RFP 15-023 SUBMITTAL DOCUMENT

SUBMITTAL INSTRUCTIONS

Proposer must complete and submit all sections of this RFP Submittal Document as its Proposal. Please follow these instructions carefully.

Proposal

The Proposer's Proposal must include all completed sections of this Submittal Document as listed below:

1. Letter of Submittal
2. Proposer's Authorized Offer
3. Proposer Information
4. Minimum Qualifications
5. Subcontractor Information
6. Diverse Business Inclusion Plan
7. Non-Cost Proposal
8. Cost Proposal
9. Appendix A
10. Appendix B

A. Complete Proposals must be received electronically on or before **December 3, 2015 at 2:00PM (PT).** Proposer must complete and submit all sections of this Submittal Document, as listed above, as its Proposal. Proposer may attach additional sheets as necessary.

B. Delivery of Proposal: The Proposal must be delivered as follows:

1) Attach the completed **Submittal Document** to a single email message and send it to **contracts@hca.w.gov.**

2) Clearly mark the subject line of the email: RFP- 15-023, Vendor Name (e.g. RFP- 15-023, ABC Company).

3) The preferred software formats are Microsoft Word 2000 (or more recent version) and PDF. If this presents any problem or issue, contact the Procurement Coordinator immediately. To keep file sizes to a minimum, Proposers are cautioned not to use unnecessary graphics in their Proposals.

4) It is preferred that electronic signatures appear on all documents requiring signature. However, an email date stamp will be accepted as signed by the legally authorized representative of the firm for the purpose of this Proposal only.

C. Time of receipt will be determined by the e-mail date and time **received** at the HCA's mail server in the **contracts@hca.wa.gov** inbox. The "receive date/time" posted by the HCA's email system will be used as the official time stamp. The HCA is not responsible for problems or delays with e-mail when the HCA's systems are operational. If a Proposal is late, it may be rejected.

Proposals should be submitted in the format described in this solicitation. All proposals and any accompanying documentation become the property of the HCA and will not be returned. Incomplete Proposals may be rejected. Proposals submitted by fax, will not be accepted and will be considered non-responsive.

LETTER OF SUBMITTAL

The Proposer's Letter of Submittal must be signed by the individual within the organization authorized to bind the Proposer to the offer. Along with introductory remarks, the Letter of Submittal is to include by attachment the following information about the Proposer and any proposed subcontractors:

- Name, address, principal place of business, DBA name (if any), telephone number, and fax number/e-mail address of legal entity or individual with whom contract would be written.
- Name, address, and telephone number of each principal officer (President, Vice President, Treasurer, Chairperson of the Board of Directors, etc.)
- Names, addresses, e-mail addresses and telephone numbers of the sole proprietors, partners, or principle officers as appropriate to the organization.
- A list identifying by name which individuals have the authority to sign contracts/amendments on behalf of the organization

PROPOSER'S AUTHORIZED OFFER

(PROPOSAL SIGNATURE PAGE)

Total Joint Replacement Bundled Episode of Care – RFP 15-023

Issued by the Washington State Health Care Authority

Certifications and Assurances

We make the following certifications and assurances as a required element of the Response, to which it is attached, affirming the truthfulness of the facts declared here and acknowledging that the continuing compliance with these statements and all requirements of the RFP are conditions precedent to the award or continuation of the resulting Contract.

1. The prices in this Response have been arrived at independently, without, for the purpose of restricting competition, any consultation, communication, or agreement with any other offeror or competitor relating to (i) those prices, (ii) the intention to submit an offer, or (iii) the methods or factors used to calculate the prices offered. The prices in this Response have not been and will not be knowingly disclosed by the offeror, directly or indirectly, to any other offeror or competitor before Contract award unless otherwise required by law. No attempt has been made or will be made by the offeror to induce any other potential Proposer to submit or not to submit an offer for the purpose of restricting competition. However, we may freely join with other persons or organizations for the purpose of presenting a single Proposal.

2. The attached Response is a firm offer for a period of 120 days following the Response Due Date specified in the RFP, and it may be accepted by the Washington State Health Care Authority (HCA) without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 120 day period. In the case of protest, our Response will remain valid for 180 days or until the protest and any related court action is resolved, whichever is later.

3. In preparing this Response, we have not been assisted by any current or former employee of the state of Washington and/or members of the PEB Board whose duties relate (or did relate) to this solicitation, or prospective Contract, and who was assisting in other than his or her official, public capacity. Any exceptions to this assurance are to be described in full detail on a separate page and attached to the Proposer's Response, along with a full description of any financial interest in the outcome of this Response that such a person or any member of that person's immediate family may have.

4. We understand that the Washington State Health Care Authority (HCA) will not reimburse us for any costs incurred in the preparation of this Response. All Responses become the property of the HCA, and we claim no proprietary right to the ideas, writings, items or samples unless so stated in the Response. Submission of the attached Response constitutes an acceptance of the evaluation criteria and an agreement to abide by the procedures and all other administrative requirements described in the solicitation document.

5. We understand that any Contract awarded, as a result of this RFP, will incorporate all the solicitation requirements. Submission of a Response and execution of this Certifications and Assurances document certify our willingness to comply with the Contract terms and conditions appearing in Appendix B [or substantially similar terms], if selected as a contractor. It is further understood that our standard contract will not be considered as a replacement for the terms and conditions appearing in Appendix B of this solicitation.

6. We (circle one) are / are not submitting proposed Contract exceptions.

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7. The authorized signatory below acknowledges having read and understood the entire solicitation and agrees to comply with the terms and conditions of the solicitation in submitting and fulfilling the offer made in its Proposal.

8. By submitting this Proposal, Proposer hereby offers to furnish materials, supplies, services and/or equipment in compliance with all terms, conditions, and specifications contained in this solicitation.

The signatory below represents that he/she has the authority to bind the company named below to the Proposal submitted and any contract awarded as a result of this solicitation.

Proposer Signature	Company Name
Title	Date

PROPOSER INFORMATION

Proposer Profile:
Proposer must provide the following:

Firm Name	_____
DBA Name	_____
Street Address	_____
City, State, Zip	_____
Federal Tax ID Number	_____
WA State UBI Number	_____
WA Statewide Vendor Number	_____
Website URL	_____
Legal Status of Firm:	☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other: _____

Proposer Authorized Representative:
Proposer must designate an Authorized Representative who will be the principal point of contact for the HCA Contract Administrator for the duration of this RFP process. Proposer's Authorized Representative will serve as the focal point for business matters and administrative activities.

Representative Name:	_____
Street Address	_____
City, State, Zip	_____
Telephone:	_____
Email:	_____

Proposer Principal Officer(s):
Proposer is instructed to identify each principal officer of the company (i.e. President, Vice President, Treasurer, etc.) not already identified herein. Proposer may add rows as necessary to incorporate all necessary information.

Name:	_____	Name:	_____
Address:	_____	Address:	_____
City, State, Zip:	_____	City, State, Zip:	_____
Phone:	_____	Phone:	_____
Email:	_____	Email:	_____

Proposer Certifications and Status:
Proposer must check the applicable boxes and provide Certification numbers as appropriate for each category below:

Washington State Certified Minority and/or Woman Owned Business

☐ Not Applicable
☐ Minority Owned
☐ Woman Owned
☐ Minority and Woman Owned

Washington State OMWBE Certification #: _____

Washington State Certified Veteran Owned Business

☐ Not Applicable
☐ Certified Veteran Owned Business

Washington State DVA Certification #: _____

Self-Certified Washington Small Business

☐ Not Applicable
☐ Micro Business
☐ Mini Business
☐ Small Business

Statement of Conflict of Interest:
Proposer must identify below any state employees or former state employees employed by the Proposer or on the Proposer's governing board as of the date of the Proposal. Include their position and responsibilities within the Proposer's organization. Proposer must also identify below if any owner, key officer, or key employee of Proposer is related by blood, marriage, or qualified domestic partner to an employee of HCA and/or members of the PEB Board or has close personal relationship to the same. If Proposer is aware of any other real or potential conflict of interest, Proposer must state so below. If following a review of this information, it is determined by the HCA that a conflict of interest exists, the Proposer may be disqualified from further consideration for the award of a contract. *If not applicable, Proposer is instructed to enter "NA" in the box below.*

Statement of Prior Contract Termination:
Proposer must disclose below if the Proposer's firm and/or any proposed subcontractors have had a contract terminated for either cause or convenience in the last five (5) years. If a contract was terminated for cause or convenience during this timeframe, submit full details of the termination including but not limited to, the reason for termination, the other party's contact information (name, address, email address, and telephone number), and the Proposer's position on the matter. The HCA will evaluate the information and may, at its sole discretion, reject the Response based on the risk to the Agency. *If not applicable, Proposer is instructed to enter "NA" in the box below.*

Statement of Financial Viability & Stability:
Proposer must disclose below any judgments, pending or expected litigation, or real or potential financial events that could affect the viability or stability of the Proposer's firm. If no such conditions exist, *Proposer is instructed to enter "NA" in the box below.*

Proprietary or Confidential Information:
Proposer must indicate below any pages and/or sections of its response that Proposer desires to claim as proprietary and exempt from disclosure under the provisions of Chapter 42.56 RCW. Indicate below the pages of Proposer's response that have been marked "Confidential" and the particular exception from disclosure upon which the Proposer is making the claim. Please see Section 23 of the RFP Solicitation Standards document for more detail on Proprietary or Confidential Information as it relates to this solicitation. *If not applicable, Proposer is instructed to enter "NA" in the box below.*

MINIMUM QUALIFICATIONS

Please keep responses clear and concise, and refrain from using company name or other information that will identify your company while preparing your response for the Minimum Qualifications Submittal. Responses to each question should be two (2) pages or less.

Minimum Qualifications:
Please answer the questions listed below to verify that your firm meets the minimum qualifications specified in Section 1.6 of the RFP. Please attach additional pages as necessary.

1. **Business License**. Please confirm below that your firm is currently licensed to conduct business in the state of Washington. If your firm is not currently licensed, please provide a commitment that your firm will become licensed within thirty (30) calendar days of being selected as the Apparent Successful Proposer.

2. **Registered Provider.** Please confirm below that your organization is a Washington In-State Provider.

3. **Network.** Please confirm that all total knee and/or total hip replacement procedures performed within the scope of the Contract by the Awarded Contractor(s) will occur in the state of Washington.

4. **Experience.** Please confirm that your organization is a health care provider(s) and/or network of provider(s) that can offer a TKR/THR Bundled Episode of Care for total knee and/or total hip replacement, effective January 1, 2017.

5. **Capacity.** Please confirm below your organization is capable and has capacity to meet the volume of total knee and/or total hip replacement procedures outlined under the background in the RFP.

6. **Volume.** Please confirm that each of the orthopedic surgeons who will be performing TKR/THR Bundled Episodes of Care, perform a minimum of fifty (50) of either total knee or total hip replacement surgeries per year.

SUBCONTRACTOR INFORMATION

Check the applicable box:

☐Yes ☐No Your firm intends on utilizing subcontractors to fulfill the service requirements outlined in RFP K 15-023, Total Joint Replacement Bundled Episode of Care.

Contractor will be required to perform all work under this contract using his/her own employees carried on payroll or by using approved subcontractors. Where subcontractors are used in the performance of the contract, proposers will indicate as required with their response to seek approval. Contractor will be held responsible for all work performed or not performed by the subcontractor(s). Subcontractors will be required to bill through the Contractor.

If revisions are required in the subcontract assignment, new parties are to be proposed in advance of assignment, in writing to the HCA and the Contract Administrator.

All subcontractors are to submit a letter on company letterhead indicating the contract has been read, the standard terms and conditions reviewed and agreeing to all requirements presented. The subcontractors shall be required to meet all requirements established for Contractor staff.

If applicable, Proposer shall identify below all subcontractors who will perform services in fulfillment of contract requirements, including their name, the nature of services to be performed, address, telephone, facsimile, email, federal tax identification number (TIN), Washington State Uniform Business Identifier (UBI), and expected work to be performed of each subcontract:

Subcontractor 1		**Subcontractor 2**	
Name:		Name:	
Services:		Services:	
Address:		Address:	
Telephone		Telephone:	
Email:		Email:	
Fed ID:		Fed ID:	
UBI:		UBI:	
OMWBE certified:	☐Yes ☐No	OMWBE certified:	☐Yes ☐No
DVA certified:	☐Yes ☐No	DVA certified:	☐Yes ☐No
WA Small Business:	☐Yes ☐No	WA Small Business	☐Yes ☐No

Subcontractor 3		**Subcontractor 4**	
Name:		Name:	
Services:		Services:	
Address:		Address:	
Telephone		Telephone:	
Email:		Email:	
Fed ID:		Fed ID:	
UBI:		UBI:	
OMWBE certified:	☐Yes ☐No	OMWBE certified:	☐Yes ☐No
DVA certified:	☐Yes ☐No	DVA certified:	☐Yes ☐No
WA Small Business:	☐Yes ☐No	WA Small Business	☐Yes ☐No

Diverse Business Inclusion Plan

In accordance with legislative findings and policies set forth in RCW 39.19, the state of Washington encourages participation in all contracts by firms certified by the office of Minority and Women's Business Enterprises (OMWBE), set forth in RCW 43.60A.200 for firms certified by the Washington State Department of Veterans Affairs, and set forth in RCW 39.26.005 for firms that are Washington Small Businesses. Participation may be either on a direct basis or on a subcontractor basis. However, no preference on the basis of participation is included in the evaluation of Diverse Business Inclusion Plans submitted, and no minimum level of minority- and women-owned business enterprise (MWBE), Washington Small Business, or Washington State certified Veteran Business participation is required as a condition for receiving an award. Any affirmative action requirements set forth in any federal Governmental Rules included or referenced in the contract documents will apply.

Do you anticipate utilizing or is this firm a State Certified: [Check all that apply]

- Minority-Owned Business? ☐
- Women-Owned Business? ☐
- Minority and Women-Owned Business? ☐
- Veteran- Owned Business? ☐
- Small Business? ☐

Do you anticipate utilizing or is this firm a Self-Identified: [Check all that apply]

- Minority-Owned Business? ☐
- Women-Owned Business? ☐
- Minority and Women-Owned Business? ☐
- Veteran- Owned Business? ☐
- Small Business? ☐

If your firm is anticipating utilizing subcontractors, please list the percentage of subcontracted work to be completed by each group:

- Minority-Owned _____%
- Women-Owned _____%
- Veteran-Owned _____%
- Small Business _____%

Please provide contact information for the individual whom manages the firms Diversity Inclusion Plan.

Name: _____
Title: _____
Phone: _____
Email: _____

NON-COST PROPOSAL

In this section, you are expected to propose how and why you are the most qualified to perform these services. You will also propose your plans, approach and methodology as to how you intend to perform these services.

Please keep responses clear and concise. Page limits are listed next to each question.

Proposal Questions:
Please answer the questions listed below attaching additional pages as necessary:

A) Provider Qualifications and Experience (Please limit your response to 3 maximum pages for this section) (25 Points)

1. Provide a brief history of your organization including the structure of ownership.
2. From July 2013- July 2015, how many TKR/THR procedures were performed? How many were performed on Medicare patients?
3. Please describe how orthopedic surgeons are credentialed in your program. What are the requirements for the surgeons who are performing the TKR/THR procedures? How are they selected?
4. Does the patient have a choice of surgeons from your facility or group? If not, please describe how the patient is assigned a surgeon, anesthesiologist, or rehabilitation team?

B) Bundle and Risk- Based Contract Experience (Please limit your response to 1 page per question for this section) (100 Points)

1. How long has your organization, including facilities and provider groups, been providing services within a care bundle for total knee and/or hip replacement?
2. Please provide a list of names of the orthopedic surgeons who perform TKR/THR Bundled Episodes of Care, the number of TKR/THR Bundled Episodes of Care, he/she has performed, facilities where surgeries were performed and any adverse events or outcomes they have had in the last two (2) calendar years.
3. Does your organization have experience with risk-sharing or gain-sharing contracts related to TKR/THR Bundled Episodes of Care or similar arrangements? If yes, please describe the general structure of the contract or arrangement.
4. Based on the information provided, why would your organization be a good fit for the Health Care Authority?
5. Is your organization able to aggregate all claims from all providers participating in the program into a single claim file and invoice for payment?

C) Total Joint Replacement Process (Please limit response to 2 pages per question for this section). The Bree Collaborative has defined four distinct stages of a TKR/THR Bundled Episode of Care, as described below. Using a flow diagram please map out the steps used by your organization in the following processes for questions 1 -4. (100 Points)

Stage 1: Disability due to Osteoarthritis despite Conservative Therapy
Prior to surgery, candidates for joint replacement therapy should have clearly documented disability and evidence of osteoarthritis according to standardized radiographic criteria. Unless highly disabling osteoarthritis is evident at the time the patient first seeks medical attention, a trial of conservative therapy is appropriate.

Stage 2: Fitness for Surgery
Prior to surgery, candidates for joint replacement therapy should meet minimal standards to ensure their safety and commitment to participate actively in return to function. If a provider chooses to proceed with TKR/THR surgery on a patient who does not meet these standards, then informed consent, patient engagement, individual review, and preauthorization are required.

Stage 3: Surgery and Repair of Osteoarthritic Joint
An experienced surgical team should use evidence-based practices to avoid complications related to implanted hardware; prevent infection, venous thrombosis, and blood loss; manage pain while avoiding side effects; and manage pre-existing medical problems carefully.

Stage 4: Post-Operative Care and Return to Function
A standard process should be in place to support the goals of avoiding post-surgical complications, ensuring rapid return to function, optimizing hospital length of stay, and avoiding unnecessary readmissions.

1. **Stage 1.** Beginning with initial assessment, please describe the following steps and activities in detail:

    a. The type of providers involved and their role; communication mechanisms used between patient and providers and the approximate length of time between each step.
    b. The approximate length of time between initial patient referral to acceptance in the program; and
    c. How your organization manages a patient who is referred for a total hip and/or knee replacement but does <u>not</u> meet the appropriateness criteria.

2. Using a flow diagram, please map out the steps used in **Stage 2** process. For each step or activity, please include details on what types of providers involved, their role, communication mechanisms used (between patient and providers), and length of time of each step.

3. Using a flow diagram, please map out the steps used in the **Stage 3** process. For each step or activity, please describe in detail:

    a. The type of providers involved and their role; communication mechanisms used between patient and providers, and the approximate length of time between each step
    b. Your organization's implant procurement process; specifically, what controls does the provider have in place to use high-quality, cost-effective implants.
    c. How your organization ensures the implant device is appropriate for each patient; and
    d. Your organization's protocols for replacement if an implant device is recalled.

4. Using a flow diagram, please map out the steps used in the **Stage 4** process through 90 days post-discharge. For each step or activity, please describe in detail the type of providers involved and their role; communication mechanisms used between patient and providers, and the approximate length of time between each step.

D) Anesthesia and Pain Management (Please limit your response to 2 maximum pages for this section) (25 Points)

1. Please describe how anesthesia and pain management are optimized across all stages. Are patients given different choices of types and techniques? How is multi-modal pain management utilized and how are risk factors assessed?
2. Please describe how anesthesiologists are involved in the provision of the Bundled Episode of Care?

E) Quality Measures (Please limit your response to 1 page per question) (100 Points)

1. Please complete Table 1 in Appendix A, with the most recent twelve (12) months of data available. In Table 1, TKR/THR patients are defined as **non-Medicare**, first-time, single-joint total knee or total hip replacement surgery for osteoarthritis, excluding patients with joint replacement for fracture, cancer, or inflammatory arthritis. Also, please note that three of the quality measures refer to specific results or scores and therefore have no numerator or denominator.
2. Please complete Table 2 in Appendix B, with the current annual rates, using the most recent twelve (12) months of data available. In Table 2, TKR/THR patients are defined as non-Medicare, first-time, single-joint total knee or total hip replacement surgery for osteoarthritis, excluding patients with joint replacement for fracture, cancer, or inflammatory arthritis.
3. Please describe your organizations participation in a multi-center joint registry that provides benchmark performance reporting to provider at physician level, and includes patient demographic, implant and functional outcome.
4. Has your organization and/or program been recognized for its' achievements, (i.e. NCQA designations, Joint Commission programs, health plan designations, etc.)? If so, please provide the organization that provided the recognition and the year of the award.

COST PROPOSAL

The evaluation process is designed to award this procurement not necessarily to the Proposer of least cost, but rather to the Proposer whose Proposal provides the overall best value to the Health Care Authority. However, Proposers are encouraged to submit proposals that are consistent with State government efforts to conserve state and federal resources.

Instructions to Proposer: Proposer shall complete Table 1 below by entering their pricing information as specified in the table.

Expenses related to day-to-day performance under the contract, including but not limited to, travel, lodging, meals, materials, and incidentals will not be reimbursed to the Proposer. Proposer's response to the Cost Proposal must include these costs.

DO NOT ADD ANY FURTHER SECTIONS TO THIS TABLE.

A Compensation table will be negotiated as part of the contract that will incorporate the prices listed here but breaking down the prices into deliverables with associated schedules. The total cost contained in the Pricing and Delivery Table will not exceed the amounts listed in this Cost Proposal.

Table 1: Deliverable Pricing (225 Points)

For the purposes of this table only, "Bundled Payment" includes all of the following:

a) Pre-Operative workup by the surgeon and any associated codes
b) The surgery including Diagnosis-Related Groups (DRG) 469, 470 or CPT codes 27130 and 27447and all related services from admission to discharge; and
c) Basic post-operative care including basic labs, x-ray if appropriate, clearance to travel, if appropriate

Assume that your organization will be guaranteed 150 to 200 TKR/THR procedures per year. What is the minimum price your organization can propose for the Bundled Payment?

Description	Total Price
1. Bundled Payment	$_____ total

If, within your proposed price, there are any deviations or additions to the Bundle Payment, such as anything your organization feels would add value to the Bundled Payment, please list those in the section provided below:

APPENDIX A

Table 1

		Total Knees			Total Hips		
Standards		Numerator	Denominator	Percentage	Numerator	Denominator	Percentage
1.	**Standards for Appropriateness**						
a.	Number of TKR/THR patients receiving formal shared decision-making decision aids pre-operatively	Number of TKR patients receiving formal shared decision-making decision aids pre-operatively	Total number of TKR patients.		Number of THR patients receiving formal shared decision-making decision aids pre-operatively	Total number of THR patients.	
b.	Number of TKR/THR patients with documented patient-reported measures of quality of life and musculoskeletal function prior to surgery (Knee Osteoarthritis Outcome Score (KOOS), Hip Osteoarthritis Outcome Score (HOOS), or PROMIS-10 Global Health tools may be used.	Number of TKR patients with documented patient-reported measures of quality of life and musculoskeletal function prior to surgery, Knee Osteoarthritis Outcome Score (KOOS), or PROMIS-10 Global Health tools may be used.	Total number of TKR patients.		Number of THR patients with documented patient-reported measures of quality of life and musculoskeletal function prior to surgery, Hip Osteoarthritis Outcome Score (HOOS), or PROMIS-10 Global Health tools may be used.	Total number of THR patients.	
c.	Results of measures from 1b, specifically including responses Quality of Life (Q2 and Q4) and Pain (P1, and P4-5) scores for KOOS and HOOS and questions regarding everyday physical activities (Question 7) and pain (Question 10) on the PROMIS-10 survey. Please list the average scores in the percent column.						

2.	**Standards for Evidence –Based Surgery**						
a.	Number of TKR/THR patients receiving measures to manage pain while speeding recovery in a multimodal format in the peri-operative period.	Number of TKR patients receiving measures to manage pain while speeding recovery in a multimodal format in the peri-operative period.	Total number of TKR patients.		Number of THR patients receiving measures to manage pain while speeding recovery in a multimodal format in the peri-operative period.	Total number of THR patients.	
b.	Number of TKR/THR patients receiving measures to reduce risk of venous thromboembolism and pulmonary embolism in the peri-operative period.	Number of TKR patients receiving measures to reduce risk of venous thromboembolism and pulmonary embolism in the peri-operative period.	Total number of TKR patients.		Number of TKR patients receiving measures to reduce risk of venous thromboembolism and pulmonary embolism in the peri-operative period.	Total number of THR patients.	
c.	Number of TKR/THR patients receiving measures to reduce blood loss such as administration of tranexamic acid in the peri-operative period.	Number of TKR patients receiving measures to reduce blood loss such as administration of tranexamic acid in the peri-operative period .	Total number of TKR patients.		Number of TKR patients receiving measures to reduce blood loss such as administration of tranexamic acid in the peri-operative period.	Total number of TKR patients.	
d.	Number of TKR/THR patients receiving measures to reduce infection such as administration of prophylactic antibiotics in the peri-operative period.	Number of TKR patients receiving measures to reduce blood loss such as administration of tranexamic acid in the peri-operative period	Total number of TKR patients.		Number of TKR patients receiving measures to reduce blood loss such as administration of tranexamic acid in the peri-operative period	Total number of TKR patients.	

e.	Number of TKR/THR patients receiving measures to maintain optimal blood sugar control in the peri-operative period.	Number of TKR patients receiving measures to reduce blood loss such as administration of tranexamic acid in the peri-operative period	Total number of TKR patients.		Number of TKR patients receiving measures to reduce blood loss such as administration of tranexamic acid in the peri-operative period	Total number of TKR patients.	
3.	**Standards for Ensuring Rapid Return to Function**						
a.	Number of TKR/THR patients with documented physical therapy within 24 hours of surgery.	Number of TKR patients with documented physical therapy within 24 hours of surgery.	Total number of TKR patients.		Number of THR patients with documented physical therapy within 24 hours of surgery.	Total number of TKR patients.	
b.	Number of TKR/THR patients with documented patient-reported measures of quality of life and musculoskeletal function six months following surgery (same as used as in standard 1b).	Number of TKR patients with documented patient-reported measures of quality of life and musculoskeletal function six months following surgery (same as used as in standard 1b).	Total number of TKR patients.		Number of THR patients with documented patient-reported measures of quality of life and musculoskeletal function six months following surgery (same as used as in standard 1b).	Total number of TKR patients.	
c.	Results of measures from 2b, specifically including responses to the questions identified in standard 1c (Quality of Life (Q2 and Q4) and Pain (P1, and P4-5) scores for KOOS and HOOS and questions regarding everyday physical activities (Question 7) and pain (Question 10) on the PROMIS-10 survey). Please list the average scores in the percent column.						

4.	**Standards for the Patient Care Experience**						
a.	Number of TKR/THR patients surveyed using HCAHPS.	Number of TKR patients surveyed using HCAHPS.	Total number of TKR patients.		Number of THR patients surveyed using HCAHPS.	Total number of THR patients.	
b.	Results of measures from 4a, specifically responses to Q6 and Q22 if HCAHPS is used						
c.	Number of TKR/THR patients surveyed using CGCAHPS scores for the medical groups that will be providing services under the Bundle.						
d.	Results of measures from 4c.						
5.	**Standards for Patient Safety and Affordability**						
a.	Number of TKR/THR patients readmitted to the hospital within 30 days of discharge, all causes.	Number of TKR patients readmitted to the hospital within 30 days of discharge, all causes.	Total number of TKR patients.		Number of TKR/THR patients readmitted to the hospital within 30 days of discharge, all causes.	Total number of THR patients.	
b.	Number of TKR/THR patients readmitted to the hospital within 30 days of discharge for any of the nine complications included under the terms of the warranty.	Number of TKR patients readmitted to the hospital within 30 days of discharge for any of the nine complications included under the terms of the warranty.	Total number of TKR patients.		Number of THR patients readmitted to the hospital within 30 days of discharge for any of the nine complications included under the terms of the warranty.	Total number of THR patients.	

APPENDIX B

Table 1

	Column A – Hips **(Total Number of Total Hip Replacement Patients)**	**Column B – Knees** **(Total Number of Total Knee Replacement Patients)**
Average length of stay for a hip/knee replacement procedure.		
Post discharge re-admission rate to hospital (includes transfers from Rehab/SNF).		
30 day		
60 day		
90 day		
The infection rate of all noted surgically-related infections within 30 days		
The dislocation rate within 90 days of original procedure date.		
The rate of incision and drainage, revision and removal procedures within 90 days of original procedure.		
The rate of medical complications (acute myocardial infarction, pneumonia, sepsis/septicema, DVT or Embolisms) within 90 days of original procedure.		