Center for Medicare & Medicaid Innovation

Episode Definitions: What you need to know for the Bundled Payments for Care Improvement Initiative

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OPERATOR: Welcome to the episode definition "What You Need to Know for Bundled Payments for Care Improvement" webcast initiative. At this time, it is my pleasure to introduce our host for today, the CMS Innovation Centers, Andy Shin. Sir, the floor is yours.

ANDY SHIN: Thank you very much, and thank you everyone for joining us today. We understand that your time is valuable and we really look forward to giving you a great comprehensive presentation, that of course will be found on the website. After this, we will be making that available to you.

So welcome to the webinar hosted by the Program Team for the Bundled Payments for Care Improvement Initiative. I'm Andy Shin, [inaudible] group here, and before I turn it over to Valinda Rutledge, Director of the Patient Care Models Group, I just want to go over the agenda very briefly.

So as you can see, we have quite a robust agenda for you today, and we're delighted to have you all join us for the kickoff of a new learning curriculum, which is designed to support our provider partners in the redesign of care through bundled payments.

Over the next weeks and a few months, we'll be offering a series of webinars to support your success in episode-based payments, and the Bundled Payments for Care Improvement Initiative. The focus of today's webinar is to provide you with an indepth understanding of how Payment thinks about episodes, in the context of the Bundled Payment for Care Improvement Initiative, and to acquaint you with some of the data resources available to you on our website. That may be useful to you as you prepare the Create Episode as part of your application process. We will also highlight key areas of convergence and divergence with other episode models.

So once again, this webinar is in response to questions and requests we received from you for additional information and clarification about the definitions about design of episodes. We've heard you, and so today's webinar will focus on the definition and structure of episodes within this initiative, the episode anchor MSDRGs as the building blocks episodes, length of episode, etcetera, and to provide you with an overview of the resources and earlier research on episode definitions that we have made available to applicants, via a link on the Bundled Payments Learning Area web page.

If you haven't visited us on the Bundled Payments Learning Area web page, I highly encourage you to do so. It really will be the hub for just a huge amount of information that we hope will be, that you will disseminate widely, you know, and we really hope to update that on a continuous basis, and that really will be the hub for information about this program and bundled payments in general.

So we also plan to leave plenty of time for you to ask questions to the program staff and presenters. These questions will need to be submitted through the chat box feature on the webinar platform. We are not enabling any sort of audio questions at this time. We'll enable the chat feature at the end of the

slide presentation. So just look out for that at the end. And lastly, [inaudible] that we'd like you to be mindful of.

So with that, I'm going to turn it over to Valinda Rutledge, who's Director of the Patient Care Models Group, who will begin with an overview of the strategic importance of bundled payments. She'll be joined, and I see that Dr. Carol Bazell, Deputy Director of the Patient Care Models Group, is listed on your slide. We will have Elyse Pegler from the Patient Care Models team taking over for her in that place and doing that part of the presentation, and then Dr. Jeffrey Clough will be also presenting.

Today in the room, just so everyone is aware, we have a robust, comprehensive amount of other program team members who are listed below, Rosa Cohen, Rachel Homer, Pamela Hosari [phonetic] and then Sheila Hanley, who are all joining us today to help manage your questions, as well as providing other assistance, technical assistance.

So with that, I'm going to turn it over to Valinda Rutledge.

VALINDA RUTLEDGE: Thank you, Andy. First of all, I'd like to welcome all of you and thank you for your presence here today. As you all are aware, the length of the letters of intent, the Models 2 through 4 closed just before Thanksgiving, and I'm sure you've all heard the amount of response that we got from providers all across the country were very overwhelming and very large.

We are deeply gratified with that overwhelming response, and I think it indicates all of your strong commitment in terms of partnering with us, to redesign care throughout the country. We appreciate your leadership efforts to improve the health care delivery systems in your own communities and your partnership with CMS, in developing and testing models of bundled payment that will redesign care and improve cost.

As Andy has said, we have three purposes for this first webinar. It will be the first of many that we will doing on a regular basis. The purpose, number one, is to emphasize the strategic opportunities for care redesign.

Number two is to clarify the episode definitions. We've had a lot of questions through the inbox regarding what is the definition of an episode, and number three, we're going to have Jeff explain the resource that the Innovation Center is going to have available on the web called the chart books, and how you can use this to begin to develop your episodes.

As we have previously said, we're using the bundled payment initiative as an opportunity to achieve the three-part aim, that are help for individuals, better help for populations, better care for individuals and lower cost through improvement for all Americans. We have an incredible opportunity to fulfill the promise of health care reform, and as we all know, change is urgently needed.

Together, we can transform our system towards our health, better care and lower cost through improvement, and we see that with the large number of applicants that have come through with this, for this program. We believe that this initiative, in conjunction with other programs that the Innovation Center has released, and we have many more that will be released in the near future, represents a great opportunity for system transformation.

These programs represent a set of initiatives designed to put our health care system on a path of quality improvement and sustainability, which has never been needed more than at any time in our country's history. We feel that bundled payments will play a crucial role in achieving the three-part aim, because it focuses on coordinating care surrounding the most costly portion of Medicare.

Those are services that are associated with an inpatient admission. Evidence has shown that there is as much as an opportunity of 20 to 40 percent that is potential waste in the system, and this is based upon research from Rand in Government, and we believe that through the redesign of care, through the bundled payment, many of that savings can be achieved.

The case for bundled payment, and as you, I'm sure many of you on the phone, we did a value proposition in October, and we covered many of these, but I want to reinforce again. We feel that the case for bundled payments is number one, that there's a large opportunity to reduce costs from waste and variation. It could be as much as 20 to 40 percent.

Number one, game-sharing incentives will align hospitals, physicians, post-acute providers in the redesign of care that achieves savings and improves quality. Number three, we feel that the improvements will spill over to private payers. Number four, the competencies that you will earn in a bundled payment will lay the foundation for each of your success in a value-driven market.

Number five, that the adoption of bundled payments is accelerating, we're hearing this around the country, across both private and public payers. So we're hearing from many of you around the country, that many of the private payers are beginning to explore or actually introduce bundled payments within a marketplace.

And the last, that we feel that there's a lot of valuable synergies between accountable care organizations, value-based purchasing, pay for performance and other payment reform initiatives that CMS has implemented. So with that, I would like Elyse to take us through an overview of the bundled payment model, and explain about episode definitions.

ELYSE PEGLER: Thank you, Valinda. As Valinda and Anthony mentioned, in this section we will provide some greater detail on the episode definition, which includes the anchor, the time frame, the exclusions and so forth. But to start with a high level overview of the four models, the first model includes—it really just focused on the acute inpatient hospitalization, and it's focused on all of the DRGs.

The services that are included are just Part A, DRG payments, just the hospital component. This differs significantly from the models that follow. Model 2 is focused on just selected DRGs that we are expecting applicants to propose, and those, the services that are included in this model are both the hospitalizations, A and B. So both the hospital component and the physician component, as well as the relevant post-acute services that are in the relevant period that's also proposed by the applicant, and readmissions are included in Model 2 as well.

Model 3 is very similar, in that it is also around defined episodes by DRGs. But in this case, the A and B services that are included are just the post-acute period and the readmissions, and the hospitalization itself is not included in the episode.

In Model 4, it is focused on back to just the hospitalization, but it does include the hospital component and the physician component and readmissions. The key difference between Models 2 and 3 and Model

4 is that Models 2 and 3, we are paying in a retrospective way, where all of the providers, the physicians, the hospitals and the post-acute providers, receive their payments as usual. At the end, we compare the actual payments that are made to a target price that is proposed by the applicant, and agreed to by CMS.

In Model 4, it is this very different approach for the payments, and that this is what we are calling a prospective payment, where the hospitals will be receiving a lump sum payment up front, and they will then distribute that payment to the physicians and the providers.

We're focused in this initiative on providing flexibility for providers. We sought to reach out to the community, and learn what you feel are important for the clinical conditions, the time frames and the services, where you feel you have the greatest opportunity for improvement. We did receive a tremendous response so far, and expect to receive a tremendous response when the applications are due, and we do expect to see commonalities. We will be looking for those and we'll be thinking about the kinds of commonalities that we're seeing, as we set and make determinations of the kind of activities that we'll engage in.

We are also looking for episodes that have large numbers of beneficiaries, to demonstrate meaningful results, and that enables scaling through simplicity, to allow rapid analysis, and to achieve the appropriate balance of financial risk and opportunity. We are building upon lessons learned from prior initiatives in CMS demonstrations, and also your experience.

In the next slide, we'll discuss our approach for using MSDRGs as the building blocks for the episodes. We felt it was important to reiterate our thinking behind why we chose to make MSDRGs the building blocks, and also to address some of the confusion that has been out there in the marketplace about the discussion for Model 3.

So we chose to make MSDRGs the building blocks because they represent an established annually refined bundle of services, that comprise the largest portion of the episodes for most models. We do think that the target price, or the prospective payment in Model 4, relying on historical MSDRG payments, is a significant component of the bundle that includes inpatient care.

We believe MSDRG builds on a widely-accepted methodology for grouping clinical conditions, and again, alluding to the prior experience, both within CMS and elsewhere, of using MSDRGs as the building blocks for episodes.

Every model, in some way, relates to a patient DRG. Even if the hospital component is not included in the episode, as in Model 3, it is important to note that the beneficiaries who are eligible in Model 3 must have had a hospitalization, and therefore must have had an MSDRG. That MSDRG is what triggers who is eligible in Model 3. Even though the episode itself, as we'll get into, is not triggered until admissions of post-acute settings, a hospitalization with an MSDRG that is eligible must be included.

Now getting into what triggers an episode, again, in Model 2, the episode begins with the inpatient hospital admission or an included MSDRG, and then the episode continues with those patients, and wherever they go to receive services. In Model 3, the episode begins at the initiation of the four types of post-acute services that we've laid out, and that's inpatient rehabilitation facility, home health agency or long-term care hospital services. So the episode begins with the initiation of those post-acute services, but there must have an inpatient hospital stay within the prior 30 days for an included MSDRG.

So again, we recognize that in some of these settings, they do not use MSDRGs as part of their coding. But because the patients must have come from hospitalizations within the past 30 days, there is where the MSDRG counts. In Model 4, the episode begins with the acute care hospital admission for the included MSDRG.

We also wanted to provide some further clarification and explanation of the types of applicant roles that organizations may apply as. We've divided these into two broad categories of organizations that intend to bear risk, and organizations that do not intend to bear risk, and are applying with organizations who will.

So in that category, in the non-risk bearing category, this is what we call facilitator-conveners. These organizations could bring together lots of different entities, and serve in an administrative [inaudible], a systems capacity to bring consistency to an application.

So CMS' relationship would be with the designated awardees that would be included in this application. The designated awardees are the ones who assume the financial responsibility for the beneficiaries who are included and eligible for their episodes, and wherever they go.

Moving over to the risk-bearing side, if an organization intends to apply and wants to bear risk, there are two roles that we see for them. The first is as a single awardee. In this case, the organization would assume responsibility for a patient and wherever they go.

In the awardee convener situation, that is a case where either a Medicare and MOE provider/supplier would like to partner with other providers. It would take risk for its patients wherever they go, and it would also take risk for its partner's patients, even if they don't see them, even if the partner -- so the partner in the case could initiate episodes, and those would be included in a noteworthy convener scenario.

A worthy convener can also be parent companies, hospital systems, where they themselves are not taking the risk, but they are taking the risk for all of their partner providers that can initiate episodes.

We also wanted to provide some further information about the time frame for episodes in this initiative. We want them to be clear, again, that in contrast to some of the different types of episodes that might be out there, that might have six months or had a variable length in time, we are asking applicants to propose to us the period of time for the episode, and once we agree to those episodes, that will be a fixed period of time.

In Model 1, the episode is just the acute care hospitalization. In Models 2 and 3, the applicants would propose the time frame, and we are requiring that it be 30 days or longer, that in Model 2 that would follow a focused charge, and in Model 3, that would follow episode initiation, which as we discussed is the initiation of post-acute services at one of the four provider types.

We are encouraging applicants to consider longer post-acute lengths of time, because we are really interested in the transition of beneficiary back to the community. In Model 4, the episode is the acute care hospitalization, but we are also including readmissions, and so we would be looking at readmissions for 30 days post-discharge.

The claims for services that begin during the episode and extend to the omni-episodes may be wholly included or pro-rated, and we are asking applicants to specify that in the application.

Another area that we are asking applicants to specify are the excluded services. We are interested in a very broad interpretation, and we are expecting that first, all services in the hospital are included. So we're really looking at only services that could be excluded in the post-hospitalization period.

We are asking applicants to define what is unrelated, because we do feel that most care is related, and we're looking for sound, clinical and material justification. We aren't allowing applicants to specify the ICD-9 diagnosis codes to determine, to propose what would be excluded, and we are—we feel very comfortable that if you would like to put a range of diagnosis codes instead of listing each and every one, that is fine. But again, we do expect that you are proposing your target price, and we'll be happy [inaudible].

We are also asking applicants to specify risk adjustment. We recognize that there is variation within MSDRG-defined episodes. So we are allowing applicants to propose risk adjustment methodologies, but we are requiring that those methodologies must be replicable, using CMS data and must be sound clinically.

So we are expecting that applicants will explain their rationale and their methodology. So any commercial risk adjustment methodologies that are based on proprietary algorithms would not meet the criteria for replicability, and so we do ask that you keep that in mind.

Moving on into a little bit more of a discussion about what is included in the target price and the discounts, we've gotten questions about IME and DSH and capital payments and outlier payments. The discounts to the MSDRG payments under this initiative will not be applied IME or DSH payments. They will be unaffected by our program. The IME and DSH and capital payments will be removed from the calculation of the target price.

Outlier payments, however, are included within the episode definition, and we expect that applicants would include outlier payments in their determination of the target price [inaudible].

We've also received many questions about how this initiative interacts with other health reform initiatives. We want to reiterate that we see these initiatives as synergistic in transforming health care, and we believe strongly that bundled payments and other initiatives can be tools in the creation of -- in the move towards large hospital care and that movement.

Our program is not a shared savings program, and so that the legal prohibition on multiple shared savings programs in the health reform law would not apply, again because our program is not a shared savings program. But we do want to ensure that if an organization is participating in multiple programs, participating in a care-based partnership [inaudible], value-based purchasing, other initiatives, that we are not counting savings twice.

So we will be making those determinations once the applications are received, and we will be in discussions with applicants as we see that play out. We also wanted to make note that penalties or rewards related to readmissions and hospital-acquired conditions and value-based purchasing will be unchanged, and they will apply, as appropriate, to the bundled payment initiative.

And the last point that I'll be talking about is how the episode target price is determined. The episode target price may be determined for each year of the program, by tracking the baseline episode period, 2009, forward three years to 2012, and thereafter for each year of the program, with application of the agreed-upon discount to that. Again, the IME and DSH are removed, along with other technical adjustments.

We would like to make it clear that the episode definition for the discounts that are proposed by the applicant may be refined with potential awardees, prior to initiation of the program. We expect to engage in those discussions with potential awardees before any awardee agreements are signed, and we will be providing the details of the methodologies to potential awardees in advance of that time.

Now, I'd like to turn it over to Jeff, to discuss the resources available.

JEFF CLOUGH: Hi. Thanks, Elyse. I'm going to be talking about two of the main resources we're making available through the learning area of the website. These are what we call the chart books, the first of them titled "The Analysis of Post-Acute Care Episode Definitions," what we refer to as the November 2009 chart book, and that's based on a five percent sample of Medicare claims data from 2006. The second is "Post-Acute Care Episode Analytic File." We call that the June 2011 chart book, which is a 30 percent sample of data going up to 2008.

Now I just want to clarify. These chart books are prior research that was developed by the Assistant Secretary for Policy and Evaluation, in conjunction with RGI, to inform policy discussions around episode payments. They're very useful as an informational backdrop, but they were not developed specifically for this program, in that the episode definitions that are included in these chart books, some of the conditions that are highlighted and even some of the quality conclusions, do not necessarily apply to this program.

So what I'm going to do is I'm going to give a sort of high level overview of how these relate to our program, and importantly, how they don't relate to our program, and then give a slightly more detailed description of what is in the chart books, and then I will walk through just a few examples of some of the data tables that are in the chart book.

So some of the high level overview, many of the tables in the chart book, they demonstrate the distribution of Medicare payments for major service categories, either for MSDRGs as a group or for some specific high volume MSDRGs. This can be very useful to applicants who don't have that information, just to get an idea of how much money is involved in each of these categories for the types of episodes they would look at, and to help them understand some of the variation in determining where it would be most fruitful to target care improvement strategies or to develop partners in designing the episodes.

They also can provide a qualified national benchmark for several MSDRGs that are listed here. I want to emphasize that this is qualified, because there are some differences in the numbers that are displayed in the chart books than the numbers that applicants will determine by looking at their own data. It's also important to note that some of the episode definitions that are displayed in these chart books are not appropriate for our program.

Then this is because occasionally there are exclusion criteria that were used in the development of these chart books that do not correspond to our program, and there are also different payment adjustments

to these payments that would make them a little bit different than an individual applicant's actual numbers.

Finally, just to reiterate, do not complicate our endorsement of the specifics of MSDRG. These are just ones that were chosen by ASPI [phonetic] and RGI for this analysis.

So to get a granular to what's actually in the chart books, so both of the resources contain episodes that begin with an acute inpatient hospital stay and extend into the post-discharge area, which are relevant to our program. The 2011 chart book contains additional analyses on episodes where a patient was admitted to a post-acute care provider, but did not have a proceeding [inaudible], and those would not be relevant to this program.

If you remove the effects of IME and DSH payments, which would be similar to our programs, but they also standardize all payments to remove the effects of the payment geographic adjustment, and again, individual providers in our program would be using our own data, which would incorporate their geographic adjustment. I also want to note that they use various episode lengths, and they include these variable episode definitions, where the end of the episode is determined by a period after which the patients receive post-acute care.

In our program, we will only be using six time periods. So just bear that in mind when you're looking at these resources. And as mentioned above, they do look at constructing episodes either with or without pro-rating prospective payments that occur and extend beyond the end of the episode, for instance, a home health payment that begins near the end of the episode. This is still an open-ended question on an issue, as you mentioned before.

And just to go a little further, so you'll see that in the various tables, oftentimes the applicant payments are broken into sort of categories, including the inpatient hospital stay, occasionally inpatient physician payments using readmissions, which just includes the hospital payment for the readmission, home health services, skilled nursing facilities, inpatient rehab facilities, long-term care hospitals. There are also therapy services which in the first chart book just includes hospital outpatient therapy services, and in the second chart book it's expended in independent therapist services.

Please note that this is not an exhaustive list of services, in that there are some that we would expect to be included in our episodes that are not included in the chart books. Just another thing to bear in mind. I want to pay particular attention that you include some episodes where they specifically excluded all key hospital readmissions, and again, we're allowing applicants only to propose unrelated readmissions for exclusion. We certainly expect that episode definitions would include readmissions.

Now I'm just going walk through just a few examples of the many tables that are available in these chart books. So the first four sections of both chart books really provide an overview, usually for the top 20 MSDRGs by volume discharges as opposed to acute care services. They display these in various ways, but will also break down those payments into service categories.

For Model 2 participants, where you're typically looking at all discharges coming from a hospital, it may be most useful to pay attention to the numbers where they're listing mean payments per hospital discharge, because those will be most closely related to your patients. From Model 3 participants, you'll typically want to pay closer attention to these mean payments per user of whichever post-acute care service providers you are, because that will just give a little closer information to what you're looking at.

I also want to note that they use hospital outpatient therapy as an episode anchor or as a post-acute care service, and that cannot be used as an episode anchor in our Model 3.

So I'm going to present a few slides that have the actual chart. Please don't try to read the numbers on this first slide. I'm going to, on the next slide, extract some of the relevant data, so that we can go over. But this is an example from the first section of the 2011 chart book, and you can see that there's 20 MSDRGs, and I think there's a variety of information related to those MSDRGs [inaudible] like a 30-day pro-rated episode.

So moving on to the next slide, just to give a sense of what information is contained in that table, there's a list of four different MSDRGs, and I've extracted some of the relevant data. So you can see in the first column what percent of beneficiaries for that MSDRG are in fact admitted to one of the post-acute care services.

In the second column, you can see, most importantly for a Model 2 participant, the mean total episode payment per discharge. This would give you, again, a qualified benchmark of what that episode payment might look like, again noting that it excludes some important services.

The third column will tell you how much of that episode is post-acute care services, which again it can give you a sense across the different MSDRGs that some are weighted more significantly in the post-acute care component, and then the fourth column, which is a slight variation of that, where it only looked at patients who are actually admitted to post-acute care service.

And then for the next chart, again I'll extract some important data from this chart, just enough to give you a sense of what it looks like in the chart book. This is from the November 2009 chart book, and this is looking at a 30-day episode as well. This is going to look a little bit more indepth in the actual service categories.

Moving onto the next slide, here I just picked out MSDRG 65. So this is basically one line item in that previous table, which as you can see, would be related to a stroke episode. So if you're a Model 2 participant, you might want to pay attention to the table on the left, where looking at your episodes, you can see how much is spent, on average, across the population of patients for these indexed hospitalization, and then each of those individual services provided.

Now obviously the average amount for each of those services is a function of the average that is spent for that service, times the percentage of beneficiaries who use that service. Then if you're a Model 3 user, you might want to look at the table on the right, and you will see the average payment per patient for that MSDRG who actually uses one of those services, and particularly if you are, for instance, the home health provider or a skilled nursing facility provider, and you want to pay attention to your amount specifically, this will be helpful information, particularly for those providers who are not used to thinking about their patients in terms of MSDRG.

Then there's the next set of sections in these chart books focus on some of the variation, particularly in post-acute care payments, and these typically look at variations across and within states and core-based statistical areas. They include both analyses for MSDRGs as a whole, and also they look at two specific MSDRGs in the 2009 chart book. Then finally, Sections 7 to 8 look a little bit more closely at ten specific states and CBSAs [phonetic]. It shows the mean payments and the variations.

So just to give one example, again, this is a table that we're not going to be able read here. This is from the November 2009 chart book, and moving to the next slide, where I've extracted information from the first five lines of that table, you can see that for the first five states by alphabetical order, this is for MSDRG 470, which is for a joint replacement of the lower extremity without major complications, that the mean post-acute care payment for discharge is pretty significantly across state, and even within state, as represented by the coefficient of variation for the individual states.

Now I do want to reiterate that these payments are standardized to account for impending changes in geographic payment. So they do seem to represent real differences in average payments. Then you can see the second, well really the third and fourth column focus on this information, per patient that actually uses post-acute care services, and finally it also looks at length of stay, which has a little bit less variation than the mean payment.

The last table that I would like to take us through, in the appendix to the June 2011 chart book, this actually includes an additional report, which is labeled the April 2011 report, and it contains some additional information that can be valuable, particularly Section 7, where they do various longitudinal analyses of expenditures following an inpatient discharge.

So here's one table I pulled out, and as you can see here, they're looking at five different MSDRGs, and they're looking at 30-day windows following discharge, and determining the mean payment, which includes all of the relevant post-acute care payments and readmissions.

What really jumps off that slide is that for each 30-day window, there's a steep decrease in the mean payment. This can just be helpful in thinking about, as you think about the length of your episode, understanding the magnitude of payments that are contained within each 30-day window.

With that, I would like to hand it back over to Valinda.

RUTLEDGE: Thank you, Jeff. So as we have previously said, we feel that the bundled payments provide an important strategic and financial opportunity for all of you, and can serve as the foundation for your success forward in a value-driven market. We are excited about the incredible amount of letters of intent that we received, and all of the interest we're hearing around the country in bundled payments, and partnering with each of you in redesigning care.

We look forward to receiving all of your applications in April, and now we're going to open it up to leave some time to answer the questions that have come in for the chat room. So Andy.

SHIN: Thank you, Valinda. So we are going to open the chat function now. If you haven't really been asking questions, this is your chance. We're going to start taking some questions that [inaudible]. Please continue to do them. We have a crack team of question compilers here who will help us just go through them.

But before we do that, I just wanted to kind of restate a few things, important dates, etcetera. First of all, something that everyone should put a bookmark on their index score or Safari, you know, address browsers, excuse me, web browser, should be the learning area for the bundled payments for Care Improvement Initiative. That can be found on the bottom of the Bundled Payments website on the Innovation Center website.

The easiest way to do that is if you're on the Innovation website, innovative.cms.gov, and you click "What's New," you'll click on the Bundled Payments for Care Improvement website, and you'll see right on the bottom a list of FAQs, different documents like the solicitation, and then on the very bottom, you'll see a link to the learning area, which will have both the slide presentation with audio, as well as the chart books that Jeff was mentioning.

So there will be a lot of information on a continual basis updated to that website, you know, pretty much on a weekly or biweekly basis. So I really encourage you to bookmark that and have that available to you as a resource. Just as a reminder, applications for Models 2 through 4 are due at the end of April, April 30th, 2012.

Further data for those who submitted. Data use applications will be available approximately two months prior to the revised submission date. April 30th is the revised date, and as I mentioned before, we really encourage you to stay tuned to the website. We'll offer some opportunities on the learning area for you to try to [inaudible], and you know, remain updated on a continual basis.

So with that, we're going to turn over to a few questions, and let's see here. So I'll just start off with a question we have, which is asking from a physician, if I am participating in an approved gain-sharing arrangement through this initiative at one participating hospital, can I also participate in another improved gain-sharing arrangement with another participating hospital?

So the answer to that is yes. Physicians are welcome to participate in multiple group gain-sharing arrangements through this initiative.

So the next question is under Model 3, whether or not the cost of Part B rehab can be included post the Part A care? For example, [inaudible], LTAPs [phonetic], home health agencies, etcetera. I think Elyse will [inaudible].

PEGLER: Sure, and so what we want to clarify here is that all services that are considered in the episode, that are related to the episode, are included post the hospitalization, period. It's not just post-acute care. It would be all services in the post-hospitalization period that are part of the episode, that are not excluded.

SHIN: And staying on Model 3 for a second, what if the patient comes through the emergency department? Is this considered part of the episode for Model 3?

PEGLER: So for Model 3, beneficiaries are eligible if they initiate services with a post-acute provider, and they have come from and they have had inpatient hospitalization within the past 30 days. So if the beneficiary went into the hospital through the emergency department and then was admitted and discharged from the inpatient hospital, and then some time within the next 30 days was either admitted to a [inaudible] or initiated services with the home health agency, then yes, they would be included.

SHIN: Okay, and we're just going to stay with Model 3, Elyse, if you don't mind, and tell me if you need a break. So for Model 3, when is the initiation for Model 3, admit to a facility?

PEGLER: Sure. So again, for the initiation of the episode in Model 3, there would be the admission to skilled nursing facility, inpatient rehabilitation facility or long-term care hospital, or there would be the initiation of services with a home health agency.

SHIN: Great. One more Model 3 question, and then we'll move on, if you don't mind. Elyse, for Model 3, how will post-acute providers know which IPPS MSDRG applies for a particular patient, given that -- and the question asked -- given that the patient may not be assigned an MSDRG code until after admission to one of the post-acute settings? Secondly, patients may come from a variety of IPPS providers, who may not share the MSDRG codes with an individual ACH [phonetic].

PEGLER: Right. We do recognize that this could be a concern for providers in Model 3, and we expect that the post-acute providers will have to coordinate with the hospitals in their areas, to learn the patient's DRGs.

CLOUGH: And I would just like to add to that. I mean it's true as well that the MSDRGs may not be known as the patient is moving through the episode, as that's defined, to discharge. We would expect that providers who want to focus on clinical conditions, to which they would be able to anticipate what the MSDRG is, most of their care improvement strategies, you know, would not necessarily be dependent on knowing what the MSDRG is up front.

SHIN: Thank you, Jeff. So the next question is regarding the letter of intent and eligibility. So the question asks if you do not apply for the letter of intent or apply with the letter of intent by the deadline, can you still participate, as opposed to your provider, another provider who did indeed submit a letter of intent in the deadline specified?

PEGLER: The answer to that is yes.

SHIN: Great. Okay. We have another question regarding post-acute providers, which is do PACS need their own patients and identified members to participate?

PEGLER: Again, as we were describing in the different applicant types, applicants can be providers that have their own patients. But applicants can also be organizations that either bring together other providers and facilitate, or they can be organizations that bring together other providers and take the risk for those other providers. But in all cases, either the applicant must have patients itself, or its partners must have patients.

SHIN: Great, thank you, Elyse. We continue to receive a couple of questions about the charts that Jeff used, and just so everyone knows, they will be available on the learning area of the Bundled Payments website, as well as the PowerPoint with audio of this presentation, and any future presentations that the [inaudible] team and the bulk payments team will be doing.

So we've got the next question, I think it's for Dr. Clough, which is how would outliers' IME and DSH be included?

CLOUGH: Sure. Well, I would refer to the previous slide, as well as the frequently-asked question we have on this subject. But in brief, IME and DSH will be unaffected by this program, and we've laid out, particularly in the FAQs, exactly how that is done in each model, and outlier payments will be included in the target prices, essentially in each episode.

SHIN: Thank you. The next question is regarding multi-campus hospitals with one CMS certification number. That's a CCN for all sites, and the question asked can I apply for only one site within my hospital to participate?

The answer is if a provider applies to participate, then all the providers sharing that same CCN must also participate. Most campus hospitals with one CCN covering all sites applies, then all sites covered by that CCN must participate, and must participate with the same parameters, such as the same discount rate [inaudible] for the same episode that [inaudible].

Okay, next question. The question asks whether or not in terms of exclusions from Model 2, can you confirm that it is only post-acute non-inpatient Part B claims that may be identified for exclusion?

CLOUGH: Sure. I'll take that one. So it is only post-acute services that can be identified for exclusion, post-discharge to be very specific. We haven't said just Part B, but again, we want to reiterate that we really expect strong justifications for exclusions, and want to be as inclusive as possible.

SHIN: All right, thank you. The next question is asking about under retrospective payments, will each provider continue to get paid directly, or will the hospital receive all payments and have to distribute payments to other providers?

CLOUGH: Sure. So under retrospective payment, each provider will be paid directly, as they normally are. So in Model 2 and 3, effectively there will be no change to the way people are paid, and then there will be this retrospective reconciliation at the end.

SHIN: Thank you. The next question is asking about what happens if a readmission occurs to another different hospital during the 30-day readmission period under Model 4, as a prospective payment?

CLOUGH: So that is included in the episode if it is a – it has not been designated as a specifically excluded readmission.

SHIN: Thank you, and the next question is regarding data. The question asks will the CMS data still be available by the end of February? I think Pamela is going to jump in here.

PAMELA: Hi. So the limited data set files that any applicant [inaudible] will be available by the end of February, and we will be continuing to communicate about those files if there are any further changes. But you can anticipate that at the end of February.

SHIN: Thank you very much, Pamela. The next question is regarding managed Medicare. The question asks does the Bundled Payment for Care Improvement Initiative apply to only traditional Medicare, or does it also apply to managed Medicare?

PEGLER: Only traditional Medicare, fee for service.

SHIN: Right. Okay, next question. Can you please explain what is meant by the awardee convener, and why an organization would apply in this manner? I think we're just going to bring up the picture, so everyone can look at it one more time, and maybe do another quick explanation.

PEGLER: Sure. So there may be scenarios where a parent company of various hospitals or other providers would, is not a provider itself, but would like to assume risk for its, we use the example of hospitals. In that case, that type of awardee would be an awardee convener. As we're specifying, to be an awardee, a single awardee, an organization must be a Medicare [inaudible] provider or supplier itself.

Another scenario that could fall under the awardee convener situation would be a scenario where that organization is a Medicare [inaudible] provider or supplier, and wants to partner with other entities, who can initiate episodes and take risks for all of their own patients and their partners' patients that they don't see.

We see different value propositions in all of the different types of applicant roles, and we just wanted to specify and be a little clearer about what we meant about the different types of roles. We recognize that there are lots of different organizations out there that are structured differently, and that may take partnerships in different ways, and we want to accommodate that.

SHIN: Thank you, Elyse. The next question is regarding whether or not CMS is going to limit the number of awardees for a particular condition, or in a health care market by geography?

So the answer to that is that CMS is not intending to limit awardees based on geographic region, type, or size of the health system. We are going to prioritize applications based on the scores, on the criteria which are listed in the RFA, and other considerations which are described in the RFA. CMS is interested in selecting awardees that will allow the evaluation of the initiative [inaudible] form recommendations regarding rapid replication and scaling, and this will inform awardee selection, which could result in the selection of a number of awardees for a particular clinical condition, or in a particular health care market.

However, I want to emphasize that we are looking forward to having a broad geographic distribution of awardees in this initiative.

Okay. So the next question is regarding whether or not hospital readmissions for care unrelated to selected MSDRGs will be excluded or included.

PEGLER: Again, we're asking applicants to propose to us the services that would be included or excluded. But we want to make it clear that hospitalization services would be included, and we're just talking about the period of time that would be post the hospitalization.

SHIN: Great. Thank you, Elyse. I think we have a question for Dr. Clough, which is if the target price is based on a trended actual amount, based on `09 through `12 but includes successive years as the project progresses, wouldn't the target price automatically reduce itself if the providers were successful in achieving their desired savings?

CLOUGH: That's a great question, and again, I'd first like to give the overview that I know many people are curious about the trending methodology. That is something that we will have discussions about after we've received the episodes and have been with all the different methodologies.

Now our intention is that the initial target price will be based on actual historical data. But then we would basically trend that established target price into the performance years [inaudible], so that it would reflect what would have been paid absent demonstration. But it would not continue to decline if the provider is actually successful in the performance years in reducing expenditures.

SHIN: Thank you. The next question regards payments for hospital-based physicians, such as pathologists and radiologists. Will pathologists and radiologists be bundled? If so, should they be listed as participants in the application?

PAMELA: Under Models 2 and 3, all payments will be made as normal. So you should continue to do everything as normal, and if you're going to be sort of working with those physicians who will be visiting patients, but they won't necessarily be [inaudible]. They're just sort of people who you're working with, and they'll be paid normally.

In Model 4, it's a little bit of a different situation, because we're bundling together the inpatient hospitalization and DRGs and the professional services that would normally be paid under the physician fee schedule. So in that situation, those physicians would have their payments be part of the bundle, and they would have to be paid by the hospitals who are taking the risk for that extra.

SHIN: And that was Pamela. Thank you, Pamela. A related question is whether or not in Model 4 how are physicians paid. I think this is more of an operational question, on whether or not the claim is Medicare or are they paid differently by the hospital?

PAMELA: So that's really to the question that I just answered. If they submit a care claim and fixed fee, the payment will be from the hospital that has agreed to take the risk for [inaudible]. So those physicians should have payment arrangements with the hospital, and the claims won't be paid directly from Medicare to the physician provider. It will be paid to the hospital.

SHIN: Thank you. The next question is whether or not in Model 3, is the three-day qualifying stay waived?

PAMELA: So the three-day qualifying stay will, it's something that you would want to refer to in your application, when you're stating sort of what waivers you would need in order to participate in this program, after you see your care redesign [inaudible] coming forth. If that's a rule that you would like to have waived, then you should put that in your application when we ask you sort of what kind of payment rules that would need waived. That would be something we'd want you to specifically mention.

SHIN: Thank you, and this may be the last question, which is will you be providing more guidance on approved fee-sharing agreements?

And the answer is generally that if you look at the RFA, that's pretty much the guidance right there. If you have further questions beyond that, you know, you really just can look at the RFA, because that's -- to the extent that we're able to comment on that, it's in there.

PEGLER: And we will be, again, having discussions with each potential awardee before we finalize the awardee agreement. So the awardee agreements will have everything spelled out about waivers, fee-sharing arrangements and a whole host of items [inaudible].

SHIN: And we have a quickie question to Laura on Model 3, but generally all with the theme of will you consider further webinars specifically on Model 3? I think the answer to that is for sure. Melissa Cohen actually, who is going to step in and I think make an announcement about that.

MELISSA COHEN: In the near future, we are going to be sending out advertisements for our next webinar, which is on January 18th, and it will be the start of our [inaudible] learning series. We will provide some more guidance and resources on episode payments. We have not at this time specifically designed a webinar around Model 3, but we do encourage everyone to send into the Bundled Payments

inbox suggestions for areas that they really would like us to focus on and provide more resources, so that we can design a curriculum that meets the needs of all our stakeholders.

SHIN: Thank you, Melissa. The next question is -- so I was incorrect. It was not the last question. I'll give a couple more. Can you clarify how capital payments are affected?

CLOUGH: So capital payments are excluded, in addition to IME and DSH payments essentially, and that is specified under the Frequently-Asked Questions on our website.

SHIN: Thank you, Jeff. The next question is regarding reinsurance, and whether or not reinsurance could be allowed under this initiative.

PEGLER: It's something that we will take into consideration and encourage you to provide details in your application.

CLOUGH: And just to, you know, add to that, you know, the financial relationships between our awardee conveners and basically however they want to manage their risk, we're allowing a fair amount of flexibility for that. We're really not specifying how they address that.

SHIN: Great. I think this might be the final question, which is can beneficiaries attend any post-acute provider, or can the hospital limit beneficiaries' choice? Very important question.

PEGLER: Beneficiary choice absolutely cannot be limited. We are still operating in traditional Medicare, and it is important to recognize that beneficiaries can go to whatever provider that they desire, and that their services are included, unless otherwise specified.

SHIN: Thank you, Elyse. Again, this webinar will be online, and we will answer further questions, you know, as they come to our inbox. But again, I'm going to ask -- excuse me. I lied again. We have another question. Okay. Oh, okay. Never mind. We are continuing to get your questions.

I just had a look at the screen here, so let's see. [inaudible], and they're asking if they submit one application, do you have to be an awardee convener? If so, can we have the individual hospital hold financial responsibility for their own patients?

CLOUGH: So just to clarify, if you were to apply as an awardee convener, the contract would be between the health system and CMS, and then the patients admitted to those individual hospitals would be included with initiating episode. If you applied as a facilitator convener, then you would definitely name which hospitals you wanted to be awardees, and they would have financial responsibility, and essentially have the contract with CMS.

PEGLER: And that's in the case of hospitals. There could be other arrangements as well.

SHIN: Thank you. We have a question about the bids, in terms of discounts. The question asked, whether or not CMS will accept the bids offered by applicants, or will CMS and the applicant discuss the proposal prior to agreeing to a final target price?

CLOUGH: So yes, there will be discussions. Again, each application will be reviewed, based on its initial bid. So we do not want applicants to expect that everyone would have [inaudible]. But you know, there

will be a number of things that we'll have to discuss, what's in the specific episode definition, the target prices, and of course we'll have to talk about the trending methodology, the quality metrics, the fee-sharing arrangements, numerous things that will have to happen after the applications have come in, before we reach a final agreement.

PEGLER: And as we've indicated, we do expect to see some commonalities. So we expect a fair amount of discussions between CMS and potential awardees, before the awardee agreements are signed.

SHIN: Thank you. The next question is regarding adding episodes after the initial application. The question asked, if an application included a certain MSDRG, but then the applicant later wanted to add more MSDRGs for other services, will that be allowed?

CLOUGH: We would not expect people to be able to do that. Again, as we refine that definition, we may want to add additional MSDRGs if they were related to that clinical episode.

SHIN: Thank you. The next question is regarding fee for service compensation for providers. The question is asking whether or not there will be a lock-in of current reimbursement under a fee for service system at the current levels?

CLOUGH: So the answer is no. Just to reiterate, the intent of this program is not to sort of insulate providers from any changes to payment policy that happen in Medicare in general. It's to demonstrate true changes in payments within these episodes. So that applies not only to changes in the various payment systems, but also, as mentioned before, policy programs like value-based purchasing and other [inaudible].

SHIN: Thank you. The next question is regarding episode definitions for multiple MSDRGs for the same clinical condition. The question asks whether or not they should propose one target price, or a bundled payment amount that applies to all included MSDRGs, or should the applicant propose a separate target price for bundled payment amounts for each MSDRG?

CLOUGH: So the target price is at the MSDRG level. So it would intentionally be a different target price for the MSDRG. Now we would expect similarities for -- for instance, it often comes up that you'll have three MSDRGs, one for a condition without complications; one is with complications; one with major complications and comorbidities. To include all three, we would expect generally the same episode parameters and discounts, but there would be a separate price for each one.

SHIN: Thank you. The next question is asking how frequently does CMS envision retrospective payment reconciliation be conducted? Hold on one second. [Pause.]

CLOUGH: We actually haven't specified that information yet. Okay. But we will specify it again during or prior to these final agreements, as we discuss the payment reconciliation methodology.

SHIN: Right, thank you. So the next question is regarding the replicability of gain-sharing models. The question asked is whether or not do gain-sharing models have to be replicable for an actual rollout, or can gain-sharing models be unique to specific awardee organizations?

PEGLER: So in general, we do have a perspective where replicability is a good thing. But we do recognize that this is also something that we are testing and looking at different models. So we look forward to

seeing different arrangements in your applications, and we will make determinations as we move forward.

SHIN: Thank you. The next question is for Model 4. If a readmission occurs to a different hospital than the awardee, will the awardee responsible for paying the other hospital out of its prospective bundled payment amount?

PAMELA: So the awardee will be responsible for the cost of the readmission, depending on sort of the specifics of the readmission and the relationship of the hospitals that are in question. Exactly how that payment will be rendered is something that sort of we'll have to discuss going forward that we can't necessarily state at this time. But I think the proposition that the awardee will be responsible for that cost, whether it's coming directly out of the payment. [inaudible] coming out of the prospective bundled payment to be determined.

SHIN: All right, and we have another question kind of asking for clarification about the awardee conveners, and whether or not they have to represent all of the hospitals in their health care system or not.

PEGLER: So this would go by provider number, specifically CCNs in the case of a hospital system, where if the various hospitals have different CCNs, then the awardee convener could absolutely specify in their application which partner hospitals they would like to include.

SHIN: Thank you. The next question is regarding beneficiaries enrolled both in Medicare and Medicaid, often refer to them as dual-eligibles. The question is how do the submissions affect Medicaid providers, with specific respect to the dual-eligible population?

And the answer to that is this initiative will be targeted, as Elyse stated before, to Medicare fee for service beneficiaries for Part A and Part B coverage, and these dual-eligibles, while excluded [inaudible] care under the demonstration, are not excluded from receiving care under this demonstration, unless they're otherwise not able to participate.

For example, like if, as we discussed before, if they're Medicaid or Medicare Advantage managed care MOE, or because they have ESRD. However, if a dual-eligible beneficiary receives Medicare covered care, but includes conditions from a participating provider, then the episode of care will be included in the initiative. So I just wanted to kind of, you know, [inaudible] for that part of that.

While the current bundled payment demonstration and payment methodology are based upon Medicare spending for Medicare and Medicaid enrollees, we are encouraging providers who engage with states, particularly for better coordinating care for Medicare and Medicaid enrollees. CMS will look favorably on applications that demonstrate partnership with state Medicaid programs, and CMS is also interested in and plans to monitor the impact of the initiative on Medicaid expenditures with respect to the dually enrolled, Medicare-Medicaid enrollees.

The next question is will CMS offer any guidance to applicants related to how bundled services or bundle-cover episodes that are interrupted by either a non-covered service election by the beneficiary, for example, a hospice? How will that be handled?

CLOUGH: So a non-covered service would essentially be the same as an excluded service, you know, would not be incorporated into the payment reconciliation [inaudible].

SHIN: Thank you, Jeff. The next question is whether or not CMS will advise only if applicants are eligible [inaudible], or submit an application that is, or is it assumed that you are sending in a letter of intent?

PAMELA: So [inaudible] is not really eligible is because –[Tape cuts.]

SHIN: I'm sorry. Are we able to be heard operator?

OPERATOR: You're able to be heard, sir.

SHIN: Okay, great. We just got interrupted there. Sorry.

PAMELA: Well, sorry. We had a little interruption. So the question was about whether you should be, wait to be advised that you're eligible to submit a letter of intent, and our answer is that we're not -- being eligible isn't really based on the letter of intent. So you should go ahead and submit the application if you're interested and have submitted a letter of intent. We're not going to notify you that you are eligible to apply.

SHIN: And I think that, you know, if you look at the FAQs on the Bundled Payment web page, there are a lot of questions around eligibility that have been answered.

The few that we're getting right now are, for example, whether or not a psychiatric hospital or a critical access hospital can participate, and the answer to that is that hospitals handling or treating Medicare fee for service beneficiaries must commit fully and solely under IPPS if you want to be eligible for this initiative.

So for example, hospitals paid under the inpatient psychiatric facility prospective payment system are paid on a cost basis, such as critical access hospitals are paid under the IPPS. But settlement is by another methodology are not going to be eligible to be an awardee. However, we encouraging, and you're welcome to participate in the initiative as partners with other eligible awardees, to try to improve your care.

So the next question is regarding whether or not this entire webinar will be posted on the website. Yes, it will be. The entire webinar slide and audio will be available on the learning section of the Bundled Payments web page.

And once again, I really encourage you to go there. It is going to be a wealth of information, and not just webinars, but all sorts of data, charts and other information will be available on that site. So again, bookmark it. You should go there often.

So right now, I think we run up near the end of our time, unless we have a few more questions. So we'll just take a quick pause, and if you have a burning question, go ahead and please try to send it to us. Otherwise, we're just going to take a moment just to see.

Okay. So it looks like we've exhausted our questions for today. We just really want to thank everyone for participating, and I really look forward to getting—we will get a schedule out there very shortly on our

website. Please sign up, you know, for the listserv and other [inaudible], and we will, you know, hopefully be hearing from you and the team here very shortly. With that, on behalf of the Bundled Payments team and the Innovation Center at large, we want to thank you very much and have a great afternoon.

OPERATOR: Ladies and gentlemen, that concludes today's conference. Thank you for your participation. Now disconnect, and have a great day.

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