

Bundled Payments for Care Improvement Initiative
Request for Application

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I. Background

A. Goals and Objectives

The Centers for Medicare & Medicaid Services (CMS) is committed to achieving the three-part aim of better health, better health care, and reduced expenditures through continuous improvement for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. To this end, CMS is interested in partnering with providers who are working to redesign care to deliver these aims. Episode payment approaches that reward providers who take accountability for the three-part aim at the level of individual patient care for an episode are potential mechanisms for developing these partnerships.

Under Section 1115A of the Social Security Act, the Center for Medicare and Medicaid Innovation (Innovation Center) is authorized to test innovative payment and service delivery models that have the potential to reduce program expenditures while maintaining or improving the quality of care for beneficiaries. Through the Bundled Payments for Care Improvement initiative described in this Request for Applications (RFA), the Innovation Center will use its authority under Sections 1115A(b)(2)(i) and 1115A(b)(2)(ii) to test alternative models for payment to incentivize care redesign; engage and protect beneficiaries; and learn and diffuse best practices, in order to inform potential changes to the Medicare fee-for-service (FFS) program.

Recently, payers and providers have been experimenting with payment approaches that attempt to align incentives between providers, physicians, and nonphysician practitioners in the FFS payment system to foster working together to improve quality and efficiency. Under the current FFS system, separate FFS payment to numerous providers for a single episode of care may result in fragmentation of care and duplication of services. FFS payments, by paying separately for readmissions and complications, also do not provide incentives for providers to invest in quality improvement and care coordination activities. Payment models that provide a single bundled payment to providers for an entire episode of care, and that hold the same group of providers accountable for the cost, quality, and patient outcomes of that episode, may spur hospitals, physicians, and other providers to better coordinate care, improve quality of care, and consider the financial implications of their decisions.

The CMS is interested in using episode payments as a payment lever to achieve these desired care episode redesign outcomes.

Bundling: "Bundled" payment approaches, which would combine payment for physician, hospital, and other provider services into a single **bundled payment** of a predetermined amount for all services furnished to a beneficiary during an episode of care, have been advocated as a way of aligning provider incentives with three-part aim outcomes. In contrast to FFS payment, the bundled payment may cover multiple providers in multiple care delivery settings. This has the potential to create incentives for providers to deliver care more efficiently through improved coordination. By offering providers a single bundled payment for an episode of care, the providers become jointly accountable and may realize a gain or loss based on how they manage resources and total costs associated with treating the individual patient throughout the episode. Please see Appendix A: Glossary, for further definition of terms.

Bundled payments are most commonly applied to organ transplantation services, with payments including pre- and post-transplant hospital and physicians' services. In these arrangements, a single payment is made prospectively for all transplantation services. The entity receiving this payment typically takes responsibility for distributing payment to other providers. Notwithstanding this experience, the fragmented nature of the delivery, billing, claims processing, and payment systems in

health care makes prospective payment for an episode operationally challenging. As a result, early adopters of the bundled payment approach have often resorted to using retrospective reconciliation against a predetermined target price, rather than a prospective payment approach, to achieve the goals of bundled payments.

Thus, bundled payment approaches can be administered as either:

1. **Retrospective:** the usual FFS payments are made and then the total payment for the episode is reconciled against the predetermined target price.
2. **Prospective:** the negotiated single payment is paid as a lump sum in lieu of FFS payment.

As these terms are used in relation to the Bundled Payments for Care Improvement initiative, “retrospective” and “prospective” may differ from other uses of these words by CMS. For example, a “Prospective Payment System” in Medicare is a method of payment in which Medicare payment for services is made at a predetermined, fixed amount. The prospective payment may be made for a bundle of services, such as the prospective payment to the hospital for the facility services furnished during an acute care hospitalization. This is conceptually the same as a prospective bundled payment for an episode which pays for a larger bundle, such as the facility and professional services for the acute care episode. A retrospective bundled payment model in the Bundled Payments for Care Improvement initiative would ultimately pay based on a predetermined, fixed amount through a reconciliation conducted at a later date that compares FFS payments made to providers with the target price.

The predetermined price typically will provide the payer with a discount compared to the historical total payment for care for the episode in exchange for the opportunity for the participating providers to share the gains resulting from the more efficient redesigned care model.

Similar to the shared savings or capitated policies that underpin Accountable Care Organizations (ACOs) or medical homes, episode payment models create a framework that rewards providers for taking accountability for three-part aim outcomes. However, episode payment models support accountability at the level of an individual patient’s care, rather than at the population level. This reduces risk and operational complexity for the provider. Bundled episode payment models are thus synergistic with the ACO and medical home models, producing better outcomes for patients and allowing providers to achieve gains that accrue due to better outcomes and more efficient care. In addition, bundled payment models may also provide a discount to Medicare over current FFS payment.

Within the context of aligning incentives under episode payment approaches, we expect that successful models will include care redesign and enhancements such as reengineered care pathways using evidence-based medicine, standardized care using checklists, and care coordination. All models may also include opportunities for gainsharing among participating providers. Under the Inpatient Prospective Payment System (IPPS) and the Physician Fee Schedule (PFS), hospitals and physicians face different financial incentives as they provide care to patients. This misalignment between hospital and physician payment incentives may prevent hospitals and physicians from collaborating to improve quality of care and cost-effectiveness. Hospitals have strong and growing incentives to provide facility services at lower cost and higher quality, but often have limited ability to encourage physicians to cooperate in cost-reduction and quality improvement efforts, as physicians’ professional services are paid separately. If hospital and physician payment incentives were aligned, hospitals and physicians could be incentivized to work together to increase the quality, patient centeredness, and cost-effectiveness of care. Under this initiative, gainsharing will be permissible within the safeguards and parameters laid out in this RFA and is extended to enable hospitals, post-acute care providers, physicians, and nonphysician practitioners to all share in gains accrued due to higher quality, more cost-

effective care. We believe cooperative engagement by physicians, hospitals, and post-acute providers has the potential to significantly improve the efficiency and quality of patient care.

Three prior Medicare demonstrations on bundled payment and two on gainsharing inform the Bundled Payments for Care Improvement initiative. These include the Medicare Participating Heart Bypass Center demonstration,¹ the Medicare Cataract Surgery Alternate Payment demonstration,² the Medicare Acute Care Episode (ACE) demonstration,³ the Physician Hospital Collaboration demonstration,⁴ and the 2005 Deficit Reduction Act (DRA) Medicare Gainsharing demonstration.⁵

Medicare achieved 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 average lengths of stay. The Medicare Cataract Surgery Alternate Payment demonstration yielded valuable information regarding the potential value 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. This demonstration resulted in some standardization of physician behavior and corresponding increases in efficiency without affecting beneficiaries' clinical outcomes. However, provider participation was quite limited and, as a result, the savings to Medicare were relatively small.

The ACE demonstration is still in progress; however, agreement between CMS and participating providers on a specified discount for cardiac and/or orthopedic inpatient procedure hospitalizations has yielded savings thus far for Medicare. Under ACE, preliminary reports indicate hospitals have also realized savings and improved quality of clinical care and patient experience due to redesigned care processes. The Medicare Gainsharing demonstration and the Physician Hospital Collaboration demonstration are required to achieve budget neutrality and may achieve savings for Medicare; however, Medicare did not receive a discount on medical severity diagnosis related group (MS-DRG) payments. Final evaluations for these demonstrations are not yet available; however, preliminary results indicate the hospitals and physicians achieved improved clinical and patient outcomes on measures such as decreased length of stay for inpatient care, which may result in savings to Medicare. In addition, preliminary results indicate that the hospitals achieved internal savings due to increased efficiency.⁶

¹ For more information on the Participating Heart Bypass Center demonstration, please see:

<http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=CMS063472>

² For more information on the Cataract Surgery Alternate Payment demonstration, please refer to Abt Associates, Inc., *Medicare Cataract Surgery Alternate Payment Demonstration: Final Evaluation Report*, Cambridge, Mass: Abt Associates, Inc; 1997

³ For more information on the ACE demonstration, please see:

<http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,keyword&filterValue=ACE&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1204388&intNumPerPage=10>

⁴ For more information on the Physician Hospital Collaboration demonstration please see:

<http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,keyword&filterValue=gainsharing&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1186653&intNumPerPage=10>

⁵ For more information the Medicare Gainsharing demonstration, please see:

<http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,keyword&filterValue=Gainsharing&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1186805&intNumPerPage=10>

⁶ http://www.cms.gov/reports/downloads/Buczko_Gain_Sharing_Final_Report_May_2011.pdf

In addition, evidence from private sector experiments with bundled payment indicates that quality, patient experience, and cost-effectiveness can be substantially improved through the use of bundled payments for an episode of care (including prospectively setting a target price, and then paying FFS with retrospective reconciliation) and gainsharing.^{7, 8}

B. General Approach of the Bundled Payments for Care Improvement Initiative

The CMS' comprehensive Bundled Payments for Care Improvement initiative has the following objectives:

- a. Support and encourage providers who are interested in continuously reengineering care to deliver three-part aim outcomes.
- b. Create a virtuous cycle that leads to continually decreasing the cost of an acute or chronic episode of care while fostering quality improvement.
- c. Develop and test payment models that create extended accountability for three-part aim outcomes for acute and chronic medical care.
- d. Shorten the cycle time for adoption of evidence-based care.
- e. Create environments that stimulate rapid development of new evidence-based knowledge – the Learning Health Care System.

The comprehensive initiative will proceed along several tracks, beginning with this RFA for acute care episode redesign in the short term, where we want to partner with providers who are already experimenting with episode payments, as well as with those eager to experiment with episode payments. In the meantime, we will undertake significant internal CMS design and operational work to prepare for a broader shift toward bundled payments, which would then be tested in future prospective payment models. We are also developing a plan to extend the concepts of episode payments and gainsharing to chronic care, and plan to begin design work to prepare providers and CMS for the conceptual and operational complexities associated with bundled payment for an episode of chronic care.

This RFA is the first in the series of activities focused on care episode redesign. CMS seeks applications from providers in four broad categories of care episode redesign models. This RFA focuses on four models included in Table 1, which we expect can be implemented in a relatively short timeframe. The lessons learned through Models 1–4 will inform the development of other CMS endeavors as described above.

⁷ Casale A.S. et al. ProvenCare: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care, *Annals of Surgery*. 2007;(246) 4:613-621.

⁸ Gosfield AG. Making Prometheus Payment Rates Real: Ya' Gotta Start Somewhere. Prometheus Payment and the Robert Wood Johnson Foundation. 2008

Table 1.

Payment of Bundle	Acute Care Hospital Stay Only	Acute Care Hospital Stay plus Post-Acute Care	Post-Acute Care Only	Chronic Care
“Retrospective” (Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)	Model #1	Model #2	Model #3	Model #7
“Prospective” (Single prospective payment for an episode in lieu of traditional FFS payment)	Model #4	Model #5	Model #6	Model #8

 = Current  = Future

The CMS currently seeks to partner with organizations that are focused on the transformation of their payment and care delivery model from one reliant on FFS volume to one that is more focused on optimizing outcomes of care. All models are expected to include care redesign and enhancements such as reengineered care pathways using evidence-based medicine, standardized care using checklists, and care coordination. All may also include opportunities for gainsharing among participating providers. Under all models, applicants must provide Medicare with a discount on Medicare FFS expenditures.

The CMS seeks applications in the following four broad categories of models:

- Model 1: Retrospective** payment models for the **acute inpatient hospital stay** only.⁹
- Model 2: Retrospective** bundled payment models for **hospitals, physicians, and post-acute** providers for an episode of care consisting of an inpatient hospital stay followed by post-acute care.
- Model 3: Retrospective** bundled payment models for **post-acute** care where the bundle does not include the acute inpatient hospital stay.
- Model 4: Prospectively** administered bundled payment models for **hospitals and physicians** for the **acute inpatient hospital stay** only.

The CMS has articulated a vision for the right care for every person every time through CMS’ three-part aim – better health care for individuals, better health for populations, and lower growth in expenditures for the Medicare population. CMS seeks to achieve this by being a major force and trustworthy partner

⁹ Gainsharing is permitted under all models, where hospitals can share gains from efficiency improvements with physicians who partner with hospitals to redesign care. Under this model, we label it retrospective since it involves typical FFS payment of hospitals and physicians, with any gainsharing resulting from a retrospective assessment of internal cost savings by the hospital that then shares those gains with participating physicians.

for the continual improvement of health and health care for all Americans. As part of this Bundled Payments for Care Improvement initiative, CMS is open to strategies that fit within these categories, and to partnering with providers working in different market and organizational contexts. CMS is seeking to support and encourage providers who are interested in reengineering care to deliver three-part aim outcomes, creating a virtuous cycle that leads to continual decreases in the cost of delivering episodes of care and improving quality of care, and creating environments that stimulate rapid development of new evidence-based knowledge as a Learning Health Care System.

This solicitation seeks innovative proposals that will build on the success of previous CMS demonstrations and private sector initiatives. In all models contained in this RFA, discussed in detail below, CMS is seeking proposals that:

- affect broad categories of conditions;
- reach many beneficiaries;
- offer significant savings to Medicare;
- are designed to be scalable and replicable by similar health systems around the country;
- already or could rapidly involve participation by other payers; and
- are able to be implemented on aggressive timelines.

Applicants are anticipated to have experience with cross-provider care improvement efforts of this type, and either have already begun to redesign care or are prepared to redesign care and enter into payment arrangements that include financial and performance accountability for episodes of care. CMS will provide applicants with data to support the development of robust episode definitions and strong discount proposals to enable providers to include Medicare patients in existing initiatives and develop new episode payment models. For applicants who are less ready to engage in care episode redesign, CMS will provide substantial learning network activity around fundamental components of care episode redesign and how to access, protect and use the data provided by CMS to applicants, as discussed further in Sections I.C.ii and II.E, below.

C. Application Submission Process

i. Model 1

a. Letter of Intent

Interested organizations must submit a letter of intent (LOI) no later than ~~September 22, 2011~~ October 6, 2011 for Model 1. Letters of intent will be used only for planning purposes, and will not be binding. Potential applicants should review instructions and use the LOI template on the Innovation Center website at: <http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>. Questions and completed LOIs can be submitted to: BundledPayments@cms.hhs.gov. **Applications from organizations that do not timely submit a Letter of Intent will not be considered.**

b. Application Deadline

Applications must be submitted as described on the Innovation Center website no later than ~~October 21, 2011~~ November 18, 2011 for Model 1. CMS reserves the right to request additional information from applicants in order to assess their applications. Application instructions and forms may be accessed at: <http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>.

ii. Models 2–4

a. Letter of Intent and Research Request Packet

Interested organizations must submit an LOI no later than November 4, 2011 if applying for one or more of Models 2–4. Letters of intent will not be binding. Potential applicants should review instructions and use the LOI template on the Innovation Center website at: <http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>. Questions and completed LOIs can be submitted to: BundledPayments@cms.hhs.gov. ***Applications from organizations that do not timely submit a Letter of Intent will not be considered.***

Along with the LOI, interested organizations who want to be considered for receipt of data (as described in Section I.C.ii.c, below) must submit a Research Request Packet. The packet requires organizations to provide specific information about their study design, including how they plan to use the data to construct an episode definition and develop care episode redesign protocols. Potential applicants should review instructions and use the Research Request Packet on the Innovation Center website at <http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>. Completed Research Request Packets can be submitted to: BundledPayments@cms.hhs.gov.

b. Data Use Agreement

In order to receive data for episode development purposes, potential applicants must first submit a Data Use Agreement (DUA). Potential applicants should review instructions and use the DUA template on the Innovation Center website at: <http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>. Potential applicants who want to receive data should submit the completed DUA along with the LOI and Research Request Packet to: BundledPayments@cms.hhs.gov no later than November 4, 2011.

c. Provision of Data

Prior to the application deadline, CMS will provide historical Medicare claims data to potential applicants for Models 2–4 submitting letters of intent and approved Research Request Packets and DUAs. The data are intended to enable potential applicants to develop robust episode definitions and discount proposals based on the historical experience of providers in the applicant’s geographic area.

At a minimum, the data will include beneficiary-level claims with masked beneficiary identifiers. Specifically, the Limited Data Set will cover the potential applicant’s geographic region and will include Part A and Part B payment amount, MS-DRG/HCPCS codes (as applicable), services rendered, dates of services, diagnosis and procedure codes, and institutional provider, as well as beneficiary age and sex, for applicants that choose to propose a risk adjustment methodology.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act, CMS may release data to organizations conducting research. For the purposes of this initiative, the act of constructing an episode definition and developing care episode redesign protocols to test in the initiative is considered research. In accordance with the research exemption to the rules governing release of data, potential applicants will be expected to submit the Research Request Packet provided by CMS along with their letters of intent in order to be considered for receipt of data. CMS will review the protocols and data management safeguards proposed by applicants. Potential applicants that are approved will be expected to submit Data Use Agreements (DUAs) before receipt of the data. The

Research Data Assistance Center (ResDAC) contractor will provide limited technical assistance once applicants receive the data.

The CMS will also provide potential applicants with informational data, including CY 2008 summary data for 18 sample episode definitions that include combinations of acute and post-acute care. Applicants are permitted to propose conditions and episode definitions that are not included in these data.

d. Application Deadline

Applications must be submitted as described on the Innovation Center website no later than March 15, 2012 for Models 2–4. CMS reserves the right to request additional information from applicants in order to assess their applications. Application instructions and forms may be accessed at:

<http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>

iii. **Participation in Multiple Models**

a. Eligibility and Application Submission

Applicants are welcome and encouraged to apply for and participate in one or more models. LOIs must be submitted separately for Model 1 and Models 2-4; however, applicants interested in applying for more than one of Models 2–4 may submit one LOI for these models. Applicants must submit a separate application for each proposed model. The LOI and application for Model 1 are due by ~~September 22, 2011 and October 21, 2011~~ October 6, 2011 and November 18, 2011 respectively; the LOI and application for Models 2-4 are due by November 4, 2011 and March 15, 2012, respectively. These applications will be considered separately.

b. Payment for Overlapping MS-DRGs

If a Model 1 awardee applies and is selected for Model 2 or 4 that include episode payment for certain MS-DRGs, CMS will amend the Model 1 Bundled Payments for Care Improvement initiative agreement with CMS to exclude those MS-DRGs for patient episodes from Model 1. This will ensure that the same clinical cases are subject to only a single episode payment model.

D. Requests to Withdraw a Pending Application or a Provider

Applicant organizations seeking to withdraw an entire application or to withdraw specific CMS Certification Numbers (CCN) from a pending application should submit via email a written request on the organization’s letterhead that is signed by an authorized corporate official.

To submit a withdrawal request, send the request in encrypted PDF format by email to BundledPayments@cms.hhs.gov. All withdrawal requests must be submitted via encrypted email and the encryption password must be submitted in a separate email to the same address.

The following information must be included:

- Applicant Organization’s Trade Name or “Doing Business As” name
- Address and Point of Contact information
- Exact Description of the Nature of the Withdrawal:
 - E.g., Withdrawal of entire application or individual providers

II. Description of Model Components

The Bundled Payments for Care Improvement initiative proposes to test models that align hospital, physician, and, where appropriate, post-acute provider payment incentives, by allowing providers to enter into payment arrangements that include financial and performance accountability for episodes of care and share with each other gains accrued from more cost-effective care. It is anticipated that the use of these models may lead to higher quality, more coordinated care at lower cost to Medicare.

This is a broad solicitation seeking partners who are interested in redesigning care through bundled payment arrangements that promote improved quality and reduced costs. We welcome alternative approaches to care episode redesign, including care episode redesign processes, payment arrangements, and arrangements among providers, that fit within the broad models described below. We note that while these are broad models, as we assess applications for the specific models proposed by stakeholders, we expect there will be some convergence of the aspects of certain models regarding clinical conditions, episode durations, or other features such that we are able to test similar models in different settings which reach many Medicare beneficiaries.

For the purposes of this initiative, the providers partnering in the models fall into two categories: 1) Bundled Payment physicians/practitioners who are expected to participate, including suppliers who may be separately paid by Medicare for their professional services (e.g., physicians, nurse practitioners, physician assistants, physical therapists); and 2) Bundled Payment participating organizations, which include all other providers or suppliers with whom the applicant plans to partner (e.g., hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies). Together, these two categories of participants are referred to as Bundled Payment participating providers.

A. Principles and Summary of the Models

i. **Model 1: Retrospective** payment models for the **acute inpatient hospital stay** only.

This model includes an episode of care focused on the acute care inpatient hospitalization. Under this model, hospitals may share gains beyond the predetermined MS-DRG payment discount that accrue due to higher quality, more efficient care, with physicians and other personnel treating patients during the hospital stay.

For Model 1, the episode of care is the acute inpatient hospital stay for all Medicare FFS beneficiaries admitted to an awardee or a Bundled Payment participating provider (acute care hospital), regardless of the assigned MS-DRG. The episode includes all Part A services furnished to included beneficiaries during the hospital stay, including hospital diagnostic testing and all related therapeutic services furnished by an entity wholly owned or wholly operated by the admitting hospital in the three days prior to admission and the hospital facility services furnished during the hospital stay.

This model can be viewed as an extension of past CMS initiatives around acute inpatient hospital episodes, including gainsharing. In addition, past gainsharing demonstrations did not provide direct savings to Medicare. The only potential savings for Medicare resulted from potential decreases in Part B expenditures during or after the hospitalization or decreases in Part A expenditures after the hospitalization. Under this model, awardees may be allowed, on a case-by-case basis, to share gains from improved care among participating providers, physicians, and practitioners. These arrangements are subject to the parameters specified here and in Section II.D, which ensure that gainsharing

arrangements promote improved quality, as well as require significant provider participation in beneficiary protection and program quality assurance initiatives.

Awardees are expected to offer a discount to Medicare from the usual Part A hospital inpatient payments, specifically the base MS-DRG payments as calculated to include all payment adjusters and applicable outlier payments, except disproportionate share hospital (DSH) payments, hospital capital payments, and indirect medical education (IME) payments. Applicants will be expected to propose a rate of discount on their expected Part A payments. The discount (incorporated prospectively into the hospital's FFS payment) will be phased in as follows:

- For the first six months of year one, providers may offer a discount of 0% or higher. Awardees may engage in gainsharing during this period even if they do not offer Medicare a discount.
- For the second six months of year one, awardees will be expected to offer a minimum 0.5% discount to Medicare on all Part A hospital inpatient payments.
- In year two, awardees will be expected to offer a minimum 1% discount to Medicare on all Part A hospital inpatient payments.
- In year three, awardees will be expected to offer a minimum 2% discount to Medicare on all Part A hospital inpatient payments.

The CMS will give preference to applications that offer a greater discount to Medicare, in the context of a robust programmatic design that ensures high quality care for beneficiaries.

All eligible beneficiaries (i.e., all patients who have both Medicare Part A and Part B and for whom Medicare FFS is the primary payer) who are treated in a participating hospital must be included in this payment model. Under this model, we expect there will be widespread engagement of the medical and hospital staff in care episode redesign processes. However, in this model, physician participation in actual gainsharing must be voluntary. Applicants will be expected to provide evidence of active participation by physicians in the initiative, including evidence of disclosure to physicians that the hospital is participating. Further discussion of the requirements and safeguards regarding how gainsharing must foster care episode redesign and improved care quality can be found in Section II.D.

Under this payment model, claims for all inpatient hospital stays will continue to be processed under existing IPPS payment rules. CMS will reduce the IPPS payment by the agreed-upon discount as claims are paid. The discount will be applied to payment rates as payment rates for participating hospitals are updated (positively or negatively) annually according to the standard IPPS updates and other adjustments that apply.

In this model, all participating hospitals are expected to report, at a minimum, the full set of Hospital Inpatient Quality Reporting Program (Hospital IQR) measures, including both those measures required to receive the full annual payment update and those measures not required for the full annual payment update, which are labeled as either CMS informational or CMS voluntary measures. These measures are listed in Appendix B to this RFA. CMS will collect the additional measures derived from claims and enrollment data, which do not require hospital reporting. These measures may change on an annual basis and are available on www.qualitynet.org. The table in Appendix B of the RFA lists the applicable measures for FY 2011. CMS will monitor the quality of care furnished at participating hospitals through these measures and ensure that, at a minimum, each hospital's performance does not decrease over the duration of the agreement period; decreased performance during the period of this initiative may result in termination of the awardee/provider agreement. In addition, applicants are expected to propose additional quality measures. See Section IV of the RFA for further information on the quality measures to be included in the application.

The CMS or its contractor will monitor and measure care provided during the episode to ensure that aggregate Medicare Part A and Part B spending for included beneficiaries does not increase as a result of participation in this initiative. As part of the same calculation, CMS or its contractor will monitor and measure care provided during a post-episode monitoring period of 30 days post-hospital discharge to ensure that aggregate Medicare Part A and Part B spending for included beneficiaries does not increase. This monitoring will include measuring expenditures for included beneficiaries at non-participating providers. Aggregate Medicare Part A and Part B expenditures for included beneficiaries during the episode and post-episode monitoring period will be compared to a historical baseline payment that has been trended over time and which will include a risk threshold. If spending exceeds the risk threshold, the awardee must pay Medicare for the excess. Further discussion of aggregate expenditures and the post-episode monitoring period can be found in Section II.C.

The goal of this model is to foster care episode redesign by aligning payment incentives among hospitals, physicians, and other providers. As such, applicants will be expected to describe how care will be redesigned and how physicians and nonphysician practitioners participating in the episode, including participation in any gainsharing arrangements, will be expected to meet standards for quality, quality improvement, and patient experience of care. CMS will work with awardees to measure and monitor care throughout the project to ensure project objectives are met in redesigning care, meeting quality and patient experience of care standards, and demonstrating improved care coordination.

Beneficiaries who receive care from Model 1 participants may benefit from increased communication and coordination between their treating providers, improved discharge planning, fewer re-operations, fewer avoidable readmissions, higher quality of care throughout the hospital stay, and shorter average lengths of stay.

Table 2.

Model 1: Retrospective Acute Care Hospital Stay Only	
Entities eligible to be awardees:	<ul style="list-style-type: none"> • Physician group practices. • Acute care hospitals. • Health systems. • Physician hospital organizations. • Conveners of participating health care providers.
Episode definition	
Criteria for beneficiary inclusion in episode:	<ul style="list-style-type: none"> • Admission to an acute care hospital for a claim paid under the IPPS under any MS-DRG
Episode anchor:	<ul style="list-style-type: none"> • Acute care hospital admission at awardee or Bundled Payment participating organization for any MS-DRG.
End of episode:	<ul style="list-style-type: none"> • Acute care hospital discharge.
Types of services included in bundle:	<ul style="list-style-type: none"> • Part A inpatient hospital services.
Payment from CMS to providers:	<ul style="list-style-type: none"> • Acute care hospital: Traditional FFS with a predetermined discount included in prospective payment. • Physician: Traditional FFS.

Model 1: Retrospective Acute Care Hospital Stay Only	
Expected discount provided to Medicare:	<ul style="list-style-type: none"> • Year 1: Minimum 0% for start date through month 6; minimum 0.5% for months 7-12 on all Part A allowed charges. • Year 2: Minimum 1% on all Part A allowed charges. • Year 3: Minimum 2% on all Part A allowed charges. • <i>Exact amount to be proposed.</i>
Reconciliation, spending calculation, disbursement, and post-episode monitoring:	<ul style="list-style-type: none"> • <u>Episode reconciliation</u>: A discount on Part A payments will be incorporated prospectively. Medicare spending for the inpatient hospital stay will not be reconciled against a set target price. • <u>Episode monitoring</u>: Medicare Part A and Part B payment for the inpatient hospital stay that exceeds trended historical aggregate Part A and Part B payment beyond a risk threshold (taking the discount into consideration) must be paid by the awardee to Medicare. • <u>Post-episode monitoring</u>: Medicare Part A and Part B payment during the post-episode monitoring period that exceeds trended historical aggregate Part A and Part B payment beyond a risk threshold must be paid by the awardee to Medicare.
Post-episode monitoring period:	<ul style="list-style-type: none"> • 30 days post-hospital discharge.
Gainsharing; Other payment arrangements between participating providers (i.e., non-hospital care settings):	<ul style="list-style-type: none"> • <i>To be proposed.</i> • <i>To be proposed.</i>
Quality measures:	<ul style="list-style-type: none"> • All Hospital Inpatient Quality Reporting (Hospital IQR) measures, including both those measures required to receive the full annual payment update and those additional Hospital IQR measures not required for the full annual payment update. • <i>Additional quality measures to be proposed. A standardized set will ultimately be required and agreed upon by CMS and the awardee. These measures will be aligned with other CMS programs to the greatest extent possible.</i>

ii. **Model 2: Retrospective** bundled payment models for **hospitals, physicians, and post-acute** providers for an episode of care consisting of an inpatient hospital stay followed by post-acute care.

This model extends the episode of care beyond the acute care inpatient hospitalization to include post-acute care following and associated with the acute care episode. However, because CMS is not prepared to process bundled payments like this prospectively, and most providers are not prepared to accept and distribute a single prospective episode payment for all services, this model uses typical FFS payment with retrospective payment reconciliation against the predetermined target price for the episode. This model, then, is distinctly different from the CMS ACE Demonstration, which makes a single prospective bundled payment for the episode and does not include post-acute services.

Applicants will have two options under this model based on the length of the episode of the care. In both options, the episode anchor is an acute care hospital admission for an agreed-upon MS-DRG. All beneficiaries admitted to an awardee or Bundled Payment participating provider (acute care hospital) for agreed-upon MS-DRGs will be included in the episode. The episode will begin with the inpatient hospital admission to a participating provider and will continue through a minimum of 30 days following discharge from the hospital. The episode will include all hospital diagnostic testing and all related

therapeutic services furnished by an entity wholly owned or wholly operated by the admitting hospital in the three days prior to hospital admission, Part A and Part B services that are furnished during the hospital stay, and Part A and Part B services in the post-discharge period related to the episode anchor. All Part A services for related readmissions and all related Part B services furnished during the post-discharge period including during related and unrelated readmissions must be included in the episode in both options that are described below. Under the first option, applicants may propose an episode that extends 30 to 89 days following the hospital discharge. Under the second option, applicants must propose an episode that extends 90 days or longer following the hospital discharge. The applicant will propose the length of the episode and need not propose a strict pro-rated episode definition (for example, services starting within the episode time period and continuing past the episode conclusion, based on days following hospital discharge, could still be included in the episode).

Applicants under both options will be expected to propose further definitions of the episode, including beneficiary identification (through MS-DRGs), excluded unrelated Part A services such as certain readmissions (identified by MS-DRGs designated as unrelated), and excluded unrelated Part B services (identified by principal ICD-9 diagnosis codes designated as unrelated). Physicians' services furnished throughout the episode period and post-acute services related to the episode anchor and furnished during the episode period must be included in the episode under either option. Applicants under the first option must offer a minimum 3% discount off of all included MS-DRGs and other Part A and Part B services within the episode. Applicants under the second option must offer a minimum 2% discount off of all included MS- DRGs and other Part A and Part B services within the episode. The lower minimum level of discount under the second option is meant to balance the increased financial risk (due to the longer episode) under that option. We encourage applicants to propose an episode with a longer period post-hospital discharge, because CMS is interested in understanding how care redesign extends to a beneficiary's transition back into the community. Applicants should factor expected Medicare outlier payments into financial models when proposing a target price that reflects a discount. CMS will consider applicant proposals using risk adjustment¹⁰ which include a description of the methodology.

Applicants will be expected to propose a target price for the episode that includes a single rate of discount on the expected Medicare payments for all included Part A and Part B services. With respect to the inpatient hospital payment considered in the target price, this proposed target price should consider the base MS-DRG payment accounting for all payment adjustors and applicable outlier payments, except disproportionate share hospital (DSH) payments, hospital capital, and indirect medical education (IME) payments, for either option. Over the model years, the negotiated discount reflected in the target price will remain constant, while we index the target price each year to FFS payment changes as the systems are updated (positively or negatively) annually according to the applicable standard IPPS, PFS, and post-acute provider prospective payment system updates and other adjustments that apply.

The CMS will give preference to applications that offer a greater discount to Medicare, in the context of a robust programmatic design that ensures high quality care for beneficiaries.

All beneficiaries eligible for the episode (based on MS-DRG) admitted to the awardee or its Bundled Payment participating providers (acute care hospitals must be included in the bundled payment model

¹⁰ Note a key issue that CMS will critically assess when considering risk adjustment models that incorporates diagnosis data is that risk scores can be affected not just by changes in the health status of the population or patient but also by changes in coding intensity and by the mix of specialists and other providers furnishing services. The experience in Medicare Advantage clearly shows that health plans can significantly increase the complexity score of their populations by focusing on more complete coding. Similarly, our experience with the Physician Group Practice demonstration shows that participating awardees have an incentive to code more fully or intensely because of the potential impact on performance payments and to provide more accurate measurement and reporting of quality measures, as well as to provide more complete and accurate information that can be used for population management.

under either option. While hospitals, physicians, and post-acute providers are encouraged to engage with each other as participating partners in the episode of care, applicants should recognize that awardees will be financially liable for Medicare payment in aggregate beyond the predetermined target price, including care for included beneficiaries that is furnished by providers who are not participating in testing the bundled payment model. No outlier payments beyond the usual FFS outlier payments that would have been paid for qualifying individual cases will be made above the agreed-upon target price for catastrophic cases at reconciliation. Awardees may not restrict beneficiary choice of provider and must notify beneficiaries of their participation in this initiative. Further discussion of the beneficiary's right to choose a provider and of the awardee's obligation to notify beneficiaries of their participation may be found in Section II.H. Applicants will be expected to provide evidence about how they would ensure beneficiaries have complete freedom of choice of providers, including post-acute providers. Payments to all physicians and other practitioners who provide care to included beneficiaries during the episode will be considered in the retrospective reconciliation for the episode. In this model, awardees may gainshare with all providers treating patients during the episode, although participation in the gainsharing element of the payment model (if the proposal includes gainsharing) must be voluntary. Given this, applicants will be expected to provide evidence of active participation by physicians and post-acute providers in the initiative, including evidence of disclosure to physicians that the hospital and post-acute providers are participating. Further discussion of requirements and safeguards around gainsharing can be found in Section II.D.

Under this payment model, claims for all services will continue to be processed under the relevant IPPS, PFS, and post-acute payment system rules under either option. There will be a regular retrospective reconciliation against the predetermined target price. If aggregate FFS payments for included services exceed the predetermined target price, the awardee must repay Medicare. If aggregate FFS payments for included services are less than the predetermined price, the awardee will be paid the difference, which may be shared among the participants. All payments for the episode of care, including outlier payments, will be included in the episode reconciliation of actual payments made against the target price. The awardee bears full risk for any expenditures beyond the target price of the episode.

The CMS will measure and monitor care throughout to ensure project objectives are met in redesigning care, meeting quality and patient experience of care standards, and demonstrating improved care coordination.

The CMS or its contractor will measure care provided during a 30 day post-episode monitoring period to ensure the aggregate Medicare Part A and Part B spending for included beneficiaries does not increase as a result of this initiative. This will include measuring expenditures for included beneficiaries at non-participating providers. Aggregate Medicare Part A and Part B expenditures for included beneficiaries during the post-episode monitoring period will be compared to a historical baseline payment that has been trended over time and which will include a risk threshold. If spending exceeds the risk threshold, the awardee must pay Medicare for the excess. Further discussion of aggregate expenditures and the post-episode monitoring period can be found in Section II.C.

Beneficiaries who receive care from Model 2 participants may benefit from increased communication and coordination between their treating providers, improved hospital discharge and facility transfer planning, fewer re-operations, fewer avoidable readmissions, more appropriate post-acute care, higher quality of care throughout the episode, and shorter average lengths of stay in the acute care hospital and in post-acute care facilities.

Table 3.

Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care	
Entities eligible to be awardees:	<ul style="list-style-type: none"> • Acute care hospital. • Health systems. • Post-acute providers. • Physician hospital organizations. • Physician group practices. • Conveners of participating health care providers.
Episode definition	
Criteria for beneficiary inclusion in episode:	<ul style="list-style-type: none"> • Organized around reason for hospitalization (MS-DRG). • Exact identification criteria to be proposed.
Episode anchor:	<ul style="list-style-type: none"> • Acute care hospital admission at awardee or Bundled Payment participating organization for included clinical conditions (identified via MS-DRG).
End of episode:	<ul style="list-style-type: none"> • Option 1: Minimum 30 days post-hospital discharge; maximum of 89 days post-hospital discharge. • Option 2: Minimum 90 days post-hospital discharge.
Types of services included in bundle:	<ul style="list-style-type: none"> • Physicians' services. • Inpatient hospital services (episode anchor). • Inpatient hospital readmission services. • Long term care hospital services (LTCH). • Inpatient rehabilitation facility services (IRF). • Skilled nursing facility services (SNF). • Home health agency services (HHA). • Hospital outpatient services. • Independent outpatient therapy services. • Clinical laboratory services. • Durable medical equipment. • Part B drugs.
Payment from CMS to providers:	<ul style="list-style-type: none"> • Traditional FFS (ultimate reconciliation with predetermined target price).
Expected discount provided to Medicare:	<ul style="list-style-type: none"> • Option 1: Minimum 3% discount on included Part A and Part B allowed charges for episodes that include a post-hospital discharge period of 30 days to 89 days. • Option 2: Minimum 2% discount on included Part A and Part B allowed charges for episodes that include a post-hospital discharge period of 90 days or longer. • <i>Exact discount rate to be proposed under either option.</i>
Reconciliation, spending calculation, disbursement, and post-episode monitoring period:	<ul style="list-style-type: none"> • <u>Episode reconciliation</u>: If aggregate FFS payments for included services during the episode are less than the predetermined target price, Medicare will pay the difference to awardee. If aggregate FFS payments for included services during the episode exceed the predetermined target price, awardee must repay Medicare. • <u>Post-episode monitoring</u>: Medicare Part A and Part B payment for included beneficiaries during the post-episode monitoring period that exceeds trended historical aggregate Part A and Part B payment beyond a risk threshold will be paid by the awardee to Medicare.

Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care	
Post-episode monitoring period:	<ul style="list-style-type: none"> • 30 days following the end of the episode.
Gainsharing; Other payment arrangements between Bundled Payment participating organizations:	<ul style="list-style-type: none"> • <i>To be proposed.</i> • <i>To be proposed.</i>
Quality measures:	<ul style="list-style-type: none"> • <i>To be proposed, but a standardized set will ultimately be required and agreed upon by CMS and the awardee. These measures will be aligned with other CMS programs to the greatest extent possible.</i>

iii. **Model 3: Retrospective** bundled payment models for **post-acute** care where the bundle does not include the acute inpatient hospital stay.

This model will test the potential for reducing Medicare expenditures and improving quality via bundled payment for an episode of care consisting of post-acute care following an acute inpatient hospital stay, but where the initial inpatient hospital stay is not included in the episode.

The episode anchor is the initiation of post-acute care services at a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, or with a home health agency within 30 days of beneficiary discharge from an acute care hospital for an agreed-upon MS-DRG. All beneficiaries who initiate post-acute care services with an awardee or Bundled Payment participating organization of the type specified previously will be included in the Model 3 episode. The episode will begin on the date post-acute services are initiated with an awardee or Bundled Payment participating organization and will continue through a minimum of 30 days following initiation of the episode. The episode must include all related Part A and Part B services furnished during the episode period, including related readmissions. All Part A services for related readmissions and all related Part B services (e.g., physicians' services and post-acute services related to the episode anchor) furnished during the episode period, including during related and unrelated readmissions, must be included in the episode. Applicants will be expected to propose further definitions of the episode, including beneficiary identification (through MS-DRGs), length of the episode, excluded unrelated Part A services such as certain readmissions (identified by MS-DRGs designated as unrelated), and excluded unrelated Part B services (identified by principal ICD-9 diagnosis codes designated as unrelated). CMS will give preference to applications that propose an episode definition longer than 30 days because CMS is interested in understanding how care redesign extends to the beneficiary's transition back into the community.

Applicants will be expected to propose a target price for the episode that includes a single rate of discount off of the expected Medicare payments for all included services. Applicants should factor expected readmissions during the episode period into their financial proposals. In addition, applicants should factor expected outlier payments into their financial models when proposing a target price that reflects a discount. Over the model years, the negotiated discount reflected in the target price will remain constant, while we index the target price each year to FFS payment changes as the systems are updated (positively or negatively) annually according to the applicable standard PFS and post-acute provider prospective payment system updates and other adjustments that apply. CMS will consider applicant proposals around risk adjustment¹¹, which must include a description of the methodology and plans for updating risk adjustment on a yearly basis based on new information.

¹¹ Ibid.

The CMS will give preference to applications that offer highly competitive discounts to Medicare, in the context of a robust programmatic design that ensures high quality care for beneficiaries.

All beneficiaries eligible for the episode initiating post-acute care services with the awardee or its Bundled Payment participating providers (SNF, IRF, LTCH, or HHA) must be included in the episode payment model. While post-acute providers and physicians are encouraged to engage with each other as partners in the episode, applicants should recognize that awardees will be financially liable for Medicare payment in aggregate beyond the predetermined target price, including care for included beneficiaries that is provided by providers who are not directly participating in testing the episode payment model. No outlier payments beyond the usual FFS outlier payments that would have been paid for qualifying individual cases will be made above the agreed-upon target price for catastrophic cases at reconciliation. Awardees may not restrict beneficiary choice of provider and must notify beneficiaries of their participation in this initiative. Further discussion of the beneficiary's right to choose a provider and of the awardee's obligation to notify beneficiaries of their participation may be found in Section II.H. Applicants will be expected to provide evidence about how they would ensure beneficiaries have complete freedom of choice of providers, including post-acute providers. Payments to all physicians and other practitioners who provide care to included beneficiaries during the episode will be considered in the retrospective reconciliation for the episode. In this model, awardees may gainshare with all providers treating patients during the episode, although participation in the gainsharing element of the payment model (if the proposal includes gainsharing) must be voluntary. Given this, applicants will be expected to provide evidence of active participation by physicians and other practitioners in this initiative. Further discussion of requirements and safeguards around gainsharing can be found in Section II.D.

Under this payment model, all claims for all services will continue to be processed under the relevant physician, post-acute provider, and other provider and supplier payment systems and rules. There will be a regular retrospective reconciliation against the predetermined target price. If aggregate FFS payments for included services exceed the predetermined target price, the awardee must repay Medicare. If aggregate FFS payments for included services are less than the predetermined price, the awardee will be paid the difference, which may be shared among the participants. All payments for the episode of care, including outlier payments, will be included in the episode reconciliation of actual payments made against the target price. The awardee bears full risk for any expenditures beyond the target price of the episode.

The CMS will measure and monitor care throughout to ensure project objectives are met in redesigning care, meeting quality and patient experience of care standards, and demonstrating improved care coordination.

The CMS or its contractor will measure care provided during a 30 day post-episode monitoring period to ensure the aggregate Medicare Part A and Part B spending for included beneficiaries does not increase as a result of this initiative. This will include measuring expenditures for included beneficiaries at non-participating providers. Aggregate Medicare Part A and Part B expenditures for included beneficiaries during the post-episode monitoring period will be compared to a historical baseline payment that has been trended over time and which will include a risk threshold. If spending exceeds the risk threshold, the awardee must pay Medicare for the excess. Further discussion of aggregate expenditures and the post-episode monitoring period can be found in Section II.C.

Beneficiaries who receive care from Model 3 participants may benefit from increased communication and coordination between their treating providers, improved hospital discharge and facility transfer

planning, fewer avoidable readmissions, higher quality post-acute care, and shorter average lengths of stay in post-acute care facilities.

Table 4.

Model 3: Retrospective Post-Acute Care Only	
Entities eligible to be awardees:	<ul style="list-style-type: none"> • Physician group practices. • Acute care hospitals. • Health systems. • Long term care hospitals (LTCH). • Inpatient rehabilitation facilities (IRF). • Skilled nursing facility (SNF). • Home health agency (HHA). • Physician hospital organizations. • Conveners of participating health care providers.
Episode definition	
Criteria for beneficiary inclusion in episode:	<ul style="list-style-type: none"> • Organized around reason for hospitalization (MS-DRG). • Exact criteria to be proposed.
Episode anchor:	<ul style="list-style-type: none"> • Initiation of SNF, IRF, HHA, or LTCH services with awardee or Bundled Payment participating organization within 30 days following discharge from an acute care inpatient hospital for an included MS-DRG.
End of episode:	<ul style="list-style-type: none"> • Minimum 30 days following the episode anchor. • Exact duration to be proposed.
Types of services included in bundle:	<ul style="list-style-type: none"> • Physicians' services. • Inpatient hospital readmission services. • Long term care hospital services (LTCH). • Inpatient rehabilitation facility services (IRF). • Skilled nursing facility services (SNF). • Home health agency services (HHA). • Hospital outpatient services. • Independent outpatient therapy services. • Clinical laboratory services. • Durable medical equipment. • Part B drugs.
Payment from CMS to providers:	<ul style="list-style-type: none"> • Traditional FFS (ultimate reconciliation with predetermined target price).
Expected discount provided to Medicare:	<ul style="list-style-type: none"> • <i>To be proposed.</i>
Reconciliation, spending calculation, disbursement, and post-episode monitoring period:	<ul style="list-style-type: none"> • <u>Episode reconciliation</u>: If aggregate FFS payments for included services during the episode are less than the predetermined target price, Medicare will pay the difference to awardee. If aggregate FFS payments for included services during the episode exceed the predetermined target price, awardee must repay Medicare. • <u>Post-episode monitoring</u>: Medicare Part A and Part B payment for included beneficiaries during the post-episode monitoring period that exceeds trended historical aggregate Part A and Part B payment beyond a risk threshold will be paid by the awardee to Medicare.
Post-episode monitoring period:	<ul style="list-style-type: none"> • 30 days following the end of the episode.
Gainsharing:	<ul style="list-style-type: none"> • <i>To be proposed.</i>

Model 3: Retrospective Post-Acute Care Only	
Other payment arrangements between Bundled Payment participating organizations:	<ul style="list-style-type: none"> • <i>To be proposed.</i>
Quality measures:	<ul style="list-style-type: none"> • <i>To be proposed, but a standardized set will ultimately be required and agreed upon by CMS and the awardee. These measures will be aligned with other CMS programs to the greatest extent possible.</i>

iv. Model 4: Prospectively administered bundled payment models for hospitals and physicians for the acute inpatient hospital stay only.

This model builds on the ongoing ACE Demonstration, which includes a single prospective payment of a predetermined amount for hospital and physicians' services for episodes of inpatient hospitalization for selected conditions. The single bundled payment includes an agreed-upon discount to Medicare. The ACE Demonstration includes elements of gainsharing between hospitals and physicians, as well as sharing savings with the patient. Proposals under Model 4 will build on the ACE demonstration, expanding to additional geographic areas and clinical conditions; however, this initiative does not include sharing savings with patients because past experiences with such policies have proven operationally challenging to administer and confusing for beneficiaries.

The episode anchor is an acute care hospital admission for agreed-upon MS-DRGs. The episode of care is the acute inpatient admission to an awardee or Bundled Payment participating provider for agreed-upon MS-DRGs, through discharge. The episode will include Part A hospital services and Part B professional services, including the diagnostic and therapeutic services furnished by the hospital or an entity wholly owned or wholly operated by the hospital in the three days prior to admission. Part A hospital services furnished during related readmissions and all related Part B professional services furnished during any readmission (related or unrelated) are also included in the episode payment. Applicants are expected to propose further definitions of the episode, including beneficiary identification (through MS-DRGs), the post-discharge period during which related readmissions will be included, excluded Part A costs such as unrelated readmissions (identified by MS-DRGs designated as unrelated), as well as excluded unrelated Part B professional services (identified by principal ICD-9 diagnosis codes designated as unrelated).

The CMS will consider applicant proposals around risk adjustment,¹² which must include a description of the methodology and may include plans for updating risk adjustment on a yearly basis based on new information. Applicants should factor related readmissions within a minimum of 30 days after hospital discharge into their financial proposals. In addition, applicants should factor expected outlier payments into their financial models when proposing a single bundled payment price for an episode that reflects a discount.

Applicants will be expected to propose a target price for the episode that includes a single rate of discount off of the expected Medicare Part A and Part B payments for all hospital facility and professional services furnished during the hospitalization and related readmissions for all beneficiaries with the agreed-upon MS-DRGs. With respect to the inpatient hospital payment considered in the bundled payment, the proposed bundled payment should consider the base MS-DRG payment accounting for all payment adjustors and applicable outlier payments, except disproportionate share hospital (DSH) payments, indirect medical education (IME) payments, and hospital capital payments. Applicants may propose the MS-DRGs that were specified in the ACE Demonstration (<http://www.cms.gov/DemoProjectsEvalRpts/downloads/ACESolicitation.pdf>), or may propose

¹² Ibid.

additional or different MS-DRGs. Based on the discounts to Medicare established in the ACE Demonstration, we expect applicants to offer at least a 3% discount on expected FFS payment for the episode of care. For applicants who propose episodes of care for clinical conditions that consist of those MS-DRGs included in the ACE Demonstration, we expect a discount greater than 3%.

The CMS will give preference to applications that offer a greater discount to Medicare, in the context of a robust programmatic design that ensures high quality care for beneficiaries.

All beneficiaries eligible for the episode admitted to the awardee or its Bundled Payment participating providers (acute care hospitals) must be included in the episode payment model. All physicians and other practitioners who provide care to included beneficiaries will be subject to the payment provisions of this initiative. In this model, awardees may gainshare with all providers treating patients during the episode, although participation in the gainsharing element of the payment model (if the proposal includes gainsharing) must be voluntary. Payments to all physicians and other practitioners who provide care to included beneficiaries during the episode will be made through the single prospectively-established bundled payment; separate payment for providers' professional services will not be made. Given this, applicants will be expected to provide evidence of active participation by physicians in the initiative, including evidence of disclosure to physicians that the hospital is participating. Further discussion of requirements and safeguards around gainsharing can be found in the Section II.D.

The participating acute care hospital (awardee or Bundled Payment participating organization) where the beneficiary is treated will be paid a single bundled payment of a predetermined amount for agreed-upon MS-DRGs. CMS and the awardee will agree to the price for the bundle of services, including the discount, in advance. CMS will pay the hospital the agreed-upon single bundled payment following claims submission at the time of beneficiary discharge. The awardee, whether the awardee is the acute care hospital or a convener, bears full risk for the price of the episode. Because the awardee bears full risk for the price of the episode, no outlier payments or additional payments for catastrophic cases will be added to the bundled payment. The bundled payment will be processed by the Part A/Part B MAC for the hospital. Professional services included in the episode and covered under Part B will be submitted as usual to Medicare but will be processed as "no-pay" claims; these claims will be used to evaluate the impact of the initiative on utilization of services. The participating hospital must accept a single bundled payment for each episode of care as payment in full. The hospital is then responsible for distributing payment to providers as appropriate. Physicians would be paid by the hospital for their professional services, which could be at the same rate as the FFS payment that would otherwise apply, or could be at another rate agreed to between the providers and physicians as proposed by the applicant.

If any Part B claims for services furnished during the episode, or other Part A and/or Part B claims for included services (such as for a related readmission), are submitted and paid separately by Medicare, the awardee must repay Medicare for those Medicare expenditures. CMS will provide the MAC contractors and standard system maintainers with a file containing a list of all awardee and Bundled Payment participating organizations and their associated identification numbers (e.g., National Provider Identifier (NPI)), as well as a list of agreed-upon MS-DRGs and MS-DRG specific rates for each Bundled Payment participating organization prior to the effective date of any included service. Over the model years, the negotiated bundled payment rate will be indexed to FFS payment changes as the systems are updated (positively or negatively) annually according to the applicable standard PFS and IPPS updates and other adjustments that may apply.

In addition to the bundled payment amount that participating providers will receive from Medicare, patients will pay a fixed Part B copayment in lieu of standard Part B coinsurance. CMS will calculate this fixed Part B copayment for each DRG included in the bundled payment. This Part B copayment based on the typical coinsurance of 20% on each Part B claim will be standard for each hospital and DRG, regardless of actual services rendered to an individual beneficiary. Beneficiaries will be responsible for this copayment. No changes to current Medicare policies regarding the obligation to collect of copayments or balance billing will result from this initiative.

The CMS will measure and monitor care throughout to ensure project objectives are met in redesigning care, meeting quality and patient experience of care standards, and demonstrating improved care coordination.

The CMS or its contractor will measure care provided during a 30 day post-episode monitoring period to ensure the aggregate Medicare Part A and B spending for included beneficiaries does not increase as a result of this initiative. This will include measuring expenditures for included beneficiaries at non-participating providers. Aggregate Medicare Part A and Part B expenditures for included beneficiaries during the post-episode monitoring period will be compared to a historical baseline payment that has been trended over time and which will include a risk threshold. If spending exceeds the risk threshold, the awardee must pay Medicare for the excess. Further discussion of aggregate expenditures and the post-episode monitoring period can be found in Section II.C.

Beneficiaries who receive care from Model 4 participants may benefit from increased communication and coordination between their treating providers, improved discharge planning, fewer re-operations, fewer avoidable readmissions, higher quality of care throughout the hospital stay, and shorter average lengths of stay.

Because CMS has already supported several ACE Demonstration awardees, we view this as an expansion of that approach, and particularly encourage proposals that are designed to be quickly implemented on a large scale.

Table 5.

Model 4: Acute Care Hospital Stay Only	
Entities eligible to be awardees:	<ul style="list-style-type: none"> • Acute care hospitals. • Health systems. • Physician group practices. • Physician hospital organizations. • Conveners of participating health care providers.
Episode definition	
Criteria for beneficiary inclusion in episode:	<ul style="list-style-type: none"> • Organized around reason for hospitalization (MS-DRG). • <i>Exact criteria to be proposed.</i>
Episode anchor:	<ul style="list-style-type: none"> • Acute care hospital admission at awardee or Bundled Payment participating organization for included clinical conditions.
End of episode:	<ul style="list-style-type: none"> • Acute care hospital discharge.
Types of services included in bundle ¹ :	<ul style="list-style-type: none"> • Physicians' services. • Inpatient hospital services (episode anchor). • Inpatient hospital readmission services.
Payment from CMS to providers:	<ul style="list-style-type: none"> • Acute Care Hospital: Prospectively-established bundled payment for identified MS-DRGs. • Physician: Paid by acute care inpatient hospital. Claims for included services are submitted to Medicare as "no-pay."

Model 4: Acute Care Hospital Stay Only	
Expected discount provided to Medicare:	<ul style="list-style-type: none"> The prospectively-established bundled payment will incorporate a minimum 3% discount on included Part A and Part B allowed charges; more for ACE MS-DRGs. <i>To be proposed.</i>
Reconciliation, spending calculation, disbursement, and post-episode monitoring period:	<ul style="list-style-type: none"> <u>Episode reconciliation:</u> The Bundled Payment participating acute care hospital where the beneficiary is treated will be paid a single prospectively established bundled payment for the episode, including related readmissions. Professional services furnished during the episode and covered under Part B would be billed to Medicare as “no-pay” claims and paid for through the bundled payment made to the hospital. If any Part B claims for professional services furnished during the episode, any claims for Part A for a related readmission, or any claims for related part B professional services furnished during any readmission (related or unrelated) are submitted and paid separately by Medicare, the awardee must repay Medicare for those expenditures. <u>Post-episode monitoring:</u> Medicare Part A and Part B payment for included beneficiaries during the post-episode monitoring period that exceeds trended historical aggregate Part A and Part B payment beyond a risk threshold (taking the prospectively established bundled payment with the discount into consideration) will be paid by the awardee to Medicare.
Post-episode monitoring period:	<ul style="list-style-type: none"> 30 days post-hospital discharge.
Gainsharing; Other payment arrangements between Bundled Payment participating organizations:	<ul style="list-style-type: none"> <i>To be proposed.</i> <i>To be proposed.</i>
Quality measures:	<ul style="list-style-type: none"> <i>To be proposed, but a standardized set will ultimately be required and agreed upon by CMS and the awardee. These measures will be aligned with other CMS programs to the greatest extent possible.</i>

B. Length of Agreement

Bundled Payments for Care Improvement agreements will include a performance period of 3 years, with the possibility of extending an additional 2 years, beginning with program start date. The program start date may be as early as the first quarter of CY 2012 for awardees in Model 1.

C. Budget Impact

For all payment models, CMS aims to ensure that total Medicare expenditures will decrease relative to what they would have been absent this initiative. Awardees may not operate projects that are expected to reduce expenditures for certain services by increasing expenditures outside the episode of care or within the episode to non-included services or providers. No financial arrangements made among providers and other entities (including States) in connection with this program can be used to increase federal Medicaid matching funds. CMS or its contractor will monitor care provided to included beneficiaries during the episode monitoring period for Model 1 and the post-episode monitoring period for all Models. This will include determination of a baseline for aggregate Medicare Part A and Part B FFS expenditures based on awardee historical baseline data around episodes of care for the same MS-DRGs. These data will be trended forward to account for changes in expected payments. A risk threshold will be set to account for random variation; awardees will be expected to pay Medicare for

expenditures above this threshold. This methodology will be provided to awardees prior to entering a final agreement.

D. Gainsharing Arrangements

Gainsharing may be a component of all proposals under Models 1-4. These arrangements will consist of the hospital or providers distributing gainsharing payments to physician(s) and/or other practitioners. These payments will represent a share of the gains resulting from collaborative efforts to improve quality and efficiency.

a. Waiver of Statutory Requirements

Under Section 1115A(d)(1) of Title XI of the Social Security Act, as added by Section 3021 of the Patient Protection and Affordable Care Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII, as well as Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii), as may be necessary for purposes of carrying out Section 1115A with respect to testing of models described in section 1115A(b). The Secretary will consider exercising this waiver authority with respect to the fraud and abuse laws in Titles XI and XVIII as may be necessary to develop and implement the Bundled Payments for Care Improvement initiative. The Secretary may also consider waiving additional provisions under Title XVIII for this purpose.

b. Gainsharing Program Requirements

Gainsharing arrangements must meet the following criteria to be eligible for participation in this initiative. These parameters are designed to ensure that care is not inappropriately reduced, that the quality of care remains constant or is improved, that there are not inappropriate changes in utilization or referral patterns, and to guard against fraud, waste, and abuse. See Section IV for a further discussion of application requirements.

Gainsharing Design

- Applicants must discuss in detail how gainsharing will support care redesign to achieve improved quality and patient experience, and anticipated cost savings.
- Applicants must describe their methodology for the sharing of gains between or among the hospital or other care settings (e.g., post-acute care facility) and physicians and other nonphysician practitioners. This must include a discussion of with whom gains will be shared (e.g., physicians only), with what frequency gains will be shared, and under what criteria gains will be shared (e.g., quality standards).
- Physician and nonphysician practitioners may not reduce or limit services that are medically necessary to a patient entitled to benefits under Medicare.
- Gainsharing arrangements must be transparent and auditable at the Department's request.
- For all proposals that include gainsharing, physician participation in the gainsharing aspect must be voluntary. There may not be adverse consequences for physicians who choose not to participate. Note that if a bundled payment model includes the opportunity for gainsharing, physicians may be required to be paid through the bundled payment model for all patients admitted for included MS-DRGs; however, physicians need not participate in the gainsharing component. Physicians may choose not to participate in gainsharing, or may be ineligible based on quality thresholds.

Quality

- Overall quality of care for beneficiaries cared for by physicians and nonphysician practitioners participating in gainsharing must meet minimum quality requirements and then remain constant or improve for the duration of the arrangement.
- Individual physicians and nonphysician practitioners must meet quality thresholds and engage in quality improvement to be eligible to participate in gainsharing. The applicant must propose the following, which will be reviewed and approved by CMS:
 - Minimum quality thresholds;
 - A process for monitoring quality and quality improvement during the project period; and
 - A set of metrics for improving quality of care during the project period.
- The applicant must discuss how physicians and nonphysician practitioners may become eligible or ineligible to participate in gainsharing.

Payment Methodology

- Payments may not be based on the volume or value of referrals or business otherwise generated between hospital and physician. Payments based on achieved savings are permitted.
- Payments to physicians and nonphysician practitioners may not exceed 50% of the amount that is normally paid to physicians and nonphysician practitioners for the cases included in the gainsharing initiative.
- The applicant must include a comprehensive plan regarding how they will distribute financial rewards in their application.

E. Shared Learning Network Activities

The CMS will provide support to potential applicants for Models 2-4 as they prepare themselves to redesign care toward the three-part aim, using bundled payments levers. Potential applicants under Model 1 are expected to have experience with cross-provider care improvement efforts of this type, and either already have redesigned care or are prepared to redesign care and enter into payment arrangements. Therefore, CMS is not planning any specific support activities for potential applicants under Model 1. Once awardees are selected for all models, CMS will support significant learning network activity to allow awardees (including Model 1) to share lessons learned, best practices, and responses to challenges.

i. Learning Networks for Potential Applicants

The CMS will support potential applicants preparing proposals under Models 2-4 to redesign care and enter into payment arrangements that include financial and performance accountability for episodes of care through learning network activity. Applicant learning network activity may include CMS creation and dissemination of resource documents on how to implement care episode redesign through bundled payments, including minimum data/system requirements, provider contracting templates, best practices around protocols for evidence-based medicine, etc.; Accelerated Development Learning Sessions (ADLSs) geared specifically towards applicants; and case studies. These will provide an opportunity to introduce key concepts to applicants and their participating providers; create a vigorous learning community; engage leadership; and initiate action planning by applicants and their participating providers. Applicants are encouraged, but not required, to participate in learning network activities to apply.

ii. Learning Networks for Awardees

The CMS will support awardees in accelerating their progress by facilitating opportunities for learning how care delivery organizations can achieve performance improvements quickly and effectively, and opportunities to share their experiences with one another and with participants in other Innovation Center initiatives. Because CMS and providers have been considering (and in some cases, experimenting) with bundled payments for over two decades, there are a wide variety of experiences available to share. Learning networks among awardees will allow awardees to learn best practices from their peers and to further develop their programs throughout the agreement period. The Innovation Center will test various approaches to group learning and exchange, helping initiative participants to effectively share their experiences, track their progress and rapidly adopt new ways of achieving improvements in the three-part aim. CMS therefore expects awardees to actively participate in and shape these shared learning network activities.

Specific learning and diffusion activities for awardees that we will consider for this initiative include ADLSs; topic-specific webinars; group-specific virtual collaboratives; semi-annual “live case” visits between awardees; regular site visits by CMS and contractors to providers showing interim positive results with structured qualitative inquiry; and case studies for formal sharing based on site visits, which include identifying, acknowledging and studying high performers.

Applicants will be expected to describe how actively they expect to participate in the learning networks, and CMS will take this into account in evaluating proposals. Further discussion can be found in Section IV.

F. Participation of Other Payers

Applicants should describe the participation of any other payers in the bundled payment structure that is described in the application. CMS encourages applicants who are partnering with States and other entities, including other payers, to redesign care through bundled payments.

CMS will look favorably on applications that demonstrate partnerships with State Medicaid programs, private payers, or multi-payer collaboratives to redesign care. See Section II.A for further details.

G. Program Monitoring

All awardees will be required to comply fully with CMS and its contractor(s)' requests for monitoring and evaluation, including providing data related to providers, beneficiaries, interventions, inter-provider arrangements, among others; being available for site visits by CMS staff and its contractors, and participating in surveys and interviews. Awardees will be expected to provide CMS with ongoing monitoring information by tracking and reporting various measures of program performance and operational metrics, including data on cost savings, incentive payments, clinical quality, and patient experience of care. These will include, but are not limited to, measures such as complication, mortality, and readmission rates.

Awardees will be expected to use a tool to evaluate beneficiary condition at discharge from the hospital, as well as intake and discharge from any post-acute care facilities, to ensure quality and document patterns in patient referrals as they relate to patient health status. Applicants may propose a novel metric, but CMS both suggests and reserves the right to require the use of the Continuity Assessment Record and Evaluation (CARE) tool for this purpose (pursuant to section 1866D(b)(1) of the Social Security Act), or a subset of measures from the CARE tool or other tools, to assess beneficiary condition at specified points in the course of post-acute care.

In addition, applicants are expected to propose other measures that may be appropriate to measure and monitor improvements in health care quality and efficiency specific to their proposals. Measures to monitor ongoing protections of beneficiary interests may include, but are not limited to, patient satisfaction and experience of care, care process data, CARE assessments, and patient safety data. Quality and efficiency measures may assess functional status improvement, reductions in rates of avoidable hospital readmissions, rates of discharge to the community, rates of admission to an emergency room after a hospitalization, incidence of health care-acquired infections, efficiency, patient-centeredness and patient perception of care, or other areas. Applicants are expected to propose quality measures but CMS and awardees will ultimately agree upon a standardized set.

For Model 1, in addition to proposing a set of quality measures, awardees must report all Hospital Inpatient Quality Reporting Program (Hospital IQR) measures, including both those required to receive the full annual payment update and those not required to receive the full annual payment update.

Awardees may not restrict access to necessary care. To safeguard against reductions of necessary care, CMS will routinely analyze data on service utilization, and may review utilization and referral patterns. Awardees will be evaluated against a baseline as well as a comparison group, and awardee/provider agreements may be terminated as appropriate. See Section I for further information.

For all four models, if applicable, awardees are required to have received the full IPPS and OPDS annual payment update for reporting quality measures to CMS (through www.qualitynet.org) since at least FY 2008 and CY 2009, respectively. Hospitals must continue to participate in all CMS quality reporting initiatives for the duration of the project, as must physicians who are already participating in quality reporting initiatives. CMS will look favorably on applications that indicate higher rates of historical physician participation in the Physician Quality Reporting System (PQRS) and on applications that indicate physicians not currently participating will participate for the duration of the project. Bundled Payment participating providers are expected to maintain or improve their performance on the measures reported through Hospital IQR, Hospital Outpatient Quality Data Reporting Program (HOP QDRP) and PQRS for the duration of this initiative; decreased performance during the period of this initiative may result in termination of the agreement. Other types of providers must participate in all established or forthcoming CMS quality reporting activities for the duration of the project.

H. Beneficiary Protections

Beneficiaries in traditional FFS Medicare are entitled to seek care from any provider of their choosing. Nothing in this initiative should be construed to limit that choice. All proposals for all four models must include a description of the patient notification process, including how it will be implemented and documented.

Awardees must agree to notify beneficiaries of their participation in the initiative through signage, individual notices and/or other mechanisms agreeable to CMS. Notices must describe the goals and objectives of the initiative and the use of financial incentives to improve quality and efficiency under the initiative. Awardees will inform beneficiaries about the initiative prior to or as soon as possible following the occurrence of the episode anchor, and it is expected that the awardee will take this opportunity to provide information on the advantages the model offers to included beneficiaries. Applicants must include a beneficiary notification plan as part of their application materials.

Beneficiaries will be informed that they may be contacted by CMS or its contractors to provide information for the evaluation of the initiative. 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.

Applicants will also be expected to provide evidence about how they would ensure beneficiaries have complete freedom of choice of providers, including post-acute providers.

Please see Section IV below for further information on how proposals must include safeguards against limiting medical necessary care. In addition, the monitoring and evaluation components of this initiative will include extensive measures to ensure beneficiaries receive needed care.

Competition in the marketplace promotes quality of care for Medicare beneficiaries and protects access to a variety of providers. All of these benefits to Medicare patients would be reduced or eliminated if CMS facilitates the creation of health care provider agreements among health care providers that reduce competition. Nothing in these agreements shall be construed to modify, impair, or supersede the applicability of any of the antitrust laws.

I. Termination of Bundled Payments for Care Improvement Agreements

The CMS reserves the right to review the status of an awardee and terminate its agreement for the following reasons, or if otherwise required under Section 1115A (b)(3)(B) of the Social Security Act. The agreement may detail additional reasons for termination.

1. If the awardee does not meet quality performance thresholds.
2. If the post-episode monitoring period consistently demonstrates increased Medicare expenditures for services within the episode.
3. If the awardee fails to comply with applicable laws regarding physician self-referral prohibitions, civil monetary penalties (CMP), Anti-kickback statute, other antifraud laws, or any other applicable Medicare laws, rules, or regulations that are relevant to operations and the application of which is not waived by the Secretary.
4. If the awardee restricts access to medically necessary care.
5. If the awardee fails to pay back money owed to the Medicare program as specified in the agreement between the awardee and CMS based on its failure to achieve the predetermined discount on expected payment for services in the bundle (when there is retrospective reconciliation) or based on increases in aggregate Part A and Part B spending during the post-episode monitoring period.
6. If the awardee fails to satisfy any of the Conditions of Participation.
7. If CMS no longer has the funds to support the program.

While we do not anticipate this circumstance, CMS reserves the right to modify or terminate the initiative in whole or in part, at any time prior to the end of the three year initiative if it determines that continuing the project is no longer in the public interest or for any reason determined by CMS. CMS will promptly notify the awardee in writing of the determination, the reasons for such termination, and the effective termination date.

J. Evaluation

The CMS will contract with an independent evaluator to conduct the formal evaluation of program results. All participating providers will be required to cooperate with the independent evaluator to track

and provide agreed upon performance data, as needed for the evaluation. These data may include, but are not limited to, the domains of clinical quality performance, patient functional status, utilization and financial data. CMS will seek to align measures in these areas and those related to ensuring patient/caregiver experience, care coordination/transitions, and patient safety with measures used for other programs, such as the Hospital IQR program and other hospital quality initiatives and those being established to set quality standards under the MSSP proposed rule and other ACO initiatives.¹³

Applicants may propose their own particular set of quality measures for ongoing monitoring, but ultimately CMS reserves the right to standardize these measures across awardees. All awardees in Model 1 must report all Hospital IQR measures, in addition to any agreed upon set of further quality measures. These measures will be aligned with other CMS programs to the greatest extent possible.

In addition, Bundled Payment participating organizations will be required to collect beneficiary contact information, to be provided to CMS or its contractor, for ongoing monitoring up to six months after discharge from the relevant facility. Patient outcome measures will be monitored to assess the extent to which care has improved or to detect deficiencies in quality of care throughout this period.

Blinded applicant proposals will be shared with contractors applying for CMS' evaluation and/or program monitoring contract and non-blinded proposals will be shared with the selected evaluator and/or program monitoring contractor. Contractors applying for CMS' evaluation and/or program monitoring contract will not be permitted to disclose any information provided by applicants under this RFA.

III. Conditions of Participation

A. Eligible Applicants

Please refer to Tables 2 - 5 for specifications around entities eligible to be awardees. CMS is not placing limitations on applicants based on geographic region (i.e., not limited to a specific MAC jurisdiction), geographic type (e.g., urban, rural), or size of health system. Current and past participants of Medicare demonstrations, including ACE sites and Medicare Hospital Gainsharing and Physician Hospital Collaboration Demonstration participants, are eligible to apply. If applications are selected, issues for awardees participating in these CMS programs related to timing, transition, and other aspects will be addressed on a case-by-case basis.

Under the theory that healthcare transformation requires some synergy between new payment methods and care improvement strategies, and the premise that the Bundled Payments for Care Improvement initiative is not a shared savings program with Medicare, CMS encourages entities to participate in the Bundled Payments for Care Improvement initiative and the Medicare Shared Savings Program, the Innovation Center Pioneer ACO and medical home initiatives, and other shared savings initiatives. However, CMS reserves the right to potentially subject these entities to additional requirements, modify program parameters, or ultimately exclude participation in multiple programs, based on a number of factors, including the capacity to avoid counting savings twice in interacting programs and to conduct a valid evaluation of interventions.

Applicants may submit proposals under multiple models of initiative.

¹³ For more information about quality standards related to Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program, please see the Federal Register, vol. 76, no. 67, April 7, 2011, pp. 19258-654.

All proposals must identify a single entity (e.g., hospital, health system, physician hospital organization) that will accept the financial responsibility to Medicare. All applicants must demonstrate the necessary partnerships between the designated awardee and its participating providers. For all proposals that include care across multiple settings, this initiative proposes no limitations on the relationship between the awardee and other entities beyond existing statutory requirements.

Conveners who are able to accept financial risk but are not enrolled Medicare suppliers or providers may also be the awardee.

The CMS encourages conveners who are organizing broad-based care redesign initiatives to apply. States are not eligible to be convener or non-convener awardees and may only apply as facilitator conveners. Other conveners may participate in one of two roles and must identify their intended role in the application:

1. **Awardee.** In order to participate as an awardee, a convener must assume the financial responsibility for the initiative. In this arrangement, the awardee convener would have an agreement with CMS, receive payment of the difference between the target price and FFS payment upon episode reconciliation (Models 2 and 3) or receive the prospective bundled payment (Model 4) directly, assume financial risk for increases in Medicare expenditures during the episode and post-monitoring period as applicable under the chosen model (Models 1-4), and make payments to participating providers as specified by contracts between the convener and those providers. A convener applying to be an awardee must specify in the application the financial arrangements with participating providers that would allow the convener to bear risk and mechanisms that would allow the convener to make payments to providers and/or Medicare. See Section IV for further details.
2. **Facilitator.** A convener may submit an application in partnership with multiple providers, where the convener would participate as a facilitator. In this capacity, the convener could serve an administrative and technical assistance function for one or more designated awardees. In this arrangement, the facilitator convener would not have an agreement with CMS, bear financial risk, or receive any payment from CMS. The facilitator convener could share in the financial risk or cost savings from increased efficiencies experienced by designated awardee(s) through contracts between the convener and the awardee(s). No financial arrangements made among providers and other entities (including States) in connection with this program can be used to increase federal Medicaid matching funds. A convener applying on behalf of designated awardees in a facilitator role must specify in the application:
 - a. The designated awardee(s);
 - b. The entity or entities (i.e., provider(s)) that would bear financial risk and receive payments from CMS; and
 - c. The financial arrangements between the facilitator convener and each awardee/risk-bearing entity.

Conveners of health care providers engaged in care redesign initiatives are encouraged to apply for any of the four models in this RFA, or to multiple models. CMS will look favorably on applications that demonstrate partnership with State Medicaid programs, private payers, or multi-payer collaboratives to redesign care. Applications from conveners (applying to participate in an awardee or facilitator role) that foster the participation of large numbers of providers, affecting large numbers of beneficiaries in an organized and efficient manner, may also be considered favorably.

B. Beneficiary Eligibility

The Bundled Payments for Care Improvement efforts will be targeted to all Medicare FFS beneficiaries with Part A and Part B coverage. 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 with end-stage renal disease (ESRD) are also excluded.

This initiative will not allow beneficiaries to “opt out” of the model payment methodology; that is, a beneficiary who meets the eligibility criteria specified in the model and receives care from a provider who is a Bundled Payments for Care Improvement awardee or Bundled Payment participating provider for a covered service or condition, cannot receive care from that provider without being subject to the Medicare payment methodology (and the related care processes of that provider) of this initiative. However, this program will not affect beneficiaries’ freedom of choice regarding providers, and awardees will be required to notify patients of their participation in the initiative and of beneficiaries’ freedom of choice.

C. Risk Bearing Capability

Applicants must include information regarding the ability of the proposed awardee(s) to bear financial risk; that is, to pay Medicare for any spending during the episode in excess of the target price (in retrospective models), to pay Medicare for any increases in spending in excess of the risk threshold for the trended historical baseline during the post-episode monitoring period (for all models) and episode monitoring period (for Model 1). This must include enforceable assurances of each awardee’s ability to pay Medicare. This assurance could take the form of an irrevocable letter of credit for the full amount of risk undertaken or any similarly enforceable mechanism that covers the full amount of risk.

IV. Application Submission, Review Process, and Selection Criteria

A. Application & Selection Process

Based on the outline that follows, applicants should include “Information to be Included in Proposals” in each proposal. Please see Section I. C, above, for further information regarding the application submission process. Applications and instructions are available at:

<http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>.

The CMS will screen all applications for eligibility, including ensuring that applicants or Bundled Payment participating providers are eligible to receive Medicare payments (checking for excluded providers or suppliers). Each complete and eligible application will be reviewed by a panel of experts from the Department of Health and Human Services as well as other governmental and nongovernmental organizations, with expertise in the areas of provider payment policy, care improvement, and care coordination. Reviewed applications will be scored based on the criteria listed below. CMS will establish guidelines for review panels, and prioritize applications based on both scores and other considerations described below to select awardees.

Because CMS is interested in evaluating all applicants and awardees from a common perspective to support rapid replication and scaling, CMS may negotiate with applicants on aspects of their proposals to promote commonalities among awardees.

Model Design	Points: 20
Criteria:	
<ul style="list-style-type: none"> • For Models 2–4, definition of episode. <ul style="list-style-type: none"> ➤ CMS is seeking applications that include episode definitions that are transparent, replicable, scalable, and will successfully align awardee and provider incentives to improve care and improve cost effectiveness, while protecting beneficiaries from adverse effects. ➤ CMS is seeking applications that propose episodes of care that will affect a larger number of beneficiaries and target the most significant avoidable costs. ➤ CMS is seeking applications that affect a broad range of categories of clinical conditions. ➤ For Models 2 and 3, CMS will give preference to applications that propose an episode definition longer than 30 days post-hospital discharge. • Level of provider engagement and participation. <ul style="list-style-type: none"> ➤ CMS is seeking applications that present strong evidence of physician commitment to align incentives through bundled payments (i.e., applications that include letters of agreement from high numbers and/or high percentages of physicians participating in the proposal). ➤ CMS is seeking applications that present strong evidence of other participating providers' commitment (i.e., applications that include letters of agreement from Bundled Payment participating organizations). • Care Improvement. <ul style="list-style-type: none"> ➤ CMS is seeking applications that present detailed and far-reaching plans to achieve Bundled Payments for Care Improvement outcomes, including: <ul style="list-style-type: none"> ▪ Aspects of care that will be redesigned. ▪ Plans for how care will be redesigned to improve care. ▪ Capacity and readiness to improve care. • Design for gainsharing (any gainsharing component of Models 1–4). <ul style="list-style-type: none"> ➤ Applicants' gainsharing proposals must meet the requirements laid out in this RFA (including safeguards). ➤ CMS is seeking applications that are transparent, replicable, scalable, and will successfully align provider incentives to improve care and improve cost effectiveness. 	
Information to be Included in Application:	
<ul style="list-style-type: none"> • Identification of entity to be designated as awardee. • Model(s) for which applicant is submitting a proposal. • Definition of episode. <ul style="list-style-type: none"> ➤ Clinical conditions (i.e., MS-DRGs) targeted for inclusion in the episode. ➤ Anticipated number of included episodes for each participating provider (volume). ➤ Identification of excluded services (e.g., unrelated readmissions, unrelated services in the post-discharge window) as applicable in each model, and rationale for their non-inclusion. ➤ Definition of the end of the episode of care. • Identification of participating providers. <ul style="list-style-type: none"> ➤ Letters of agreement from providers indicating commitment to participate in this initiative. ➤ Description of plans for disclosing participation in this initiative to physicians/practitioners. 	

- Description of plans to obtain and retain widespread engagement by participating providers in this initiative.
- Care Improvement.
 - Description of the aspects of care that will be redesigned, plans for how care will be redesigned to improve care and, capacity and readiness to improve care, including in the following areas:
 - Evidence-based medicine (e.g., through the establishment and implementation of evidence-based guidelines at the organizational or institutional level).
 - Beneficiary/caregiver engagement (e.g., any shared decision-making processes or tools with which the patient can assess the merits of various treatment options in the context of his or her unique needs, preferences, values, and priorities, methods for fostering what can be termed "health literacy " in patients and their families, routine assessments of beneficiary/caregiver experience of care, among others).
 - Coordination of care and care transitions (e.g., sharing of electronic records across providers, telehealth, remote patient monitoring or other enabling technologies, care plans, medication reconciliation, registries, case conferences, standard protocols, provision of patient self-management tools and education, among others).
- For any proposals under Models 1-4 which include gainsharing.
 - Description of the nature of the relationship and agreements between the proposed awardee and participating providers.
 - Prior experience with gainsharing or pay-for-performance initiatives, including with non-Medicare payers.
 - Specific plans and methodology for sharing of gains, including:
 - Proportion of hospital gains to be shared with Bundled Payment participating organizations and physicians/practitioners.
 - Description of how gains will be calculated.
 - The timing and periodicity of incentive payment determinations and the timing and method of distribution of gains to Bundled Payment participating organizations and physicians/practitioners.
 - Description of how the allocation of gains incorporates quality, patient safety, and internal efficiency measures, as well as eligibility requirements (e.g., quality thresholds) for participation in gainsharing.
 - Plans to ensure gainsharing payments do not exceed 50% of the amount normally paid by Medicare to physicians/practitioners for the episodes included in the initiative.
 - Gainsharing-specific quality control mechanisms.
 - Description of how gainsharing will support care improvement and redesign, including proposed safeguards to ensure that medically necessary care is not reduced to achieve gains.

Comments:

- Applicants may submit proposals to participate in multiple models of this RFA. However, the same specific patient episode may not be included in more than one model in the Bundled Payments for Care Improvement initiative within a Bundled Payment participating organization. If an awardee or Bundled Payment participating organization participates in Model 1 and any other model, the MS-DRGs for the patient episode(s) included in the Model 2–4 award will be excluded from their Model 1 model.
- Proposals may not include sharing savings with beneficiaries.
- Please see Section II, Description of Model Components, for requirements around inclusion of certain service types in some models and minimum lengths of episodes.

Financial Model	Points: 40
Criteria:	
<ul style="list-style-type: none"> • Overall savings to Medicare. <ul style="list-style-type: none"> ➢ CMS will give preference to proposals that offer a greater discount to Medicare, in the context of a robust programmatic design that ensures high quality care for beneficiaries. ➢ Applicants should provide a comprehensive, valid, transparent, and replicable description of the discount, expected expenditures, volume, and expected target price for Models 2 and 3/expected bundled payment for Model 4. • Risk adjustment (if applicable). <ul style="list-style-type: none"> ➢ For applications that include risk adjustment proposals, applicants should provide a comprehensive, valid, transparent, and replicable description of the risk adjustment methodology. • Anticipated actions that will result in lower spending. <ul style="list-style-type: none"> ➢ CMS is seeking applications that demonstrate how the planned care improvement interventions described above will result in improved efficiency, cost savings, and/or reduced Medicare spending. 	
Information to be Included in Application:	
<ul style="list-style-type: none"> • Discount offered to Medicare. <ul style="list-style-type: none"> ➢ Total relevant historical payment (Part A and/or Part B, as appropriate) for proposed episode definition(s). ➢ Volume of episodes and average price per episode in calendar year 2009. ➢ Proposed target discount (Model 1), proposed target price (Models 2 and 3) and proposed bundled payment (Model 4) in CY 2009, incorporating minimum discounts on the historical payment for proposed episode definition(s). <ul style="list-style-type: none"> ▪ Please refer to the RFA for relevant model specifications. ➢ Description of data used if other than data provided by CMS, which must be presented in a way that allows for CMS analysis. • Risk adjustment (if applicable). <ul style="list-style-type: none"> ➢ For applications that include risk adjustment proposals, description of methodology for risk adjustment, including clinical conditions to which risk adjustment would be applied, formulas, data sources, and plans for updating it. • Actions that will result in increased efficiency and reduced spending. <ul style="list-style-type: none"> ➢ Detailed discussion of how care improvement and redesign efforts will result in improved efficiency, cost savings, and/or reduced Medicare spending. ➢ Description of other planned cost-saving approaches. 	
Comments:	
<ul style="list-style-type: none"> • Note that the discount for Models 2 - 4 may be constant across all bundled payments offered by a provider for different clinical conditions, or may vary based on definition of the episode (e.g., 5% off an episode for orthopedic surgery and 6% off an episode for cardiac surgery.) • Any data used to define episodes, target price, and risk adjustment (as applicable) if other than data provided by CMS, must be presented in a way that CMS or its contractor may reconstruct and validate the applicant's proposal. 	
Quality of Care and Patient Centeredness	Points: 25

Criteria:

- Proposed mechanisms to improve quality and patient experience of care.
 - CMS is seeking applications that demonstrate how redesigned care, including coordination of care across care settings, will lead to improved quality and patient experience of care.
 - CMS is seeking applications that demonstrate how the applicant will use Health Information Technology (HIT) to enable quality measurement, reporting and feedback, use Electronic Health Records (EHRs) as a part of care redesign, and exchange patient records across treating providers to ensure coordination of care across settings.
 - CMS may look favorably on applications that incorporate tools to collect information and assess functional status into the application.
- Proposed quality measures.
 - CMS is seeking applications that propose a comprehensive, meaningful, evidence-based, and credible set of quality measures to track quality and ensure quality does not decrease during this initiative in the domains of quality performance, patient functionality, patient and caregiver experience, care coordination and transitions, and patient safety.
 - CMS is seeking applications that meet quality reporting requirements as specified in this RFA, including the full set of Hospital IQR Program quality measures for Model 1.
 - CMS will look favorably on applications that indicate higher rates of historical physician participation in the Physician Quality Reporting System and on applications that indicate physicians not currently participating will participate for the duration of the project.
- Quality assurance and continuous quality improvement.
 - CMS is seeking applications that have a comprehensive plan for ensuring that measures of quality outcomes will be used to continuously improve project operations and care provided.
- Beneficiary protections.
 - CMS is seeking applications that include comprehensive plans for beneficiary protection, including plans around freedom of choice of providers, notification, and engagement and education.

Information to be Included in Application:

- Quality improvement.
 - Detailed discussion of how care improvement and redesign will improve quality and patient experience of care.
 - Description of proposed measures to assess quality performance, patient functionality, patient and caregiver experience, care coordination and transitions, and patient safety, source of measure, reliability of measure (e.g., National Quality Forum-endorsed), and descriptions of numerators and denominators.
 - Description of past experience reporting quality measures.
 - Description of experience, participation, and results from mandatory and voluntary CMS quality improvement programs or measurement systems, including physicians' participation in PQRS.
 - Description of experience, participation, and results from other HHS or private sector care improvement, quality improvement, and care coordination activities.
 - Description of experience using HIT to improve care and enable care redesign.
 - Description of experience with and plans for use of assessment tools, including the Continuity Assessment Record and Evaluation (CARE) tool or comparable tool.
- Internal quality assurance and continuous quality improvement processes.
 - Description of internal quality assurance and improvement processes, including how participation in this initiative would fit within existing quality assurance and improvement strategies.

- Description of plans for internal monitoring of clinical and functional outcomes.
 - Description of plans for continuous quality improvement.
 - Certifications and accreditations earned by each participating organization, including hospitals, acute-care facilities, and/or physician groups, as applicable.
 - Description of the role of beneficiaries, physicians, hospital staff and post-acute care staff on quality improvement committee(s).
 - Results from relevant quality assurance studies.
- Beneficiary Protections:
 - Description of proposed beneficiary protections.
 - Evidence that beneficiaries will have complete freedom of choice of providers, including post-acute providers.
 - Description of the patient notification process, including how it will be implemented and documented.
 - Description of proposed plan for beneficiary engagement and education.

Comments:

- Applicants are expected to propose quality measures but CMS and awardees will ultimately agree upon a standardized set.
- Applicants must demonstrate that adequate mechanisms are in place such that clinically appropriate services are provided during the episode of care, regardless of where the services are provided, and that there are mechanisms in place to track the clinical and functional outcomes of participants across providers and during the course of an episode of care.
- The quality measurement and improvement plan should specifically target cross-provider coordination, as well as patient-centered care leading to improved patient experience.

Organizational Capabilities, Prior Experience, and Readiness Points: 15

Criteria:

- Financial arrangements.
 - CMS is seeking applications that demonstrate an ability to bear financial risk.
 - CMS is seeking applications that include transparent, detailed plans on how financial rewards will be distributed to participating providers.
- Commitment and credentials of executives and governance bodies.
 - CMS is seeking applications that include strong leadership support and are aligned with the applicant’s vision and mission.
 - CMS will look favorably on applications that include governance bodies with meaningful representation from consumer advocates, patients, and all participating provider types/organizations.
- Success and readiness to participate.
 - CMS is seeking applications that demonstrate prior success coordinating care across providers.
 - Stronger evidence of readiness to launch the program will carry more weight.
 - CMS will give preference to applicants who are meaningful users of HIT resources or who have a minimum of 50% of providers meeting the standards for meaningful use. This includes the ability to electronically exchange patient summary records with relevant providers as necessary to ensure care coordination, medication reconciliation, and prevention of unnecessary readmissions.
 - CMS is seeking applications that have a comprehensive and credible implementation plan, including a timeline.

- Partnerships.
 - CMS will look favorably on applications that demonstrate partnership with State Medicaid programs, private payers, or multi-payer collaboratives to redesign care.
 - Applications from conveners (applying to participate in an awardee or facilitator role) that foster the participation of large numbers of providers, affecting large numbers of beneficiaries in an organized and efficient manner, may also be considered favorably.

Information to be Included in Application:

- Financial arrangements:
 - Letter of commitment from designated awardee ensuring ability to bear the financial risk associated with this initiative.
 - Description of any financial arrangements to share or delegate risk.
 - Description of the financial arrangements and logistical mechanisms for distributing gains among partner Bundled Payment participating organizations and/or physicians/practitioners. Note these financial arrangements must meet the gainsharing requirements described in this RFA.
 - Percentage of revenues from Medicare FFS, Medicare Advantage, Medicaid, commercial health plans, self-pay patients, and any other sources.
- History and prior experience:
 - Description of prior business relationships with participating organizations.
 - Geography, years of operation, market share for delivery of services related to proposed episode(s).
 - Description of prior experience with care improvement across care settings and experience in achieving medical expenditure targets in such arrangements.
 - Description of how this initiative will relate to other care redesign efforts applicant is undertaking, if any. These include all Medicare, Medicaid (including any Innovation Center initiatives), and private sector ACO, medical home, or bundled payment pilots, as well as any other relevant initiatives.
 - Identification of partnerships with other payers who would utilize the same (or similar) models as proposed for payment in the application.
 - Description of experience with process improvement efforts, such as Six Sigma, Lean Enterprise, etc.
- Readiness and partnerships:
 - Description of governing body that will oversee the operation of the project and how that body will conduct oversight.
 - Description of key personnel, including educational backgrounds, professional experience, special qualifications, proposed responsibilities, financial resources that will be made available to them to implement this initiative.
 - Detailed implementation plan, including milestones, how tasks will be sequenced, and in what timeframe; the management control and coordination tools that will be used to ensure the timely and successful conduct of this project; descriptions of the processes in place to handle tasks occurring simultaneously; resource allocations (e.g., staff, systems, related departments); designation of the tasks to be performed by an employee, subcontractor, or consultant; and evidence of the feasibility of this plan based on your ongoing operations and past experience .
 - Description of how the model design would allow for rapid scaling /replication at other care sites if this program is successful.
 - Description of availability and access to systems and facilities, including staff, consultants, computer systems and technical equipment, types of IT vendors/software , if applicable, and discussion of whether bundling will require additional hardware and software beyond current infrastructure.
 - Description of institutional efforts at becoming meaningful users.

- Identification of other payers who are interested in or planning to participate in this application.
- Discussion of ongoing data needs that are not regularly available once this initiative begins.
- Description of how actively applicant expects to participate in CMS learning and diffusion activities.

- Conveners.

- All conveners, whether applying to participate in an awardee or facilitator role, must include:
 - Description of the nature of the relationships between participating providers and the convener, including financial arrangements.
 - Description of prior experience the convener and provider(s) have working together.
 - Description of the value that the convener adds to the participating providers and CMS.

Comments:

- Applicants may be current or prior participants in the Medicare ACE Demonstration, the Medicare Hospital Gainsharing Demonstration, and/or the Physician Hospital Collaboration Demonstration. This should be disclosed in the proposal.
- Applicants may apply for or participate in other Innovation Center initiatives. This should be disclosed in the proposal.
- While meaningful use is not a requirement for participation, in the future CMS reserves the right to make meaningful use a condition of participation in bundled payment initiatives.

Appendix A: Glossary

Accountable Care Organization (ACO) – The Medicare Shared Savings Program (MSSP) proposed rule defines an ACO as a legal entity that is recognized and authorized under applicable State law, as identified by a Taxpayer Identification Number, and comprised of an eligible group of ACO participants that work together to manage and coordinate care for Medicare FFS beneficiaries. For the purposes of this initiative, ACO participants may include either those defined in the MSSP proposed regulation, the MSSP final regulation, or the Pioneer ACO initiative.

Awardee – An entity that has an agreement with Medicare to assume financial risk and receive payment (as applicable to the Model) under the Bundled Payments for Care Improvement initiative. The entity may be a convener or a supplier or provider enrolled in Medicare.

Bundled Payment / Bundling – A single negotiated episode payment of a predetermined amount for all services (physician, hospital, and other provider services) furnished during an episode of care. This could be paid prospectively or retrospectively. In contrast to fee-for-service (FFS) payment, the bundled payment covers services furnished by multiple providers in multiple care delivery settings. This differs from capitation or global payment in that the bundled payment is a single payment only for the specified episode, rather than for all care for a patient during a specified time period.

Bundled Payment participating organization – All providers or suppliers, other than physicians and/or practitioners, with whom the awardee plans to partner. Examples include acute care hospitals, skilled nursing facilities, and home health agencies.

Bundled Payment physicians/practitioners – All physicians and/or practitioners who are expected to participate in the episode of care, including suppliers who may be paid separately by Medicare for their professional services (e.g., physicians, nurse practitioners, physician assistants, and physical therapists).

Bundled payment participating providers: For the purposes of this initiative, all Bundled Payment participating providers fall into one of the above definitions (Bundled Payment participating organization or Bundled Payment physicians/practitioners). Collectively, these providers are termed Bundled payment participating providers.

Convener – An entity that can bring together multiple participating health care providers, such as a state hospital association or a collaborative of providers. For the purposes of this initiative, a convener may be the applicant, but may be subject to special provisions. A risk-bearing convener who also may receive payments from CMS can participate in the initiative as an awardee. A convener that is not able to bear risk may not receive payments from CMS but may participate in the initiative as a facilitator for participating awardee providers.

Episode – The defined period of time during which all Medicare-covered services required to manage the specific medical condition of a patient are grouped and paid as a unit. Episodes that are subject to episode payment are identified by an episode anchor. The episode may include the episode anchor and can include a period of time both before and/or after the anchor.

Episode Anchor – The event which triggers beneficiary inclusion in the episode. In Model 1, this is any admission to a participating acute care hospital; in Model 2 this is admission to a participating acute care hospital for the agreed-upon MS-DRG; in Model 3 this is initiation of post-acute services at a participating organization (LTCH, SNF, IRF, HHA) within 30 days of beneficiary discharge from an acute

care hospital stay for an agreed-upon MS-DRG; in Model 4 this is admission to a participating acute care hospital for an agreed-upon MS-DRG.

Episode Reconciliation – A regular comparison of the total FFS payment to providers for services included in the episode with the predetermined target price for the episode. If aggregate FFS payments exceed the predetermined target price, the awardee must repay Medicare. If aggregate FFS payments are less than the predetermined price, the awardee will be paid the difference, which may be shared among the participants.

Episode Target Price – The agreed upon total Medicare payment for the episode.

Facilitator – A convener who is participating in the Bundled Payments for Care Improvement initiative as a partner with providers, but who does not assume financial risk or receive payment directly under an agreement with Medicare.

Fee-for-Service (FFS) – Original Medicare where Medicare pays health care providers directly for Part A and/or Part B benefits on a service-specific basis under the specific statutory payment rules that apply to payment for services furnished by each type of provider.

Gainsharing – Payments shared among providers that represent a portion of the gains achieved due to more coordinated, efficient, higher quality care. Under this project, we extend the concept to enable hospitals, post-acute care providers, physicians, and nonphysician practitioners to all benefit from the gains achieved.

Global Payment – *Note: This is not a component of the Bundled Payments for Care Improvement Initiative.* A fixed payment to a provider for all care provided to a patient during a specified time period (e.g., one month). Global payments differ from bundled payments in that a bundled payment is payment for all services provided for a specific clinical condition during an episode.

Learning Health Care System – A health care system that is designed to generate and apply the best evidence for the collaborative healthcare choices of each patient and provider; to drive the process of discovery as a natural outgrowth of patient care; and to ensure innovation, quality, safety, and value in health care

Post-Episode Monitoring – A mechanism to detect those services/expenditures expected to be included in an episode of care that are furnished/paid outside of the episode (before or after), thereby potentially increasing total Medicare spending for services related to the episode. Typically this will compare the actual Medicare spending to a historical baseline to detect overall increased expenditures despite the discount provided through the target price or prospective bundled payment for the episode.

Post-Episode Monitoring Period – The length of time after the episode of care during which Medicare Part A and Part B spending for included beneficiaries is monitored to ensure no increase in aggregate expenditures for included beneficiaries occurs. In this initiative, this period of time is 30 days.

Prospective Episode Payment – The payment mechanism whereby the bundle of services and a target price would be defined in advance and paid as one sum. The amount would be paid to a single entity at the time an episode-defining claim is submitted for the episode (e.g., hospital discharge). That entity would be responsible for payment of any other providers whose services are included in the episode.

Retrospective Episode Payment – The payment mechanism whereby the bundle of services and a target price would be defined in advance, but operationally, hospital, physician, and post-acute provider claims would be paid using existing FFS payment systems for the duration of the episode of the care. A retrospective reconciliation process would compare the actual total payment of FFS claims for the included services during the episode with the predetermined target price. If the total FFS payment is less than the target price, the awardee would be paid the difference at reconciliation.

Shared Savings – *Note: This is not a component of the Bundled Payments for Care Improvement Initiative.* An agreement between Medicare and another entity to share a specified percentage of savings or losses that result from a care intervention. For the purposes of this initiative, a Bundled Payments for Care Improvement discount is not considered shared savings.

Appendix B: Mandatory Minimum Quality Measures

Inpatient Measures

The following is a list of Hospital Inpatient Quality Reporting Program (Hospital IQR) quality measures for FY 2011 and their classification as Required, CMS Voluntary, CMS Informational, or automatically captured via claims. All the measures in Table 6, below, will be required for participants in Model 1 of the Bundled Payments for Care Improvement program, whereas only measures with an IQR classification of 'required' will be required for participants in Models 2-4. Note that measures may be updated on an annual basis.

Table 6

Measure	Description	IQR Classification
AMI-1	Aspirin at Arrival	Required
AMI-2	Aspirin Prescribed at Discharge	Required
AMI-3	ACEI or ARB for LVSD	Required
AMI-4	Adult Smoking Cessation Advice/Counseling	Required
AMI-5	Beta-Blocker Prescribed at Discharge	Required
AMI-7	Median Time to Fibrinolysis	CMS Informational
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	Required
AMI-8	Median Time to Primary PCI	Required
AMI-8a	Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)	Required
AMI-9	Inpatient Mortality	CMS Informational
AMI-10	Statin Prescribed at Discharge	Required
AMI-T1a	LDL-Cholesterol Assessment	CMS Voluntary (will be retired and not applicable for 2012)
AMI-T2	Lipid-Lowering Therapy at Discharge	CMS Voluntary (will be retired and not applicable for 2012)
HF-1	Discharge Instructions	Required
HF-2	Evaluation of LVS Function	Required
HF-3	ACEI or ARB for LVSD	Required
HF-4	Adult Smoking Cessation Advice/Counseling	Required
PN-2	Pneumococcal Vaccination	Required
PN-3a	Blood Cultures Performed Within 24 Hours Prior to or 24 Hours After Hospital Arrival for Patients Who Were Transferred or Admitted to the ICU Within 24 Hours of Hospital Arrival	CMS Informational
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	Required
PN-4	Adult Smoking Cessation Advice/Counseling	Required
PN-5	Antibiotic Timing (Median)	CMS Informational
PN-5c	Timing of Receipt of Initial Antibiotic Following Hospital Arrival	Required
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	Required

PN-6a	Initial Antibiotic Selection for CAP in Immunocompetent – ICU Patient	CMS Informational
PN-6b	Initial Antibiotic Selection for CAP in Immunocompetent – Non-ICU Patient	CMS Informational
PN-7	Influenza Vaccination (Note: Reported by Flu Season ONLY)	Required
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	Required
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	Required
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	Required
SCIP-Inf-4	Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose	Required
SCIP-Inf-6	Surgery Patients with Appropriate Hair Removal	Required
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery being Day Zero	Required
SCIP-Inf-10	Surgery Patients with Perioperative Temperature Management	Required
SCIP-Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who received a Beta-Blocker During the Perioperative Period	Required
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	Required
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	Required
VTE-1	Venous Thromboembolism Prophylaxis	CMS Informational
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	CMS Informational
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	CMS Informational
VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram	CMS Informational
VTE-5	Venous Thromboembolism Discharge Instructions	CMS Informational
VTE-6	Incidence of Potentially-Preventable Venous Thromboembolism	CMS Informational
STK-1	Venous Thromboembolism (VTE) Prophylaxis	CMS Informational
STK-2	Discharged on Antithrombotic Therapy	CMS Informational
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	CMS Informational
STK-4	Thrombolytic Therapy	CMS Informational
STK-5	Antithrombotic Therapy By End of Hospital Day 2	CMS Informational
STK-6	Discharged on Statin Medication	CMS Informational
STK-8	Stroke Education	CMS Informational
STK-10	Assessed for Rehabilitation	CMS Informational
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	CMS Voluntary
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	CMS Voluntary

HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey	Required
HAI	Central Line Associated Bloodstream Infection (CLABSI)	Required
Structural-1	Participation in a Systematic Database for Cardiac Surgery	Required
Structural-2	Participation in a Systematic Clinical Database Registry for Stroke Care	Required
Structural-3	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Required
Data Accuracy	Data Accuracy and Completeness Acknowledgement	Required
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	Automatically Captured
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	Automatically Captured
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	Automatically Captured
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	Automatically Captured
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	Automatically Captured
READM-30-PN	Pneumonia (PN) 30-Day Readmission Rate	Automatically Captured
PSI-04	Death Among Surgical Patients with Serious, Treatable Complications	Automatically Captured
PSI-06	Iatrogenic Pneumothorax, Adult	Automatically Captured
PSI-11	Post-Operative Respiratory Failure	Automatically Captured
PSI-12	Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)	Automatically Captured
PSI-14	Postoperative Wound Dehiscence	Automatically Captured
PSI-15	Accidental Puncture or Laceration	Automatically Captured
PSI-90	Complication/Patient Safety for Selected Indicators	Automatically Captured
IQI-11	Abdominal Aortic Aneurysm (AAA) Mortality Rate (with or without volume)	Automatically Captured
IQI-19	Hip Fracture Mortality Rate	Automatically Captured
IQI-91	Mortality for Selected Medical Conditions (composite)	Automatically Captured
Nursing sensitive	Death Among Surgical Patients with Serious Treatable Complications	Automatically Captured (Harmonized with PSI 4)
HAC-1	Foreign Object Retained After Surgery	Automatically Captured
HAC-2	Air Embolism	Automatically Captured
HAC-3	Blood Incompatibility	Automatically Captured
HAC-4	Pressure Ulcer Stages III & IV	Automatically Captured
HAC-5	Falls and Trauma: (Includes; Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)	Automatically Captured
HAC-6	Vascular Catheter-Associated Infections	Automatically Captured
HAC-7	Catheter-Associated Urinary Tract Infection (UTI)	Automatically Captured
HAC-8	Manifestations of Poor Glycemic Control	Automatically Captured

Source:

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1138900298473> Accessed 8/17/2011.

Outpatient Measures

The following is a list of Hospital Outpatient Quality Data Reporting Program (HOP QDRP) quality measures for CY 2011 and their classification as required or automatically captured via claims. All the

measures in Table 7, below, will be required for participants in all Models of the Bundled Payments for Care Improvement program. Note that measures may be updated on an annual basis.

Table 7

Measure	Description	HOP QDRP
OP-1	Median Time to Fibrinolysis	Required
OP-2	Fibrinolytic Therapy Received Within 30 Minutes	Required
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention	Required
OP-4	Aspirin at Arrival	Required
OP-5	Median Time to ECG	Required
OP-6	Timing of Antibiotic Prophylaxis	Required
OP-7	Prophylactic Antibiotic Selection for Surgical Patients	Required
OP-8	MRI Lumbar Spine for Low Back Pain	Automatically Captured
OP-9	Mammography Follow-up Rates	Automatically Captured
OP-10	Abdomen CT – Use of Contrast Material	Automatically Captured
OP-11	Thorax CT – Use of Contrast Material	Automatically Captured
OP-12	The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data	Required
OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low- Risk Surgery	Automatically Captured
OP-14	Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT	Automatically Captured
OP-15	Use of Brain CT in the Emergency Department (ED) for Atraumatic Headache	Automatically Captured

Source:

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1192804531207> Accessed 8/17/2011.