Bundled Payments for Care Improvement Application
Model 3 – Awardee Convener

In this proposal, all references to "applicant" mean the proposed awardee convener[1]. For questions that require information about the applicant only, please provide information about the proposed awardee convener organization only.

Many questions, however, require information more broadly about the applicant's partners. For the purposes of this initiative, these partners 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, including all other providers or suppliers with whom the awardee convener plans to partner (e.g., acute care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies). Episode-initiating Bundled Payment participating organizations are a sub-set of Bundled Payment participating organizations that initiate episodes (post-acute providers in Model 3).

In each question, we will specify whether to answer the question about the applicant alone, its Bundled Payment physicians/practitioners, its Bundled Payment participating organizations, and/or its episode-initiating Bundled Payment participating organizations. In cases where the applicant (proposed awardee convener) is not a Medicare provider/supplier and we ask about the applicant's broad model, please complete the question with information about the applicant's Bundled Payment participating organizations. In cases where the applicant (proposed awardee convener) is a Medicare provider/supplier and we ask about the applicant's broad model, please complete the question with information about the applicant and its Bundled Payment participating organizations.

Please complete all questions. If a question is not applicable, please enter "N/A."

Section A: Organization Information

1. Applicant Organization Trade Name: _____

"Doing Business As" if different from applicant organization trade name: _____

2. Applicant Contact Person at Applicant Organization

Name: _____

Title: _____

Street Address: _____

Address line 2: _____

City, State, Zip code: _____

Telephone: _____ Fax: _____

Email: _____

[1] Parent companies, health systems, and other organizations that wish to take risk for the patients of its partner providers/suppliers but are not providers/suppliers themselves would be awardee conveners. In this scenario, the awardee convener would be responsible for all of its episode-initiating Bundled Payment participating organizations' eligible patients.
Providers/suppliers would be awardee conveners if their model more broadly includes patients of other providers that initiate episodes (post-acute providers in Model 3). In this scenario, the awardee convener would be responsible for all of its eligible patients regardless of the other providers where the patient receives care during the episode and its episode-initiating Bundled Payment participating organizations' eligible patients, even those that are not cared for by the awardee convener during the episode.

3. Please provide the applicant organization's tax identification number (TIN), type of organization, and type of entity. If the applicant is a Medicare provider/supplier, please also include bed size of the applicant's facility if applicable, whether the applicant is planning to participate in a Medicare shared savings program[2], and organization CMS certification number (CCN) and national provider identifier (NPI), as applicable. If the organization listed is an institution (acute care hospital, skilled nursing facility, inpatient rehabilitation facility, long term care hospital), the application will not be processed without a valid CCN.

Table A3. Applicant Information

Organization Name	Organization Type	TIN	NPI	CCN[3]	Facility Bed Size if Applicable	Type of Entity	Participating or Planning to Apply to a Medicare Shared Savings Program[4]

4. Please complete the following table identifying the Bundled Payment participating organizations the applicant expects to partner with in this application. For each Bundled Payment participating organization, please include name, contact information, a brief description, bed size of the facility if applicable, type of entity, and whether they are planning to participate in a Medicare shared savings program. Please include the national provider identifier (NPI) and tax identification number (TIN) for all organizations. Include the CMS certification number (CCN) for each organization, as applicable. If the organization listed is an institution (acute care hospital, skilled nursing facility, inpatient rehabilitation facility, long term care hospital), the application will not be processed without a valid CCN.

Table A4. Bundled Payment Participating Organization Information

Org. Name	Org. Type	TIN	NPI	CCN[5]	Contact	Phone	Email	Address	Description of Org.	Bed Size if Applicable	Type of Entity	Medicare Shared Savings Program[6] Y/N

For a physician group practice applicant, please complete the following table listing all physicians in the practice and their NPI numbers. Please note for each physician whether they are currently a member of the group and whether they were a member of the group at any time during CY 2008 and CY 2009. Include physicians who are not current members but were during those calendar years.

Physician	NPI	Current Member of the Group	Group Member CY 2008	Group Member CY 2009

[2] 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.

[3] CCNs are typically six digits, with the first two digits representing a state code, followed by a dash, followed by four digits

[4] Physician Group Practice Demonstration, Independence at Home Demonstration, Medicare Shared Savings Program, Comprehensive Primary Care Initiative, Pioneer ACO Initiative, Medicare-Medicaid financial alignment initiative

[5] CCNs are typically six digits, with the first two digits representing a state code, followed by a dash, followed by four digits

[6] Physician Group Practice Demonstration, Independence at Home Demonstration, Medicare Shared Savings Program, Comprehensive Primary Care Initiative, Pioneer ACO Initiative, Medicare-Medicaid financial alignment initiative

5. Provide a brief summary of the applicant organization.
For example:

- if a post-acute care facility, number of beds
- if a large multi-organization entity, description of the system
- region/geography
- when organization was established

6. Please attach an executive summary of the application. Include a summary of the overall approach to redesigning care to maximize coordination, patient-centeredness, efficiency, and high quality health care through accountability for an episode of care. (Suggested: two pages, double-spaced).

Section B: Model Design

Episode Definition

1. Please complete the tables below for each episode with the following information:

- the episode name;
- the rate of discount that will be incorporated into the target prices in Section C, question 2;
- a definition of the end of the episode, which must be at least 30 days following the initiation of the episode[7].

If the applicant would like to propose multiple episodes to be included in this application, please complete a separate table for each episode.

Table B1. Episode Parameters

Episode Number:	
Episode Name:	
Rate of Discount	
Length of the episode (days)	

2. Please complete the tables below defining the episode MS-DRG anchors and proposed exclusions for each episode. Episode length and rate of discount along with the proposed exclusions below must be the same for the whole episode. In Section C, question 2 the applicant will be asked to provide target prices, which may differ for each MS-DRG in the episode. In the table(s) below, the applicant should list:

- the anchor MS-DRGs[8] the applicant proposes to use to define the episode of care;
  - Please use MS-DRG version v26.
  - An episode must include at a minimum the full family of related MS-DRGs based on severity.
- the proposed MS-DRGs that could be used to exclude beneficiary readmissions[9] to an acute care hospital from the episode of care as well as the rationale for why each of these readmissions should be excluded, given the proposed episode definition;
  - Readmissions for all MS-DRGs other than the proposed excluded MS-DRGs will be included in the episode and should be incorporated into the target prices provided in Section C, question 1.
- the proposed principal ICD-9 diagnosis codes that could be used to exclude unrelated Part A and unrelated Part B services[10] during the episode as well as the rationale for why each of these services should be excluded when furnished for included beneficiaries with the specified ICD-9 diagnosis codes, given the proposed episode definition.

[7] The episode is initiated by the start of post-acute care services at the applicant or one of its episode initiating Bundled Payment participating organizations (skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, home health agency) within 30 days of beneficiary discharge from an acute care hospital stay for an agreed-upon anchor MS-DRG for the patients of an applicant (if a Medicare provider/supplier) or its episode-initiating Bundled Payment participating organizations.

[8] While the episode is initiated by the start of post-acute services in Model 3, the anchor(s) that determine beneficiary eligibility are the MS-DRG(s) with which beneficiaries are discharged from the hospital.

[9] If a beneficiary eligible under the episode definition is readmitted to an acute care hospital during the defined episode window with an agreed-upon excluded MS-DRG, all Part A payment for the period of that readmission would be excluded from the episode reconciliation.

[10] If a beneficiary eligible under the episode definition receives Part A or Part B services for an excluded principal ICD-9 diagnosis code during the episode, those payments would be excluded from the episode reconciliation

- Please use the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).
- These ICD-9 codes would be reported as the principal diagnosis on claims for the Part A or Part B services unrelated to the episode anchor.

Please complete a separate table for each episode proposed in table B1.

Table B2: Episode Anchors and Exclusions

Episode Number:	
Episode Name:	
Anchor MS-DRG[11] for Episode:	**Description:**
MS-DRGs for Excluded Readmissions:	**Justification for Exclusion:**
ICD-9 for Excluded Part A Services:	**Justification for Exclusion:**
ICD-9 for Excluded Part B Services:	**Justification for Exclusion:**

Provider Engagement

3. Please attach letters of agreement from Bundled Payment physicians/practitioners or physician/practitioner representatives who may be separately paid by Medicare for their professional services indicating their willingness to participate in this model, including describing any gainsharing agreements, if applicable. These letters should demonstrate agreement that the applicant shall coordinate any distribution of gains resulting from care improvement under this initiative.

Please include all letters in one attachment.

How many physicians/practitioners are represented in these letters of agreement?

Estimate the proportion of physicians/practitioners regularly practicing in the care settings associated with this application represented in these letters of agreement.

4. Please attach letters of agreement from Bundled Payment participating organizations indicating their willingness to participate in this model, including describing any agreements to share gains and/or risk, if applicable.

Please include all letters in one attachment.

[11] While the episode is initiated by the start of post-acute services in Model 3, the anchor(s) that determine beneficiary eligibility are the MS-DRG(s) with which beneficiaries are discharged from the hospital.

5. Please attach letters of agreement from each of the applicant's episode-initiating Bundled Payment participating organizations (long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, home health agencies) indicating their willingness to participate in this initiative. The letters should be executed by individuals who are able to pledge participation on behalf of these organizations.

Please include all letters in one attachment.

6. Please describe the applicant's plan to disclose participation in this initiative to physicians/practitioners practicing at the applicant organization or its Bundled Payment participating organizations.

7. Please describe the applicant's plan to obtain widespread endorsement and engagement by physicians/ practitioners at the applicant organization and its Bundled Payment participating organizations for this initiative. Describe the applicant's plan to retain Bundled Payment physicians/practitioners and Bundled Payment participating organizations in care redesign activities related to this initiative.

Care Improvement

8. Please describe the applicant's plan for care redesign in order to achieve Bundled Payments for Care Improvement outcomes. Include specific mechanisms and actions to redesign care processes in the following areas, at a minimum:

- evidence-based medicine;
- beneficiary/caregiver engagement;
- coordination of care; and
- care transitions.

Please describe a single holistic approach for the applicant and its Bundled Payment participating organizations.

9. Please describe the capacity and readiness of the applicant and its Bundled Payment participating organizations to redesign care.

10. Please describe how the applicant's plan to conduct routine assessment of beneficiary, caregiver, and/or family experience of care will lead to improved care throughout participation in this initiative. Please describe a single holistic approach for the applicant and its Bundled Payment participating organizations.

11. Please list the waivers the applicant believes will better enable care redesign and how each of these waivers will lead to improved beneficiary outcomes.

Gainsharing

These questions refer to the distribution of any gains resulting from care improvement under this initiative, including any payments from episode reconciliation.

12. Does the proposal include gainsharing between or among the applicant, its Bundled Payment participating organizations, and/or physicians/practitioners?

Yes No

13. Please describe the applicant's and its Bundled Payment participating organizations' prior or current experience with any gainsharing or pay-for-performance initiatives, including with Medicare, Medicaid, or commercial purchasers. Please describe at a high level the gainsharing methodology used and how cost savings and quality of care were measured to determine gainsharing payments.

14. Describe the applicant's proposed methodology for sharing gains among Bundled Payment participating organizations and physicians/practitioners, including with whom gains will be shared, the proportion of gains to be shared with Bundled Payment participating organizations and with physicians/practitioners, the mechanism for calculating gains, the timing and periodicity of payment determinations, and the timing and method of distributing gains. Specify the plan to ensure that gainsharing payments to physicians/practitioners do not exceed 50% of the amount normally paid by Medicare to physicians/practitioners for the episodes included in the initiative. Describe how the allocation of gains will incorporate best practice norms, quality, patient safety, patient experience, and efficiency measures. Please describe a single holistic approach for the applicant and its Bundled Payment participating organizations.

15. Please describe how the applicant's proposed gainsharing methodology will support care improvement, and specify proposed safeguards and quality control mechanisms to ensure that medically necessary care is not reduced to achieve savings. Please describe a single holistic approach for the applicant and its Bundled Payment participating organizations.

16. Describe the eligibility requirements, such as quality thresholds and quality improvement requirements, for physicians/practitioners and Bundled Payment participating organizations to participate in gainsharing. Include a discussion of how a physician/practitioner or Bundled Payment participating organization may become eligible or ineligible to participate in gainsharing.

Section C: Financial Model: Awardee Convener

1. Please complete the following C1 table(s) using the episode definitions from table B1 and B2 of this proposal.

In Model 3, the episode is initiated by the start of post-acute care services at the applicant (if a Medicare provider/supplier) or one of its episode-initiating Bundled Payment participating organizations (skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, home health agency) within 30 days of beneficiary discharge from an acute care hospital stay for an agreed-upon anchor MS-DRG[12] for the patients of an applicant (if a Medicare provider/supplier) or its episode-initiating Bundled Payment participating organizations.

Please note that if an applicant is a Medicare provider/supplier, it will be responsible for all of its own eligible patients and its episode-initiating Bundled Payment participating organizations' eligible patients, even those that are not cared for by the applicant during the episode. Parent companies, health systems, and other organizations that wish to take risk for the patients of their partner providers/suppliers but are not providers/suppliers themselves will be responsible for all of their episode-initiating Bundled Payment participating organizations' eligible patients.

- Please complete a separate set of tables for every episode that is proposed in Section B.
- The applicant should complete a separate table for each episode-initiating Bundled Payment participating organization (skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, home health agency) for each episode.
- The applicant should also complete a table for itself for each episode if the applicant is a Medicare provider/supplier.

In each table the applicant should include:

- Under "Historical Episode Payment," please list the total 2009 historical payment for each service type for that organization for all episode cases that began and ended in calendar year 2009 including all the MS-DRGs that were included in the episode parameters in Section B.
- On the right hand side of the table, the discount is auto-generated from the discount provided in Table B1 for that episode.
- Under "Number of Episode Cases," please list the number of cases in 2009 broken out for each specific MS-DRG within the episode.

[12] While the episode is initiated by the start of post-acute services in Model 3, the anchor(s) that determine beneficiary eligibility are the MS-DRG(s) with which beneficiaries are discharged from the hospital.

Table C1: Historical Episode Payments and Number of Episode Cases

Episode Number:							
Episode Name:							
Org. Name:							
Service Type	Historical Episode Payment[13]			Discount	Number of Episode Cases for Anchor MS-DRG[14]		
	Total Episode $ CY 2009[15]	Total # Episode Cases	Average $ per Episode CY 2009	Rate of Discount	# of Episode Cases from MS-DRG x	# of Episode Cases from MS-DRG y	# of Episode Cases from MS-DRG z
Inpatient acute services							
Hospital outpatient facility services							
Skilled nursing facility services							
Inpatient rehabilitation facility services							
Long-term care hospital services							
Home health agency services							
Part B professional services							
All other Part A services							
All other Part B services							
TOTAL				0%	0	0	0

2. Please complete the following summary table C2 at the applicant level. It should reflect all cases covered by the applicant (if a Medicare provider/supplier) and all of its episode-initiating Bundled Payment participating organizations.

- The applicant will need to fill out this table separately for each episode proposed in question B1.
- The first 2 columns of this table under "Total Historical Payment" are an automatic summation of all the C1 tables completed for that episode.
- The next column, the "Rate of Discount," is automatically generated from the episode parameters set in table B1.
- Under "Sum of Number of Episode Cases per MS-DRG," the total number of episode cases per MS-DRG is an automatic summation of the number of episode cases per MS-DRG for all the C1 tables for that episode.
- Please calculate the "Average Episode Target Prices" as the volume weighted average payments with the discount incorporated based on the historical episode payments for the applicant's (if a Medicare provider/supplier) and its episode-initiating Bundled Payment participating organization's eligible beneficiaries, broken out by MS-DRG.

[13] For items left of the grey box, fill in totals for all MS-DRGs within the episode combined.
[14] While the episode is initiated by the start of post-acute services in Model 3, the anchor(s) that determine beneficiary eligibility are the MS-DRG(s) with which beneficiaries are discharged from the hospital.
[15] "Total Episode $" = All Part A and Part B services from initiation of the episode through the end of the episode related to the episode, including all Part A services for related readmissions and all related Part B services within the episode window, regardless of whether they are furnished during a related or unrelated readmission.

- Please propose a target price in calendar year 2009 dollars. CMS will trend proposed target prices to the applicable year in our application review and for purposes of final agreements with awardees.

- The "Total Episode Target Payment" will be automatically calculated as the volume weighted sum of the target prices for each anchor MS-DRG within the episode and each episode-initiating Bundled Payment participating organization within the application.
- The "Net Savings to Medicare" will be automatically calculated as the "Sum of Total Episode Payment" minus the "Total Episode Target Payment."

Table C2: Summary Table with Proposed Target Prices

Episode Number:											
Episode Name:											
	Summary Table with Proposed Target Prices										
Service Type	**Total Historical Episode Payment**		**Discount**	**Average Episode Target Price and Number of Episode Cases Per MS-DRG**[16]						**Savings to Medicare**	
	Sum of Total Episode $ Payment CY 2009	**Sum of Total # Episode Cases**	**Rate of Discount**	**Sum of # of Episode Cases for Anchor MS-DRG x**	**Target Price $ per MS-DRG x**	**Sum of # of Episode Cases for Anchor MS-DRG y**	**Target Price $ per MS-DRG y**	**Sum of # of Episode Cases for Anchor MS-DRG z**	**Target Price $ per MS-DRG z**	**Total Episode Target Payment**	**Net Savings to Medicare**
Inpatient acute services											
Hospital outpatient facility services											
Skilled nursing facility services											
Inpatient rehabilitation facility services											
Long-term care hospital services											
Home health agency services											
Part B professional services											
All other Part A services											
All other Part B services											
TOTAL			0.0%	0	$0	0	$0	0	$0	$0	$0

[16] While the episode is initiated by the start of post-acute services in Model 3, the anchor(s) that determine beneficiary eligibility are the MS-DRG(s) with which beneficiaries are discharged from the hospital.

3. Applicants should complete this table for each episode-initiating Bundled Payment participating organizations (skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, home health agency). If the applicant is a Medicare provider/supplier, please also complete this table for the applicant itself.

In each table the applicant should include:

- the Hospital Referral Cluster(s) (HRC) that best describe the organizations' catchment area [hyperlink to list of HRC counties] and the percentage of Medicare fee-for-service patients that reside in that HRC;
- the HRCs listed should capture at least 85% of the organization's Medicare fee-for-service population.

Table C3: Market/Geography by Hospital Referral Cluster

Organization Name:	
HRC (1-92)	**% of Medicare FFS Patients that Reside in that HRC**

4. Is the applicant proposing a risk adjustment methodology?

Yes No

If so, please describe the methodology with sufficient detail for replication, including formulas, data sources, years of data used, risk adjustment factor for calendar year 2009 population, plans for updating risk adjustment on a yearly basis based on new information, etc. If the applicant is proposing multiple episode definitions, please describe the risk adjustment methodology for each with sufficient detail for replication, including formulas, data sources, years of data used, risk adjustment factors, plans for updating risk adjustment on a yearly basis based on new information, etc.

5. Please describe the universe of patients the applicant used for analysis that forms the basis of the proposed target price(s). Please describe the data used to analyze the historical payments for the defined episode and to estimate target prices if other than the data provided by CMS. The data used to construct target prices for the defined episode(s) must be presented in a way that allows for CMS analysis. Additionally, please describe any analytic decisions that either deviated from or were not specified in recommendations from CMS, including the applicant's decision of whether or not to pro-rate payments for services that span the end of the episode.

6. Please describe how the planned care improvement interventions that the applicant proposed in Section B will result in improved efficiency, cost savings, and/or reduced Medicare spending?

7. Please describe any other cost-saving approaches that the applicant and its Bundled Payment participating organizations plan to use, such as the use of formularies, protocols for discharge, etc.

Section D: Quality of Care and Patient Centeredness

Please describe a single holistic approach for the applicant and its Bundled Payment participating organizations in the questions that follow.

Quality Improvement

1. Using evidence from past experience and research, please describe how the applicant's and its Bundled Payment participating organizations' planned care improvement interventions described in Section B will result in improved quality and patient experience of care.

2. Please complete the following table proposing measures to assess quality performance, patient functionality, patient and caregiver experience, care coordination and transitions, and patient safety. Include the source and evidence of the reliability of each measure (e.g., endorsed by the National Quality Forum), as well as proposed descriptions of numerators and denominators.

If the applicant is proposing multiple episodes, please complete a separate table for each episode.

Table D2: Proposed Quality Measures

Episode Number:					
Episode Name:					
Measure	**Description**	**Define Numerator**	**Define Denominator**	**Source of Data**	**Source of Measure**

3. Please describe the applicant's (if a Medicare provider/supplier), its Bundled Payment participating organizations' and Bundled Payment participating physicians'/practitioners' experience reporting quality measures.

4. If the applicant or any of its Bundled Payment participating organizations are acute care hospitals, please describe their experience with the Medicare Hospital Inpatient Quality Reporting (Hospital IQR) Program and the Hospital Outpatient Quality Data Reporting Program (HOP QDRP). Include whether all organizations have received full IPPS (since at least FY 2007) and OPPS (since at least CY 2009) annual payment updates for reporting measures, and a description of achievements in quality improvement. Please include past performance with the Hospital IQR program and the HOP QDRP. CMS expects that any applicants and Bundled Payment participating organizations that are acute care hospitals will maintain or improve performance on the measures reported through the Hospital IQR program and the HOP QDRP; decreased performance during the period of this initiative may result in termination.

5. Please describe the applicant's (if a Medicare provider/supplier) and its Bundled Payment participating organizations' experience with other mandatory CMS quality measurement and improvement initiatives, such as Nursing Home Compare. Include a description of past performance and achievements in quality improvement. CMS expects that the applicant (if a Medicare provider/supplier)and its Bundled Payment participating organizations will maintain or improve their performance on the measures reported in any mandatory CMS quality measurement and improvement initiatives; decreased performance during the period of this initiative may result in termination.

6. Please describe the applicant's (if a Medicare provider/supplier), its Bundled Payment participating organizations', and Bundled Payment physicians'/practitioners' experience with voluntary Medicare quality measurement and improvement initiatives, including the Physicians Quality Reporting System (PQRS). Include a description of past performance and achievements in quality improvement. Please describe the extent and percentage of physicians/practitioners who are included in these programs. Please include whether physicians not currently participating in PQRS will participate for the duration of the project and discuss plans to encourage physician participation if selected. Physician participation and performance in PQRS should remain steady or improve during this initiative. If participation or performance shows a marked decline, CMS may terminate the agreement.

7. Please describe the applicant's and its Bundled Payment participating organizations' experience using health information technology (HIT) to measure and improve quality of care, enable care redesign, and coordinate care across multiple providers.

8. Please add any additional comments about the applicant's and its Bundled Payment participating organizations' participation in the initiatives listed here, and/or describe participation in quality improvement initiatives not listed here, including HHS or private sector care improvement, quality improvement, and care coordination activities.

9. Please describe the applicant's and its Bundled Payment participating organizations' experience with assessment tools, including the Continuity Assessment Record and Evaluation (CARE) tool (or comparable tool). Please describe how such a tool would be used during the initiative.

Quality Assurance

10. Please describe the internal quality assurance/monitoring the applicant and its Bundled Payment participating organizations will use to ensure clinical quality, patient experience of care, and clinical appropriateness throughout participation in this initiative. Include plans to monitor:

- inappropriate reductions in beneficiary care;
- clinical and functional outcomes in each Bundled Payment participating organization;
- clinical and functional outcomes across the course of an episode of care;
- clinical appropriateness of procedures.

11. How would the applicant's participation in this initiative fit with existing quality assurance and continuous quality improvement processes, standards, and strategies?

12. Please describe how the applicant and its Bundled Payment participating organizations will use this quality information to improve the project design, resolve any identified deficiencies, and constantly improve beneficiary care and satisfaction.

13. Please describe a detailed plan for implementing the applicant's and its Bundled Payment participating organizations' proposed quality assurance procedures, with a description of what aspects are already in use and what steps would be needed to implement new measures. Describe the feasibility of this plan based on ongoing operations and past experience.

14. Please complete the following table describing the certifications and accreditations that the applicant and its Bundled Payment participating organizations have earned.

Table D14: Certifications and Accreditations

Org Name	Accrediting Body	Provider or Department Receiving Certification/Accreditation	Review Cycle	Date of Last Accreditation or Certification		
				Month	Day	Year

15. Please complete the following table describing any sanctions, investigations, probations or corrective action plans that the applicant, its physicians/practitioners and/or Bundled Payment participating organizations are currently undergoing or have undergone in the last three years.

Table D15: Sanctions, Investigations, Probations or Corrective Action Plans

Organization or Physician/Practitioner Name	Nature of Sanction, Investigation, or Corrective Action Plan	Nature of Federal or State Agency or Accrediting Organization (e.g., DOJ, OIG, The Joint Commission, State Survey Agencies.	Description	Status

16. Please describe the role of beneficiaries, physicians, hospital staff, and post-acute care staff on the applicant's and its Bundled Payment participating organizations' quality assurance and quality improvement committees.

17. Summarize the results from any specific quality assurance studies the applicant or its Bundled Payment participating organizations have conducted for the target patient population(s) in this proposal.

Beneficiary Protections

18. Please describe the applicant's and its Bundled Payment participating organizations' plan for beneficiary protections beyond those components outlined above.

19. Please describe the applicant's and its Bundled Payment participating organizations' plan to ensure beneficiary freedom of choice of providers.

20. Please describe the applicant's plan for beneficiary notification of participation in this initiative as well as ongoing processes to handle and track beneficiary questions and concerns.

21. Please describe the applicant's plan for beneficiary engagement and education.

Section E: Organizational Capabilities, Prior Experience, and Readiness

Please describe a single holistic approach for the applicant and its Bundled Payment participating organizations in the questions that follow.

Financial Arrangements

If the applicant is selected, it must agree to accept some financial risk as part of participating in this initiative. Awardees must repay Medicare for expenditures for the episode above the agreed-upon episode target price. CMS or its contractor will monitor and measure care provided to included beneficiaries by participating and non-participating providers during a post-episode monitoring period of 30 days following the end of the episode. Aggregate Medicare Part A and Part B expenditures for included beneficiaries during the post-episode monitoring period will be compared to a trended baseline historical payment, which will include a risk threshold. If spending exceeds the risk threshold, the awardee must pay Medicare for the excess.

Prior to entering into an Awardee Agreement with CMS, the applicant must provide proof of ability to bear risk. Awardee conveners who are not Medicare providers will be required to provide an irrevocable line of credit executable by CMS or a similarly enforceable mechanism.

After CMS has reviewed applications, CMS will provide information regarding the amount of financial risk for which each recommended awardee would be accountable and other details regarding this financial assurance. We encourage applicants to start soliciting guidance from a bank or other financial institution on the application processes and underwriting criteria for irrevocable letters of credit executable by CMS or other similarly enforceable mechanisms that could meet this requirement (e.g., application documentation requirements, application approval lead time, collateral requirements, credit rating thresholds, transaction costs, and recurring financial institution fees).

1. Please describe all financial arrangements with episode-initiating Bundled Payment Participating Organizations that will allow the applicant to bear financial risk, and describe the mechanisms that will allow the applicant to repay Medicare if need be.

2. Please describe any financial arrangements with Bundled Payment participating organizations and Bundled Payment physicians/practitioners to share or delegate the financial risk associated with this initiative.

3. Please describe the financial and logistical mechanisms for distributing any gains resulting from care improvement under this initiative.

4. Please complete the table below for the applicant (if a Medicare provider/supplier) and its episode-initiating Bundled Payment participating organizations detailing the percent of net patient revenues by payer in calendar year 2011for Medicare FFS, Medicare Advantage, commercial health plans, Medicaid, self-pay patients, and any additional sources (e.g., local uncompensated care funds).

Table E4: Percent of Net Patient Revenues by Payer

Organization Name	Medicare FFS payments	Medicare Advantage payments	Commercial Health Plans	Medicaid	Self-Pay Patients	Other Sources

Leadership and Governance

5. Please describe the applicant's and its Bundled Payment participating organizations' governing bodies, including a list of the members and positions of each governing body. Describe whether there is meaningful representation from consumer advocates, Medicare beneficiaries, and all participating organization types.

6. Please describe how the applicant's governing body will conduct oversight of participation in this initiative.

7. List the 5–10 key personnel for the applicant's participation in this initiative, such as the Chief Operating Officer, Chief Medical Officer, Chief Quality Officer, etc. Identify the point person for this initiative. Attach information about these personnel, including educational background, professional experience, special qualifications, whether the person is an employee of the applicant or a proposed subcontractor or consultant.

Please include all information in one attachment.

8. Please describe how the key personnel will be integrated organizationally, their proposed responsibilities, and the percentage of their time to be dedicated to this project. Please describe the financial resources that will be made available to key personnel to implement this initiative and improve care processes.

History, Prior Experience, and Readiness to Participate

9. Please describe the applicant's and its Bundled Payment participating organizations' geography, years of operation, and market share for delivery of services related to the proposed episode(s). Indicate whether the market share for delivery of services related to the proposed episode(s) has changed in the past five years and/or is expected to change during the term of this initiative (e.g., major additions or expansions of particular services).

10. Please describe the applicant's and its Bundled Payment participating organizations' experience using care redesign strategies across care settings to achieve the following outcomes: quality improvement, patient experience of care, efficiency, cost savings, and/or reduced Medicare spending.

11. Please describe how participation in this initiative will relate to any other care improvement/redesign efforts the applicant is undertaking or participating in (include all Medicare, Medicaid, and private sector bundled payment, ACO, medical home, or other relevant initiatives).

12. Please describe how the applicant's proposal differs from any other episode-based payment initiatives in which the applicant or its Bundled Payment participating organizations participate.

13. Please describe the applicant organization's experience with process improvement efforts such as Six Sigma, Lean Enterprise, or other efforts.

14. Please describe how participation in this initiative relates to the applicant's overall strategic planning for better care for individuals, better health for populations and lower costs through improvement.

15. Please describe the HIT resources the applicant and its Bundled Payment participating organizations will use to implement this initiative. Include availability of and access to systems and facilities, including personnel, computer systems, and technical equipment. Include information on what types of IT vendors/software the applicant uses, if applicable. Please discuss whether any components of participation in this initiative (e.g., tracking beneficiary care across care settings; distributing gains to participants) will require additional hardware and software beyond current infrastructure and provide a timeframe to implement them.

16. What percentage of the eligible professionals in the applicant's organization, its Bundled Payment participating organizations, and the physicians/practitioners the applicant expects to participate that will meet the standards for meaningful use of electronic health records in order to receive incentive payments by the end of 2012?

17. Please attach a 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 ongoing operations and past experience. (Suggested: two pages, double-spaced)

Partnerships

18. Please describe the applicant's history with its Bundled Payment participating organizations, including prior business relationships and collaboration on care improvement/redesign initiatives.

19. Please describe any partnerships that the applicant, its Bundled Payment participating organizations, and the physicians/ practitioners the applicant expects to participate, have entered into with state Medicaid programs, private payers, or multi-payer collaboratives to redesign care.

20. Are any private purchasers or payers interested in or planning to participate in this application?

Yes No

If so, please list them here and describe the nature of their participation.

21. A key component of the Bundled Payments for Care Improvement initiative will be the learning networks, including technical assistance for awardees and a wide range of peer-to-peer learning opportunities. Please describe the applicant's past experience with learning network activities and the types of learning network activities the applicant plans to engage in as part of this initiative, such as participation in webinars, presenting in webinars, hosting site visits at the applicant's care settings, and sharing processes and lessons learned about redesigning care through case studies or presentations.

Section F: Certification

Please upload a scanned, dated one-page PDF statement on the applicant organization's letterhead stating: "I certify that all information and statements provided in this proposal are true, complete, and accurate to the best of my knowledge and are made in good faith." This statement must be signed by the CEO or Senior Executive of the applicant organization who has authority to make such commitments.

Upload Document Here.