Program Objective	Bundled Payments for Care Improvement Initiative (BPCI), one of the Center for Medicare and Medicaid Innovation's (CMMI) largest initiatives, promotes improved outcomes, higher quality and increased coordination of care for Medicare beneficiaries, by requiring participants to assume financial and performance accountability for an entire episode of care as opposed to separate individual procedures. Participants select of one of four options of episode based payment models tied to inpatient hospital admission, each varying by types of providers involved, the length of the bundle after the hospitalization, and whether payment is prospective or retrospective in nature. BPCI is designed to enhance collaboration across specialties and settings through necessitating information sharing to achieve improved outcomes for an entire episode of care.
Program Purpose	Initiative is designed to align provider incentives across specialties and settings. BPCI provides a degree of flexibility in payment approaches to support achieving better outcomes for Medicare beneficiaries.
Duration and Number of Participants *as of January 2016	Each model is three years in duration. Performance years typically begin in Spring or Fall. Model 1: consists of one implementation phase. The first cohort began in April 2013. 11 participants exist. Note: Models 2-4 consist of two implementation phases: Phase 1 (preparation period) and Phase 2 (risk-bearing phase). The majority (2115 participants) are in phase 2. The first cohort for these models began in October 2013. Model 2: 741 participants Model 3: 1353 participants Model 4: 10 participants See here for a full list of participant awardees and episode initiators in all models.
Core Care Delivery Elements	Participants must choose one of four payment model options. Each model has core care delivery elements: acute and post-acute care, length of episode, types of conditions, hospitals only or a combination of services provided by hospital, physicians and other practitioners, as well as conveners. Model 1 episode of care includes hospital services for inpatient stay only (Part A services) for all MS-DRGs. Models 2-4 require participation in a designated list of up to 48 clinical episodes (non-hospice Part A and B services). *See here for a full list of 48 clinical episodes and DRGs included in each.
Clinical Episodes Relevant to Cardiology (Models 2-4)	Of the designated 48 clinical episodes for Models 2-4, those of particular relevance to cardiology are the following: acute myocardial infarction, atherosclerosis, automatic implantable cardiac defibrillator generator or lead, cardiac arrhythmia, cardiac defibrillator, cardiac valve, chest pain, CHF, coronary artery bypass graft surgery, major cardiovascular procedure, pacemaker, pacemaker device replacement or revision, percutaneous coronary intervention
Participant Eligibility	Providers and other entities may participate in BPCI based on whether they accept risk under BPCI through an agreement with CMS ("Awardee") provide services that initiate a bundle ("Episode Initiator" or "EI"), provide services to patients in a BPCI bundle (providers i.e. clinicians, health systems, facilities) or facilitate provider participation by acting as a convener. Model 1: Episode initiators must be acute care hospitals. Hospitals may enter gainsharing agreements with physician partners ("Enrolled Practitioners"). Model 2: Episode initiators must be acute care hospitals or physician group practices.

	Model 3: Episode initiators must be physician group practices, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities or home health agencies. Model 4: Episode initiators must be acute care hospitals. Hospitals, physicians and other practitioners providing services are eligible to receive payment from amount CMS provides to awardee hospital.
Payment Model	BPCI consists of 4 payment model options, three retrospective (Models 1-3) and one prospective (Model 4), respectively. Model 1: Retrospective Acute Care Hospital Stay Only Episode of care includes all MS-DRGs for inpatient stay in the acute care hospital. Model 2: Retrospective Acute & Post Acute Care Episode Episode of care includes a Medicare beneficiary's inpatient stay in acute care hospital and post-acute care for which participants choose ending date of either 30, 60, or 90 days after hospital discharge. All providers are paid on a fee-for-service basis. Total expenditures for episode is later reconciled retrospectively against a bundled payment amount (the target price) determined by CMS. Responsible Awardee receives any savings or repays any excess spending. 3-Day Hospital Stay for SNF, telehealth, and post-discharge home visit waivers are available. Model 3: Retrospective Post Acute Care Only Episode of care only includes post-acute care with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. Providers are paid on a fee-for-service basis with retrospective reconciliation against an established target price. Telehealth, and post-discharge home visit waivers are available. Model 4: Prospective Acute Care Hospital Stay Only Medicare makes a single, prospectively determined bundled payment to the hospital awardee that encompasses all services furnished by hospital, physicians, and other practitioners during the episode of care. Awardee uses this prospectively determined amount to pay individual providers. Episode of care spans entire inpatient stay. Physicians and other practitioners submit "no-pay" claims to Medicare and are paid by the hospital out of the bundled payment.
Beneficiary Notification	BPCI participants and provider partners are required to give beneficiaries written notification explaining BPCI, the beneficiary's right of access to medically necessary services, and the beneficiary's right to choose any provider or supplier of items or services.
Quality & Metrics Reporting	Model 1: All Hospital Inpatient Quality Reporting (IQR) program measures and any other measures agreed upon between CMS and awardees Models 2-4: Metrics are largely from existing programs, falling into these domains: 1)Patient Case Mix, 2) Structural and Organizational Characteristics 3) Clinical Care and Patient Safety and 4) Patient Experience.