**Comparison of Bundled Payment Models**

| | Model 1 | Model 2 | Model 3 | Model 4 |
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| *General Description* | **Retrospective** payment models for the acute inpatient hospital stay only. | **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. | **Retrospective** bundled payment models for post-acute care where the bundle does not include the acute inpatient hospital stay. | **Prospective** bundled payment models for hospitals and physicians for the acute inpatient hospital stay only |
| *Eligible awardees* | • Physician group practices<br>• Acute care hospitals<br>• Health systems<br>• Physician hospital organizations<br>• Conveners[1] of participating health care providers | • Physician group practices<br>• Acute care hospital<br>• Health systems<br>• Physician hospital organizations<br>• Post-acute care providers<br>• Conveners of participating health care providers | • Physician group practices<br>• Acute care hospitals<br>• Health systems<br>• Long term care hospitals<br>• Inpatient rehabilitation facilities<br>• Skilled nursing facilities<br>• Home health agencies | • Physician group practices<br>• Acute care hospitals<br>• Health systems<br>• Physician hospital organizations<br>• Conveners of participating health care providers |

[1] The RFA defines a convener as an entity that can bring together multiple participating health care providers, such as a state hospital association or a collaboration of providers. The 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. Centers for Medicare & Medicaid Services, Bundled Payments for Care Improvement Initiative Request for Applications, 39 (Aug. 22, 2011).

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| | | | • Physician hospital organizations<br>• Conveners of participating health care providers | |
| **Defining the Episode** | | | | |
| *Episode anchor (event that triggers beneficiary inclusion in the episode)* | Admission to an acute care hospital for a claim paid under the inpatient prospective payment system (IPPS) under any MS-DRG. | Acute care hospital admission for agreed-upon MS-DRGs. | Initiation of post-acute care services at a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long term care hospital (LTCH), or home health agency (HHA) with awardee or bundled payment participating organization within 30 days of beneficiary discharge from an acute care hospital for agreed-upon MS-DRGs. | Acute care hospital admission for agreed-upon MS-DRGs. |
| *Episode end point* | Acute care hospital discharge. | Episode continues through a minimum of 30 days following discharge from the hospital, with two options:<br>Option 1 – applicant may propose an episode that extends 30 days to 89 days following hospital | Episode continues through a minimum of 30 days following initiation of the episode. Exact date to be proposed. | Acute care hospital discharge. |

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| | | discharge;<br>Option 2 – applicant may propose an episode that extends 90 days or longer following hospital discharge. | | |
| *Included services* | Part A inpatient hospital services.<br>Includes all Part A services furnished to included beneficiaries during the hospital stay, including hospital diagnostic testing and 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. | Physician services, inpatient hospital services, inpatient hospital readmission services, LTCH services, IRF services, SNF services, HHA services, hospital outpatient services, independent outpatient therapy services, clinical laboratory services, durable medical equipment, and Part B drugs.<br>Includes 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 | Physician services, inpatient hospital readmission services, LTCH services, IRF services, SNF services, HHA services, hospital outpatient services, independent outpatient therapy services, clinical laboratory services, durable medical equipment, and Part B drugs.<br>All Part A services for related readmissions and all related Part B services furnished during the episode period, including during related and unrelated readmissions, must be included in the episode.<br>Applicants will be expected to propose | Physician services, inpatient hospital services, inpatient hospital readmission services.<br>Includes 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.<br>Part A hospital services furnished during related readmissions and all related Part B professional services furnished during any related or unrelated readmissions are also included in the episode payment. |

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| | | are furnished during the hospital stay, and Part A and Part B services in the post-discharge period related to the episode anchor.<br>All Part A services for related readmission and all related Part B services furnished during the post-discharge period, including during related and unrelated readmissions, also must be included in the episode in both options. | further definitions of the episode, including beneficiary identification through MS-DRGs, length of episode, excluded unrelated Part A services, and excluded unrelated Part B services. | |
| **Payment Mechanics** | | | | |
| *Minimum required discount to Medicare* | Applicants are expected to propose a rate of discount, which will be phased in as follows:<br>--0% or higher for start date through month six;<br>--0.5% or higher for months seven through 12;<br>--1% or higher for year two;<br>--2% or higher for year three. | Option 1 – minimum 3% discount off all included MS-DRGs and other Part A and Part B services within the episode.<br>Option 2 – minimum 2% discount off all included MS-DRGs and other Part A and Part B services within the episode.<br>Actual discount rate will be proposed under either option. | To be proposed by applicant. | To be proposed by applicant, but CMS expects applicants to offer at least a 3% discount on expected fee-for-service (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 Medicare Acute Care Episode Demonstration, CMS |

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| | | | | expects a discount greater than 3%. |
| *Target price (agreed upon total Medicare payment for the episode)* | N/A | Applicants will be expected to propose a target price for the episode that includes a single rate of discount (described above) off the expected Medicare payment for all included Part A and Part B services. | Applicants will be expected to propose a target price for the episode that includes a proposed single rate of discount off the expected Medicare payments for all included services. | Applicants will be expected to propose a target price for the episode that includes a single rate of discount off 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. |
| *Claims payment and reconciliation* | Acute care hospital will be paid the discounted FFS rate. Claims will be processed under existing IPPS payment rules. Physicians will be paid traditional FFS payments. | Claims will continue to be processed under the relevant IPPS, Physician Fee Schedule, and post-acute payment system rules. There will be a regular retrospective reconciliation against the predetermined target price. If aggregate FFS payments for included | Claims will be processed under the appropriate payment systems and rules. There will be regular retrospective reconciliation against the predetermined target price. If aggregate payments for included services exceed the | Participating acute care hospital (awardee or bundled payment participating organization[2]) 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 upon a price for the |

[2] Bundled payment participating organization is defined to include all providers or suppliers, other than physicians and/or practitioners, with whom the awardee plans to partner. Examples include acute care hospitals, SNFs, and HHAs.

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| | | services exceed the target price, the awardee must repay Medicare. If the aggregate FFS payments are less than the predetermined price, the awardee will be paid the difference. | predetermined target price, the awardee must repay Medicare. If aggregate FFS payments are less than the predetermined target price, the awardee will be paid the difference. | bundle, including a discount, in advance. CMS will pay the agreed-upon single payment following claims submission at the time of beneficiary discharge.<br>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.<br>The hospital is responsible for distributing payment to other providers and physicians as appropriate. |
| *Gainsharing permitted?* | Yes. | Yes. | Yes. | Yes. |
| **Episode Population** | | | | |
| *Beneficiaries included in the bundled payment* | All eligible beneficiaries (i.e., patients who have both Medicare Part A and Part B and for whom Medicare FFS is the primary payer) who are | All beneficiaries admitted to an awardee or bundled payment participating provider for agreed-upon MS-DRGs will be included. | All beneficiaries who initiate post-acute care services with an awardee or eligible bundled payment participating | All beneficiaries eligible for the episode admitted to the awardee or its bundled payment participating providers will be included. |

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| | treated in a participating entity. | | organization will be included. | |
| **Quality Measurement and Reporting** | | | | |
| *Quality measurement and reporting* | Participating hospitals are expected to report, at a minimum, the full set of Hospital Inpatient Quality Reporting Program measures, including those measures required to receive the full annual payment update and those labeled as either CMS informational or CMS voluntary measures. Additional quality measures will 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. | 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. | 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. | 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. |