reduce post-discharge emergency department visits and hospital readmissions. ECIP requires hospitals to share earned incentive payments with their Care Partners, or provide a significant amount of care management resources or other intervention resources to their care partners. Additional information on the episodic payment approach can be found in Appendix A.

ECIP promotes the following objectives:

- **Financial Accountability:** Create extended financial accountability for the outcomes of improved quality and reduced spending, in the context of acute and chronic episodes of care.
- **Care Redesign:** Support and encourage hospitals and their Care Partners who are interested in continuously reengineering care.
- **Data Analysis and Feedback:** Decrease the cost of a clinical episode by eliminating unnecessary or low-value care, increasing care coordination, and fostering quality improvement.
- **Health Care Provider Engagement:** Create environments that stimulate rapid development of new evidence-based knowledge.
- **Patient and Caregiver Engagement:** Increase the likelihood of better health at lower cost through patient education and ongoing communication throughout the clinical episode.

For CY 2023 and beyond, key elements of ECIP evolved to align with Maryland Care Transformation Initiative (CTI) policy. CTIs reward hospitals for generating total cost of care savings through the interventions they deploy. The HSCRC treats each ECIP clinical episode categories as a 90-day Care Transitions CTI in which the anchor event is excluded from the episode. ECIP episodes take precedence other CTI definitions—the HSCRC does not allow a hospital to have overlapping episodes.

B. Hospital Role and Responsibilities

A hospital participating in ECIP will act as the “episode initiator,” facilitating coordination with and among Care Partners. The hospital shall select the clinical episodes for which it will commit to be held accountable and must put into effect the core components of ECIP: (1) implementing Allowable ECIP Interventions (e.g., care delivery enhancements such as reengineered care pathways using evidence-based medicine, standardized care pathways); (2) engaging Care Partners; (3) using CEHRT; (4) notifying patients about the program; and (5) required reporting.

(1) Allowable ECIP Interventions. Allowable ECIP Interventions in this CRP are activities and processes the hospital may select and implement to improve care and lower costs under ECIP. The table below shows Allowable ECIP Interventions, which will be selected by hospitals in their online Implementation Protocols, along with any others proposed by the hospital. Upon initially joining ECIP or after selecting new episodes, hospitals may take up to a quarter for planning prior to implementation, and this may be reflected in associated reporting for that first quarter. However, after this grace period, hospitals must implement interventions and submit intervention measurement data to the HSCRC in order to qualify for shared savings payments and to distribute care partner incentive payments.

Allowable ECIP Interventions

Intervention Category	Intervention
Clinical Care/ Care Redesign	• Standardized, evidence-based protocols are implemented, for example for discharge planning and follow-up care.
	• Implementation of enhanced coordination with post-acute care providers.
	• Interdisciplinary team meetings address patients’ needs and progress.
	• Pharmacists embedded on unit.
Beneficiary/ Caregiver Engagement	• Patient education is provided pre-admission and addresses post-discharge options.
	• Shared decision-making processes and/or tools are implemented to help patients assess treatment options.
	• Methods for fostering "health literacy" in patient/family education are implemented.
	• Patient supports, items, and/or services are furnished to beneficiaries.
Care Coordination and Care Transitions	• Patient risk assessment/stratification is used to target services.
	• Assignment of a care manager/ coordinator/ navigator to follow patient across care settings (e.g., to help coordinate follow-up appointments and to connect patient to needed community resources).

Intervention Category	Intervention
	• Performance of medication reconciliation. • Remote patient consultation monitoring.

(2) **Engagement of Care Partners.** The hospital will invite eligible Care Partners to participate in ECIP. In accordance with the PA and the CRP Calendar, hospitals must vet prospective Care Partners with CMS on an annual basis and must submit lists of certified Care Partners—i.e., those Care Partners that have signed Care Partner Arrangements—to the HSCRC and CMS on a semi-annual basis. Hospitals must certify Care Partners by the second certification period of the year. Hospitals may only share incentive payments with care partners who were certified for the period of performance.

(3) **Health Information Technology (HIT).** Use of CEHRT is a required program element for hospitals and Care Partners to document and communicate clinical care with patients and other health care professionals. HIT will enable quality measurement, reporting and feedback, and use of electronic health records (EHRs) as a part of care redesign across treating health care providers.

(4) **Patient Notification.** All patients admitted to a hospital participating in ECIP will receive information stating that the hospital and its medical staff are participating in CRP. The notice should indicate that Care Partners and hospitals may receive financial incentives when meeting specific performance goals of improving quality, streamlining care, and reducing spending. ECIP does not allow beneficiaries to “opt out” of the payment methodology. However, the initiative will not affect beneficiaries’ freedom to choose their health care provider, meaning that beneficiaries may elect to see a provider or supplier that does not participate in ECIP.

(5) **Monitoring and Reporting.** The State will measure and monitor care in hospitals’ selected ECIP episodes to ensure that objectives are met in redesigning care, achieving quality measure thresholds and patient experience-of-care standards, and demonstrating improved care coordination. As described in Appendix A, the State will adjust a hospital’s reconciliation amounts based on the hospital’s quality performance on applicable quality measures. The State will also produce additional metrics to evaluate the overall performance of ECIP:

- 30-day all-cause readmission rates;
- 90-day all-cause readmission rates;
- 30-day emergency room visit rates post discharge;
- 90-day emergency room visit rates post discharge;
- 7-day follow up with physician (specialist or PCP);
- Average hospital LOS during anchor stay; and

- Average LOS in post-acute facility.

Hospitals will be expected to provide the State with ongoing monitoring information according to the CRP Calendar schedule (via “CRP Reports”) by tracking and reporting various measures of performance improvement efforts and operational metrics, including aggregate performance on Allowable Interventions, the number of Care Partners participating in ECIP and any Incentive Payment amounts made to Care Partners. Hospitals must report experience within two quarters of joining ECIP or selecting new episodes (that is, after a one-quarter grace period for intervention planning prior to implementation).

The interventions, targets, and conditions of payment included in CRP Reports must be consistent with the interventions and measures indicated by hospitals in the online Implementation Protocol. Hospitals sharing incentives with Care Partners will internally track individual Care Partners performance on conditions of payment. For each episode category, hospitals will report Care Partner performance on conditions of payment as an aggregate for the provider category (e.g., 80% of physicians met a given conditions of payment). Hospitals sharing incentives with Care Partners must attest that incentives will be paid in accordance with the Participation Agreement and Implementation Protocol. Hospitals that are providing intervention resources in lieu of sharing incentives with Care Partners do not need to report whether Care Partners met conditions of payment. However, these hospitals must still report on interventions, progress towards targets, and the fair market value of care management resources or other intervention resources provided to Care Partners.

If hospitals wish to make changes to their interventions or measures during the performance period, they must first request approval by emailing care.redesign@crisphealth.org and formally amend their Implementation Protocol accordingly.

C. ECIP Incentive Payments to Hospitals

A semi-annual reconciliation compares actual Medicare fee-for-service (FFS) expenditures for all completed clinical episodes attributed to the hospital to the final target price for those clinical episodes (subject to adjustments based on quality performance). Reconciliation occurs at the hospital level, across all episodes. The hospital earns ECIP savings If the sum of the following is positive:

- Positive amounts by which Medicare expenditures for selected clinical episodes are below the target prices of those episodes, and
- Negative amounts by which Medicare expenditures for selected clinical episodes are above the benchmark prices for those episodes.

A component of the Medicare Performance Adjustment (MPA) adjusts Medicare payments to hospitals based on their CTI performance.¹ For CY 2023 performance and beyond, a hospital's ECIP performance is aggregated with the performance of other CTIs for the period, as described in the [CTI Introduction Policy Guide](#).

Hospitals may keep the full aggregated ECIP and CTI savings they produce below the target price; however, hospitals are required to exceed a minimum savings threshold before the State makes any payments. The minimum savings rate is based on the total volume of ECIP and non-panel CTI episodes completed during a given six-month period. The variable minimum savings rate based on aggregate episode volume is included as Exhibit 25 in [CTI Specifications and Methodology](#) (Minimum Savings Rate % and Episode-Based CTI Volume).

This is illustrated in the example below.

Example of Performance Assessment

- Baseline period episode payment benchmarks:
 - DRG A: \$15,000
 - DRG B: \$10,000
- Episode target prices:
 - DRG A: \$15,000 (\$15,000 x 100%)
 - DRG B: \$10,000 (\$10,000 x 100%)
- Aggregate actual performance year episode payments:
 - DRG A: \$14,300 across 25 episodes (\$14,300 x 25 = \$357,500)
 - DRG B: \$9,500 across 50 episodes (\$9,500 x 50 = \$475,000)
 - Total: \$832,500 (\$357,500 + \$475,000)
- Aggregate target price = \$15,000 x 25 + \$10,000 x 50 = \$875,000
- ECIP savings = \$875,000 - \$832,500 = \$42,500
- MSR for 75 ECIP episodes + 300 CTI episodes (assumed, for example) = 4.0%
- Minimum savings threshold = 4% * \$875,000 = \$35,000
- \$42,500 > \$35,000, ECIP shared savings payment of \$42,500 earned

ECIP payments for the period July through December 2022 were the final set of results identified separately from CTI. Results for January through June 2023 will be incorporated into aggregate CTI performance with payments reflected in the July 2024 MPA adjustment. Quality and post-episode monitoring for January through June 2023 will be available in Fall 2024 and reflected in the July 2025 MPA adjustment.

¹ Described in the "[Final Recommendation for the Medicare Performance Adjustment Framework](#)" from the October 2019 Commission meeting.

ECIP results for July through December 2023 will be available in Fall 2024 with quality and post-episode monitoring adjustments available in Spring 2025. ECIP results will be incorporated into aggregate CTI performance with payments reflected in the July 2025 MPA adjustment.

D. Care Partner Role and Responsibilities

Care Partners provide care under the ECIP initiative, participate in Allowable ECIP Interventions, and are paid separately by Medicare for their services. Hospitals may vet and certify Care Partners from the following provider types:

- General or specialist physician or physician group practice;
- Clinical nurse specialist or nurse practitioner;
- Physician assistant;
- Physical therapist;
- Skilled nursing facility (SNF);
- Home health agency;
- Long term care hospital;
- Hospice; and
- Inpatient rehabilitation facility.

Each potential Care Partner must meet, at a minimum, the following Care Partner Qualifications specific to ECIP in addition to the Care Partner requirements described in the Participation Agreement:

- (1) A clinician must have a National Provider Identifier (NPI) and a facility must have a Taxpayer Identification Number (TIN);
- (2) The provider must participate in the Medicare program;
- (3) The provider must be licensed;
- (4) The provider must use CEHRT and CRISP, Maryland's health information exchange; and
- (5) The provider will be subject to a federal vetting process; while hospitals can opt to engage Care Partners at the physician group practice level, all members of the group must be vetted and certified individually.

Care Partners must sign a Care Partner Arrangement with the hospital and comply with all applicable requirements under the Participation Agreement. Hospitals must certify Care Partners by the second certification period of the year.

A Care Partner may participate in multiple hospitals' ECIP programs. ECIP Care Partners who meet the requirements of the Maryland Primary Care Program (MDPCP) are not prohibited from participating in both MDPCP and ECIP.

E. Incentive Payment Methodology: Incentive Payment Pool Development, Care Partner Incentive Payments

On a semi-annual basis, a hospital must share savings with Care Partners consistent with the hospital's Implementation Protocol. A hospital may pay incentives to Care Partners out of the hospital's global budget in accordance with the terms of this Implementation Protocol to enable more timely distributions to Care Partners. A hospital may pay incentives out of the hospital's global budget to Care Partners that met targets within a given clinical episode category even if the net hospital savings across clinical episode categories was zero. Refer to **Appendices B and C** for additional details.

A hospital may make sharing of ECIP incentives with Care Partners contingent on the hospital's aggregate ECIP and CTI performance. A hospital may choose to forgo payment of ECIP incentives to Care Partners if the hospital does not attain aggregate CTI rewards. To adopt this approach, the hospital must state in its ECIP Implementation Protocol that ECIP incentives will be shared with Care Partners only if the hospital attains aggregate CTI rewards in excess of the amount of ECIP incentives to be distributed to Care Partners. Regardless of CTI performance, a hospital cannot increase ECIP incentives to Care Partners beyond what is described in the ECIP Implementation Protocol.

The following steps form the conceptual basis for ECIP Incentive Payments to Care Partners. The hospital will describe its approach to sharing incentive payments and intervention resources with Care Partners in its online Implementation Protocol. The following steps are illustrated in an example in Appendix B.

- (1) **Maximum Eligible Payment to Care Partners.** In the Implementation Protocol, each hospital elects whether to distribute Incentive Payments to qualifying Care Partners. If the hospital elects to make such payments, the hospital enters the maximum share of any positive savings it is making available for Incentive Payments. Once the State determines each participant's shared savings (net reconciliation) amount for a reconciliation period, it will calculate each participant's Shared ECIP Incentive Payment Fund, for each clinical episode category. The Shared ECIP Incentive Payment Fund is the product of the hospital's positive savings achieved and the maximum share the hospital elects to share, per C. ECIP Incentive Payments to Hospitals. Regardless of the maximum share selected, payments to Care Partners from the ECIP Incentive Payment shall not exceed the Incentive Payment Pool described in step 6.
- (2) **Distribution Proportions Among Care Partners.** Each hospital will select Incentive Payment distribution proportions among the nine available Care Partner types for each episode category. A hospital may elect to make available incentives to some or all of the participating Care Partner types. As an example, for the major joint replacement of the lower extremity (MJRLE) episode category, a hospital may reserve 50% of the incentive pool for individual physicians or physician group practices, 25% for SNFs, and 25% for HHAs. A hospital may

choose to use the same distribution across all or some episodes, or set individual distributions by episode category.

- (3) **Establishment of Care Partner Conditions of Payment.** A hospital will further designate at least one condition of payment per care redesign intervention for each clinical episode category and each Care Partner type. In order to qualify for incentive payments, a Care Partner must perform the required Allowable ECIP Interventions and meet the condition(s) of payment. These conditions of payment may be uniform across episodes and Care Partner types or tailored to specific segments. Each condition of payment may be given its own weight by the hospital, or all conditions of payment may have equal weight, at the hospital's election. For each episode category, hospitals will report Care Partner performance on conditions of payment as an aggregate for the provider category (e.g., 80% of physicians met a given condition of payment).
- (4) **Episode Attribution to Care Partners.** During the performance year, the HSCRC will attribute each individual clinical episode to a single Care Partner within each participating provider category (e.g., physician, SNF). Episodes will be weighted using the APR DRG weight for that episode. Available Incentive Payment totals within a Care Partner type will be allocated based on the aggregation of these weights. Hospitals will apply each Care Partner's performance on conditions of payment and the conditions of payment weights to the Available Incentive Payment total to calculate the Care Partner's Incentive Payment.
- (5) **Incentive Payment Cap.** The Incentive Payment is then capped at the stop-gain limit for that provider type to arrive at the final Incentive Payment. If the Care Partner is a physician or non-physician practitioner, the hospital must work with the HSCRC to ensure that the total amount of Incentive Payments distributed to the Care Partner does not exceed the Physician Incentive Payment Cap as determined by CMS, in accordance with the CRP Participation Agreement. Per the Participation Agreement, the Physician Incentive Payment Cap is twenty-five percent (25%) of the Average Care Partner Physician Fee Schedule Expenditures for the preceding calendar year. The Incentive Payment Cap for SNFs, home health agencies, long term care hospitals, hospices; and inpatient rehabilitation facilities is fifty percent of the Incentive Payment Pool described in (6) below.
- (6) **Incentive Payment Pool Development and Application.** The ECIP Incentive Payment Pool, established by the HSCRC and approved by CMS, will serve as a limit on the aggregate incentive amount that hospitals can distribute to participating Care Partners based on performance in a reconciliation period. HSCRC will set the Incentive Payment Pool that hospitals may distribute to their Care Partners equal to the hospitals actual, positive performance in each episode. The ECIP Incentive Payment Pool is calculated after each semi-annual performance period.

A hospital's ECIP Incentive Payment Pool is based on only those clinical episode categories in which the hospital achieved savings (yielded a positive reconciliation amount). A hospital's ECIP Incentive Payment Pool is the sum of the savings achieved in such clinical episode categories (that is, its savings in Potentially Avoidable Utilization, or PAU Savings), adjusted by the Quality Adjustment Score used in the MPA (based on readmissions and hospital-acquired conditions at a minimum), in accordance with the State's agreement with CMS.

Each hospital must ensure that aggregate incentives paid to Care Partners do not exceed its ECIP Incentive Payment Pool. If the amounts calculated for Incentive Payments exceed the hospital's Incentive Payment Pool amount, the Incentive Payments will be reduced by a flat percentage so Incentive Payments do not exceed the hospital's Incentive Payment Pool.

Track Implementation Protocol Instructions

Please complete all required sections of this Track Implementation Protocol.

Section 1, Hospital provides general information.

Section 2, Hospital provides a description of the key personnel and the CRP Committee responsible for ECIP.

Section 3, Hospital provides information on the model plan.

Section 4, Hospital explains plans for making Incentive Payments to Care Partners (if applicable).

1. Hospital Information

Date of Track Implementation Protocol Submission:

Organization Name and D/B/A:

TIN:

CMS cert #(s) for organization:

Point of Contact:

	Hospital
Name:	
Title:	
Street Address:	
City, State, Zip:	
Telephone:	
Fax:	
Email:	

Name the key personnel and describe the function of the key management personnel for ECIP:

Key Personnel	Title	Program Role/Responsibilities

2. CRP Committee

Provide the names of your CRP Committee members. During each performance period, at least one CRP Committee member must be a Medicare FFS beneficiary living in the hospital's service area.

Name, Credentials	Job Title and Organization, if applicable	Check if Care Partner Rep	Check if Medicare Bene Rep
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Provide an explanation of the following.

Please answer the following questions about how the CRP Committee will provide oversight, guidance, and management for ECIP.	
1. How often will the CRP Committee meet? (monthly, bi-monthly, quarterly, bi-annually)	
2. How often will the CRP Committee receive progress/ dashboard reports on program performance? (monthly, bi-monthly, quarterly, bi-annually, annually)	
3. How will the CRP Committee assist hospitals in selecting the allowable clinical episodes?	
4. How will the CRP Committee assist hospitals in selecting the Allowable ECIP Interventions?	
5. How will the CRP Committee provide a forum for sharing ideas, identifying problems, and developing solutions between the hospital and its Care Partners?	

Please answer the following questions about how the CRP Committee will provide oversight, guidance, and management for ECIP.	
6. How will the CRP Committee offer the internal leadership to ensure the integrity of and opportunity for success of the CRP and each CRP Track in which the Hospital is participating?	
7. How will the CRP Committee conduct a qualitative analysis on the status of the Allowable ECIP Interventions and offer suggestions to the hospital on how implementation could be improved?	

3. ECIP Model Plan

Please briefly explain how the elements listed below will be executed.

Category	Changes to Current Care Model	Describe Program at a High Level (≤ 200 words)
Infrastructure and HIT	Please describe your process for engaging Care Partners.	
	How will you use CEHRT to document and communicate clinical care with patients and other health care professionals?	
	How will use of Electronic Health Records (EHRs) as a part of care redesign across treating health care providers help ensure coordination of care across settings?	
	How will use of HIT enable quality measurement, reporting and feedback?	
Data	Please describe how your hospital will utilize monthly CMS data files in the care redesign program.	
	Please describe how data will be used to support Incentive Payments and processes.	
Care Redesign Processes	Please describe how your hospital will identify opportunities for improvement.	
	Please describe the monitoring and reporting process.	

Category	Changes to Current Care Model	Describe Program at a High Level (≤ 200 words)
	Please describe your processes for communicating and educating physicians and clinical staff regarding ECIP.	
	Please describe how you will use feedback from Care Partners in order to improve Allowable ECIP Interventions.	

Define your process and frequency for monitoring a Care Partner's completion of the Allowable ECIP Interventions. How will you ensure that medically necessary care is not reduced in an effort to reduce Medicare FFS expenditures?

How will you communicate allowable ECIP intervention performance results to Care Partners and the CRP Committee?

4. Incentive Payments and Intervention Resources

Please indicate whether your hospital is sharing Incentive Payments with Care Partners and/or providing Intervention Resources:

☐ Intervention Resources

☐ Incentive Payments

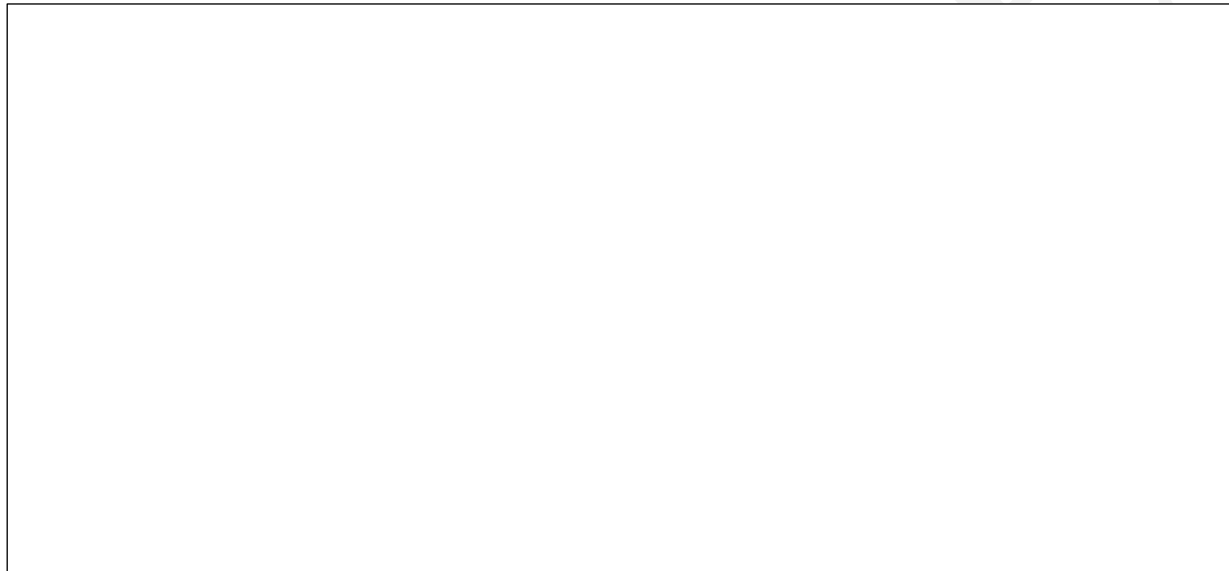
If you are not making incentive payments, you must provide Intervention Resources to care partners to be eligible for participation. For Intervention Resources, in the box below, please:

(1) provide the aggregate annual fair market value of intervention resources provided to ECIP certified Care Partners,

(2) indicate for each care partner type (physician, nurse specialist/practitioner, PA, PT, SNF, HHA, LTC Hospital, Hospice, IRF) the category of resources provided (CHW/navigator services, 24/7 provider support, standardized protocols or care pathways, coordination with PAC providers, interdisciplinary team meetings, patient/family education, medication reconciliation, remote patient monitoring, other), and

(3) if “other” category of intervention resources please describe.

Hospitals will provide information on Intervention Resources shared with care partners in their CRP Reports submitted twice a year.



For Incentive Payments, please complete the following sections.

Do you attest that Incentive Payments to Care Partners will be paid in accordance with the Participation Agreement and Implementation Protocol?

Yes ☐ No ☐

Please describe the process by which you will distribute the Incentive Payments to Care Partners, including, for example, the timing and periodicity of payments, the entities issuing the payments, the method for distributing payments to Care Partners, form of payments, and the documentation of payments.

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Appendix A: Episodic Payment Approach: Clinical Episodes and Target Prices

ECIP will use a prospective bundled payment approach where FFS payments are made as usual and the total FFS payments for clinical episodes are then retrospectively reconciled against a target price based on the historical price for the episodes updated for inflation. The HSCRC will base the list of clinical episodes on the inpatient clinical episodes included in the federal BPCI Advanced program. The BPCIA clinical episode categories are mapped from MS-DRGs used in the federal program to APR DRGs, which are more familiar to Maryland hospitals, resulting in 23 clinical episode categories for ECIP.

Similar to federal policy, ECIP hospitals must have sufficient volume during the baseline period to be able to participate in a given episode category. Hospitals with fewer than 30 episodes for a particular category are ineligible to participate in that bundle and will not receive target prices for those episode categories.

Participating hospitals will complete and submit to the HSCRC an online Implementation Protocol, in which hospitals will identify which clinical episodes they choose to participate in and the Care Partner types involved in each of the clinical episode categories.

Clinical episodes are triggered by the submission of a claim for an inpatient hospital stay (referred to as an anchor stay). Episodes begin upon discharge from the anchor stay and extend 90 days starting on the day of discharge. See Appendix B for additional detail on the items and services included in the clinical episodes.

The State will provide preliminary target prices to potential hospitals prospectively to enable them to evaluate their ability to improve the cost and quality of care prior to their commitment to be held accountable for a clinical episode. The target will be based on a benchmark price, calculated using the historical Medicare FFS expenditures for most items and services furnished during the clinical episode during a specified baseline period (Maryland FY 2019), updated to reconciliation year dollars. Based on the total, actual Medicare FFS expenditures for that clinical episode relative to the total aggregate target price, hospitals have the opportunity to earn an ECIP Incentive Payment, to be paid through the MPA.

The State will conduct semi-annual reconciliation against these prospectively determined clinical episode-specific target prices. All positive and negative reconciliation amounts will be netted across all clinical episodes attributed to the hospital to calculate the total reconciliation amount. If, during the semi-annual reconciliation process, all non-excluded Medicare FFS expenditures for a clinical episode category in which the hospital is participating are **less than** the final **target price** for that clinical episode, this results in a **positive reconciliation amount**. By contrast, if all non-excluded Medicare FFS expenditures for a clinical episode are **greater than** the final **benchmark price**, this results in a **negative reconciliation amount**. Although episodes' poor performance can offset or even zero out any potential ECIP payments to hospitals, ECIP has no downside risk to hospitals; that is, no payments will be required from hospitals due to ECIP performance. Hospitals

may keep the full savings they produce below the target price; however, hospitals must exceed the minimum savings threshold before the State pays out any savings.

In instances of intra-ECIP episode overlap, the State will give prioritize the initial ECIP episode based on trigger data and remove the subsequent episode with a later trigger date. In instances of episode overlap between CTI and ECIP, the State will prioritize ECIP.

ECIP incentive payments to hospitals will be capped at 20% of the volume-weighted sum of final target prices across all clinical episodes netted to the episode initiator level. In the federal programs, this is referred to as a stop-gain amount.

A reconciliation appeals and management process will be maintained to address any issues raised by participants or the State with regard to incorrect payments or payments made based on incorrect information. This will include a record of all payments made to hospitals, distributed to Care Partners, and any adjustments made to such.

Accountability for Quality Performance

The State will adjust a hospital's reconciliation amounts based on the hospital's quality performance on the applicable quality measures. Adjusting payment for quality performance helps align resources while ensuring that cost saving strategies do not lower the quality of care for beneficiaries.

The two quality measures that apply to all clinical episodes are:

- All-cause Hospital Readmission Measure (NQF #1789); and
- Advanced Care Plan (NQF #0326)

The five clinical episode-specific quality measures, in accordance with CMS methodology, are as follows:

- Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268);
- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550);
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558);
- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881); and
- AHRQ Patient Safety Indicators (PSI 90).

Appendix B: Clinical Episode Approach

ECIP will operate under a total-cost-of-care concept, based on the implementation of the national BPCI Advanced program, in which the total Medicare FFS spending on items and services furnished to a beneficiary during the clinical episode will be part of the clinical episode expenditures for purposes of the target price and semi-annual reconciliation calculations, unless specifically excluded.

Episodes begin upon discharge from the anchor stay and extend for 90 days, including the day of discharge. Anchor stay expenditures are excluded from the clinical episode.

Inclusions: Each clinical episode will include Medicare FFS expenditures for:

1. Part A and Part B items and services (adjusted per CTI GBR fix)
2. Part A and Part B non-excluded items and services furnished in the 90-day period following discharge from the anchor stay, including hospice services.

Exclusions: Clinical episodes will exclude those Medicare FFS expenditures for:

1. New technology add-on payments under the IPPS; and
2. Payment for blood clotting factors to control bleeding for hemophilia patients.

In addition, Medicare FFS expenditures on items and services furnished to Medicare beneficiaries covered under managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations), to Medicare beneficiaries eligible on the basis of end-stage renal disease (ESRD); to Medicare beneficiaries for whom Medicare is not the primary payer, and to Medicare beneficiaries who died during the anchor stay are also excluded.

Clinical Episode Category List: The 23 inpatient clinical episode categories listed below are similar to the 29 clinical episodes used in the federal Bundled Payments for Care Improvement Advanced program, but mapped to the APR DRGs more commonly used in Maryland and excluding some bundles used in due to low volume (e.g., cardiac defibrillator). The 23 inpatient clinical episode categories in ECIP are as follows:

1. Acute myocardial infarction (AMI)
2. Back and neck except spinal fusion
3. Cardiac arrhythmia
4. Cardiac valve
5. Cellulitis
6. Cervical spinal fusion / Combined anterior posterior spinal fusion / Spinal fusion (non-Cervical)
7. Chronic obstructive pulmonary disease (COPD), bronchitis/asthma
8. Congestive heart failure (CHF)
9. Coronary artery bypass graft surgery (CABG)

10. Major joint replacement of the lower extremity (MJRLE) / Double joint replacement of the lower extremity
11. Fractures, femur and hip/pelvis
12. Gastrointestinal hemorrhage
13. Gastrointestinal obstruction
14. Hip and femur procedures except major joint
15. Lower extremity and humerus procedure except hip, foot, femur / Major joint replacement of upper extremity
16. Major bowel procedure
17. Pacemaker
18. Percutaneous coronary intervention (PCI)
19. Renal failure
20. Sepsis
21. Simple pneumonia and respiratory infections
22. Stroke
23. Urinary tract infection (UTI)

In the online Implementation Protocol, each participating hospital will prospectively select which of the applicable clinical episode categories it will be held accountable for in ECIP.

Appendix C: Example of Incentive Payment Methodology

1. Hospital A is participating in **two episode categories** – Episode Category 1 and Episode Category 2. As described in Section 3, Step 2 of this Implementation Protocol, Hospital A elected to provide Incentive Payments equal to 50% of its total positive savings for both of these clinical episode categories. Its total aggregate positive savings across all episode categories \$1,000,000, resulting Hospital A having a Shared ECIP Incentive Payment Fund of **\$500,000** (i.e., \$1,000,000 x 50%).

Note that if Hospital A did not achieve savings for Episode Category 1, the same steps below would still apply in calculating the Incentive Payments for Episode Category 2 – just based on the savings in that episode category alone.

2. As described in Section 3, Step 3, the hospital elected in its online Implementation Protocol to distribute Incentive Payments to Care Partners, allocated as follows:

Episode Category	Physician	SNF	HHA
Episode Category 1	50%	50%	N/A
Episode Category 2	50%	25%	25%

3. As described in Section 3, Step 4, hospital sets required conditions of payment weights, as well as the minimum number of conditions of payment to qualify for any payment, in its online Implementation Protocol as follows:

Episode Category	CoP 1	CoP 2	CoP 3	CoP 4	CoP 5
Episode Category 1 (minimum = 3)	20%	20%	20%	20%	20%
Episode Category 2 (minimum = 2)	25%	25%	25%	25%	N/A

4. As described in Section 3, Step 5, each included clinical episode is attributed (by HSCRC and its administrator) to a single Care Partner within each participating provider category according to the following volume:

Episode Category	DRG	Volume
Episode Category 1	DRG 1	10 episodes
	DRG 2	10
Episode Category 2	DRG 3	15
	DRG 4	20
	DRG 5	5

Episodes are weighted (by HSCRC and its administrator) by DRG weight within the episode category.

DRG	DRG Weight
DRG 1	1
DRG 2	1.5
DRG 3	1.25
DRG 4	2
DRG 5	3

Episode Category 1 = 50% of the total, positive savings (amount by which episode payments were under the aggregate target price) for Episode Category 1 = **\$126,500**

This is allocated to Care Partner types using the proportions provided to determine maximum Incentive Payment from the Shared ECIP Incentive Payment Fund:

Physician = 50% x \$126,500 = \$63,250

SNF = 50% x \$126,500 = \$63,250

Episode Category 2 = 50% of the total, positive savings (amount by which episode payments were under the aggregate target price) for Episode Category 2 = **\$373,500**

This is allocated to Care Partner types using the proportions provided to determine maximum Incentive Payment from the Shared ECIP Incentive Payment Fund:

Physician = 50% x \$373,500 = \$186,750

SNF = 25% x \$373,500 = \$93,375

HHA = 25% x \$373,500 = \$93,375

The resulting application of episode weights results in the following allocation of available Incentive Payments (numbers are rounded here for simplicity):

Care Partner	Episode Category	DRG	Volume	Weight
Physician Group A	Episode Category 1	DRG 1	2	2
		DRG 2	5	7.5
Physician Group B	Episode Category 1	DRG 1	6	6
		DRG 2	5	7.5
Physician Group C	Episode Category 1	DRG 1	2	2
		DRG 2	0	0
Physician Group A	Episode Category 2	DRG 3	5	6.2
		DRG 4	10	20
		DRG 5	5	15
Physician Group B	Episode Category 2	DRG 3	5	6.25
		DRG 4	7	14
		DRG 5	0	0
Physician Group C	Episode Category 2	DRG 3	5	6.25
		DRG 4	3	6
		DRG 5	0	0
Care Partner	Episode Category	DRG	Volume	Weight

SNF D	Episode Category 1	DRG 1	7	7
		DRG 2	0	0
SNF E	Episode Category 1	DRG 1	3	3
		DRG 2	4	6
SNF D	Episode Category 2	DRG 3	7	8.75
		DRG 4	10	20
		DRG 5	5	15
SNF E	Episode Category 2	DRG 3	7	8.75
		DRG 4	10	20
		DRG 5	0	0

Care Partner	Episode Category	DRG	Volume	Weight
HHA F	Episode Category 2	DRG 3	6	6
		DRG 4	3	6
		DRG 5	0	0

Physician Group A was attributed 38% of the weighted volume for Episode Category 1 and 55.9% of the weighted volume for Episode Category 2. This is equal to $.38 \times 63,250 + .559 \times 186,750 = \$128,000$. We will (for the sake of example) say that 25% of their final average MPFS payments for the year only totals \$122,000, however, so their final capped incentive is \$122,000. The hospital would then be responsible for evaluating their stated Conditions of Payment and paying them the appropriate proportion of this total capped incentive based on successful completion of the conditions.

Physician Group B was attributed 54% of the weighted volume for Episode Category 1 and 27.5% of the weighted volume for Episode Category 2. So, they are eligible for to $.54 \times 63,250 + .275 \times 186,750 = \$85,500$. They do not hit their incentive payment cap, so are eligible for the full amount.

Again, the hospital would be responsible for evaluating conditions of payment and paying an amount proportional to their success in meeting those conditions.

Physician Group C was attributed 8% of the weighted volume for Episode Category 1 and 16.6% of the weighted volume for Episode Category 2, this is equal to $.08 \times 63,250 + .166 \times 186,750 = \$36,000$.

SNF D was attributed 43.8% of the weighted SNF volume for Episode Category 1 and 60.3% of the weighted SNF volume for Episode Category 2, this is equal to $.438 \times 63,250 + .603 \times 93,375 = \$65,000$.

SNF E was attributed 56.3% of the weighted SNF volume for Episode Category 1 and 39.7% of the weighted SNF volume for Episode Category 2, this is equal to $.563 \times 63,250 + .397 \times 93,375 = \$60,700$.

HHA F is the only home health agency certified as a participating care partner for Episode Category 2, so the entire \$93,375 allocated incentive pool for HHAs for Episode Category 2 is allocated to them, contingent on successful completion of their conditions of payment.