

Solicitation for Applications Acute Care Episode Demonstration

The Centers for Medicare & Medicaid Services (CMS) is accepting applications for participation in the Acute Care Episode (ACE) demonstration. The ACE demonstration will test the use of a global payment for an episode of care as an alternative approach to payment for service delivery. In this case, an episode of care is defined as Part A and Part B services provided during an inpatient stay for Medicare fee-for-service (FFS) beneficiaries for selected procedures. As such, this demonstration seeks to align financial incentives within health care groups (i.e., affiliations of hospitals and physicians) to provide quality care according to best practices at a savings to Medicare. Providing financial and other incentives to providers to stimulate improvements in the quality and efficiency with which they deliver care is an example of value-based purchasing (VBP). The ACE demonstration reflects CMS' ongoing commitment to VBP.

Potential applicants for this demonstration are limited to health care groups, specifically physician-hospital organizations (PHOs), with at least one physician group and at least one hospital that routinely provide at least one of the two main procedures included in the demonstration: hip/knee replacement surgery and/or coronary artery bypass graft (CABG) surgery. Also, applicants must meet particular procedure volume thresholds, have established quality improvement mechanisms, and be located in Medicare Administrative Contractor (MAC) Jurisdiction 4 (comprising Texas, Oklahoma, New Mexico, and Colorado). Further discussion of eligibility requirements can be found in **Section 3.1** below.

ACUTE CARE EPISODE DEMONSTRATION WEBSITE: To locate the ACE demonstration webpage, go to <http://www.cms.hhs.gov/demoprojectsevalrpts>; select "Medicare Demonstrations" from the left-hand column and select "Medicare Acute Care Episode Demonstration" from the main display. Applicants are responsible for monitoring the website to obtain the most current information available. To request email notification when new material has been posted to the demonstration webpage, please sign up at the link provided at the above-mentioned webpage.

APPLICANT TELECONFERENCE: An informational teleconference will be held for potential applicants and other interested parties on June 4, 2008 from 3 to 4:30 p.m. EST. The teleconference will be an opportunity to ask questions and for CMS to clarify issues in both the solicitation and the demonstration project itself. The call-in number for the teleconference is 1-888-982-4492 (participant passcode "Acute Care").

APPLICATION: The **Medicare Demonstration Waiver Application** is available online at: <http://www.cms.hhs.gov/demoprojectsevalrpts>. Select "Medicare Demonstrations" from the left-hand column and select "Medicare Acute Care Episode Demonstration" from the main display to locate the ACE webpage and associated documents. Please provide two hard copies and one electronic copy or CD-ROM of the full application. Microsoft Excel table shells are available on our webpage for use in completing the application requirements. Applicants may, but are not required to, submit a total of 10 copies to assure that each reviewer receives an application in the manner intended by the applicant (for example, collated, tabulated, color copies). Hard copies

and electronic copies must be identical. Applicants must designate one copy as the official proposal.

Interested applicants who would like information on total Part B payments (including consultants and other non-surgeon physician fees) may request historical hospital-specific data from CMS and its contractors. This data may be useful in developing applicant bids for demonstration procedures.

APPLICATION DUE DATE: Applications must be received on or before 5:00 P.M. EST on August 15, 2008.

MAIL OR DELIVER APPLICATIONS: Applications may be mailed or hand-delivered to:

Centers for Medicare & Medicaid Services
Attention: Rachel Duguay
7500 Security Boulevard
Mail Stop C4-17-27
Baltimore, Maryland 21244

Please note we will not accept applications by facsimile (FAX) transmission or by e-mail. Applications postmarked after the closing date, or postmarked on or before the closing date but not received in time for the panel review, will be considered late applications. Applicants will receive acknowledgment of receipt of their application.

CMS CONTACT: Rachel Duguay at (410) 786-6654 or by e-mail at acedemonstration@cms.hhs.gov.

1.0 Background

CMS has articulated a vision for health care quality, the right care for every person every time. This vision is motivated by well-documented deficiencies in the quality and safety of healthcare as well as unsustainable growth in healthcare spending in the United States health system overall. Because Medicare's current payment systems reward quantity of services provided, rather than quality of care, CMS is pursuing new methods (through public reporting programs, demonstration projects, and other efforts) of paying providers that will encourage improvements in both the efficiency and quality of care provided to Medicare beneficiaries.

The ACE demonstration is specifically designed to align financial incentives across providers and provide flexibility to hospitals and physicians by bundling all related inpatient services into an "episode of care." This is achieved by paying a single, global payment that can be used as the health care groups deem most appropriate. The use of bundled payment methods to purchase health care services has gained support among hospitals, large employers, insurance companies, and physician groups as a means to help reduce health care costs while maintaining or possibly improving quality.¹ CMS has had previous experience in the design and implementation of

¹ MedPAC public meetings and documents released October 2007, November 2007, and January 2008.

demonstrations similar in approach to the ACE demonstration. In 1996, CMS completed two negotiated bundled payment demonstrations, the Medicare Participating Heart Bypass Center demonstration and the Medicare Cataract Surgery Alternate Payment demonstration. These demonstrations were designed to test the feasibility of a bundled payment for surgical procedures.

Medicare accrued substantial savings under the Participating Heart Bypass Center demonstration without any decrease in the quality of care provided to beneficiaries. The demonstration sites achieved cost efficiencies through streamlined processes leading to fewer re-operations, lower readmissions, and shorter lengths of stay. Patients in the demonstration had lower mortality rates, were more satisfied with the quality of nursing care they received, and appreciated the simplicity of a single coinsurance payment. The Medicare Cataract Surgery Alternate Payment demonstration yielded a key finding regarding the importance of using the bundled payment methodology for high volume services where economies of scale can result in savings for both Medicare providers and the Medicare program.

The results achieved from the early global payment demonstrations have increased the appeal of using bundled payment as a means of encouraging high-quality, patient-centered, coordinated care under the Medicare program. The ACE demonstration builds upon these earlier efforts by expanding this concept to a broader set of inpatient orthopedic and cardiovascular procedures with the potential to include or expand to post-acute care services (e.g., cardiac and orthopedic rehabilitation) after Year 1 of the demonstration. Also, ACE will use a competitive bidding, rather than negotiated pricing, approach to awarding voluntary applicants. The ACE demonstration will be implemented for 3 years on a limited scale potentially involving up to 15 sites in a multi-State area (Texas, Oklahoma, New Mexico, and Colorado). Finally, unlike previous bundling demonstrations, beneficiary participants will share in Medicare savings and CMS intends to take an active role with ACE demonstration sites in the marketing of the demonstration.

The specific goals of this demonstration are to improve quality of care by raising consumer awareness of price and quality information, increase collaboration among providers and health systems, and reduce Medicare payments for acute care services using market mechanisms. CMS expects this global payment arrangement will result in greater program efficiency as well as higher quality of care and outcomes for Medicare beneficiaries. An independent evaluation will be conducted for this demonstration to evaluate the feasibility and cost effectiveness of the bundled payment methodology and the improvement in quality of care and other benefits to Medicare beneficiaries.

2.0 Important Elements of the ACE Demonstration

2.1 Coordination of Care to Maximize Quality and Efficiency

Typically, Medicare patients receive care from multiple physicians and sometimes across multiple care settings for individual episodes of care (defined as inpatient stays and including both Part A and Part B services in this demonstration). This demonstration tests whether improvements in quality of care result from aligning payment incentives between hospitals and physicians in such a way that they must coordinate care on a case-by-case basis. Coordination of

care may have condition-specific elements or may target continuity and coordination across multiple settings.

2.2 Provider Incentives

Under this demonstration, sites have the option to reward individual clinicians, teams of clinicians, or other hospital staff who succeed with measurable clinical quality improvement. Often, health care groups choose to reward clinical quality improvement that leads to increased efficiency. Sometimes referred to as gainsharing, under this demonstration a provider incentive arrangement within a health care group (e.g., a PHO) allows physicians and hospital staffs to receive remuneration for quality improvements. Interested applicants can find a list of criteria for provider incentive programs on CMS's website at <http://www.cms.hhs.gov/demoprojectsevalrpts>². All provider incentive programs must follow CMS guidelines which are available on the demonstration webpage cited above.

2.3 Beneficiary Incentives

Applicants should be able to design and offer an attractive set of incentives to encourage greater use of their facility by Medicare beneficiaries and referring physicians. Incentives fall under two broad categories: in-kind services to beneficiaries and their families; and in-kind services to referring physicians. Note that as part of this demonstration, CMS will share up to 50 percent of the Medicare savings in the form of payments to beneficiaries to offset their Medicare cost-sharing obligations³. CMS will share savings achieved through competitive bidding with Medicare beneficiaries in the form of a payment not to exceed their annual Part B Premium amount.

If the applicant plans to offer any in-kind services, the package of services should be specified in detail. In-kind services to both beneficiaries and physicians must follow general Medicare guidelines regarding appropriateness.

2.4 Competitive Bidding

Competitive bidding, also known as competitive contracting, is a VBP tool that could potentially allow the Medicare program to purchase care at a lower cost while promoting greater efficiency among providers and quality care for Medicare beneficiaries. Competitive bidding, the process by which providers bid for the right to provide a good or service, is one tool that has been tested and used in both the public and private sectors.

CMS expects to award only one ACE demonstration site per market, where a market is defined as a metropolitan core-based statistical area, or the aggregate of non-metropolitan (rural) areas within a given State. After Year 1 of the demonstration, CMS will consider expanding the demonstration to test alternative competitive bidding models, such as awarding multiple sites per

² On the CMS website, chose "Medicare Demonstrations" and select "Medicare Acute Care Episode Demonstration".

³ Shared savings under the demonstration will be countable as income. This may cause beneficiaries who are dually eligible for Medicare and Medicaid to exceed the Medicaid eligibility income thresholds. To avert this unintended consequence, CMS will not share savings with dual eligible beneficiaries through this demonstration.

market area, in a new geographic area (i.e., MAC jurisdiction) (see **Section 3.1**). In this demonstration, sites will bid to provide selected cardiac and/or orthopedic services to Medicare patients in inpatient settings. One goal of the demonstration is to encourage care for high-risk surgeries in high-quality institutions by acquiring competitive bids from Medicare-approved sites. In addition to potential market share advantages, the demonstration presents applicants with an opportunity for product line development.

2.5 Hospital Marketing and CMS Marketing of the Demonstration

Sites will be encouraged to market their unique programs and their participation as ACE demonstration sites. Demonstration sites will be required to provide a marketing plan and to submit all marketing materials to CMS for review and approval prior to publication or release to the public. If sites choose to market themselves under a special designation or imprimatur, the term “Medicare Cardiac Value-Based Care Center” and/or “Medicare Orthopedic Value-Based Care Center” should be used. This term is in alignment with CMS’ VBP initiative. A positive element of being designated a Value-Based Care Center is enhanced reputation and visibility in the community the site serves and potentially increased physician referrals.

CMS intends to take an active role in publicizing the demonstration to Medicare beneficiaries and providers in the relevant geographic locations. Beneficiary outreach may include updating the Medicare.gov website’s two popular tools (“Find a Doctor” and “Hospital Compare”) with ACE demonstration-specific information and data (participating providers, Hospital Quality Alliance-approved quality measures, etc.). Also, a link to further information about how beneficiaries may benefit from receiving care at participating demonstration sites may be included on the Medicare.gov homepage. Standard media outlets would be useful in reaching both beneficiaries and providers. Finally, provider-specific outreach may include education efforts through CMS Regional Offices, local provider and interest groups, relevant medical and hospital conferences, and the CMS Open Door Forum.

3.0 Provisions of this Solicitation

3.1 Eligible Applicants

Section 1866C of the Social Security Act provides a definition for the type of "health care group" eligible to participate in these demonstrations (under section 646), one of which is physician groups.

For purposes of the ACE demonstration, health care groups are defined as entities including an affiliation between at least one physician group with at least one hospital, which routinely provide the procedures included in the demonstration. This type of health care group may be known as a physician hospital organization (PHO). CMS is also interested in PHOs affiliated with post-acute health care settings. If multiple hospitals are part of the same PHO, the applicant must make clear which particular hospital(s) will be the demonstration site(s). Applicants must include documentary evidence of an agreement between the entities comprising the PHO. Also, applicants may establish a PHO in order to compete in the demonstration.

Applicants must have received the full Inpatient Prospective Payment System (IPPS) annual payment update for reporting quality measures to CMS (through www.qualitynet.org) since at

least FY 2006. Participating sites, limited to PHOs within MAC Jurisdiction 4 (comprised of Texas, Oklahoma, New Mexico, and Colorado), must continue to participate in quality data collection efforts throughout the demonstration and meet additional quality reporting and monitoring standards outlined in **Section 3.9**. After Year 1 of the demonstration, CMS will consider expanding the demonstration to additional geographic areas and testing alternative competitive bidding models (such as awarding multiple sites per market area) (see **Section 2.4**).

Applicants that show evidence of a quality committee with both hospital and board-certified physician representatives and dedicated time to overseeing this demonstration will be given preference. In addition, demonstration applicants are required to show that they meet specific volume thresholds as per peer reviewed medical literature (see **Section 3.3** below) for the lead orthopedic and cardiovascular procedures that are the focus of this demonstration. Applicants which have multi-disciplinary provider teams and participate in clinical improvement programs/registries will also be given preference. Please see the Microsoft Excel formatted table shells available on our webpage for use in completing the application requirements.

3.2 Selected ACE Demonstration Procedures

CMS is seeking global payment bids for a set of (1) cardiovascular and/or (2) orthopedic procedures. CMS is focusing on this initial set of services because margins and volume have historically been high, services are easy to specify, and quality metrics are available.

Applicants have the option to bid on both the cardiac and orthopedic Medicare severity diagnostic related groups (MS-DRGs or simply DRGs), or on either cardiac or orthopedic MS-DRGs. However, applicants will be required to offer bids on all MS-DRGs/procedures within the cardiac or orthopedic categories. Additionally, applicants may choose to submit ideas for additional DRGs/procedures that might lend themselves to inclusion in the ACE demonstration in the future.

Table 1 and **Table 2** list the cardiac and orthopedic DRGs for the ACE demonstration. Note: “CC” and “MCC” refer to “complications or co-morbidities” and “major complications or co-morbidities,” respectively.

Table 1: Required Cardiac MS-DRGs for ACE Demonstration

MS-DRG	Description
216	Cardiac valve & other major cardiothoracic procedure with cardiac catheterization with MCC
217	Cardiac valve & other major cardiothoracic procedure with cardiac catheterization with CC
218	Cardiac valve & other major cardiothoracic procedure with cardiac catheterization without CC/MCC
219	Cardiac valve & other major cardiothoracic procedure without cardiac catheterization with MCC
220	Cardiac valve & other major cardiothoracic procedure without cardiac catheterization with CC
221	Cardiac valve & other major cardiothoracic procedure without cardiac

	catheterization without CC/MCC
226	Cardiac defibrillator implant without cardiac catheterization with MCC
227	Cardiac defibrillator implant without cardiac catheterization without MCC
231	Coronary bypass with PTCA with MCC
232	Coronary bypass with PTCA without MCC
233	Coronary bypass with cardiac catheterization with MCC
234	Coronary bypass with cardiac catheterization without MCC
235	Coronary bypass without cardiac catheterization with MCC
236	Coronary bypass without cardiac catheterization without MCC
242	Permanent cardiac pacemaker implant with MCC
243	Permanent cardiac pacemaker implant with CC
244	Permanent cardiac pacemaker implant without CC/MCC
246	Percutaneous cardiovascular procedure with drug-eluting stent with MCC or 4+ vessels/stents
247	Percutaneous cardiovascular procedure with drug-eluting stent without MCC
248	Percutaneous cardiovascular procedure with non-drug-eluting stent with MCC or 4+ vessels/stents
249	Percutaneous cardiovascular procedure with non-drug-eluting stent without MCC
250	Percutaneous cardiovascular procedure without coronary artery stent or AMI with MCC
251	Percutaneous cardiovascular procedure without coronary artery stent or AMI without MCC
258	Cardiac pacemaker device replacement with MCC
259	Cardiac pacemaker device replacement without MCC
260	Cardiac pacemaker revision except device replacement with MCC
261	Cardiac pacemaker revision except device replacement with CC
262	Cardiac pacemaker revision except device replacement without CC/MCC

Table 2: Required Orthopedic MS-DRGs for ACE Demonstration

MS-DRG	Description
461	Bilateral or multiple major joint procedures of lower extremity with MCC (Note: exclude ICD-9 code 81.56 which relates to ankle replacement.)
462	Bilateral or multiple major joint procedures of lower extremity without MCC (Note: exclude ICD-9 code 81.56 which relates to ankle replacement.)
466	Revision of hip or knee replacement with MCC
467	Revision of hip or knee replacement with CC
468	Revision of hip or knee replacement without CC/MCC
469	Major joint replacement (Note: exclude ICD-9 codes 84.26, 84.27, and

- 84.28, which relate to various forms of limb reattachment.)
- 470 Major joint replacement (Note: exclude ICD-9 codes 84.26, 84.27, and 84.28, which relate to various forms of limb reattachment.)
- 488 Knee procedures without primary diagnosis of infection with CC/MCC
- 489 Knee procedures without primary diagnosis of infection without CC/MCC

3.3 ACE Demonstration Procedure Volume Thresholds

Applicants should have active cardiovascular and orthopedic medical and surgical programs that meet the following required minimum volume thresholds in 2007:

Procedures	Medicare	Total
CABGs & Valves	100	200
PTCAs	200	400/facility with at least 90/physician
Hip & Knee Replacements	90	125

By limiting the demonstration to applicants that meet evidence-based volume standards, CMS is emphasizing the quality component of VBP. Research has shown that hospitals with higher volumes of certain surgical procedures have better results, and surgeons who perform more of certain operations have fewer patient deaths. As such, this demonstration encourages health care groups to redesign care processes to maximize quality of care and health outcomes by allowing them to share the resulting savings in ways that are not currently permissible by law.

Institutions will also be evaluated on whether they meet the following additional threshold volumes, although sites will not necessarily be excluded if all of these volumes are not met. However, CMS will give preference to applicants with the largest proportion of physicians who do meet these additional thresholds at the physician/surgeon level.

Procedures	Medicare	Total
Defibrillator implants	At least 10/ physician	At least 10/physician
Pacemaker implants	At least 10/physician	At least 10/physician

3.4 Calculation of Applicants' Bids

Entities may submit proposals for a global payment under the demonstration for one or both of the categories listed in **Section 3.2**, "Selected ACE Demonstration Procedures." Applicants must bid on every listed DRG in the selected category. All admissions for eligible beneficiaries for DRGs in the category for which a facility is selected shall be processed under the demonstration payment rules.

CMS will provide data to applicants on estimated Part A and Part B payments that would be made in the absence of the demonstration such that bids are informed by actual data. Provision of this data will be discussed further at the ACE demonstration bidders' teleconference and will be provided on request. Each applicant should submit a bundled payment rate for each episode

of care included in the demonstration at that site. The rate will cover all Medicare Part A and Part B services for a given DRG including outliers. These rates shall be specific to each hospital and DRG.

Applications will be scored, in part, on the percentage discount across all selected demonstration DRGs, using a weighted average of the applicant's own historical volumes by DRG. Discounts on current Medicare rates will be given significant weight as part of the evaluation of the overall application. Also considered will be the applicant's overall global bid relative to other proposals received. Applicants should provide sufficiently competitive discounts to Medicare to yield meaningful savings to both the beneficiary and the Medicare program.

The applicable discount should be expressed as a discount off of the base DRG payment amount. Disproportionate share hospital (DSH) payments and indirect medical education (IME) payments should not be included in the discount calculation; however, the bids should include applicable outlier and capital payments. Specific instructions on how to calculate bids will be provided to applicants through the bidders' teleconference and guidance available by email and on the demonstration webpage.

3.5 Beneficiary Eligibility and Enrollment

The demonstration will apply to the inpatient care of all FFS beneficiaries with Medicare Part A and Part B, who have a medical need for the services provided under the demonstration at any of the participating sites. Beneficiaries covered under the Railroad Retirement Board or United Mine Workers, managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans), cost-based health maintenance organizations, or any other similar plan), and instances where Medicare is not the primary payer are excluded.

Medicare beneficiaries receiving services included under the demonstration at participating sites will be counted as participants. However, beneficiaries at each site will be informed by the site about the demonstration on or before admission, and it is expected that the site will take this opportunity to provide information on the advantages it offers to participating beneficiaries.

Beneficiaries will be informed that they may be contacted by CMS or its contractors to provide information for the evaluation of the demonstration. However, beneficiaries will be specifically advised that refusal to participate in the evaluation or respond to requests for information will not affect their Medicare benefits in any way.

3.6 Medicare Payment to Demonstration Sites

The bundled payment amounts agreed upon by CMS and participating demonstration sites shall be processed by the Part A/Part B MAC serving the demonstration hospital. Sites must accept the single bundled payment for each episode of care as payment in full. CMS staff shall provide the MAC contractors and standard system maintainers with a file containing a list of all demonstration facilities and their associated identification numbers (e.g., National Provider Identifier, Medicare legacy provider identification number, etc.), as well as DRGs covered under the demonstration for each facility and the DRG-specific rates for each at least 60 days prior to the effective date of any demonstration service.

Rates will be subject to update on an annual basis, effective in October with other DRG payment updates for the coming fiscal year. Specifically, the agreed-upon discount will be applied to the relevant IPPS rates. Applicants not chosen for participation in the ACE demonstration will continue to be paid according to FFS Medicare reimbursement rules.

The ACE demonstration is designed to produce cost savings to the Medicare program and should not jeopardize budget neutrality requirements. To ensure that costs are not being shifted pre-admission or post-discharge, CMS will monitor expenditures for beneficiaries participating in the demonstration and compare them with historical expenditures from the particular health care group as well as similar, non-participating beneficiaries at comparable facilities to ascertain whether there is a significant difference in utilization and cost to Medicare. If cost-shifting occurs, CMS will terminate the health care group's participation in the demonstration.

All physicians practicing at the demonstration hospitals will be subject to the payment provisions and bundled payment if they provide services to demonstration beneficiaries. Physicians and other professional providers shall submit claims as usual; however, they will be processed as “no pay” claims and used to evaluate the impact of the demonstration on utilization.

In addition to the global payment amount, CMS will calculate a fixed Part B co-payment for each DRG covered by the demonstration, representing the beneficiary's cost-sharing (in lieu of Part B coinsurance). This Part B co-payment will be unique for each hospital and DRG regardless of actual services rendered to an individual beneficiary. The calculated amounts will be provided to the applicable MAC by CMS annually. We anticipate that supplemental insurers will pay applicable co-payment amounts.

3.7 Scope of Services Included in Bundled Payment

There are no changes in Medicare-covered services under this demonstration. The time window for an episode of care during Year 1 of the demonstration will be the traditional window covered by current Medicare hospital IPPS rules. Therefore, the demonstration sites will include all pre-admission hospital testing services provided during the current IPPS pre-admission window in the bundled payment. Also, the demonstration sites will include post-discharge services according to the current IPPS payment rule pertaining to readmission on the same day as the discharge (in the same DRG and before midnight).

While the time window for an episode of care will follow current Medicare Part A rules, the scope of included services is different because Part B services provided during the inpatient visit will be included in the bundled payment. Therefore, all inpatient facility and professional services rendered to the demonstration beneficiaries from the date of admission through the date of discharge at the demonstration facility are included in the bundled payment.

All facility services provided in the emergency room of a demonstration site on the date of admission or discharge or during a hospital stay shall be paid according to current Medicare IPPS policy. Therefore, if a demonstration episode includes emergency room services, those services would be included in the bundled payment if they would normally be included in the

IPPS DRG payment. After Year 1 of the demonstration, CMS and demonstration sites may consider including some post-acute care services in the episode of care. Further analysis will be performed prior to a change in the demonstration's scope of work and demonstration sites will have the opportunity to modify their bids if the scope of services included in the bundled payment changes.

3.8 Quality Reporting and Monitoring

About 95 percent of prospective payment system hospitals currently participate in CMS' pay-for-reporting initiative, Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU). CMS will require ACE demonstration applicants to have received the full IPPS annual payment update for reporting quality measures to CMS (through www.qualitynet.org) since at least FY 2006. Hospitals must continue to participate in RHQDAPU throughout the demonstration period. In addition, CMS will require hospitals to provide other quality reporting data which is specific to the DRGs/procedures in the ACE demonstration. Quality measures such as complication, mortality, and readmission rates are specified in **Section 4.2** of this document and are elaborated in separate guidance provided to applicants on the demonstration webpage.

3.9 Participation in the Demonstration Evaluation

An independent evaluation will be conducted for this demonstration. Demonstration sites are required to provide full cooperation to the evaluation contractor and CMS project officer for the evaluation. Demonstration sites will be asked to provide information on patient outcomes and costs of furnishing care to the Medicare beneficiaries participating in the project for the evaluation. This information will be compared to outcomes and costs for beneficiaries receiving similar services at other demonstration sites and at comparable facilities not participating in the demonstration.

3.10 Demonstration Period of Performance

The ACE demonstration is scheduled to begin operation in January 2009. CMS and the ACE demonstration implementation contractor will work with demonstration sites to set up and market the demonstration in advance of implementation in January 2009. Payment will be made under the demonstration for patients admitted on or after January 1, 2009 and discharged before December 31, 2011.

4.0 Applicant Review Process, Selection Criteria, and Weights

4.1 Description of Applicant Review Process

Site selection for this solicitation is limited to eligible health care groups in the following States: Colorado, New Mexico, Oklahoma, and Texas. These States comprise the claims processing service area for a single MAC region known as MAC Jurisdiction 4. The Jurisdiction 4 MAC contains the greatest number of hospitals which meet procedure volume quality standards for the main procedures included in the demonstration. Therefore, CMS will maximize opportunity for the largest number of qualified applicants by concentrating on these States and ease the administrative burden of implementation and evaluation.

Clearly written proposals that adhere to the stated intent of the demonstration and specific directions in the application and that provide appreciable discounts to Medicare and high quality

services to Medicare beneficiaries will be considered most responsive to this solicitation. Applicants must be aware that proposals may be accepted in whole or in part. Awards may be subject to special terms and conditions that are identified during the review process. CMS reserves the right to conduct one or more site visits before making awards.

CMS will convene an expert review panel to provide an objective review as well as rate and rank proposals. The CMS Administrator will make the final site selection from among the recommended applicants.

4.2 Selection Criteria and Weights

The demonstration review panel will rate applications based on responsiveness to the following evaluation criteria. The evaluation criteria and related criteria weights are provided below.

Demonstration Design (10 points)

Describe how the proposed efficiencies and discounts will be achieved. Address which process or other changes will enable your institution to offer the proposed discounts while maintaining/improving quality of care. Demonstrate how savings and financial risk from a single bundled payment will be shared across different physician groups and the hospital.

The applicant should provide a marketing plan describing an achievable outreach strategy directed at eligible Medicare beneficiaries and their providers. Special or in-kind services offered or provided to beneficiaries under the demonstration will be considered.

Organizational Structure and Capabilities (20 points)

Present evidence that the organization is capable of implementing and managing the demonstration. Include the responsibilities of the administrative and clinical professionals in managing the demonstration. Documentary evidence of an agreement between the entities comprising the PHO is required. Describe how savings and financial risk from a single bundled payment will be shared across different physician groups and the hospital.

Appropriateness of clinical pathways and provisions to manage the patient population under the demonstration must be consistent with the intent of the demonstration. The proposal must provide a description of the availability and adequacy of facilities, equipment, personnel and data systems to successfully conduct the proposed project. Also, sites should demonstrate capacity for coordination of care, including between inpatient and post-discharge sites of care. Site/provider accreditations, clinical team composition, physician board-certification credentials, and demonstration procedure volumes will be rated.

In the implementation plan, indicate how the health care group will support or facilitate the independent evaluation of the demonstration through the development of operationally sound processes for tracking demonstration participation from pre-admission to post-discharge.

Performance Results (35 points)

Applicants must provide information about current quality assurance systems and special quality improvement projects. The role of physicians and hospital staff on quality improvement committee(s); specific quality assurance studies for relevant patient populations; documented

level of patient follow-up; as well as complication, mortality, and readmission rates will all be considered in rating applicants.

Applicants must demonstrate that adequate mechanisms are in place such that clinically appropriate medical and social services are provided during the episode of care, regardless of where the services are provided during the demonstration, and that there are mechanisms in place to track the clinical and functional outcomes of demonstration participants. To what degree has your institution adopted a hospital-wide electronic health record (EHR) system? What kinds of clinical data is captured by the EHR system?

Payment Methodology & Budget Neutrality (35 points)

CMS will work with applicants to satisfy budget neutrality requirements. In this section of the application, applicants should focus on developing competitive bids according to the formula provided:

$$\left(\frac{\text{((expected payments in absence of the demonstration - proposed bid)/expected payments in absence of demonstration)}}{1} \right) * 100$$

The bundled (global) bid and amount of the discount represented by the bundled payment amounts compared with regular average payments to the hospital and physicians will be evaluated by CMS and initial bids should be presented in FY2008 dollars which will be updated annually. The size of the discount will be weighted more heavily than the total gross savings to Medicare. Describe how the proposed discounts will be achieved. What process or other changes will enable your institution to offer the proposed discounts while maintaining/improving quality of care? Applicants should express their bundled payment bids in absolute dollars and percentage terms for Part A, Part B, and total payments by DRG.

4.3 Collection of Information Requirements

This information collection requirement is subject to the Paperwork Reduction Act of 1995. This specific collection is approved under the Office of Management and Budget control number 0938-0880 entitled "Medicare Demonstration Waiver Application" with an expiration date of November 30, 2010. Applicants must submit the Medicare Demonstration Waiver Application to be considered for this demonstration.

5.0 Statutory Authority

Section 1866C of the Social Security Act, as added by section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (P.L. 108-173) allows the Secretary to approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources.