



Bundled Payments for Care Improvement Models 2-4: Panel Timeline

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PRESENTATION

Pamela: Welcome to this presentation regarding application consideration for Models 2 through 4 of the Bundled Payments for Care Improvement initiative. Today, I am joined by several members of the Patient Care Models group in the Bundled Payment for Care Improvement project. If you can give me just one moment to make sure I can move these slides forward.

So today I'm joined by Jeffrey Plough, Amy Harbaugh and Elizabeth Truong from the Patient Care Models group. To start off, we'd like to thank you so much for your continued engagement in this initiative. We have received an enthusiastic response from providers across the country. We've received applications from hundreds of providers which cover thousands of different episode definitions. Thank you for your creativity in putting those forward. Today, we're hoping to give you some more information about what the process will be going forward as we are working to operationalize your innovative ideas.

Today we're going to cover three things. First, we're going to review the timeline for the next several months. That'll include the different activities that will be going on during this time period. After that, we're going to discuss the process of episode convergence. So this is something that we've put out some statements before and talked a little bit about during the application process and we want to describe more to you how we see that process working.

Then finally, we're going to save some time at the end to answer your questions. We're going to do that using the Q&A feature on your screen so you won't be able to speak, but you can type in your question. We won't answer them until the end, most likely, but you're welcome to type them in now. The feature should be active and we will answer as many as we can at the end of the session.

Before we start, we want to make sure that when we're talking, you understand sort of our meaning. So we're going to use a couple of terms. One of them is candidate awardees. So that is defined by sort of applicants that have been identified by panel recommendations combined with program judgment. So that would be how we would sort of talk about applicants after they have been recommended by the technical review panel and that has sort of passed through the program judgment that these are candidate awardees that we may proceed with based on panel recommendation.

Recommended awardees, that's sort of a leader in the game. Those are the applicants to whom CMMI would intend to offer awards. So you'll hear both of those terms and I just want to make sure that those are clear and we can go over those again as we continue. So first, we'll be talking about the timeline and I'm going to turn it over to Elizabeth Truong to discuss that.

Elizabeth: Good afternoon; thank you very much, Pamela. So we'll today look to give you an overview of what the activities and process looks like over the next few months. Starting in late September, we are going to be conducting the expert review panels. These panels include numerous and academic and industry experts. They include clinicians such as doctors in medical and surgical specialties and other healthcare professionals; health services researchers, providers, administrators, people with particular expertise in areas such as financing and quality.

The experts will review and score the applications against the criteria in the RFA and provide their recommendations to CMS. The scoring criteria in the RFA include an assessment of an application's model design and those elements include definition of episode, the level of provider engagement of participation, care improvement, gain sharing design. Also, the applications are scored on their financial model. This includes the overall savings to Medicare and then the quality of care in patient centeredness. So the elements included there would be quality measures and beneficiary protection.

The applications will also be scored on their organizational capabilities, their prior experience, their financial arrangements and assessment of the commitment and credentials of the executives in governance bodies. Then after the review panels, in early October, CMMI will notify candidate awardees of their status. At that time, we'll describe the converged episode definitions for BPCI Models 2 through 4 and the principles for key episode parameters that should be considered by candidate awardees. Today, we're going to talk to you a little bit and introduce those general terms and the concept of convergence and the key episode parameters in anticipation of the deeper discussion in October.

So in October, CMMI staff will conduct groups and individual discussions on these preliminary episodes to address questions. At that time, we may be asking that all candidate awardees consider their interest and readiness to engage in the range of episodes we present, even if their initial application only related to one or several of the converged episodes. Then in late October, we'll have further discussions regarding candidate questions and issues and concerns about the preliminary episode definitions. CMMI, we can discuss the CMMI analysis, the candidate interviews to discuss the key programmatic issues that cover questions and issues that arose during the expert review of the applications. We'll be bringing that back to candidates and we'll have discussions.

We also have extended the arrays for applicants which would include candidate awardees who may wish to engage in further data analysis. Many of you have already heard from us on this front. I believe there was an email that went out on August 30th regarding the extension of those arrays. You may also be familiar with our accelerated development learning sessions, the ADLS webinar series. We have several plans for the coming months around the topic of sharing

information across care settings ranging from the sharing of clinical information to available tools.

In this slide, we talk about next steps. After these conversations in October, we're going to be vetting and clearing the model plans with federal agencies. Vetting will be conducted to confirm that we expect recommended awardees will be good business partners and involves, I guess, assigning any program integrity concerns we may have of our provider partners or applicants. Renewed discussions with recommended awardees, so once the vetting occurs, we now have recommended awardees and in early 2013, we will be renewing discussions. We will be reviewing the terms and conditions in the model agreement with these recommended awardees as well as provide information on any applicable waivers. With the signing of model agreements, that's the first step in awarding implementation which we anticipate in spring of 2013.

Pamela, you want to discuss episode convergence.

Pamela: Sure, so we've, in our request for applications, we stated that we noted that these are broad models. We've asked you to sort of come in with your ideas and as we assess applications for the specific models proposed, we expect there will be some convergence of the aspects of certain models regarding clinical conditions, episode durations, or other features such that we are able to test similar models in different settings which may reach many Medicare beneficiaries.

So to sort of translate that statement that was in our requestor applications to now, we do appreciate your innovative ideas and we've gotten, as I said, sort of thousands of different episode definitions coming from hundreds of providers across the country. Just a very wide diversity has come in and we appreciate that diversity and we, at the same time, have an operational need for some convergence of certain parameters so that we can actually sort of test this model in different settings. We were very much so informed by what was submitted, what applicants have said they're prepared to do, and CMS program policy objectives have come into play as well. I think that in the group and individual discussions that Elizabeth mentioned in the last slide, we will be coming back to you with some—our plans and sort of our thoughts based on what has come in in the applications.

So we're excited to work with all of you towards a workable solution and an operational program for everyone involved. We anticipate there will be significant engagement with all of you in the coming months. A preview of the topics to be discussed includes the anchor clinical condition, the part A and part B exclusions that you were able to propose, the length of the episodes, the methodologies that we'll be using to do payment reconciliation and risk adjustments, proration methodologies, and beneficiary exclusion criteria as well as the discount percentage and the waivers that may be offered as a part of this program.

So moving into the next slide, I think we'll discuss some of those issues in a bit more detail.

Jeff:

So this is Jeff Plough. I'm going to talk a little bit about some of the—a little more specifically about some of the items that Pamela just mentioned. So the first set of topics, we're targeting initial presentation of these in early October. They include clinical definitions for the episode. So this includes the anchor clinical conditions and by that it's really the anchor MS DRGs which define the episodes; the part A and part B exclusions, so the excluded readmissions by MS DRG and the excluded part A or part B services by primary diagnosis code; and then the episode length.

You can imagine that given the very large number of codes out there that this is an area where we saw many, many permutations of episodes. We expect to offer dozens of episodes. Each clinical episode would have a defined set of anchor clinical conditions and defined set of exclusions and we would potentially be offering multiple lengths for each episode.

We believe that the preliminary episode definitions we present will include the majority of opportunities for care improvement represented in the applications. We will present a rationale for our preliminary definitions, drawing upon lessons from prior CMS and private sector experiences, with a goal to provide the greatest opportunity for care improvement while simultaneously protecting providers from the risk of uncontrollable events and guarding against unintended negative consequences of the payment model. We recognize there is no gold standard for these clinical episodes and given the need to balance the issues we have identified, there are too many parameters for everybody to get exactly what they want and our best professional judgment is necessary.

We will make every attempt to be clear, thoughtful, and responsive to your questions through analysis and discussion. We hope that you will address our concerns in a similar manner. We expect to utilize a variety of formats to communicate with you as a group and on an individual basis as needed. The process will necessarily adapt as we move forward and understand your questions. Remember, there are many of you and just a few of us, so please carefully consider the explanations we provide, any written information or anything we discuss in webinars such as these when crafting your responses.

The next set of topics, which we're targeting a preliminary discussion in mid-October, really involved the way that target prices are determined and address the insurance risk inherent in the bundled payments. So, several of the topics are sort of rolled into the methodology for determining the target price and performance years and performing payment reconciliation. Included in that methodology, many of these issues were brought forth in applications and communications throughout the application period.

They include mechanisms to address outlier cases; mechanisms to address setting a target price when there are a small number of historical episodes for a given MS-DRG and of course, setting the actual trending rate for determining the target price and performance years. Then associated with that are any potential risk adjustment methodologies that would be applied. We're currently performing analyses in modeling to arrive at recommended policies; again, formed by your proposals as well as prior research in payment policy and actuarial expertise.

Again, similar to the clinical parameters, there really is no perfect solution. We cannot eliminate all risk inherent in these bundles and of course, there are unlimited strategies we could develop. So again, we really hope that we work together, we mutually understand each other's concerns, and we arrive at a strategy that, to the greatest extent possible, protects against risk but also prevents any unintended negative consequences for beneficiaries or the Medicare Trust Fund.

Then, sorry, next slide. Then lastly, I just wanted to mention there is one new policy change we have already made in response to many concerns. That is in Model 2, we intend to exclude beneficiaries who die during the index admission stay; so, not for the entire episode, but during the index admission stay. We also recognize that you'll need a specified methodology for proration, if we are to do proration.

By that I mean addressing services that span the end of the episode. We have received many policy recommendations through the applications and based on these proposals and our internal analyses here, we intend to specify a preliminary recommendation for that in early October as well because we recognize that will be important for you to replicate the episodes and conduct ongoing analyses. I'll turn it over to Amy.

Amy: The next slide we will talk about the discount percentage and the waivers. In terms of the discount percentages, as part of the discussions with candidate awardees on the converged episodes, we expect to be communicating the discount percentages associated with those episodes. Moving on to waivers, BPCI expects to offer certain appropriate waivers for particular legal and regulatory requirements based on our assessment of the characteristics and needs of BPCI Models 2 to 4 candidate awardees and we're balancing those requests with protecting beneficiaries and including ensuring access to care and freedom of choice.

We plan to discuss with you these waivers we are seriously considering for the episodes and the models in early October. Broadly speaking, we believe that a candidate awardee should have exhausted the possible options for accomplishing the care redesign goal without such a waiver, as the legal and regulatory requirements of Medicare provide a framework for beneficiary protection that is

vitaly important to us. If an applicant believes that a specific waiver is critical to their program and it is not one that we specifically discuss, there could be a number of reasons for this including our conclusion that a waiver is not advisable given our needs to balance concern, a lack of justification provided by the applicant, a lack of interest by a significant number of applicants, or our belief that an awardee could meet the care redesign goal of the waiver without a waiver being granted.

We expect to engage in significant discussions around the potential waivers in October as you raise questions and issues in the context of the preliminary episodes we will identify at that time. We intend to be responsive and use many formats to communicate information as we understand issues. Please keep in mind, and as Jeff previously mentioned, that there are many candidate awardees being managed by relatively few staff.

So we would be best prepared to respond to data in clearly articulated plans that reflect the principles we lay out. Also please keep in mind, as Elizabeth mentioned, we'll be restarting our accelerated development learning session series. So please stay tuned for these exciting opportunities to stay engaged in the bundle payments for care improvement initiative.

Pamela: Thanks very much. So at this time, we're going to start accepting questions via the chat feature on your screen. We're going to pause for just a minute or two to give you a chance to write your questions down and we'll start answering them in just a moment.

Hello, so thank you for your questions. Please keep them coming. We're going to start answering them. I'm already predicting that we might not have enough time to answer all the questions that are coming in. So again, please ask them but at the end, if your question hasn't been answered, please email us at bundledpayments@CMS.hhs.gov and we'll do our best to get back to you with information that's currently available.

So we've received several questions about the extension of data use agreements for folks who have submitted applications. Anyone who has submitted an application and has been using data that they received as part of this initiative should have received an email, as Elizabeth mentioned, on the 30th of August that notified you that your DUA was going to be extended. So first of all, if you did not receive that email and you did apply, you should email that email address you see on your screen right away and let us know the name of your organization as well as your DUA number, if you know it, and the primary contact person.

A lot of you have asked because I believe you received an email within the last two days that was automatically generated by the DUA Management System here at Medicare, that let you know that your data was expiring. So that email was automatically generated. If you received a notice from us on the 30th of August

that said your DUA was going to be extended, it will be. So you do not need to take action on that email you automatically received.

You're welcome to let us know if you have some confusion, and several people have done that, but the problem is simply that your DUA extensions which we notified you were going to happen, were not processed before yesterday. Some of them were and some of them were not. So those of you whose were not, you received an automated message to remind you that your DUA was expiring. So we apologize for the confusion there and again, if this doesn't quell your concerns, please feel free to email us. But if you received that August 30th email and the information in it was correct regarding that you applied, the DUA number and your organization name, then you don't need to take any action because your DUA will be extended.

Another question we've gotten is regarding the timeline we just discussed and when implementation will occur with relation to when the agreements are signed.

Elizabeth: Sure, so this is Elizabeth, if I can answer that question. Implementation starts with that signing of the agreement. So when awardees sign the agreements with the CMS that launches Models 2, 3, and 4, but there are performance years that will be associated with each of those models and those performance years will be designated in the agreement. So signing of the agreement, that's the first step to implementation. After that signing, we will, CMMI will be issuing a public announcement to announce publically the participants of each of those models.

Pamela: Thank you so much. So someone has asked if we could restate the information that was stated regarding beneficiary exclusion in Model 2.

Jeff: Sure, so in Model 2, we will be excluding beneficiaries from the program. So from the payment reconciliation in Model 2, if that beneficiary dies during the index admission of the Model 2 episode, so we would still potentially be monitoring those beneficiaries but they would not be included in either setting the target price or in the payment reconciliation.

Pamela: Thank you very much. So a number of different people are asking questions related to how many applications were received; how many awards we anticipate there will be for this program.

Elizabeth: So at this time, we are reviewing the applications and we are not going to be making any announcements on who those applicants are or the possible awards until after the awardee agreements are signed and we will be announcing the participants then.

Pamela: Thank you so much. So a couple of folks are asking either what the selection criteria are that our technical review panels are using, or if we have a document outlining them.

Elizabeth: So as I mentioned earlier, in the RFAs there are scoring criteria including things like the model design, the financial model, the quality of care in patient centeredness. Those are several of the scoring criteria that are listed in the RFA and you can find our RFA posted on our website. There's a link directly to the RFA on the innovation center website of bundled payments.

Pamela: Thank you. So, several people are asking us to provide a bit of clarification regarding the episode convergence. If we could sort of further explain what we mean by that and also, when we expect to have those converged episode definitions available. Related to this, a couple of people have asked how long they'll have to reanalyze their data in response.

Jeff: Sure, so at this time again, the episode convergence is taking those many, many thousands of definitions, which in part differ only because there are so many choices out there. People may really be targeting the same clinical episode and we need to come to a smaller set that can operationally be tested. Again, we intend to present the sort of core clinical pieces of the episodes that will allow you to reanalyze your data in early October. That is our target and really as soon as your analysis begins, we can hear feedback and we will proceed from there.

We're not specifying a time right now at which that process concludes. That will be partly determined by how the process goes. Again, because this is so complex and there are so many of you and there is a lot to discuss, this will adapt as we go along and we'll do our best to communicate and sort of keep you abreast of where we are in the process and give you ample warning of when decisions are made.

Pamela: Thank you very much. Related to that, we're getting a lot of logistical questions regarding this webinar and the timeline we've been discussing. Just to let you know, on our website these slides which we've gone through, which include the timeline we discussed, are already posted. So the slides are available to you to download now. If you go just to the bundled payments home page on the innovation center website, it's the very first alert I believe. You can click on the length of the page for this webinar and the slides are posted there. Within the next week, there will also be a recording and a transcript posted for those who were not able to attend this event.

Someone has asked from a policy perspective, if patients will still have the right of freedom of choice in post-acute providers.

Elizabeth: Yes, they will absolutely have the freedom of choice. That is a key piece of beneficiary protection.

Pamela: We have several people asking if there is an expected start date for Model 4. Maybe we could comment on all models regarding our expected start time.

Elizabeth: Sure. So we at this time, we anticipate that the possible start date would be spring of 2013. As we discuss the convergence activities and the process, there are a lot of activities that need to occur between now and then. So we anticipate keeping in close contact with you all and having discussions to make sure that we engage with you until that start date.

Pamela: Thanks very much, Elizabeth. Another question that has come in, which is relevant to these discussions that we'll be having is how discussions will occur with conveners. Will CMS be contacting only the convener applicant or will we be contacting each individual designated awardee or a combination?

Elizabeth: Okay, so as Pamela mentioned, making sure we all speak a common language, the candidate awardees are the applicants that have been identified by panel recommendations combined with program judgments. So we will be going back to the candidate awardees to discuss the converged episodes. We know that some of the applications are quite involved and include multiple partners and so we would encourage the applicant entity to get in touch with their partners and in cases where it's appropriate, bring them into the conversation as well.

Pamela: Thanks very much. Another question that someone has asked is if we can explain—a couple of people have asked—if we can please explain what we mean by proration.

Jeff: Sure, so proration addresses—there are several services which Medicare pays a single payment for services that span a period of time. So obviously an inpatient admission that we pay a single payment for the entire admission and you can imagine if that admission began during an episode timeframe but ended after the end of the episode, there are several ways you could address that in very high level. You could either just include the entire payment, that would be not prorating. Or you could include only the portion of the payments that occurs during the episode itself and that would be proration and there are some nuances for different payment systems how exactly that proration occurs. We will be providing recommendations in early October sort of globally.

Pamela: Thanks, Jeff. On a related note, many folks are asking when they'll know if they've reached the next stage in the process here.

Elizabeth: So in early October, after the review panels CMMI will notify candidate awardees of their status and at that time, the candidate awardees will know whether they are progressing to the next stage.

Pamela: Thank you. So some folks are also asking given this convergence that's going on and that they'll be hearing back from us in early October with sort of a lot more information about these topics, will they need to reanalyze their data to submit new target prices once they're aware of sort of the parameters that we'll be describing to them in the discussion?

Jeff: Sure, so you won't be required to do any reanalysis and submit new data. We would imagine that many of you will want to perform these analyses using episode parameters. We will, as we move forward and we elucidate the methodology by which target prices will be calculated in performance years, we will aim to provide clarity as to how that will be done so that you can accurately estimate what your target price is. Most likely we will be providing specific information to awardees. I don't want to be absolutely specific at this time because this will unfold, but we are going to make every attempt to be as transparent as possible and give you any information that is possible to make you feel comfortable with the terms that we agree on.

Pamela: I'm getting some feedback from folks who are listening that they are somewhat concerned that they've been working internally towards implementing the model that they described in their application and they're wondering if now that they're hearing about the standardization coming down the pike or the convergence and the different factors we'll be discussing, should they stop working because they anticipate such a major difference in what we're coming back with versus what they have proposed.

Jeff: Well, that's a bit of a challenging question to answer but I think what I would say is while there will be this convergence, again we're expecting that our definitions broadly will really target largely the same care improvement that was represented by your definitions. There are many parameters that don't have a huge impact. I mean there are obviously the anchor MSDRGs are important because they define the conditions and the patients that are in the program.

The lengths are important and we would expect that there may be some differences but really depending on what you're doing, I think generally we wouldn't expect there would be huge changes in the preparation you're making now. But at the same time, you'll have much more clarity very shortly. So I would advise that you not set expectations based on the old episode definitions and look forward to what we present in the near future.

Pamela: Thank you. On that note, some of the folks are asking about the early October timeframe that we've been given. If we're going to, in that same timeframe, be letting people know if their application is not going to move forward?

Elizabeth: Yes, at that time in early October, we'll be notifying candidate awardees of their status both whether they are progressing to the next stage or whether the expert panel has not recommended them to go forward.

Pamela: Thank you. Several people I think have been a little bit confused by some of the terms we're using. They're wondering what the distinction is between things like the project start date, the implementation date, and the performance year. Could one of you clarify sort of which of those might be relevant in terms of someone

who's thinking about implementing the program and really it seems like there's a concern by several of you of when they need to be ready. What's sort of the earliest possible time that they would need to be ready to go with this program based on what we've been saying?

Elizabeth: So the first step in implementation is signing those awardee agreements. Once you sign the awardee agreements, there might be a short period in which some implementation protocols might be required of you and need to be approved before you progress to the next stage. But I would, to be safe; you should assume that implementation date is when you need to be ready with the program. The performance year is actually when you will start to be, when your evaluation period will start when we will be collecting data from you. That will be in the awardee agreements so that when we discuss terms and conditions with you, you will see all those dates laid out.

Pamela: Thank you. So what I hear you saying, which again is being echoed in some of the questions that are coming in, is that there isn't currently a firm date available for people to know exactly when they'll be signing an agreement and when the program is going to begin.

Elizabeth: So that's correct. We don't have a date certain and the reason for that is between now and spring of 2013, there are a number of very involved, complicated tasks and discussions with you all that need to occur before implementing the program.

Jeff: I'd just like to add, I mean we recognize the importance for your planning that you want to have as firm a dates as possible and I think for those that have sort of studied the history of bundled payments, you recognize this next phase, this is the challenging area. It's really where sort of the heirs and providers have to agree on the bundles and the mechanisms for setting the prices and we're trying to do this on sort of an unprecedented large scale. So we're going to do the best job we can and a lot of this will depend on how well we do our job and how well you respond and whether you're interested in our programs.

Pamela: Thanks very much for chiming in. So I'm seeing several policy related questions that are coming in. Someone has asked if it's been determined what will be included in the bundled payment, whether it will be just the facility, the inpatient stay, therapy, anesthesia, surgeons, and things like that. Could someone clarify where folks could find that kind of information?

Jeff: Sure, so we're not changing anything about the way the bundles are constructed. So that information is in our RFA as well as the multiple documents that have been put on our website through the application process as clarifications were made. The key parameters that are being discussed here are the actual clinical conditions that will be included or excluded. Basically the MSDRGs for readmissions or the primary diagnosis codes for other services, but the types of services that are included in the episodes have not changed.

Pamela: Thank you. Someone has asked for an example of what kind of convergence we would be doing around the anchor condition. The example or the comment they've made is if we have submitted an episode for total joint replacement, would that be combined with other separate procedures like spine for instance? Do you think that you could comment on sort of where folks can find information about what our principles were perhaps in doing this?

Jeff: Right, so we've specified that the entire family MS DRGs must be included and that remains the same. Again, the target price continues to be set at the MS DRG level, so the significance of potentially having multiple MS DRG families is that it would require the provider to take on all of those patients. That information will be available when we present the clinical episodes. Basically that will be available in early October.

Pamela: Jeff, a couple of folks have asked if there has been any resolution on the frequency of reconciliation that will occur in conjunction with this program. Do you have any comments on that or when folks might be able to have that information?

Jeff: We haven't formally announced that frequency. Again, that information is fed by the analytics that we're doing and we will need to present that information, obviously, before agreements are signed at some point during this process but I don't have specific information at this time. But we do recognize that providers are interested in seeing frequent reconciliations and we want to do it in a way that is operationally feasible and doesn't sort of limit the amount of variation that one might see so that we're not overpaying and underpaying from period to period.

Pamela: Thanks, Jeff. Another question that recently came in is sort of what happens between the project's start date and the performance year's start.

Elizabeth: Sure, so after you sign the awardee agreements, there are implementation protocols that I mentioned earlier that need to be submitted, and some of the things that we would be looking for in implementation protocols would be the gain sharing arrangement. Many of you applied to these models with the gain sharing arrangement in mind. We would need details on that. We would also need to have a list of those gain sharing partners and so those kinds of details would be covered in these implementation protocols which would then need to be submitted to CMS and approved before your performance year starts and before you can have gain sharing, for example. So really it's the short period between the signing of the agreement and the start of the performance year to allow for all of us to get all of our ducks in a row and make sure that we are best prepared to start the period in which you will be evaluated.

Pamela: Thanks very much, Elizabeth. So there are several questions that are coming in regarding billing procedures under Model 4, some very specific questions. I'm

going to have to defer those questions to sort of closer to the implementation. We are going to be able to give you a lot more information regarding how that billing will occur but again, sort of that is not available at this time.

We also have some questions regarding folks who've submitted an application that had a lot of different bundles in it. They're saying in the event that we were selected as a candidate awardee, if we were to reduce the number of different bundles that we were hoping to engage in potentially by a large factor, carving out most of the things that we had intended to do, would this have an impact on their status as a candidate awardee?

Elizabeth: The answer to that is no; because the expert panel will be reviewing your application and looking for such things as quality of care, patient centeredness. There are multiple elements to looking at your application and scoring it. So it should really not affect that activity down through selecting converged episodes to test.

Pamela: Thanks very much, Elizabeth. So in this question period we've gotten sort of many dozens questions about data. I'm going to try and answer several of them at the same time here.

So several folks are asking questions about the data they currently have. Which again, if you've applied, it has been extended or will be extended. If you have a question about that, just email us on your personal situation. Some folks are asking if they can use that data that you already have to assess the new converged episode. The answer to that is yes. That's sort of part and parcel to the extension is that we believe this data can be useful to you in considering these new converged episode definitions.

Several people are asking if we're going to provide more updated claims data to you in order to do what I just said. So sort of within the next few weeks, you will be receiving new data. The answer to that question is no. We are not providing new data at this time for purposes of application to the program. So you should not be anticipating receiving updated data sets that go, say, into 2010 or 2011.

Further, there are several questions about data that will be received during the life of the program. If you are selected as an awardee, will you be getting data sets or sort of what other kind of feedback would you be receiving? So those details won't be available at this time and likely, sort of, our things that we are still considering what kinds of feedback folks are going to need to effectively manage our bundled payments program. We've received a lot of feedback from folks about what they would believe they need and we are sort of doing some internal work around that; what kind of quality based or claims based data you might need. Again, sort of that information is not currently available but we are working on it. So again, you're welcome to let us know your thoughts but it is

something that we are currently considering and working towards a solution that meets your needs.

Several people—let's see what else we have. Several people also related to data are saying that the ResDAC has told them something that may conflict with what you've heard here. That they sort of have to be sending us a letter that says they want an extension. If you've received an email such as that from ResDAC, feel free to email it to us and we can work out the details of that specific situation. I would not recommend that you just ignore what ResDAC is saying but please do email us and let us know if you're getting conflicting information.

We do only have a few minutes left so I don't know if we will be able to answer any more questions in the next few minutes. We would appreciate though, if you have a question that's really—a lot of people are saying this is really important to us and we do understand that. But from a planning and strategic perspective in your organization, you need to know when to anticipate these things are happening. Sort of when you're going to get information that you might need to have your data analysts ready to do some work on or when you would be expected to start doing the programs or start implementing the care redesign that you've described, particularly for those who sort of might have already been going down a path or might have been waiting for feedback from us. We understand your need for information and we are making every effort to sort of give you the information you need as it becomes available.

Please don't hesitate to email us with questions, if you don't feel that your concerns have been quelled by this conversation. Again, as we said, we do anticipate in the next several months, significant engagement with applicants to the program regarding their applications, these converged episodes. So we do look forward to speaking with you both in groups and sort of one-on-one in the coming months.

Thank you so much for joining us today. We do appreciate it and please do visit our website to see the slides and the transcript and recording of this presentation and let us know if you have any questions into the future. That concludes the presentation for today. Thank you very much and we hope to speak with you soon.