# Bundled Payments for Care Improvement Application
## Model 2 – Designated Awardee/Awardee Convener Sub-Proposal

*In this proposal, the facilitator convener[1] is the applicant. A facilitator convener, an entity that serves an administrative and technical assistance function for one or more designated awardees/awardee conveners[2], and who would not have an agreement with CMS, bear financial risk, or receive any payment from CMS, may apply with or on behalf of designated awardees/awardee conveners. Designated awardees/awardee conveners are defined as the entities that would bear financial risk and receive payments from CMS (using the same rules as risk-bearing awardees and risk-bearing awardee conveners). This is a sub-proposal of the facilitator convener proposal. It may be completed by the facilitator convener on behalf of the designated awardees/awardee conveners or by the designated awardees/awardee conveners themselves.*

*For questions that require information about the designated awardee/awardee convener only, please provide information about the proposed designated awardee/awardee convener organization only. Many questions, however, require information more broadly about the designated awardee's/awardee convener's partners. Designated awardees/awardee conveners may have partners like any other risk-bearing awardees. 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). Designated awardee conveners would also have episode-initiating Bundled Payment participating organizations, which are a sub-set of Bundled Payment participating organizations that initiate episodes (acute care hospitals in Model 2).*

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

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[1] An entity may submit an application in partnership with multiple providers, where the entity would participate as a facilitator convener. 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 awardees/awardee conveners through contracts between the convener and the designated awardees/awardee conveners. A facilitator convener applying on behalf of designated awardees/awardee conveners must specify in the application:
-The designated awardees/awardee conveners, which is defined as the entity that would bear financial risk and receive payments from CMS (using the same rules as risk-bearing awardees and risk-bearing awardee conveners); and
-The financial arrangements between the facilitator convener and each risk- bearing designated awardee/awardee convener.

[2] Individual providers/suppliers would be designated awardees if their model includes only their eligible patients. The awardee would be responsible for all of its eligible patients, regardless of the other providers where the patients receives care during the episode. Awardees would be expected to partner with other providers/suppliers to redesign care and gainshare, but in this scenario they would not take risk for the partner providers/suppliers' patients that could meet the episode definition but are not cared for by the awardee.
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 designated awardee conveners. In this scenario, the designated awardee convener would be responsible for all of its episode-initiating Bundled Payment participating organizations' eligible patients.
Providers/suppliers would be designated awardee conveners if their model more broadly includes patients of other providers that initiate episodes (acute care hospitals in Model 2). In this scenario, the designated 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 designated awardee convener during the episode.

## Section A: Designated Awardee/Awardee Convener Organization Information

1. Designated Awardee/Awardee Convener Organization Trade Name: _____
"Doing Business As" if different Designated Awardee/Awardee Convener organization trade name:
_____

2. Designated Awardee/Awardee Convener Contact Person at Designated Awardee/Awardee Convener Organization:
Name: _____
Title: _____
Street Address: _____
Address line 2:_____
City, State, Zip code:_____
Telephone: _____ Fax: _____
Email: _____

3. Please provide the designated awardee/awardee convener organization's tax identification number (TIN), type of organization, and type of entity. If the designated awardee/awardee convener is a Medicare provider/supplier, please also include bed size of the designated awardee/awardee convener's facility if applicable, whether the designated awardee/awardee convener is planning to participate in a Medicare shared savings program[3] , 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 sub-proposal will not be processed without a valid CCN.

### Table A3. Designated Awardee/Awardee Convener Information

| Organization Name | Organization Type | TIN | NPI | CCN[4] | Facility Bed Size if Applicable | Type of Entity | Participating or Planning to Apply to a Medicare Shared Savings Program[5] |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

4. Please complete the following table identifying the Bundled Payment participating organizations the designated awardee/awardee convener 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,

[3] 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.

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

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

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[6] | Contact | Phone | Email | Address | Description of Org. | Bed Size if Applicable | Type of Enitity | Medicare Shared Savings Program[7] Y/N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

For a physician group practice designated awardee/awardee convener, 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 |
|---|---|---|---|---|
| | | | | |
| | | | | |

5. Provide a brief summary of the designated awardee/awardee convener organization.
For example:

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

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

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

## Section B: Model Design

### Episode Definition

1. Please complete the table below, indicating which episodes from the main facilitator convener application in which the designated awardee/awardee convener is choosing to participate.

**Table B1. Episodes**

| Episode Number | Episode Description |
|---|---|
| | |
| | |
| | |

### Provider Engagement

2. 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 designated awardee/awardee convener 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.*

3. 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.

4. For designated awardee conveners, please attach letters of agreement from each of the designated awardee convener's episode-initiating Bundled Payment participating organizations (acute care hospitals) 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.

## Care Improvement

5. Please describe the capacity and readiness of the designated awardee/awardee convener and its Bundled Payment participating organizations to redesign care.

6. Please describe any ways in which the designated awardee's/awardee convener's approach to redesigning care differs from that outlined in the overall facilitator convener proposal.

**Section C: Financial Model: Designated Awardee/Awardee Convener**

1. If the designated awardee is a non-convener risk-bearing awardee, please complete the following C1 table(s). Please use the episode definitions from table B2 and B3 of the main facilitator convener proposal.

In Model 2, if the designated awardee is an acute care hospital, the episode is initiated by admission to the designated awardee's hospital for an agreed-upon anchor MS-DRG. If the designated awardee is not an acute care hospital, for the patients of the designated awardee, the episode is initiated by the admission to any acute care hospital for an agreed-upon anchor MS-DRG.

Non-convener designated awardees will be responsible for their eligible patients only. The designated awardee would be responsible for all of its eligible patients, regardless of the other providers where the patients receive care during the episode.

Please complete a separate table for every episode that the designated awardee chooses to participate in from the facilitator convener's main proposal (Section B, question 1 above). In each table the designated awardee 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 of the facilitator convener's main proposal.
- On the right hand side of the table, the discount is auto-generated from the discount provided in Section B of the facilitator convener's main proposal.
- Under "Target Price and Number of Episode Cases":
  - In the columns labeled "# Episode Cases", please list the number of cases in 2009 broken out for each specific MS-DRG within the episode.
  - In the columns labeled "Target Price per MS-DRG", please calculate a target price with the discount incorporated based on the historical episode payments for the designated awardee for each MS-DRG within the episode.
    - Please propose a target price in calendar year 2009 dollars, incorporating at least a 3% discount on the historical payment for episodes that include a post-discharge window of 30 to 89 days, and at least a 2% discount on the historical payment for episodes that include a post-discharge period 90 days or longer.
    - 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.
- The "Net Savings to Medicare" will be automatically calculated as the "Total Episode Payment" minus the "Total Episode Target Payment."

## Table C1: Designated Awardee Historical Episode Payments, Target Prices, and Number of Episode Cases

| **Episode Number:** | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Episode Name:** | | | | | | | | | | | | | | |
| **Service Type** | **Historical Episode Payment[8]** | | | | | **Discount** | **Target Price and Number of Episode Cases** | | | | | | **Savings to Medicare** | |
| | Total $ Episode Initiating Hospital Stay | Total $ Post-Discharge Period[9] | Total Episode $ Payment CY 2009 | Total # Episode Cases | Average $ per Episode CY 2009 | Rate of Discount | # of Episode Cases from MS-DRG x | Target Price $ per Anchor MS-DRG x | # of Episode Cases from MS-DRG y | Target Price $ per Anchor MS-DRG y | # of Episode Cases from MS-DRG z | Target Price $ per Anchor 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 | | |

[8] For items left of the grey box, fill in totals for all MS-DRGs within the episode combined.

[9] Post-Discharge Period = All Part A and Part B services furnished post-discharge through the end of the episode related to the episode anchors, 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.

2. If the designated awardee is a risk-bearing awardee convener, please complete the following C2 table(s). Please use the episode definitions from table B2 and B3 of the main facilitator convener proposal.

In Model 2, the episode is initiated by admission to the designated awardee convener's (if an acute care hospital) or one of its episode-initiating Bundled Payment participating organizations (acute care hospital(s)) for an agreed-upon anchor MS-DRG for the patients of a designated awardee convener (if a Medicare provider/supplier) or its episode-initiating Bundled Payment participating organizations. If the designated awardee convener is a Medicare provider/supplier but is not an acute care hospital, for the patients of a designated awardee convener, the episode is initiated by the admission to any acute care hospital for an agreed-upon anchor MS-DRG.

Please note that if the designated awardee convener 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 designated awardee convener 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 designated awardee convener should complete a separate table for each episode-initiating Bundled Payment participating organization (acute care hospital) for each episode.
  - In the case of a hospital system where all hospitals have the same CCN, please only fill out one table for the hospital system for each episode as all of these hospitals are required to participate and they will have the same target price.
  - In the case of a hospital system where hospitals have different CCNs, the designated awardee convener may designate which hospitals are participating and complete different tables for each hospital.
- The designated awardee convener should also complete a table for itself for each episode if the designated awardee convener is a Medicare provider/supplier.

In each table the designated awardee convener 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 of the facilitator main proposal.
- On the right hand side of the table, the discount is auto-generated from the discount provided in Section B of the facilitator main proposal.
- Under "Target Price and Number of Episode Cases":
  - In the columns labeled "# Episode Cases", please list the number of cases in 2009 broken out for each specific MS-DRG within the episode.
  - In the columns labeled "Target Price per MS-DRG", please calculate a target price with the incorporated discount for each MS-DRG within the episode.
    - Please propose a target price in calendar year 2009 dollars, incorporating at least a 3% discount on the historical payment for episodes that include a post-discharge window of 30 to 89 days, and at least a 2% discount on the historical payment for episodes that include a post-discharge period 90 days or longer.

- CMS will trend proposed target prices to the applicable year in our application review and for purposes of final agreements with awardees.

**Table C2: Designated Awardee Convener Episode Payments and Number of Episode Cases with Proposed Target Prices**

| **Episode Number:** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Episode Name:** | | | | | | | | | | | | |
| **Org. Name:** | | | | | | | | | | | | |
| **Service Type** | **Historical Episode Payment[10]** | | | | | **Discount** | **Target Price and Number of Episode Cases** | | | | | |
| | Total $ Episode Initiating Hospital Stay | Total $ Post-Discharge Period[11] | Total Episode $ Payment CY 2009 | Total # Episode Cases | Average $ per Episode CY 2009 | Rate of Discount | # of Episode Cases from MS-DRG x | Target Price $ per Anchor MS-DRG x | # of Episode Cases from MS-DRG y | Target Price $ per Anchor MS-DRG y | # of Episode Cases from MS-DRG z | Target Price $ per Anchor 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 | 0 | $0 | 0 | $0 |

[10] For items left of the grey box, fill in totals for all MS-DRGs within the episode combined.

[11] Post-Discharge Period = All Part A and Part B services furnished post-discharge through the end of the episode related to the episode anchors, 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.

The Designated Awardee Convener Episode Summary table below is an automatic summary of all the C2 tables completed for each episode for the designated awardee convener and all of its episode-initiating Bundled Payment participating organizations (acute care hospitals).

- The first 4 columns of this table under "Total Historical Payment" are an automatic summation of all the C2 tables completed for that episode.
- 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 C2 tables for that episode.
- 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 proposal.
- The "Net Savings to Medicare" will be automatically calculated as the "Sum of Total Episode Payment" minus the "Total Episode Target Payment."

| **Episode Number:** | | | | | | |
|---|---|---|---|---|---|---|
| **Episode Name:** | | | | | | |
| **Target Price and Number of Episode Cases** | | | | | | |
| | **Sum of Total $ Episode Initiating Hospital Stay** | **Sum of Total $ Post-Discharge Period** | **Sum of Total Episode $ CY 2009** | **Sum of Total # Episode Cases** | **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 | | | | | | |

3. For designated awardees, please complete this table for the designated awardee. Designated awardee conveners should complete this table for each episode-initiating Bundled Payment participating organizations (acute care hospitals). If the designated awardee convener is a Medicare provider/supplier, please also complete this table for the designated awardee convener itself.
In each table the designated awardee/awardee convener 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. Please describe the universe of patients the designated awardee/awardee convener 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 designated awardee's/awardee convener's decision of whether or not to pro-rate payments for services that span the end of the episode. .

## Section D: Quality of Care and Patient Centeredness

*Please describe a single holistic approach for the designated awardee/awardee convener and its Bundled Payment participating organizations in the questions that follow.*

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

2. If the designated awardee/awardee convener 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 designated awardees/awardee conveners 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.

3. Please describe the designated awardee's/awardee convener'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 designated awardee/awardee convener (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.

4. Please describe the designated awardee's/awardee convener'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.

5. Please describe the designated awardee's/awardee convener'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.

6. Please add any additional comments about the designated awardee's/awardee convener'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.

7. Please describe the designated awardee's/awardee convener'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

8. Please describe the internal quality assurance/monitoring the designated awardee/awardee convener 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.

9. How would the designated awardee's/awardee convener's participation in this initiative fit with existing quality assurance and continuous quality improvement processes, standards, and strategies?

10. Please describe a detailed plan for implementing the designated awardee's/awardee convener'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.

11. Please complete the following table describing the certifications and accreditations that the designated awardee/awardee convener and its Bundled Payment participating organizations have earned.

**Table D11: Certifications and Accreditations**

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

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

**Table D12: 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 |
|---|---|---|---|---|
| | | | | |
| | | | | |

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

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

## Section E: Organizational Capabilities, Prior Experience, and Readiness

*Please describe a single holistic approach for the designated awardee/awardee convener and its Bundled Payment participating organizations in the questions that follow.*

### Financial Arrangements

If the designated awardee/awardee convener 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 designated awardee/awardee convener must provide proof of ability to bear risk. Designated 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 designated awardee conveners 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. If a designated awardee convener, please describe all financial arrangements with episode-initiating Bundled Payment Participating Organizations that will allow the designated awardee convener to bear financial risk and the mechanisms that will allow the designated awardee convener 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 designated awardee/awardee convener (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 designated awardee's/awardee convener'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 designated awardee's/awardee convener's governing body will conduct oversight of participation in this initiative.

7. List the 5–10 key personnel for the designated awardee's/awardee convener'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 designated awardee/awardee convener 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 designated awardee's/awardee convener'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 designated awardee's/awardee convener'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 designated awardee/awardee convener 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 designated awardee's/awardee convener's proposal differs from any other episode-based payment initiatives in which the designated awardee/awardee convener or its Bundled Payment participating organizations participate.

13. Please describe the designated awardee/awardee convener 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 designated awardee's/awardee convener'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 designated awardee/awardee convener 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 designated awardee/awardee convener 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 designated awardee's/awardee convener's organization, its Bundled Payment participating organizations, and the physicians/practitioners the designated awardee/awardee convener 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 designated awardee's/awardee convener's history with its Bundled Payment participating organizations, including prior business relationships and collaboration on care improvement/redesign initiatives.

19. 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 designated awardee's/awardee convener's past experience with learning network activities and the types of learning network activities the designated awardee/awardee convener plans to engage in as part of this initiative, such as participation in webinars, presenting in webinars, hosting site visits at the designated awardee's/awardee convener's care settings, and sharing processes and lessons learned about redesigning care through case studies or presentations.