**Episode Care Improvement Program**

**(ECIP)**

**Track Implementation Template**

**Performance Period Four (January 2019 – December 2019)**

**Hospital Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Submission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Introduction

The Episode Care Improvement Program (ECIP) is a track under the Care Redesign Program (CRP) designed to allow a hospital that has signed a CRP Participation Agreement (hospital) to link payments across providers during an episode of care. Maryland modeled ECIP on CMS’s Bundled Payments for Care Improvement Program Advanced (BPCI-Advanced).

Episode payment models bundle payments to health care providers for certain items and services furnished during an episode of care. ECIP’s bundled payment approach aligns incentives across hospitals, physicians, and post-acute care facilities to generate savings and improve quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge Emergency Department (ED) visits and hospital readmissions. ECIP provides hospitals with the opportunity to provide incentive payments to care partners that help achieve these goals.

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.

# ECIP Components and Hospital Requirements

A hospital participating in ECIP will act as the “episode initiator,” facilitating coordination with and among care partners. The hospital must participate in ECIP activities, including implementing **ECIP interventions** (e.g., care delivery enhancements such as reengineered care pathways using evidence-based medicine, standardized care pathways); **reporting on all applicable quality measures**; and **using CEHRT**. The hospital shall select the clinical episodes for which it will commit to be held accountable.

ECIP includes the following core components:

* + - 1. **Allowable ECIP Interventions.** Allowable ECIP Interventions in this CRP are activities and processes that the hospital may choose to do for ECIP implementation. The table below shows allowable ECIP interventions, which will be selected by hospitals in the Supplemental Excel workbook, along with any others proposed by the hospital. The hospital’s completed Supplemental Excel workbook must accompany the hospital’s completed Implementation Protocol in its submission to HSCRC for approval by HSCRC and CMS.

**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). |
| * Performance of medication reconciliation. |
| * Remote patient consultation monitoring. |

* + - 1. **ECIP Incentive Payments to Hospitals.** If the sum of the following is positive, the hospital will receive a ECIP Payment:
         * 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 hospital has the option to distribute a share of the net positive amount to care partners via incentive payments. Refer to **Section** **E and Appendices A and B** for additional details.

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 and must submit lists of certified care partners—i.e., those care partners that have signed care partner arrangements—to the HSCRC and CMS.

Depending on the results of each semi-annual reconciliation, during which the actual Medicare fee-for-service (FFS) expenditures for all clinical episodes attributed to the hospital are compared to the final target price for those clinical episodes (and subject to adjustments based on quality performance), the hospital may receive a ECIP payment, as illustrated in the example below. Reconciliation will occur at the hospital level, across all episodes. The ECIP payment would be in the form of a positive adjustment to the hospital’s Medicare Performance Adjustment (MPA) — separate from and additive to the regular MPA adjustment that relies on an attribution algorithm of Medicare FFS beneficiaries to hospitals.

**Example of Performance Assessment**

* Regression-based episode benchmarks:
  + DRG A: $15,000
  + DRG B: $10,000
* Discount: 3%
* Episode Targets:
  + DRG A: $14,550 ($15,000 x 97%)
  + DRG B: $9,700 ($10,000 x 97%)
* 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 = $14,550 x 25 + $9,700 x 50 = $848,750
* ECIP payment to hospital = $848,750 - $832,500 = $16,250

**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.

**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 the program. The disclosure will indicate that if the care partners and hospital meet specific performance goals of improving quality, streamlining care and reducing spending, the hospital and care partners may receive a payment. 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. Hospitals must inform beneficiaries about the initiative prior to, or as soon as possible following, the submission of a claim for the “anchor stay” that triggers a clinical episode, by sending the beneficiary a notification letter.

**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. Hospitals will be expected to provide the State with ongoing monitoring information by tracking and reporting various measures of performance improvement efforts and operational metrics, including incentive payments made to care partners, clinical quality, and patient experience of care. Such data may include, but are not limited to, system-level measures of complication, mortality, and readmission rates, as well as measures of process improvement.

In addition to the CRP reporting requirements in the Participation Agreement, hospitals should include the following information specific to ECIP in the CRP Report for Medicare beneficiaries:

|  | Required Metrics |
| --- | --- |
| Care Partner Enrollment and Activities | * Number of Care Partners participating in ECIP * Total incentives paid per 6-month reconciliation period |
| Hospital Utilization, Efficiency and Care Redesign Impact | * 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 * Average LOS in post-acute facility |
| Patient Safety and Patient Satisfaction | * Mortality Rates |

The HSCRC and its third party administrator will produce most of these measures on behalf of hospitals.

# Care Partner Responsibilities

Care partners provide care under the ECIP initiative, participate in ECIP interventions, and are paid separately by Medicare for their services. Hospitals may choose care partners from the following provider types:

* General or specialist physician;
* Clinical nurse specialist or nurse practitioner;
* Physician assistant;
* Physical therapist;
* Skilled nursing facility (SNF);
* Home health agencies;
* Long term care hospitals;
* Hospice; and
* Inpatient rehabilitation facilities.

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 must pass the federal program integrity screening process.

Care partners must sign a care partner arrangement with the hospital and comply with all applicable requirements under the Participation Agreement.

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.

# Bundled Payment Approach: Clinical Episodes and Target Prices

ECIP will use a retrospective bundled payment approach where the usual FFS payments are made, and the total FFS payment for the clinical episode is then retrospectively reconciled against a predetermined target price. The HSCRC will base the list of clinical episodes on the inpatient clinical episodes included in the federal BPCI-Advanced. Those 23 clinical episode categories are mapped from MS-DRGs, used in the federal program for episode stratification, to APR-DRGs, which are more familiar to Maryland hospitals. 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 during the baseline period of the most recent three years 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 the Supplemental Excel workbook, 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 A for additional detail on the items and services included in the clinical episodes.

The State will prospectively provide preliminary target prices to potential hospitals and care partners 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 price will be calculated by applying a discount to the benchmark price. For the first year of ECIP the discount is three percent. The benchmark price is calculated based on the historical Medicare FFS expenditures for most items and services furnished during the clinical episode. Based on the actual Medicare FFS expenditures for that clinical episode relative to the target price, hospitals have the opportunity to earn an ECIP Payment, to be paid through the MPA.

The State will conduct semi-annual reconciliation against prospectively determined clinical episode-specific target prices. Reconciliation will be adjusted retrospectively in a manner similar to and the federal Comprehensive Care for Joint Replacement Model (CJR) to account for quality performance, the actual case mix of patients treated during a performance period, and other factors such as ACO overlap, extreme and uncontrollable circumstances, and the stop-gain provisions described previously. 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 for which the hospital has committed to be held accountable 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 ECIP payments will be required from hospitals.

Reconciliation payments 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 redesign partners, and any adjustments made to such.

**Accountability for Quality Performance**

The State will adjust a hospital’s positive or negative 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).

# Incentive Payment Methodology: Incentive Payment Pool Development, Care Partner Incentive Payments

To the extent the hospital elects to provide payment incentives to care partners under ECIP, on a semi-annual basis the hospital will distribute a share of its ECIP payment to its care partners based on the selections made in this Implementation Protocol and the attached Supplemental Excel workbook. ECIP payments to hospitals will be made through the MPA’s Efficiency Adjustment. The following eight steps form the conceptual basis for ECIP incentive payments to care partners. Each participating hospital will complete this Implementation Protocol as well as the Supplemental Excel workbook to provide the detailed information to the HSCRC on its approach to completing the incentive payment steps. The following steps are also illustrated in an example in Appendix B.

* + - 1. **Incentive Payment Pool Development.** 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 CY 2019. The ECIP incentive payment pool is calculated prior to the performance period and is based on reductions in potentially avoidable utilization—in particular, the reduction in readmissions statewide for Medicare FFS beneficiaries to CY 2017, one of the quality measures described in Section D above.

The incentive pool will be apportioned to each hospital by the HSCRC based primarily on the proportion of each hospital’s CY 2017 federal Medicare payments as a share of those payments for all hospitals statewide. In addition, in accordance with the State’s agreement with CMS, each hospital’s ECIP incentive payment pool will also be adjusted by the quality adjustment score used in the MPA, based on readmissions and hospital-acquired conditions.

Each hospital’s portion of the ECIP incentive payment pool will be communicated to all hospitals prior to the start date of the performance period (that is, before January 1, 2019). The hospital must ensure that aggregate incentives paid to care partners do not exceed its ECIP incentive payment pool.

This ECIP incentive payment pool does not determine care partners’ incentive payments under the program, but serves as a prospectively set limitation on how much each hospital can share overall. Actual ECIP incentive payments are calculated based on the remainder of the steps.

* + - 1. **Share of Hospital’s ECIP Payment Available to Care Partners for Incentive Payments.** In this Implementation Protocol (Section 4), each hospital elects whether or not to distribute a share of its ECIP payment to qualifying care partners. If the hospital elects to make such payments, the hospital enters the maximum share of its ECIP payment it is making available for incentive payments. Once the hospital’s own ECIP payment is determined, the hospital’s Shared ECIP Incentive Payment Fund is calculated as the product of the hospital’s ECIP payment and the maximum share the hospital elects to share per Section 4. (Regardless of the maximum share selected, payments to care partners from the Shared ECIP Incentive Payment Fund shall not exceed the Incentive Payment Pool described in the preceding step.) (If the hospital does not qualify for an ECIP payment, then there will be no funding for the Shared ECIP Incentive Payment Fund, and the hospital cannot make any incentive payments.)
      2. **Distribution Proportions Among Care Partners.** Each hospital electing to distribute a share of its ECIP payment to qualifying care partners (not to exceed the Incentive Payment Pool) will select — in this Implementation Protocol and the Supplemental Excel workbook — distribution proportions among the nine available care partner types listed in Section C, for each episode category.   
           
         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 physicians, 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. Likewise, a hospital may elect to make available incentives to some, all, or none of the participating care partner types.
      3. **Establishment of Care Partner Conditions of Payment.** A hospital will further designate at least one condition of payment per care redesign interventions for each episode category and each care partner type. These conditions of payment may be uniform across episodes and care partner types or tailored to specific segments, as the hospital sees fit to best meet its care redesign goals. In order to qualify for payment, a care partner must meet the condition(s) of payment, as specified by the hospital in the Supplemental Excel workbook. Once a care partner has met the hospital’s specified minimum, they earn their portion of the incentive payment. No care partner will receive any incentive payment unless the care partner performs the required ECIP interventions as defined by the hospital’s CRP Committee. 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.
      4. **Episode Attribution to Care Partners.** During the performance year, 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 DRG weight for that episode. Available incentive payment totals within a care partner type will be allocated based on the aggregation of these weights, as will the total incentive pool distribution between episode categories.
      5. **Application of Conditions of Payment and Attribution.** During each reconciliation period, the HSCRC and its administrator will evaluate the prescribed conditions of payment and apply the weights described in (3) and (4) above to each care partner to arrive at a total incentive payment.
      6. **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. The Physician Incentive Payment Cap is twenty-five percent (25%) of the Average Care Partner Physician Fee Schedule (PFS) Expenditures for the preceding calendar year.
      7. **Application of Incentive Payment Pool.** Payments from the hospital’s Shared ECIP Incentive Payment Fund cannot exceed the hospital’s Incentive Payment Pool amount calculated in Step 1 above. If the amounts calculated for incentive payments per Steps 2 through 7 exceed the hospital’s Incentive Payment Pool amount calculated in Step 1 above, then the incentive payments will be reduced by a flat percentage so incentive payments do not exceed the hospital’s Incentive Payment Pool.

Track Implementation Template Instructions

Please complete all required sections of this Template.

**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,** Hospitalexplains plans for making incentive payments to care partners (if applicable).

# 1. Hospital Information

**Date of 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** |
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# 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** |
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**If the hospital is part of a larger system, is the CRP Committee a system-wide committee?** Yes  No

**Did the committee exist prior to your participation in CRP?** Yes  No

**If yes, please complete the following information:**

|  |
| --- |
| **Pre-Existing Committee** |
| Name, membership, and purpose of pre-existing committee: |

**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? |  |
| 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. |  |
| 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?

|  |
| --- |
|  |

1. **Incentive Payments**

Please indicate whether or not your hospital is opting to make incentive payments to care partners: Yes  No

If yes, please complete the rest of Section 6 as well as the Supplemental Excel workbook. The Supplemental Excel workbook provides information to the HSCRC on incentive payment distribution proportions among care partner types for each episode category; conditions of payment and their weighting for each episode category and each care partner type; episode attribution to care partners; and application of conditions of payment and attribution.

What is the maximum share (percentage) of ECIP payments that will be shared with care partners?

|  |
| --- |
|  |

Please describe the process by which you will distribute the incentive payments to care partners, including the timing and periodicity of payments, the entities issuing the payments, the method for distributing payments to care partners, form of payments, the documentation of payments, etc.

**Appendix A: Clinical Episode Approach**

ECIP will operate under a total-cost-of-care (TCOC) concept, based on the implementation of the national , 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. Unlike BPCI-Advanced, spending during the anchor stay is excluded from the episode, as other State programs address inpatient costs of care.

Episodes begin upon discharge from the anchor stay and extend 90 days starting on the day of discharge.

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

1. 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; and
2. If applicable, a standardized readmission amount for all readmissions except those in excluded DRGs (i.e. organ transplant, major trauma, ventricular shunts, and cancer-related care).

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

1. Any Part A and Part B services furnished to a beneficiary during anchor stay;
2. New technology add-on payments under the IPPS; and
3. 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 List*: The 23 inpatient clinical episodes listed below are similar to the 29 clinical episodes used in the federal Bundled Payments for Care Improvement Advanced, 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 episodes 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 Supplemental Excel workbook that accompanies this Implementation Protocol, each participating hospital will prospectively select which of the applicable APR-DRGs/episodes it will be held accountable for in ECIP.

**Appendix B: Example of Incentive Payment Methodology**

1. As described in Section 3, Step 2 of this Implementation Protocol, Hospital A elected to provide incentive payments of 20% of its ECIP payment. Its ECIP payment was $2,500,000, resulting Hospital A having a Shared ECIP Incentive Payment Fund of **$500,000** (i.e., $2,500,000 x 20%). Hospital A is participating in **two episode categories**.
2. As described in Section 3, Step 3, the hospital elected in its Implementation Protocol and Supplemental Excel workbook 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% |

1. 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 Implementation Protocol and Supplemental Excel workbook 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 |

1. 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 |

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

**Episode Category 1** = Shared ECIP Incentive Payment Fund x (DRG 1 volume x DRG 1 weight + DRG 2 volume x DRG 2 weight) / (Sum of all DRG volumes / weights) = 500,000 x (10 \* 1 + 10 \* 1.5) / (10 \* 1 + 10\* 1.5 + 15 \* 1.25 + 20 \* 2 + 5 \* 3) = **$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** = Incentive pool total x (DRG 3 volume x DRG 3 weight + DRG 4 volume x DRG 4 weight + DRG 5 volume x DRG 5 weight) / (Sum of all weighted DRG volumes) = 500,000 x (15 \* 1.25 + 20 \* 2 + 5 \* 3) / (10 \* 1 + 10\* 1.5 + 15 \* 1.25 + 20 \* 2 + 5 \* 3) = **$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

Participating in care for these episodes are Physicians A, B, and C, SNFs D and E, and HHA F. During the reconciliation period, their Conditions of Payment are reviewed, with the following result:

Physician Group A

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Episode Category | CoP 1 | CoP 2 | CoP 3 | CoP 4 | CoP 5 |
| Episode Category 1  (met = 100%) | Met | Met | Met | Met | Met |
| Episode Category 2  (met = 100%) | Met | Met | Met | Met | N/A |

Physician Group B

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Episode Category | CoP 1 | CoP 2 | CoP 3 | CoP 4 | CoP 5 |
| Episode Category 1  (met = 60%) | Failed | Met | Met | Met | Failed |
| Episode Category 2  (met = 25%) | Met | Failed | Failed | Failed | N/A |

Physician Group C

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Episode Category | CoP 1 | CoP 2 | CoP 3 | CoP 4 | CoP 5 |
| Episode Category 1  (met = 80%) | Failed | Met | Met | Met | Met |
| Episode Category 2  (met = 100%) | Met | Met | Met | Met | N/A |

SNF D

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Episode Category | CoP 1 | CoP 2 | CoP 3 | CoP 4 | CoP 5 |
| Episode Category 1  (met = 100%) | Met | Met | Met | Met | Met |
| Episode Category 2  (met = 75%) | Met | Met | Met | Failed | N/A |

SNF E

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Episode Category | CoP 1 | CoP 2 | CoP 3 | CoP 4 | CoP 5 |
| Episode Category 1  (met = 80%) | Met | Met | Met | Failed | Met |
| Episode Category 2  (met = 75%) | Met | Met | Met | Failed | N/A |

HHA F

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Episode Category | CoP 1 | CoP 2 | CoP 3 | CoP 4 | CoP 5 |
| Episode Category 2  (met = 25%) | Met | Failed | Failed | Failed | N/A |

With volumes as follows:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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** met 100% of their CoP for both Episode Category 1 and Episode Category 2, earning them their full incentive payment allocation. Since they were 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 1 x .38 x 63,250 + 1 x .559 \* 186,750 = $128,000. However, 25% of their final MPFS payments for the year only totals $122,000, so their final capped incentive is $122,000.

**Physician Group B** met 60% of their CoP for Episode Category 1 but only 25% of their CoP for Episode Category 2. They do not receive incentive payments for Episode Category 2. Since they were attributed 54% of the weighted volume for Episode Category 1, this is equal to .6 x .54 x 63,250 = $20,500. However, 25% of their MPFS payments for the year only total $19,000, so their final capped incentive is $19,000.

**Physician Group C** met 80% of their CoP for Episode Category 1 and 100% of their CoP for Episode Category 2. Since they were attributed 8% of the weighted volume for Episode Category 1 and 55.9% of the weighted volume for Episode Category 2, this is equal to .8 x .08 x 63,250 + 1 x .166 \* 186,750 = $35,000. This is below the cap of 25% of their MPFS payments, so they receive the full $35,000.

**SNF D** met 100% of their CoP for Episode Category 1 and 75% of their CoP for Episode Category 2. Since they were 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 1 x .438 x 63,250 + .75 x .603 \* 93,375 = $56,000.

**SNF E** met 80% of their CoP for Episode Category 1 and 75% of their CoP for Episode Category 2. Since they were 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 .8 x .563 x 63,250 + .75 x .397 \* 93,375 = $47,000.

**HHA F** is not participating in Episode Category 1 and has only met one CoP for Episode Category 2, so does not earn any incentive payments. The $93,375 allocated incentive pool for HHAs for Episode Category 2 is retained by the hospital.

As a result, approximately $280,000 could be payable from the hospital’s $500,000 Shared ECIP Incentive Payment Fund. Thus, in this example, Hospital A retains the remaining $220,000 in Shared ECIP Incentive Payment Fund not paid out to care partners.

If Hospital A’s Incentive Payment Pool, as described in Section 3, Step 1, was $210,000 — that is, less than the sum of incentive payments otherwise available to care partners — then the amount of incentive payments actually paid to care partners would be reduced proportionally, as described in Section 3, Step 8. Thus, the adjusted final capped incentive payments would be 75% — that is, $210,000 / $280,000 — of the payments calculated above.