

BoardBrief

Prepared for Colorado Hospital Association Trustees

Health Care Reform Payments Simplified Breaking Down the Basics

Passage and implementation of the Patient Protection and Affordable Care Act (ACA) has driven America's health care system into a state of transformation. One of the primary objectives of the ACA's new reimbursement/payment methods is to shift the nation's health care delivery system from one that is paid based on volume (the services received/fee-for-service) to a payment system based on value (payment for high quality, cost-effective care). ACOs, bundled payments, readmission penalties, and value-based purchasing (VBP) are among the payment methodologies being implemented under the ACA.

Being well-informed about ACA requirements, with all of their complexity, is the starting point to applying critical, "so what now" leadership thinking. Before hospital leaders can envision the future of their organizations, define potential strategic scenarios or begin the work essential to ensuring optimal success during the economic and health care transformations ahead, they must have a sound, fact-based, working understanding of the terms and provisions driven by the ACA.

But in the rush and complexity of implementing the many ACA requirements, popular and common use of new terms in health care conversations too often assumes an in-depth understanding of these provisions.

While hospitals are experiencing significant changes in regulations and how they are paid, they continue to face deep economic pressure from today's below-cost Medicare and Medicaid reimbursement, the *Budget Control Act's* sequester cuts, growth in costs that outpace revenue growth, declining patient volumes, along with the lingering effects of the recent economic recession.

The implications of reductions in existing reimbursement and changes in how hospitals will be paid in the future are critical to all hospitals. It is imperative that hospital trustees and others have the information and resources necessary to make well-informed, fact-based, and confident decisions. Critical components of the ACA's new payment methodologies include:

- Accountable care organizations (ACOs);
- Bundled payments;
- Hospital-acquired conditions (HACs);
- The readmission reduction program; and
- Value-based purchasing (VBP).

Accountable Care Organizations

ACOs are the much-talked-about health care entity created by the ACA.

An ACO is a group of providers and suppliers who agree to be accountable for achieving three aims:

- Better care for individuals;
- Better health for populations; and
- Lower growth in health care spending.

If successful in achieving pre-determined quality thresholds and benchmark savings, the ACO will be eligible for a share of the

"Growth strategies, physician alignment and greater efficiencies, along with effective management and governance, will be integral in positioning the hospital for payment reform."

-Moody's Investors Services

cost-savings. ACOs must also be willing to assume risk for potential losses.

What Is It? According to the U.S. Department of Health and Human Services (HHS), the ACO “agrees to be held accountable for improving the health and experience of care for individuals and improving the health of populations while reducing the rate of growth in health care spending.” In its program analysis after issuing the final rules, the Center for Medicare and Medicaid Services (CMS) describes the goal of shared savings to “reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first.”

Who Can Be Part of an ACO? To participate in the Medicare Shared Savings Program associated with ACOs, an ACO must meet all eligibility requirements and serve at least 5,000 Medicare fee-for-service patients. The ACA and the implementation rules are flexible as to who may work together as an ACO, including the following types of groups:

- Professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements;
- Networks of individual practices of professionals;
- Partnerships or joint ventures arrangements between hospitals and professionals;
- Hospitals employing physicians and other clinical professionals; and
- Other Medicare providers and suppliers as determined by the Secretary of Health and Human Services.

Critical Access Hospitals (CAHs), Federally Qualified Health

ACOs Critical Actions for Board Members

1. For general purposes, ensure a firm understanding of ACOs.
2. Whether participating in an ACO or not, consider how your organization contributes to and achieves the three objectives of ACOs (better care for individuals, better health for populations, and lower growth in expenditures) by delivering high-quality, patient-centered, and seamless care for patients.
3. Evaluate the potential for establishing your organization as an ACO (or as part of an ACO) , including an in-depth and detailed analysis of all requirements, costs, risks and benefits.
4. Consider a competitor’s potential for establishing an ACO and the implications to your organization.

Centers (FQHCs) and Rural Health Clinics (RHC) may participate in ACOs, but in most instances may not independently form an ACO.

ACOs must have a shared-governance structure, and the final rules require that at least 75% of the ACO governing board be comprised of ACO providers. In addition, at least one board member must be a Medicare beneficiary. However, the rule does allow for CMS to consider innovative ACO approaches that don’t follow this governance structure.

When Do ACOs Begin? The voluntary program began January 1, 2012; however, ACOs may continue to apply now. ACOs must submit an application to participate, and there is no guarantee of acceptance. ACOs must agree to participate in the program for three years.

Why Should a Provider Participate? In addition to the benefit of providing high-quality, well-coordinated care to patients and improving the health of the population, if the ACO can demonstrate cost-savings by delivering high-quality care it will be eligible to share in those savings with CMS.

How Does it Work? ACO providers continue to receive payment under the current Medicare fee-for-service rules. However, at the same time CMS develops a benchmark for each ACO to measure whether it qualifies to receive shared savings in addition. The shared savings (or loss) is an estimate of what the cost would have been in the absence of the ACO, and takes into account beneficiary characteristics and other factors that may affect the need for health care services.

Initially, ACOs must choose to participate in one of two risk models:

- **One-sided model:** Under the one-sided model, ACOs share in savings, but not losses. ACOs participating in the one-sided model are eligible for sharing up to 50% of the savings.
- **Two-sided model:** Under the two-sided model, ACOs share in savings and risk. ACOs participating in the two-sided model are eligible for sharing up to 60% of the savings, but are also liable for sharing part of the losses.

The one-sided model was designed to allow ACOs with less experience with risk and population management, particularly smaller ACOs, to enter the program. The two-sided model is an opportunity for ACOs with more experience to earn a greater share of the savings, but with the responsibility of repaying Medicare a portion of any losses.

Do Beneficiaries Sign Up for an ACO? Beneficiaries do not sign up to be part of an ACO, and may seek services outside of the ACO. Medicare will retrospectively look at beneficiaries' use of services to determine if the ACO should be credited with cost-savings and improvement in care.

The ACO must notify beneficiaries that they are in an ACO at the time of service, allowing the beneficiary to continue with the services or seek services from another provider. The ACO must also notify the beneficiary that claims data may be shared within the ACO, allowing beneficiaries to opt-out of the data sharing.

In the absence of beneficiary assignment, ACOs will receive monthly data reports from CMS on the services their beneficiary patients are receiving, allowing an estimation of performance.

How Will CMS Measure Quality? To be eligible for shared savings, the ACO must meet or exceed quality performance standards, which are measured using nationally recognized measures in four categories: 1) patient/caregiver experience; 2) care coordination/patient safety; 3) preventive health; and 4) at-risk population (diabetes, hypertension, ischemic vascular disease, heart failure, and coronary artery disease). The pay-for-performance is phased in for the 33 individual measures, allowing ACOs an opportunity to work together and coordinate care before actually being paid for performance. For the first period, ACOs will be paid as follows:

- **Year 1:** Pay for reporting for all 33 measures;
- **Year 2:** Pay for performance for 25 measures, and pay for reporting for the remaining 8 measures; and
- **Year 3:** Pay for performance for 32 measures, and pay for reporting for one measure.

ACOs will be compared against national benchmarks in each of the 33 categories, and will receive points on a sliding scale based on their level of performance. The points translate into the shared savings ACOs receive. ACOs must also achieve a minimum number of points to avoid being placed on a corrective action plan.

Bundled Payments

The "Bundled Payments for Care Improvement Initiative" was rolled out by CMS under the requirements of the ACA. Designed to improve quality and control costs, a bundled payment is one single payment for multiple services received

by a patient from one or more providers during an "episode of care."

Organized systems of hospitals, physicians and other providers participating in a bundled payment program agree contractually to work together to coordinate the patient's care. They also agree on how the single payment – and financial risk – will be shared. Designed to align the financial incentives of all providers, the initiative includes four different models of bundled payments (Models 1, 2, 3 and 4). The four models differ by the type of health care providers involved and the services covered in the bundled payment for that model.

According to CMS Administrator Marilyn Tavenner, "The objective of this initiative is to improve the quality of health care delivery for Medicare beneficiaries, while reducing the program expenditures, by aligning the financial incentives of all providers."³

What is an "Episode of Care?" An episode of care typically covers a specified period of time and includes the services provided for a specific diagnosis, like pneumonia or heart attack. For the bundled payment initiative, episodes will vary depending on the different models. For example, they may cover all diagnoses, but only for the time an individual is in the hospital, or under a different model, the episode may cover only certain diagnoses for services that are received after discharge from the hospital.

According to CMS, an episode of care for each model is defined as:

- **Model 1, "Retrospective Acute Care Hospital Stay Only":** The inpatient stay in an acute care hospital. In this model,

Bundled Payments Critical Actions for Board Members

1. How strong is your hospital/medical staff alignment? Are you well integrated? Do you have or can you establish the organizational or contractual relationships needed to coordinate care across required services?
2. Can you communicate well with your other contracted providers? Do you have well-established electronic health records, good data and the strength of collaboration necessary to succeed?
3. Are you willing and able to assume and manage risk?
4. Can you align and manage incentives?
5. Are you willing and able to assume responsibility for the costs and quality of services that other providers deliver?
6. Do you have the infrastructure to manage and disburse (or accept) payments?

an episode of care includes all acute patients and all diagnosis-related groups (DRGs).

ACA: Potential for 6% of Hospital Payments "At Risk" by 2017

- Model 2, "Retrospective Acute Care Hospital Stay Plus Post-Acute Care": The inpatient stay in an acute care hospital and all related services during the episode, which may end 30, 60, or 90 days after the start of the episode. Participants in this model may select up to 48 different clinical condition (diagnosis) episodes.
- Model 3, "Retrospective Post-Acute Care Only": The post-acute care services (skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency) beginning within 30 days of discharge from an inpatient stay and ending either 30, 60, or 90 days after the initiative of the episode. Participants in this model may select up to 48 different clinical condition episodes.
- Model 4, "Acute Care Hospital Stay Only": The inpatient stay in an acute care hospital and related readmissions for 30 days following discharge. Participants in this model may select up to 48 different clinical condition episodes.



What's the Difference Between Retrospective and Prospective Payments? If the payment is "retrospective," providers submit claims just as they would under fee-for-service. At the end of the episode of care, the charges are reconciled against a target price for an episode of care. If the amount is less than the amount of the bundled payment, Medicare pays the difference to the providers. If the amount is

more than the bundled payment, the providers must pay for the additional difference. How the providers allocate their gains and losses is determined in advance, by contract. Models 1, 2 and 3 are retrospective.

If the payment is "prospective," a lump sum payment is made to the provider for the entire episode of care. Only Model 4 is prospective. According to the CMS website, under Model 4, "CMS will make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians, and other practitioners. Physicians and other practitioners will submit "no pay" claims to Medicare and will be paid by the hospital out of the bundled payment."⁶

CMS Bundled Payment Models

	Model 1	Model 2	Model 3	Model 4
Episode	All acute patients, all DRGs	Selected DRGs, hospital plus post-acute period	Selected DRGs, post-acute period only	Selected DRGs, hospital plus readmissions
Services Included in the Bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions	All non-hospice Part A and B services during the post-acute period and readmissions	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective

Source: CMS Fact Sheet. *Bundled Payments for Care Improvement Initiative*. www.cms.gov. January 30, 2014.

What Does the Bundled Payment Cover? The services covered by the bundled payment also vary depending on the model:

- Model 1, "Retrospective Acute Care Hospital Stay Only": All Medicare Part A services are paid as part of the MS-DRG payment.
- Model 2, "Retrospective Acute Care Hospital Stay Plus Post-Acute Care": All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions are included in the bundled payment.
- Model 3, "Retrospective Post-Acute Care Only": All non-hospice Part A and B services during the post-acute period and readmissions are included.
- Model 4, "Acute Care Hospital Stay Only" (Prospective): All Part A and B services (hospital and physician) during the initial inpatient stay and readmissions are included.

Models 2 and 3 will also include physicians' services, care by post-acute providers, related readmissions, and other Medicare Part B services such as clinical laboratory services, durable medical equipment, prosthetics, orthotics and supplies, and Part B drugs.

What Factors Will Be Most Critical to Success? Hospital and medical staff alignment and collaboration are critical to success in participating in a bundled payment arrangement. In addition, shared information and data (electronic health records) and a strong infrastructure to manage and disburse payments are essential. Changes in payment structures, including bundled payment, are prompting some organizations to approach payer relationships differently. These organizations are seeking a more strategic partnership with payers to achieve financial viability.⁷

Hospital-Acquired Conditions

The Deficit Reduction Act of 2005 required payment adjustments to be implemented for certain hospital-acquired conditions (HACs). For discharges beginning on or after October 1, 2008, CMS stopped paying for certain HACs. To identify applicable conditions, hospitals are required to report "present on admission" (POA) information on diagnoses for discharges. Under the new rule, hospitals do not receive the higher payment for cases when a HAC is acquired during hospitalization (meaning it was not present on admission). Hospitals are paid if the secondary diagnosis is not present.

In April 2011, CMS began to publish hospitals' HAC performance on the Hospital Compare website, and are

proposing to add new conditions to the list for non-payment.

CMS also issued the final rules implementing non-payment to Medicaid programs for hospital-acquired conditions. The implementation essentially extends Medicare HAC provisions to Medicaid programs. The rule is broader than Medicare, however. States may add other conditions for non-payment, as long as implementation doesn't result in a loss of access to care or services for Medicaid beneficiaries.

What's Next? Beginning in FY 2015, under the ACA, Medicare payments (base DRGs) to hospitals in the lowest-performing quartile for HACs will be reduced by one percent. This payment reduction applies to all Medicare discharges.

Are All Hospitals Included? HAC payment requirements presently only apply to Inpatient Prospective Payment System (IPPS) Hospitals. Critical Access Hospitals and specified other facilities are exempt.

What Are They? A hospital-acquired condition is a condition that an individual "acquires," or that results from a hospitalization, that is presumed to be reasonably preventable. A Present on Admission code indicates which diagnoses were present at the time an order for inpatient admission occurs.

How are HACs Determined? The HHS Secretary determines the inclusion of specific HACs based on the criteria that the condition is:

- High cost, high volume or both;
- The cause for a higher paying DRG (Diagnosis Related Group) when present as a secondary diagnosis; and
- Reasonably preventable using evidence-based guidelines.

HACs Critical Actions for Board Members

1. Examine, review and understand your hospital's data on Hospital Compare.
2. Understand the HAC information provided on Hospital Compare and its implications.
3. Understand your state's rules for non-payment of HACs.
4. Determine how your hospital compares to your competitors and your peers, and how your performance impacts your revenues.
5. Approve quality improvement plans as required, and monitor your hospital's progress and performance.
6. CMS makes HAC data available to hospitals prior to posting; ensure it is previewed annually for accuracy.
7. Review releases of proposed and final rules regarding Medicare payment reduction to hospitals for HACs in 2015.

What is Included on the HAC List? Beginning FY 2015, CMS will use measures which fall into two domains. The first domain includes:⁷

- Pressure ulcers
- Iatrogenic pneumothorax
- Central venous catheter-related blood stream infections
- Postoperative hip fracture
- Postoperative pulmonary embolism or deep venous thrombosis
- Postoperative sepsis
- Wound dehiscence
- Accidental puncture and laceration

The second domain includes:

- Central line-associated blood stream infection
- Catheter-associated urinary tract infection

In FY 2016, CMS expects to add surgical site infections to domain two.⁷

How are HAC Scores Determined? Scores are calculated for each domain, and the two domains are each weighted in determining the total HAC score. To avoid unfairly penalizing hospitals caring for greater percentages of sicker patients, patient age, gender and comorbidities are considered in calculations. Hospitals with scores in the lowest quartile will be penalized the one percent Medicare payment reduction after the base DRG payment adjustments have been made for readmission and VBP programs.

Readmissions

Beginning in FY 2013, CMS reduced its payments to hospitals with “high rates” of readmissions in an effort to improve quality and reduce costs. Whether a hospital’s payment is cut depends on how well the hospital controls its preventable readmissions.

The reduction, which applies across all discharges, is limited to one percent in FY 2013, two percent in FY 2014 and three percent in FY 2015 and thereafter.

What is the Readmission Reduction Program? As an incentive to get hospitals to improve quality and reduce costs, CMS will cut payments to hospitals with high rates of

Readmission Reductions Critical Actions for Board Members

1. Understand the information provided about the readmission reduction program.
2. Ask your hospital’s leadership (CEO, CFO) to evaluate how the readmission reduction program may impact your organization’s revenues.
3. Monitor your hospital’s readmission rates and ensure that quality improvement plans are in place to minimize or eliminate readmissions.
4. CMS will make readmission data available to hospitals prior to posting on Hospital Compare; ensure it is previewed annually for accuracy, and to determine potential implications.
5. Monitor release of additional proposed and final rules regarding the Medicare readmission reduction program.

“preventable readmissions.” This is defined as a patient’s return to an acute care hospital within 30 days after discharge to a non-acute setting (home, skilled nursing, rehabilitation, etc.). CMS’ methodology takes into account planned readmissions for applicable measures.⁵

Readmissions are counted following discharge for five conditions:⁵

- Acute myocardial infarction (AMI) (heart attack);
- Heart failure;
- Pneumonia;
- Chronic obstructive pulmonary disorder (COPD); and
- Hip and knee arthroplasty.

CMS plans to add coronary artery bypass graft (CABG) surgical procedures to the list of conditions in FY2017.

Next Steps. Hospitals with high readmission rates may participate in a voluntary program with a patient-safety organization (PSO), and will need to implement improvement plans.

According to the Agency for Healthcare Research and Quality (AHRQ), “a PSO is an entity or a component of another organization that is listed by AHRQ based upon self-attestation by the entity or component organization that it meets certain criteria established in the Patient Safety Rule. The primary activity of an entity or component organization seeking to be listed as a PSO must be to conduct activities to improve patient safety and health care quality. A PSO’s workforce must have expertise in analyzing patient safety events, such as the

identification, analysis, prevention, and reduction or elimination of the risks and hazards associated with the delivery of patient care.”

Value-Based Purchasing

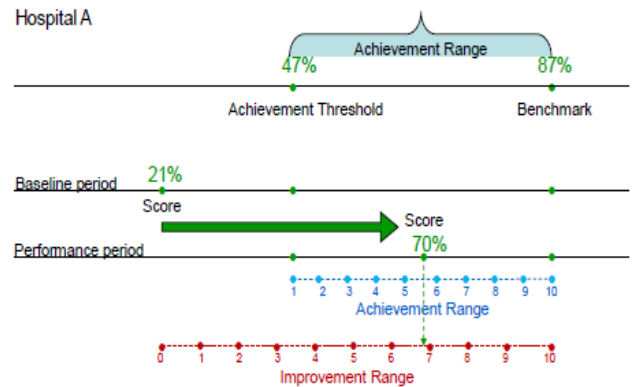
Value-Based Purchasing (VBP) is payment for actual performance vs. payment for just reporting hospital performance. With reporting, the Medicare payment is the same whether the hospital’s performance is good or bad. Under VBP, CMS will keep between one and two percent of hospitals’ payments – and hospitals will have a chance to earn back the withheld depending on the quality of their care.

CMS began withholding a percentage of Inpatient Prospective Payment System (IPPS) hospital operating payments in FY 2013 at one percent, increasing the amount 0.25 percent annually up to two percent in 2017. It’s estimated the 1.5 percent withhold for FY 2015 represents \$1.4 billion. Hospitals have a chance to earn back some or all of this withhold, either by achieving high-level quality scores on specified measures or, if a hospital’s performance is not at achievement levels yet, by improving its quality performance.

How is “Quality Performance” Defined? Under the VBP program, CMS scores hospitals based on specified quality measures. Before being included in VBP, measures must have been included in the Inpatient Quality Reporting Program (IQRP) and posted on Hospital Compare for one year.

Sample Value-Based Purchasing Scoring for a Measure

The chart below demonstrates scoring for a hospital under the new VBP system. The top line shows the achievement range, with the minimum achievement threshold and the benchmark. The second line shows the hospital’s baseline period score. During the performance period, the hospital’s score was 70%, which earned 6 points for achievement (above the achievement threshold but not all the way to the benchmark). The hospital’s performance improved from 21% to 70%, earning 7 points. The highest of the two is used for each measure. For this sample measure the hospital receives 7 points.



Hospital A earns 6 points for achievement and 7 points for improvement
 Hospital A score = higher of achievement or improvement = 7 points

Source: American Hospital Association. AHA Regulatory Advisory. Hospital Value-Based Purchasing Program: The Final Rule. May 24, 2011.

Domain Weighting

	Clinical Process of Care	Patient Experience of Care	Outcome	Efficiency
FY 2013	70%	30%		
FY 2014	45%	30%	25%	
FY 2015	20%	30%	30%	20%
FY 2016	10%	25%	40%	25%
	Clinical Care	Patient Experience of Care	Safety	Efficiency
FY 2017	Outcomes 25% Process 5%	25%	20%	25%

Source: Understanding Value-Based Purchasing. www.stratishealth.org. July, 2014.

Each measure is categorized into one of several identified domains; and each of the domains is weighted differently in determining a total score.

In VBP’s initial year, FY 2013, CMS scored 12 measures in two domains: Clinical Process of Care and Patient Experience of Care. In FY 2014, a third domain, Outcomes, was added, and in FYs 2015 and 2016 a fourth domain, Efficiency was added. For FY 2017, there will be four domains, but there have been changes. A Safety domain has been added and Processes and Outcomes will be grouped as sub-domains under Clinical Care. Patient Experience of Care and Efficiency remain. More than 80 percent of the measures in these domains assess health outcomes, patient experience and cost.

CMS also makes annual updates and changes to the measures in each domain. For example, two new safety measures (hospital-onset methicillin-

resistant *Staphylococcus aureus* (MRSA) bacteremia and *Clostridium difficile* infection) and one new clinical care measure (early elective deliveries) will be added for FY 2017 and six “topped out” clinical process measures will be removed.

For each measure, a hospital’s performance is scored in two ways—achievement and improvement. CMS uses whichever score is best in each category.

How Will “Achievement” Be Measured? Achievement is measured using pre-determined thresholds. The first is a minimum achievement threshold. A hospital must get at least to the minimum achievement threshold point to earn any points.

The second is the benchmark, which is determined using national data from the baseline period. Any score above the benchmark gets maximum points.

The scoring system uses the following scale:

- Less than the minimum threshold: 0 points;
- Between the minimum threshold and the benchmark: 1-9 points; and
- At or above the benchmark: 10 points.

How Will “Improvement” Be Measured? Hospital improvement is measured by comparing a hospital’s quality measures from a “baseline” period to a “performance period.” A hospital’s baseline is how well the hospital performed in the quality measures, initially measured from July 1, 2009 to March 31, 2010. A hospital’s performance period is its opportunity to improve, initially measured from July 1, 2011 to March 31, 2012.

Value-Based Purchasing Critical Actions for Board Members

1. Understand how VBP applies to your organization. Some hospitals, including CAHs and those with small numbers of patient cases or measures, are excluded now, but may be included in the future.
2. Know and evaluate your hospital’s performance scores. What was your baseline performance? What are your performance scores? Have your scores improved or declined? Will they be good enough to earn back your withhold money?
3. Use the current Inpatient Quality Reporting (IQR) program to evaluate your organization’s performance. How do you compare to your peers? Where should your scores be to compete for VBP payment? What improvement plans should be implemented? Monitor your progress towards achieving and/or maintaining target scores.
4. Should you expect a loss or the possibility of earning back some of your withhold? Use AHA’s VBP calculator to estimate your scores and their effect on your payment (www.aha.org/VBPcalc).

If a hospital improves between its baseline and performance period it earns points. Those points translate into payment. Hospitals may earn up to nine points for performance improvement (a hospital may only earn ten points for achievement, not improvement).

Calculating the Final Score. All the scores for the measures in each domain are added up and multiplied by the domain’s weighting, and then all domain scores are totaled for a final performance score. Scores are published on Hospital Compare, and are used to calculate each hospital’s payment adjustment.

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