

**Center for Medicare & Medicaid Innovation
Bundled Payments for Care Improvement Initiative**

**Distinguishing Between Applicant Roles in the Bundled Payments
for Care Improvement Initiative**

Thursday, March 8, 2012, 2:00pm – 3:30pm ET

OPERATOR: Good afternoon ladies and gentlemen and welcome to the How to Apply to the Bundled Payment for Care Improvement Initiative conference call. My name is Kim and I'll be your operator for today. At this time all participants are in a listen only mode. Later we will conduct a Q&A session. If at any time you require operator assistance, please press star zero and we'll be happy to assist you. I would now like to turn the conference over to your host for today, Ms. Elizabeth Truong. Please proceed.

ELIZABETH TRUONG: Good afternoon everybody. Welcome, we're very happy here to talk to you today about Bundled Payments for Care Improvement Initiative. Of the patient care models group the members who are going to be talking today will be myself, and Elyse Pegler and Pamela Pelizzari. Our Director of Patient Care Models Group is Valinda Rutledge and Carol Bazell is our Deputy Director. We also have other members of the team in the room and we will be, once we present we will be answering questions from everybody.

So today's purpose really is we look forward to receiving strong applications for Bundled Payments for Care Improvement, Models Two through Four. And to help you submit a strong application our goal for today is to help you think through the applicant role to enable you to choose the best fit for you and then show you how applicant roles function in the context of models two through four.

PAMELA PELIZZARI: This is Pamela Pelizzari with the Patient Care Models Group, we'd also like to help you understand the implications of the applicant role that you select for episode initiation and data analysis. It will be very important to understand how the role you select influences which beneficiaries will be included in your episodes and how you should analyze your data to understand the target price or bundled payment amount that you'll include in your application.

ELYSE PEGLER: This is Elyse Pegler. We are deeply gratified with the overwhelming response by providers from across the country to the Bundled Payment for Care Improvement Initiative. This is evidence of your strong commitment to quality improvement and of the tremendous interest in bundled payment. We appreciate your leadership efforts to improve the healthcare delivery systems in your own community and the important role that providers play in coordinating primary care across multiple settings.

We appreciate your interest in participating in the Bundled Payment for Care Improvement Initiative and your partnership with CMS to develop and test new models of care and payment that will improve patient outcomes and reduce costs, the three part aim.

ELIZABETH TRUONG: Well, by now you know there are four Bundled Payments for Care Improvement models. And Model One applications have been received and soon the online applications for Models Two through Four will be available.

ELYSE PEGLER: For now we will be posting a non-fillable PDF version of the application questions on our website so that you can preview and prepare for a strong application submission. We will continue to keep you all posted on when the online application submission portal will be ready.

PAMELA PELIZZARI: We also want to give you an update on the HRC data request. So organization to submit a data request and completed that process in a timely manner have received their data so far. We have been in contact with anyone who requested data but did not receive it. So if you think you requested data and you just haven't heard from us you should definitely get in touch, because those requests have already been shipped out.

At this time we believe in terms of the data analysis cap before you we should be providing some additional guidance on applicant roles because that's directly impacting how you'll need to analyze the data. So that's what we'll be talking about for the rest of this session.

ELIZABETH TRUONG: Yes, thank you Pamela, so we'd like to quickly review the models before we begin. We'll start with Model Two. Model Two is a retrospective acute care hospital stay, post acute care model. It begins with an acute care hospital stay and goes through the end of the episode which is episode which is specified by the applicant. It includes all Part A and Part B services in the episode. Applicants are asked to specify the clinical conditions to be tested by proposing relevant MS-DRGs.

ELYSE PEGLER: Next in Model Three, the episode begins at the initiation of post acute services at one of the four post acute care providers. And we mean the home health agencies, the inpatient rehab facilities, the skilled nursing facility and the long term care hospital. And the initiation would begin within 30 days after discharge from any acute care hospital for specific clinical conditions and the applicants are asked to propose an episode length that would extend to at least 30 days following the initiation of post acute care.

Now, the types of services included in this episode would be the post acute care and other related services furnished during the episode, including the Part B services and the inpatient hospital readmissions, if there are any. And finally I'd like to point out that with this model while the episode is initiated at one of the four post acute care provider settings rather than at the acute care hospital, the applicants are asked to specify clinical conditions to be tested by proposing relevant MS-DRG.

PAMELA PELIZZARI: Model Four is a prospective acute care hospital stay only model. So that will initiate with admission to the acute care hospital and will extend into 30 days after discharge for readmissions only. So that's bundle will include Part A services happening during, that would be the MS-DRG payment during the hospital stay as well as Part B professional services that are furnished during the hospitalization and it will include readmissions as I mentioned for 30 days after discharge from that hospital stay.

As with Models Two and Three, applicants will be asked to specify some clinical conditions to be tested by proposing relevant MS-DRGs.

ELIZABETH TRUONG: So before we go further, let's define a few terms for you. Here are a few terms that we commonly use to describe elements of the program. Now audience as we go along today if you hear us use a term that you would like us to define remember there's a chat function in the webinar,

send us a note, we'll try to work it in and we also have question and answer time at the end. Elyse and Pamela are going to go through these terms with you next.

ELYSE PEGLER: So we recognize that we've used these various, these terms with various iterations before and we'd like to now take the time to make sure that everyone has a common understanding. The first term is a bundled payment beneficiary. This is an eligible Medicare fee for service beneficiary that is included in an episode. Anchor MS-DRGs are one parameter of the episode definition. And they have slightly different usages in Models Two and Four from Model Three.

In Models Two and Four the anchor MS-DRG is the MS-DRG assigned to the acute care hospital stay that initiates the episode. And it is included in the target price or the bundled payment amount. In Model Three the anchor MS-DRG determines the potential for a beneficiary to initiate an episode. It is important to note that these are the MS-DRGs that beneficiaries are discharged with from the hospital prior to the initiation of the episode in Model Three.

Episode initiation is another term that we'll be using throughout the presentation. This is when a beneficiary enters an episode based on the parameters defined by the applicant according to the model. These parameters include the time period, the providers involved, the nature of the provider relationship, and the anchor MS-DRGs. The last term on this slide is episode initiating providers. These are acute care hospitals in Models Two and Four and skilled nursing facilities, home health agencies, long term care hospitals and inpatient rehabilitation facilities in Model Three.

PAMELA PELIZZARI: Redesigning care is an important part of the Bundled Payment for Care Improvement Initiative and we do anticipate that applicants will be partnering with other entities to redesign care. These partners fall into two categories as described on this slide. The first category is bundled payment physicians or practitioners. Those would be expected to participate and include those who may be paid separately by Medicare for their professional services, such as physicians, nurse practitioners, physician assistants, physical therapists.

And the other category is bundled payment participating organizations. So this includes all other Medicare providers or suppliers with whom the applicant plans to partner, such as acute care hospitals, skilled nursing facilities, inpatient rehabilitation facilities and home health agencies, among others. Episode initiating bundled payment participating organizations are a subset of those bundled payment participating organizations and it's the subset that initiates episodes. So in Models Two and Four this would be hospitals and in Model Three this would be post acute providers.

At the Center for Innovation, we were very pleased by the creativity of our letter of intent submitters. And the sort of wide variety of letters of intent that were submitted prompted us to clarify these roles, because we saw a lot of sort of innovative combinations of organizations and partnerships and we want to make sure that we have a place for as many people as possible in this initiative.

ELYSE PEGLER: Specifically the three roles that we'll be discussing today in depth are the awardee role, the awardee convener role, and the facilitator convener role, which is an entity that we'll be applying with designated awardees and/or designated awardee conveners.

ELIZABETH TRUONG: So to determine what applicant role best fits your needs and intentions we've provided these questions for you to ask. The first is what organizational type am I? Am I a hospital, a

physician group practice, a healthcare system, a parent company, an association? And then ask yourself do I want to bear risk or do I want to facilitate others who will bear risks? And if I am willing to bear risk do I want to bear risk only for my own bundled payment beneficiary or in the redesigning of care am I capable of taking on the risk for all the bundled payment beneficiaries that I and my partners take care of? And then who are my partners? And what roles will they fulfill?

Now the answer to each of these questions can help inform you on what role and model to select and also helps you with the data analysis.

PAMELA PELIZZARI: So if you're not interested in bearing risk but you'd like to facilitate other organizations, which we've mentioned are called designated awardees and designated awardee conveners in redesigning care the facilitator convenue role would be the role for you. This is the only opportunity in the program to be a non-risk bearing applicant. And examples of what kind of organizations or applicants would be facilitator conveners will be provided in just a few slides.

ELYSE PEGLER: The two types of awardee roles that are risk bearing are an awardee and an awardee convenue. You would be an awardee if you bear risk only for your bundled team beneficiaries wherever they go in the episode. You would be an awardee convenue if you want to apply with partners and bear risk for the bundled payment beneficiaries of at least one of those partners. If you were an entity that doesn't have beneficiaries, for example, a parent company, you would bear risk for your episode initiating partners bundled payment beneficiary.

If you are a provider or supplier that does have patients you would bear risk for your own bundled payment beneficiaries wherever they go in the episode and your partners, your episode initiating partners, bundled payments beneficiaries wherever they go in the episode, even if you don't treat them.

ELIZABETH TRUONG: So the last two slides that Pamela and Elyse just reviewed with you are critical. So this slide is meant to illustrate roles in its entirety. And so to review there are three types of applicant roles. There's the awardee, the awardee convenue where you would be applying with episode initiating bundled payments participating organizations and then there's the facilitator convenue where you would apply with designated awardees and/or designated awardee conveners.

So therefore in total there will be 12 applications available. And you will be completing the application that is appropriate to your selected role and model.

PAMELA PELIZZARI: So now we're going to go into a bit more depth about each of those applicant types to make sure that we're really all on the same page. So the first type would be the awardee. An example of this kind of applicant would be an individual hospital or an individual physician group practice, for instance. They would be responsible for all of their own bundled payment patients as we defined earlier, only their own, but also all of their own bundled payments patients, regardless of the other providers where these patients receive care during the episode. This is contrasted by the other awardee types or the awardee convenue, which has a bit of a different meaning.

ELYSE PEGLER: So the awardee convenue type, this would be parent companies, health systems or other organizations that wish to take risks more broadly. They would be responsible for all of their own bundled payments beneficiaries during the episode if the awardee convenue has patients. And either

case they would be responsible for all of the bundled payment beneficiaries of their episode initiating bundled payments participating organization partners. These would be regardless of the other providers where these patients receive care during the episode.

And these awardee conveners could have episode initiating partners and also non-episode initiating partners.

ELIZABETH TRUONG: As for the facilitator convener an entity may submit an application in partnership with multiple providers where that entity would participate as a facilitator convener. So in this capacity the convener could serve an administrative and technical assistance function for one or more designated awardees and/or awardee conveners. And in this arrangement the facilitator convener would not have an agreement with CMS, would not bear financial risk or receive any payment from CMS.

As we mentioned previously facilitator conveners can have the designated awardee and/or designated awardee conveners. For example, a facilitator convener in Model Two can have hospitals and health systems in their applications. The hospitals would be the designated awardees and the health system would be awardee conveners.

As for which beneficiaries are they responsible for? Well, each designated awardee and/or designated awardee convener is responsible for the same definitions as Elyse and Pamela spoke of earlier.

ELYSE PEGLER: Recognizing that these terms are complex we felt that examples could help bring concreteness to the concept. So we're going to go through the different applicant roles by model and provide some examples which we hope will be helpful to the audience. In Model Two, in the case of an awardee we have two examples here, one is a single acute care hospital and one is a physician group practice.

The single acute care hospital would initiate episodes for every beneficiary charged with the anchor MS-DRGs which we've defined previously regardless of which physicians they saw, services they had, type of post acute care and so forth. This is a little bit different for a physician group practice. In a physician group practice situation in Model Two for a single awardee, the physician group practice would be responsible for the patients of the physician group practice. And those patients would initiate episodes when they are admitted to any hospital with the anchor MS-DRG, which is assigned at discharge regardless of the services that they had the type of post acute care and so forth.

The next two examples, also within Model Two, are for awardee conveners. We wanted to provide an example of a hospital system with five acute care hospitals; to illustrate the awardee convener situation where the awardee convener itself would be taking risks for the beneficiaries in each of acute care hospitals. So each of the five hospitals would initiate episodes for every beneficiary discharged with the anchor MS-DRG, again, regardless of physicians they saw, services the had and type of post acute care, etc.

The second scenario of a health system that includes an acute care hospital, an inpatient rehabilitation facility and a skilled nursing facility the hospital would initiate episodes for every beneficiary discharged with the anchor MS-DRG regardless of which physicians they saw, services they had, episodes of acute care, etc., but the episodes would not be initiated for patients seen at the IRF or the SNF if those patients had not had their inpatient care at the acute care hospital in the system.

The last two examples that we wanted to provide for Model Two are for facilitator conveners. We wanted to provide an example of a state hospital association. The hospital association would partner with some number of hospitals or hospital systems as designated awardees or designated awardee conveners, respectively and that these entities would follow the same rules for awardees or awardee conveners.

The facilitator convener will define the episode parameters that include anchor MS-DRGs, length, discounts and so forth. But the designated awardees and/or designated awardee conveners will be able to select which episodes they'd like to do, some could do just episode A, some could do just episode B. But all of the A episodes would be the same, have the same parameters and all of the "B" episodes would also have the same parameters.

In the case of a venture capital company that does not wish to take risks for but engages with an acute care hospital, an IRF and a SNF, the hospital designated awardee would initiate episodes for every beneficiary discharged with the anchor MS-DRG regardless of the physicians they saw, services they had, type of post acute care, etc., following the same rules that we've discussed just now. But for the IRF and the SNF designated awardees it would be the patients of the IRF and the SNF would initiate episodes when they're admitted to any hospital with the anchor MS-DRG regardless of the services they had, the type of post acute care and so forth.

ELIZABETH TRUONG: Thank you Elyse for those examples from Model Two. For Model Three for those of you interested in Model Three, again the point of these examples is to go through each of the applicant types and show you how and who would be initiating an episode, so it would help you to develop the data, to analyze the data. So let's take the awardee role. And in Model Three the awardee could be an IRF, a SNF, a LTCH or a home health agency, but let's just take the example of a single inpatient rehab facility, an IRF.

So the IRF would initiate episodes for all the patients, admitted to the IRF who were discharged from an acute care hospital with an anchor MS-DRG within 30 days of admission to the IRF, regardless of which hospital they came from, the physicians they saw, services they had and so forth. It's important to note that while the episode is initiated by the start of post acute services in Model Three the anchor that determined beneficiary eligibility are the MS-DRG for which beneficiaries are discharged from the acute care hospital.

In the case of a physician group practice the patients of the physician group practice would initiate episodes when they start any post acute services at an IRF, a SNF, an LTCH or an HHA within 30 days of discharge from an acute care hospital with an anchor MS-DRG. And again it's regardless of which hospitals they came from, other physicians they saw, services they had. So this is true regardless of which post acute provider provides that post acute care.

Let's move onto the awardee convener. And let's look at the example of a hospital system with just five acute care hospitals. Now in Model Three you already know that the episode is initiated at a post acute care facility or a home health agency. Since this example as a hospital with five acute care hospitals there are no episode initiating entities involved. So there are no episodes, so this is not an option.

Let's look at another example. If the health system includes an acute care hospital, a home health agency and a SNF, then the home health agency and the SNF would initiate episodes for all patients who start services with the home health agency or admitted to the SNF who are discharged from an acute

care hospital with an anchor MS-DRG within 30 days of the start of the post acute care service, regardless of which hospitals they came from, physicians they saw, services they had, etc., and even if the discharge did not come from the acute care hospital of the systems in question.

And finally in the facilitator convener role let's take the example of a national association of skilled nursing facilities. The association would partner with some number of SNFs or SNF parent companies as designated awardees or designated awardee conveners. And these entities would follow the same rules for awardees or awardee conveners. The facilitator convener will define the episode parameters that would include the anchor MS-DRGs, the length for the discounts. The business designated awardees and/or designated awardee conveners will be able to select which ones they'd like to do.

Some could do just episode A and some could do just episode B, but all A episodes should be the same parameters and all B episodes would be the same parameters. Each of the SNF designated awardees or SNFs within the designated awardee conveners would initiate episodes for all beneficiaries who initiate services at the SNF within 30 days of discharge from an acute care hospital with an anchor MS-DRG, all that we've been speaking of previously.

And finally what of the case of the venture capitalist company that partners with an acute care hospital along an LTCH and a SNF? Well, then you know that the LTCH and the SNF are designated awardees and they would initiate episodes for all the patients admitted to the LTCH and SNF who are discharged from an acute care hospital with an anchor MS-DRG within 30 days of admission to the LTCH or SNF.

For the hospital designated awardee, the patients of the hospital would initiate episodes when they start services at any SNF, IRF, HHA, or LTCH within 30 days of discharge from that hospital and with the anchor MS-DRG regardless of the services that they have, etc.

PAMELA PELIZZARI: So we're hoping these examples are helping you to contextualize your own collection of providers and the models that you're looking to apply for, obviously we don't think they cover every situation and will have some time for discussion if you're still left confused about what you would do in your specific situation.

Model Four is an interesting scenario because is it an acute care bundle. And so as we noted in our RFA, payments for this model will be going to hospitals. That doesn't mean hospitals are the only people who we imagine will be engaged though, so we'll go through these similar examples for this Model Four situation.

For a risk bearing non-convener awardee an example would be a single acute care hospital. That hospital would initiate episodes for every beneficiary discharged with the anchor MS-DRG regardless of which physicians they saw while they were in the hospital, which services they had or where they headed after their hospital stay. For the awardee convener, I'm sorry for a physician group practice as a single awardee in Model Four it's a little bit of a different situation given that nuance I described about hospitals receiving payment for this model.

This is single practice that's looking to participate in Model Four must partner with an acute care hospital in Model Four. That hospital would initiate episodes for every beneficiary discharged with the anchor MS-DRG regardless of which physicians they saw, which services they had and so forth. In terms of the awardee convener role if we were to have another one of these hospital systems with five acute

care hospitals that wants to participate in Model Four each of the five hospitals would initiate episodes for every beneficiary discharged with an anchor MS-DRG regardless of which physicians they saw.

If it's a health system that has an acute care hospital, an inpatient rehab facility, perhaps a skilled nursing facility, any collection of post acute providers as an awardee convener the hospital in that health system would initiate episodes for every beneficiary discharged with the anchor MS-DRG regardless of which physicians they saw or services they had. But really we would be looking at the hospital in that scenario.

As a facilitator convener in Model Four, if a state hospital association was coming in as a facilitator convener it would partner with some number of the hospitals or hospital systems in the association or outside as designated awardees or designated awardee conveners. Each of those hospitals or hospital systems would follow the same rules as we described above for awardees or awardee conveners.

The facilitator convener would define the episodes parameters, such as the anchor MS-DRGs and the discounts, but designated awardees or designated awardee conveners would be able to select which of those episodes they'd like to do. So as we described before it's possible that some of the hospitals would just do episode A, some would just do episode B, but all of the similar episodes, A episodes would be the same, with the same parameters and all of the B episodes would have the same parameters.

If a venture capital company didn't want to take risks but was engaging with an acute care hospital, an inpatient rehab facility and a SNF the hospital designated awardee there would initiate episodes for every beneficiary discharged with the anchor MS-DRG regardless of which physicians they saw while they were in the hospital. For the inpatient rehab facility and the skilled nursing facility designated awardees they would have to each partner with one acute care hospital if they were their own designated awardees and then that hospital would initiate episodes for every beneficiary discharged with the anchor MS-DRG regardless of which physicians the saw.

So as you can see there are some differences between, both between the models and between the different roles that people play in each of those models. So now that we've given you all this information, it's important to ask yourself how that influences your data analysis. Since episodes are defined on a clinical condition level, which must at a minimum include a family of MS-DRGs that represents all severity levels, it's important for you to figure out which beneficiaries would be initiated into those episodes.

And that depends on the applicant role, the model and your episode definition as we just described. So if you're considering yourself a certain one of these types of applicants that will help you define which beneficiaries in your data set that you should be looking at.

ELYSE PEGLER: As Pamela indicated the data will be used to create target prices for Models Two and Three and bundled payment amounts for Model Four. And these should be proposed for each MS-DRG within an episode. There is an exception however for the awardee convener role. And in that role there is a different approach for Models Two, Three and Four. And I'll go through those right now.

For Model Two target prices should be proposed for each episode initiating bundled payment participating organization, which by definition are hospitals in Model Two and for each MS-DRG within an episode. For Model Three target prices should be proposed for the awardee convener application as a whole and for each MS-DRG within the episode but the target prices in Model Three would not be

broken out by the episode initiating bundled payment participation organizations, which are some health agencies, LTCHs, and SNFs in Model Three.

For Model Four it's not a target price it's a bundled payment amount and those would be proposed for each episode initiating bundled payment participating organization which again by definition are hospitals in Model Four and for each MS-DRG within an episode.

PAMELA PELIZZARI: So given all that information there is sort of a pathway that it's important to follow when you're calculating your target price or bundled payment amount. I mean, you need to determine your applicant type which is based on the provider partners and the risk or incidents that we've been describing throughout this webinar. Using that collection of provider partners and risk arrangements you would determine your applicant type and then be able to determine the beneficiaries that would be included in your episodes, which is dependent on the applicant type that you're looking at.

As such those beneficiaries are the ones for which risk is being taken and payments reconciled, so you need to look at those and then you will analyze historical episode payments made for beneficiaries that will be included in your episodes based on the episode parameters that you're applying to your given situation. So that would be where you sort of take those beneficiaries who have the relevant clinical condition and you would look at their service utilization and the payments made by Medicare on behalf of those beneficiaries. That historical experience will be what we're looking for you to propose in your applications.

ELIZABETH TRUONG: Thanks Pamela. So hopefully from our discussion today where we've shown you examples of applicant roles in context of each of the models you've come to understand some of the implications of the applicant role. And as you analyze the data we hope you will keep in mind the questions that we shared with you in slide 11.

ELYSE PEGLER: In conclusion we believe that bundled payments provide an important strategic and financial opportunity and can serve as a foundation for success in a value driven market. We are excited by your tremendous interest in bundled payments and on partnering with you to redesign care. We look forward to receiving your applications and are here to assist with questions.

PAMELA PELIZZARI: We also have some additional upcoming learning activities that we wanted to inform you of. So on Tuesday, March 13th we'll be having our fourth Accelerated Development Learning Session, which is called, What to Pack in Your Bundle, Episode Selection Definition and Clinical Management for Care Improvement. On Thursday, March 22nd we'll be having our fifth Accelerated Development Learning Session called, Contractual and Governance Issues Among Providers in Bundled Payments.

We also having ongoing data related technical assistance calls with the Research Data Assistance Center. We've already had three of those calls and you or your data analyst might have participated in them. They'll be continuing next Wednesday, March 14th at 12 noon. And starting next week they'll be every Wednesday at noon we'll be having that call in. And we would encourage you or your data analyst to participate as they're a really good opportunity to ask questions and get live feedback regarding problems or questions with the data files that you have.

ELIZABETH TRUONG: So we have left additional time today for questions and we'll be taking them over live chat and over the phone. We ask that if you're asking a question over the phone you state both your first name and identify the type of organization that you represent as well as the model or models you're interested in applying for so that we can better address your needs. At this time the moderator will read the instructions for how to cue up to ask the questions.

OPERATOR: Ladies and gentlemen if you have a question please press star followed by one on your phone. If your question has been answered or you would like to withdraw your question, press star followed by two. Questions will be taken in the order received. Please press, star one to begin.

PAMELA PELIZZARI: So while we're waiting for the first question we have already gotten some over chat that we're happy to sort of start answering while people think about what they want to say on the phone. The first question is will the slides be available for download anywhere? And I'm going to ask our colleague Melissa to answer that one.

MELISSA COHEN: Yes, the slides will be available on the Innovation Center website on the Bundled Payments for Care Improvement learning area. And we should have those posted by next week.

PAMELA PELIZZARI: Thank you Melissa. So another question that's come is can an episode have more than one anchor DRG? So I'm going to look to Elyse to describe again sort of what anchor MS-DRG means and how that translates to your application.

ELYSE PEGLER: Sure. So again the anchor MS-DRG is the one of the parameters that defines eligibility for a beneficiary starting an episode. And, yes, we would expect that episodes would include at a minimum the family of related MS-DRGs for a clinical condition. So we do expect that episodes are focused around clinical conditions and that they would have at a minimum the family of related MS-DRGs in terms of severity.

PAMELA PELIZZARI: Thanks very much for that answer. We've also received a question about when the non-billable PDF application will be posted. And so I think that Melissa can give you an update about that was well.

MELISSA COHEN: The non-fillable PDF which will be a 508 compliant document that we will post on our website that you can use for reference. It will contain all of the questions that will be on the online application that will be available on our website, the Innovation Center website, next week.

PAMELA PELIZZARI: Thanks very much Melissa. That's very helpful I imagine for our constituents. Is there anyone in the queue to ask a question on the phone at this time?

OPERATOR: We do have one person on the line; the first question comes from the line of Bome. Please proceed.

BOME: Yes, we are a post acute provide looking at Model Three and my question is about the slide that showed the three steps in the process determining a type of applicant and determining the beneficiaries

and then constructing the episode. The question is that when we start to drill down from an all cause admission to an MS-DRG level for episode construction we notice that the number of episodes kind of drops very significantly. And this probably has two ramifications, one for the bidder and one for CMS.

For the bidder our best efforts to carefully construct an episode could be jeopardized by the statistical variations because of small volumes. And for CMS, I suspect that you are looking for reaching as many beneficiaries as possible with significant savings to Medicare. Could you provide some color on this situation and any solution to that?

JEFF CLOUGH: Thank you for your question. This is Jeff Clough, one of the team members. It is true that obviously as you select individual MS-DRGs that will bring the numbers down. Basically you have the option of putting as many MS-DRGs that you like in the episode. And generally we would like an episode to be built around a clinical condition so that they can be related. You could do multiple episodes where you group the relevant MS-DRGs. Those are sort of ways to increase the numbers. Ultimately we will be sort of looking at the total numbers and designing our payment reconciliations that most appropriately match the target price.

But it is true that essentially the more numbers you have then you have the ability to do as many episodes in as many MS-DRGs as you like, you will have more power essentially. Does that answer your question?

BOME: Yes, thank you.

OPERATOR: We have no further questions over the phone line at this time.

PAMELA PELIZZARI: Great. We have tons over the chat, so we'll keep looking at those. The next question that I'm seeing is, can a single hospital apply as an awardee for some episodes and have a facilitator convener that submits for others episodes? I'll go ahead and answer that question. The answer to that question would be yes. So as long as a given MS-DRG is only covered in one of those situations that wouldn't be a problem.

So, for instance, if you're using DRGX as an individual awardian, so patients who come to your hospital for DRGX would be initiated into that episode. And for DRGY you're participating with a facilitator convener. That wouldn't present a problem. But for a given beneficiary they can only be initiated into one of those two episodes and so it's important that there's not overlap for a given DRG.

Another question that I see here is in Model Two if a hospital including participating organizations with a skilled nursing facility, a home health agency in the hospital assumes the risk, but shares the risk with the post acute facilities is a hospital, an awardee or an awardee convener? I'm going to ask my colleagues Melissa and Elyse to answer that one.

MELISSA COHEN: So again the applicant type depends on which patients you want to be taking risks for. So if you want to be taking risk for all of the patients of an acute care hospital and all of the patients for the SNF and the home health agency wherever all of those patients go then you would be, wherever they come from, then you would be an awardee convener. If however you only want to take on the risk for the patients from the acute care hospital but then also enter into other types of risk sharing

arrangements that are not with CMS then you would be considered an awardee. The issue is which patients are going to be in the episode that you are taking risks for.

PAMELA PELIZZARI: Thanks very much. So we have some more questions here. As a hospital can I simply be an awardee and have game sharing agreements with bundled payment participating organizations without being an awardee convener? The participating organizations would not initiate episodes. I'm going to give this question to Elyse.

ELYSE PEGLER: The answer to that is yes, they would be a single awardee. And so it would be important when choosing your role that if you would like to pursue that situation that you make sure to choose the role of an awardee and not to choose the role of an awardee convener.

PAMELA PELIZZARI: Great, thanks very much. So here's another one. In Model Four do all the hospitals working with a venture capital company have to submit their own application as an awardee?

ELYSE PEGLER: I think that that depends on if the venture capital company and the hospitals are intending to apply in a facilitator convener and designated awardee arrangement. If that is the case then the facilitator convener would be filling out certain aspects of the application and then they or the hospitals that are the designated awardees would be filling out their information. However, if the hospitals are working with a venture capital company and that venture capital company does not want to be playing a purposeful facilitator convener role then those individuals hospitals are certainly welcome to apply as single awardees or if they are systems awardee conveners.

MELISSA COHEN: And this is Melissa, if I can just add to that. We want to emphasize that the facilitator convener role as an applicant you're supposed to present an overarching methodology for your entire application. So the episodes would be defined on the facilitator convener level. And so if you are applying with a venture capital company and you would like to propose different episodes then the episodes proposed by that venture capital company that would not be possible.

PAMELA PELIZZARI: Thanks very much. So we have plenty more questions, keep them coming. Is there anyone else on the phone line at this time?

OPERATOR: We do have another question from the line of Matt.

PAMELA PELIZZARI: Great. Thank you.

OPERATOR: Please proceed.

MATT: I'm with a health system and we have multiple hospitals, IRFs and home health choice. For Model Three it says our IRF and our home health have to both put in a joint application, or can one or the other?

MELISSA COHEN: For Model Three, again the applicant role and who applies has a lot to do with which patients are going to be included in the episode. So if your plan is for all of the patients of the IRF and

the home health agency to initiate episodes then you could either apply as an awardee convener or if you wanted to apply separately they could apply each as separate awardees. But then again it wouldn't be one organization taking on the risk.

MATT: Let me rephrase that. If the system is applying as an awardee convener could we have only the IRF as the participating organization?

PAMELA PELIZZARI: So you're saying you have a system and you only want some of your post acute providers to be participating organizations, you don't want all of them to? As long as they're distinct entities that shouldn't be a problem. If they have the same provider number that would be a problem and you can email that question to our inbox if you want to more specifically examine that. But I think that that sort of, being separate entities with separate CCNs is an important distinction here and that's the level on which we would anticipate participating organizations to be determined as participating or not.

MATT: They have separate CCNs. So that takes care of my question. Thanks very much.

MELISSA COHEN: And just to add to that the organizations that include that should just be reflected in the target price that you propose.

MATT: Okay. Thank you.

PAMELA PELIZZARI: So do we have any other questions on the phone?

OPERATOR: There are no further questions on the phone lines at this time.

PAMELA PELIZZARI: Okay. We'll keep going through the chat questions then. Someone has asked in the application can you specify a subset of beneficiaries within an MS-DRG episode? Elizabeth can you answer that one?

ELIZABETH TRUONG: The answer would be no, you cannot.

PAMELA PELIZZARI: And further this person has asked if you set separate prices for separate MS-DRGs within the episode and sort of how that works. Could you continue and describe that again?

ELIZABETH TRUONG: Sure. So the target price for Models Two and Three are dependent on a MS-DRG basis. You would propose them on a MS-DRG basis.

MELISSA COHEN: For each MS-DRG within the episode.

ELIZABETH TRUONG: Correct.

PAMELA PELIZZARI: I see that there is a related question here that maybe we could address at the same time. So someone has asked what we mean by target prices should be proposed for each episode initiating hospital. So this person is saying they have a main hospital and also a hospital dedicated to orthopedics, but some orthopedic surgeries still get done in the main hospitals. So, they're wanting to clarify if each hospital needs a different price for the orthopedic MS-DRGs that they're proposing to construct episodes around, even if the volume at the main hospital is still very small. I think Elyse can answer that one.

ELYSE PEGLER: Yes, and for awardee conveners for Model Two we are asking that the target price be set for each MS-DRG as well as for each episode initiating hospital. And that is because the target price is based in large part on historical experience of spending for each and we recognize that different hospitals would have different historical spending experiences.

PAMELA PELIZZARI: And it looks like just to clarify some people are asking if that's still true if you're an awardee convener and saying you have bundles in three separate HRCs, would they all have different prices? And Elyse is saying yes. But would they also have different parameters or would they have the same parameters?

ELYSE PEGLER: So the episode would still have the same parameter. So as long as the MS-DRGs are within the same episode they would still have the same parameters, such as the discount, the length of the episode, and so forth. But the target prices would be set within the, for the MS-DRGs within the episode and for Model Two they would be set for awardee conveners for each episode initiating hospital and then for Model Three as we discussed is set at the application level, the awardee convener level and not for each episode initiating post acute providers.

And then for Model Four to the awardee conveners as we discussed the bundled payment amount would also be set for each MS-DRG and for each episode initiating hospital.

JEFF CLOUGH: I just wanted to add one thing to that question to make sure I clarify what you said. They had three different HRCs. If those three HRCs were for the same hospital you would just have one target price, you wouldn't have a separate target price for each HRC.

PAMELA PELIZZARI: That's a great point. We want to always go back to that that you're constructing a target price not for the HRC but for the historical experience of specific beneficiaries that would be initiated into your episode based on your applicant type and collection of providers. Thank you so much for pointing that out. So someone has asked what the difference is between a bundled payment and a target price? I think they're referring to the difference in our terminology between target price and bundled payment amount, which I think Elyse can describe.

ELYSE PEGLER: Sure. Since Model Two and Three are retrospective models where we will be having a payment reconciliation after, regularly throughout the period of performance of this initiative, that is why we have target prices which the actuals experience will be reconciled against. In Model Four it is a prospective model and so therefore, there is not an episode reconciliation against the target price, it is simply that the amount you will pay is a bundled payment amount for the episode.

PAMELA PELIZZARI: Thanks very much. So here's another one. With regard to Model Four let's say there are three hospitals in a metro area with common ownership, management and infrastructure but they have different CMS certification numbers, but they share everything else, including their medical staff. Can they apply as a single awardee rather than an awardee convener given that they have so many similarities?

So it's important to remember that the CMS certification number is a significant factor in sort of determining your organization type. If those three hospitals have separate CMS certification numbers then they would be considered separate entities even though they're closely spaced and share medical staff. So if they wanted all three of those to be initiating episodes then they would either need to apply as three separate awardees, or as an awardee convener. Do we have any other questions on the phone at this time?

OPERATOR: There are no questions on the phone lines at this time.

PAMELA PELIZZARI: We'll keep on going. So someone has asked regarding the data files how to find a cross walk of ICD9 grouping to MS-DRGs. And we just want to clarify that the inpatient portion of this program is largely defined by MS-DRGs and the Part B services are defined by ICD9. If you have specific questions about the data files, what's in them and how to analyze them, that would be something we'd like you to bring up in our technical assistance calls or email to ResDAC, the Research Data Assistance Center, at resdac@umn.edu and they'll be able to answer any further questions you have about identifying MS-DRGs or ICD9 codes in your data files.

Here's another question, in a facilitator convener situation can the awardees each propose a different discount? And perhaps Elizabeth can answer that question.

ELIZABETH TRUONG: So the awardee, the designated awardee or the awardee convener needs to propose a discount based on an episode on a MS-DRG basis. The discount is defined at the episode level by the facilitator convener and so the facilitator convener will define the episode and all the designated awardees or designated awardee conveners will follow that definition.

PAMELA PELIZZARI: So the only thing that's defined is the designated awardee or awardee convener level is going to be the target price. The parameters of the episode are all defined at the facilitator convener level.

So here's a question, we are a post acute chain of skilled nursing facilities and home health agencies considering participating in Model Three. Can we engage in gain sharing agreements with hospitals?

MELISSA COHEN: This is Melissa. If you are a SNF or a home health agency considering Model Three then your agreement will be with CMS. However you can gain share and develop risk sharing arrangements with any of your bundled payment participating organizations, which is separate from your agreement with CMS.

PAMELA PELIZZARI: And we have a similar question as a hospital or health system awardee convener can you gain share with bundled payment participating organizations such as non-employed physicians?

MELISSA COHEN: And the answer to that question is yes.

PAMELA PELIZZARI: Thank you. Yes?

MELISSA COHEN: Just to add to that in the application we will be asking applicants to propose any waivers that they believe would be necessary for their care improvement and care redesign.

PAMELA PELIZZARI: So here's a question, under Model Two in the facilitator convener model is a health system an awardee convener or an awardee if they are only accepting risk for patients that initiate episodes within the health system's hospitals?

ELYSE PEGLER: So in Model Two in the facilitator convener model a health system would be a designated awardee convener. And in that case they would accept risk for the bundled payment beneficiaries that initiate episodes at the hospitals, since we're in Model Two, within the health system.

PAMELA PELIZZARI: Thank you for answering that question. So here's another question, if I'm an awardee hospital taking risk for Model Two can I combine DRGs for the same condition with a single target price?

JEFF CLOUGH: This is Jeff Clough again. No, so the target price is always set at the MS-DRG level, so basically there's, so you would set a different target price for MS-DRG 469 and 470.

PAMELA PELIZZARI: Great. Thank you. We've gotten a lot of sort of iterations of that particular question. So it's important to clarify. Here's another question. If a beneficiary does not follow the episode we have defined are awardees penalized? So I think that's an interesting question. And taking a step back, when we're talking about defining episodes we're not really meaning that you're defining a specific care pathway that all of your beneficiaries have to follow, rather you're putting together sort of a collection of service providers that you feel would cover all of the needs of a certain type of beneficiary, that being the type who has a certain MS-DRG, the anchor MS-DRG that helps to define your episode.

So there wouldn't be direct penalization for people who go outside of your network of providers that are participating in this program, but it's important for you to try and understand using the data that you've received the care patterns of your patients so that you don't, so that you understand what kind of target price you should come up with, because even if the beneficiary's engaging care outside of the network that you set up, you'll still be responsible for those costs in terms of payment reconciliation against the target price that you've set.

So it's important to understand these things, but we wouldn't say that you'll be penalized for that. Someone has asked if a transfer from a hospital to an inpatient rehabilitation facility is considered a readmission?

JEFF CLOUGH: This is Jeff Clough. So I think we would consider the payments associated with the inpatient rehab facility in the category of inpatient rehab facility. Again these would all be components that are part of the episode, so you know ultimately they would all be included in the target price. But if

you're referring to how you fill out the application and putting things in the right cells then you would probably consider the inpatient rehab facility to be part of that bucket.

I guess if you're also trying to ask whether that would be an excluded readmission that would not, excluded readmissions would be defined by the MS-DRG as acute inpatient hospitals.

PAMELA PELIZZARI: Thank you so much for that. It looks like another question we have here, if I am a hospital system with two acute care hospitals but they have the same CCN, am I an awardee or an awardee convener?

MELISSA COHEN: If you have one CCN number then you will be considered an awardee.

PAMELA PELIZZARI: Thank you for answering that. So do we have any other questions on the phone line at this time?

OPERATOR: There are no more questions on the phone at this time.

PAMELA PELIZZARI: Okay. We're just trying to page through some of these questions to make sure we've answered as many as possible. Sorry for the delay. So I see another one, as a Model Three awardee convener are you saying that we would set up separate bundled prices for each DRG? Are you encouraging lumping bundled prices together for say a diagnosis group of ortho DRGs?

JEFF CLOUGH: This is Jeff again. So similar to the prior question it looks like you're asking about whether the target price can be set at the episode level. And again in fact it has to be set at the MS-DRG level.

MELISSA COHEN: However, different than Model Two and Model Four we are not asking for different target prices for each episode initiating bundled payment participating organization. The target price is still defined at the MS-DRG level; there are just not different target prices for each organization.

ELYSE PEGLER: Only in the Model Three awardee convener situation.

PAMELA PELIZZARI: So it looks like someone has asked about the role of the facilitator convener more broadly, sort of that being what is their role in the project other than being a central sort of forum for episode definition? Do they have to have an overarching role in quality improvement or quality measurement, for instance?

ELYSE PEGLER: So the facilitator convener concept we believe to be around providing the technical assistance and support to the designated awardees and the designated awardee conveners. In terms of the application the facilitator convener does provide a role in establishing an overarching model for the entire initiative for their set of designated awardees or designated awardee conveners. And so that could include both the episode definition parameters, but it also can include aspects such as the quality measures that all of the designated awardees and awardee conveners would sign up for.

The care improvement model, we would like to see consistency among the group for that. And, of course, we will allow flexibility among the designated awardees and designated awardee conveners, but

we are looking for consistency in overarching model that includes the episode definition, the quality parameters and the care improvement plan.

PAMELA PELIZZARI: Thanks so much. So if the moderator can, if you could at least one person is saying they don't remember how to ask a question, so could you remind everyone on the phone how they would go about doing that?

OPERATOR: Of course ladies and gentlemen if you have a question, you can press star followed by one on your phone. And if you would like to withdraw your question, you can press star followed by two. You do have a question on the phone line when you're ready.

PAMELA PELIZZARI: Sure. Yes.

OPERATOR: The question comes from the line of William. Please proceed.

WILLIAM: Hi, this is William from Dartmouth and I've got actually two quick questions. One is could you clarify, you said you can't limit the beneficiaries, so we're talking about anyone with just Part A regardless of how they got there whether disability or age?

PAMELA PELIZZARI: So we said you can't limit the beneficiaries that initiate episodes in this program. And that's a very good question. So there are criteria in our RFA that define which beneficiaries will be initiated into this program. That includes things such as they have to be eligible for Part A and enrolled in Part B. They have to have at least one lifetime reserve day, they can't be an ESRD beneficiary, and there are about three more.

Those are in our request for application. And those would be overarching criteria that define which beneficiaries will be initiated into episodes and which will not, which ones are eligible to initiate episodes, and so that you can't limit it beyond those criteria other than through the things that we've discussed today by setting an anchor DRG, that being.

WILLIAM: So you couldn't, for instance, limit to a DRG for a particular diagnostic code?

PAMELA PELIZZARI: No, that's a question we actually just got from someone else as well that you cannot use sort of procedure codes within a DRG to adjust your price essentially or sort of affect which people will be in your bundle, in your episodes that you're defining. But as it states in the RFA, you can suggest a risk adjustment methodology in your application.

WILLIAM: Okay. And then finally are there capital requirements for the risk bearing?

PAMELA PELIZZARI: Can you explain a little bit more what you mean by capital requirements for risk bearing?

WILLIAM: Generally like if you're an insurer you would have some kind of reserve requirement for bearing risk, if you're taking on kind of an insurance role.

JEFF CLOUGH: We've initiated some language about sort of what's required if you're not a Medicare provider/supplier and you are applying as the risk bearing awardee or awardee convener. I believe we actually have a Frequently Asked Question on our website that probably has the most appropriate information, I'd prefer to direct you there rather than to give an off the cuff answer.

ELYSE PEGLER: And just to clarify this would apply for awardee conveners that are not Medicare provider/suppliers because single awardees are Medicare providers. But Jeff is correct in pointing you to the website where we have a Frequently Asked Question about the kinds of activities that organizations that are not Medicare provider/suppliers should be engaged in at this point and going forward around being able to... think separate.

WILLIAM: Great, thanks.

PAMELA PELIZZARI: And for anyone else who's wondering some of these same things, I think we would encourage you to directly any specific questions you have about your situation to our inbox at BundledPayments@cms.hhs.gov, recognizing that we don't necessarily have an answer that applies to sort of everyone in this scenario, but we welcome your questions or concerns through that forum. So do we have any other questions on the phone line at this time?

OPERATOR: We have no further questions on the phone at this time, no.

JEFF CLOUGH: We're just trying to look for any unique questions over the web.

PAMELA PELIZZARI: Okay. So it looks like we have a question regarding if an awardee, if an organization applies as an awardee convener for several acute care hospitals can each of the hospitals participate in different bundles or must they all participate in the same bundled payment scheme, essentially?

JEFF CLOUGH: So at the awardee convener level basically every episode initiating bundled payment participating organization must participate in all the episodes in that application. At the facilitator convener level you can define a set of episodes for the application but then each awardee, designated awardee can pick a subset.

PAMELA PELIZZARI: Thank you so much. So it looks like we have some follow up questions about our discussion of risk taking. And so I think we'd like to point out at this time, some people are asking if we need to check with their state insurance commission to make sure the state allows risk taking or whether we're going to override state laws. And I think that you should not at this point make an assumption that we are overriding state laws, but we would encourage you to engage both us and your state insurance commission if you're going to start having those discussions because we're well aware that that's an issue that people are concerned about and you're welcome to contact us with those concerns.

But at this point in the process you should not view that as something that we are expecting you to have done before you put in your application. But you also shouldn't be expecting that we will necessarily be able to waive or override state laws that exist, because we are still subject to those. Do we have any more questions on the phone line at this time?

OPERATOR: Ladies and gentlemen as a reminder that is star one if you'd like to ask a question. We do have a question on the phone line from the line of Charles.

CHARLES: For Models Two and Four is there any scenario where a physician group would receive the bundled payment for all care provided, and distribute it according to pre-arranged agreements with other providers, including the hospital?

JEFF CLOUGH: This is Jeff. So in Model Four which is where there's the bundled payment amount that's distributed that would go to the hospital. It wouldn't go to any other entity. In Model Two where you're receiving essentially the difference between your target price and the actual payments that occurred, again this is a retrospective reconciliation, that would go to the awardee, so that would go to the physician group if the physician group was the awardee and they could disperse that amount.

CHARLES: Thank you.

OPERATOR: You do have another question from the line of Dave.

DAVE: Hi, I was just curious have you guys defined a date when you might be rolling out Models Five through Eight? Thank you.

PAMELA PELIZZARI: So we don't a date that we can share in terms of when we'll be rolling Models Five through Eight at this time. I think our primary concern is taking Models One through Four into their operational phases and we'll keep you as updated as possible in terms of any developments we make in Models Five through Eight, but we really can't comment on those at this time. So on similar lines to that question, someone has asked what the expected duration of this program is and what the expected initiation date is for Bundled Payment Model Four specifically.

We can say that the duration of these programs as defined in the request for applications is slated to be three years with potential extension to five years and that we don't have currently an expected initiation date or an expected end date. We'll be working with you throughout the process to make sure that we are sort of setting achievable goals on all sides. Are there any other questions on the phone line at this time?

OPERATOR: There are no further questions on the phone lines at this time.

PAMELA PELIZZARI: Okay. So someone has asked for further clarification again on this issue if you're an awardee convener, specifically Model Three they're saying, can you not group two or three DRGs together under one target price that would be the same for all those DRGs?

MELISSA COHEN: So we're asking awardees, awardee conveners, all applicants to set their target prices at the anchor MS-DRG level. And if you want those three target prices to be the same based on historical episode payments you can do that, you can propose the same target price for all three.

JEFF CLOUGH: The discount amount would be applied to your, or the discount percentage would be applied to those DRGs. I mean, I suppose they could be different episodes if they're not closely related to MS-DRGs and you could have different discounts. But if they are related in that they are severity adjusted affiliates of one another then they would have to be part of the same episode and they would have to have the same discount I guess for historical episode payments...

MELISSA COHEN: Right, but the different target prices...

JEFF CLOUGH: So it would end up having a different target price because presumably the historical cost would be different for the MS-DRG.

PAMELA PELIZZARI: I think if you have any further questions on that issue if you could send them to our inbox. We're trying to be as clear as possible. We know that this is a very complex and detailed situation and so we're trying to meet everyone's needs here. Please feel free to email us at BundledPayments@cms.hhs.gov if you have a question that hasn't been answered.

On that note there are a couple logistical questions here that I think I can before we wrap this up since we're nearing that time. First of all, if you pending all this new information need to add some data analysts to your data use agreement you can still do that using the data use agreement signature addendum. That's available on our website and you just need to fill it out completely and email it to BundledPayments@cms.hhs.gov.

Someone has asked how long it takes to get a response from that email address. And please understand that we do have a significant email volume there and we're trying to deal with everyone's questions as quickly as possible, particularly given that we really do value your feedback and want to know as many of your thoughts as you care to share, so most people should get a response within about ten business days. If you don't get a response then you can feel free to email us back. But we assure you that likely that doesn't mean that we've forgotten you, more so it means that your question really made us think of it and we want to make sure that we get you as correct and complete of an answer as possible.

So I think at this time we're going to wrap up the webinar. We assure you that we're going to get these slides online as soon as we possibly can. A lot of you have been giving that feedback that you need these sort of right away. We understand that this is very complicated and we can see why you would. So we're working on that. We are. And there will also be an audio file and transcript so that you can look back and read anything or listen to anything that you forgot.

If you have any further questions that were not answered on this webinar, please email them to BundledPayments@cms.hhs.gov. We will not be reaching out you based on the questions that you asked on the chat that we didn't get to, so please email those to us and we'd be happy to answer them. Thank you so much and hopefully we'll hear from you all on our webinars starting next Tuesday.

OPERATOR: Ladies and gentlemen that does conclude today's conference. Thank you for your participation you may now disconnect and have a great day.

[END OF FILE]