

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

Application Guidance Webinar

Thursday, April 19, 2012, 12:00 pm - 1:30 pm ET

OPERATOR: Good day ladies and gentlemen, and welcome to the Bundled Payments for Care Improvement Application Guidance webinar, hosted by the Bundled Payments for Care Improvement team at the Center for Medicare and Medicaid Innovation. The full presentation, slides and audio are available via the web.

If you do not have computer speakers or prefer to listen via phone, please call the following number, 888-776-9631, Pass code 9100747. A few housekeeping items to remember before we get started. All participant lines are in listen-only mode throughout the presentation. You may access and download a PDF of the PowerPoint slides. You can find the document in the Chat window. It can also be found in the Documents folder in the bottom right of your screen at any time.

You may submit questions via the Chat feature at any time. Look below the slides, in the field next to Message to Moderators, and there, you may type in your question and hit send. Your question will only be visible to the moderators. As there will be many more questions than we will have time, we will be answering selected questions at the end of the event, following the conclusion of the slide presentation.

In addition, we will also ask that you take a few minutes to complete a survey before logging off today at the end. With that, I'll turn it over to Elyse Pegler with the Center for Medicare and Medicaid Innovation. Thank you.

ELYSE PEGLER: Thank you so much. Good morning and thank you for joining us today. My name is Elyse Pegler from the Patient Care Models Group here at the Center for Medicare and Medicaid Innovation. I would like to welcome you to the Bundled Payments for Care Improvement Team webinar.

Today, Sheila Hanley, Rachel Homer and myself, from the Bundled Payments team will be discussing our recently-posted application guidance document. We hope that this webinar and this document will assist you and support you as you prepare strong applications for the Bundled Payments for Care Improvement Initiative. We want thank you so much for partnering with the Innovation Center and with CMS, to help redesign care, improve quality and lower costs. We appreciate your leadership efforts to improve the health care delivery system in your own community, and your partnership lists CMS in developing and testing models of bundled payments that will redesign care, improve quality and lower costs. Now, I would like to turn it over to Rachel Homer.

RACHEL HOMER: Thank you, Elyse. The purpose of this webinar is to provide further guidance on what information should be included in strong bundled payment for care improvement applications. This webinar builds on a document that we have recently posted on our website. We strongly encourage everyone viewing this webinar and anyone applying to this initiative to review this document.

We'll be discussing key portions of that document today on this webinar. But we'd like to take this opportunity to remind everyone that we're only discussing small portions of this document today.

There's significantly more information available online, and we encourage everyone again to read this document.

The agenda for today, we will start by reviewing applicant roles, and then we will discuss key sections of the application guidance document, including guidance for facilitator-convener, guidance on care improvement and gain sharing, guidance on provider engagement, and guidance on the episode definition in Table C-1 section of the application, as well as guidance on the quality of care and patient-centeredness. Finally, we'll review upcoming webinars and key dates. With that, I'd like to turn it over to Elyse.

ELYSE PEGLER: Thank you so much. As we discussed in the applicant role webinar on March 8, 2012, just a couple of weeks ago, we have three types of applicants, and I will review those briefly, just to provide the context for the rest of the webinar.

As a Bundled Payment for Care Improvement applicant, you must apply as one of the following types of applicants: either as an awardee; an awardee-convener; or as a facilitator-convener who would be applying with designated awardees and/or designated awardee-convener.

This is another slide that was presented on the application role webinar, and we just want to review it again. There are two buckets of applicants, the risk-bearing applicants and the non-risk-bearing applicants. The type of applicant role that falls in the non-risk bearing category is the facilitator-convener, who would be applying with risk-bearing designated awardees and/or designated awardee-convener.

So in making the determination about what kind of applicant you would like to apply as, if you would like to not bear risk and facilitate other organizations, and those organizations would be the entities who would bear risk, then you would apply as a facilitator-convener. If you would like to apply as a risk-bearing entity, you can be either an awardee, where you would bear risk only for your own Bundled Payment beneficiaries. If you would like to bear risk for your own Bundled Payment beneficiary and/or your Episode-initiating Bundled Payment participating organization beneficiary, then you would be an awardee-convener.

We do ask that you refer to the applicant role webinar recording for more information about examples and the different—and more detail about the definitions of each of those roles.

RACHEL HOMER: Thank you, Elyse. I'd like to remind everyone that the full transcript and audio from the webinar that Elyse referenced is available on our website under the Learning Area tab. Now, I'd like to turn it over to Sheila Hanley, to begin discussing key sections of the application guidance document. Sheila will be discussing guidance for facilitator-convener.

SHEILA HANLEY: Hello. I'd like to start with the facilitator-convener role. Most of the questions in the facilitator-convener application focus on your overarching model, a framework for things like care management, care improvement intervention, clinical interventions and gainsharing arrangements that apply across the board to all of your designated awardee or awardee-convener.

However, we know there may be instances when the approach for a given individual designated awardee or awardee-convener will differ from the overarching approach. There are several questions in the application in Sections B, C and D for all models that will ask you to identify instances in which the overall response may not apply to all designated awardees or awardee-convener that are encompassed by your proposal.

In the application, you will see optional check boxes for these questions, and we are asking applicants to highlight one significant deviation from the overarching approach to a given clinical condition are expected for specific designated awardees or awardee-conveners.

As background, CMS values the role of a facilitator-convener and the consistency across multiple organizations that facilitator-conveners bring, and we generally expect proposed care redesign interventions for facilitator-conveners to be substantially consistent across designated awardee and awardee-conveners within a facilitator-convener application.

That said, we understand that the care redesigned interventions may vary by clinical conditions, and not all designated awardees or awardee conveners in a facilitator-convener application may be participating in each proposed episode. So what do we mean by a “significant variation”? For the purposes of this application, a significant deviation from the overall framework proposed is defined as the use of a fundamentally different approach or intervention, the absence of a core element of the overarching response, the application of the overarching approach to a fundamentally different population, a difference in the timing of an intervention or approach that is expected to impact the timing of results, or other differences you believe are relevant and merit discussion.

CMS wants to understand those deviations that represent a fundamental difference in approach, and that have the potential to impact the effectiveness of the intervention. Deviations could include the use of different metrics, assessment and measurement tools, a different time table for key components of a program, or for the entire program, significant differences in support requirements, and differences in projected results.

When there are significant deviations, we ask that the applicant present a strong rationale for this variation, and discuss how any operational changes will be addressed, as well as to indicate to which designated awardee or awardee-conveners these variations apply. I’m going to turn it back to Rachel Homer.

RACHEL HOMER: Thank you, Sheila. Now we will move on to discussing Section B, Model Design, regarding care improvement and gainsharing. The goal of the Bundled Payments for Care Improvement initiative is to promote better at lower cost by using episode-based care to support care redesign. In the care improvement section of the application, applicants should clearly articulate the comprehensive care improvement plan. Please note that other questions in the application ask applicants to build on the responses that you provide in this section.

For example, you will be asked in later questions how the gainsharing methodology supports the care improvement interventions, and you will be asked how the quality metrics you propose measure the care improvement interventions. As discussed, gainsharing and care improvement go hand in hand. Applicants in this initiative may propose to use gainsharing as a tool to align incentives to redesign care. Again, redesign care leading to better outcomes for beneficiaries is the end goal.

Because gainsharing is a tool to support that care redesign, gainsharing payments must be tied to actual changes in behavior, and/or increases in quality. I’d like to take a moment to define some of the terms that you’re hearing today, to ensure that we are speaking a common language. Applicants are expected to partner with other entities to redesign care. These partners fall into two large categories. The first is Bundled Payments participating organizations, or BPPOs. BPPOs are providers or supplier organizations with whom the applicant plans to partner, such as acute care hospitals, skilled nursing facilities, inpatient rehabilitation facilities or other kinds of facilities or organizations.

Episode-initiating Bundled Payment participating organizations are a subset of BPPOs. These are for awardee-conveners or designated awardee-conveners only. These are the subset of BPPOs who initiate episodes. In Models 2 and 4, episode-initiating BPPOs are hospitals. In Model 3, episode-initiating BPPOs are post-acute providers of the following types: skilled nursing facilities, inpatient rehabilitation facilities, home health agencies and long-term care hospitals.

The second category of partners are Bundled Payment participating practitioners, or BPPPs. These are physician and non-physician practitioners who are expected to participate, including those who may be separately paid by Medicare for their professional services, such as physicians, nurse practitioners, physician assistants or physical therapists.

Gainsharing is a distribution of gains accrued due to internal organizational cost savings during the episode of care, and distribution of gains received via episode reconciliation payments. Gainsharing arrangement contracts refer to the contracts among the entities who will share these gains. Enrolled BPPOs and enrolled BPPPs are the subset of BPPOs and BPPPs who are participating in the gainsharing arrangements, and who are party to gainsharing arrangement agreements.

Now we'd like to highlight three crucial questions in this section of the application. Again, the application guidance document contains more detailed information regarding what information we are looking for in strong applications for this initiative. In this webinar, we are discussing only key areas of this guidance document. However again, we would encourage everyone to review this entire document, as this webinar is not a comprehensive overview.

The first question in this gainsharing section that we'd like to discuss focuses on the methodology, capacity and contractual relationships of applicants, as well as the particular nuance relevant to Model 4. The second question that we would like to discuss focuses on how gainsharing supports care improvement, and the oversight of gainsharing payments.

The third question in this section that we would like to discuss focuses on the process and requirements for becoming an enrolled Bundled Payment participating organization, or enrolled Bundled Payment participating provider. We will now discuss each of these in more depth.

The first question is Question B-13 in the awardee application, B-14 in the awardee-convener application and B-15 in the facilitator-convener application. In response to this question, applicants should address the following issues: first, their methodology for allocating gains among all of the enrolled BPPOs and BPPPs; second, applicants should discuss their capacity to track internal costs, quality performance and changes in care that can be attributed to actions taken by Bundled Payment participating organizations and/or Bundled Payment participating practitioners.

This could include their health applicant's health information technology capabilities, or information-sharing arrangements between and among awardees, their BPPOs and their BPPPs. Third, in response to this question, applicants should discuss the contractual relationship governing these gainsharing payments. They should discuss who are signatories to the gainsharing arrangement contract, as well as, the relationships between the BPPPs and the organizations with which they are affiliated.

So for example, whether the BPPPs are employed or independent, and whether this changes the nature of the contracts and who the signatories to these contractual arrangements are. Finally, if you're applying for Model 4, in response this question, there is particular information that you should provide.

In Model 4, the participating hospital, whether an awardee or an Episode-initiating Bundled Payment participating organization, will receive a single bundled payment for each episode of care as payment in full; the hospital is then responsible to distributing payments to providers as appropriate. Physicians would therefore be directly paid by the hospital for their professional services.

This payment rate could be set at the same rate as the fee-for-service payments that would otherwise apply, or could be set at another rate as agreed to between the providers and the physicians and proposed by the applicants. Any physician payment in Model 4 that would be hired in the Medicare physician fee schedule payment that would otherwise apply, whether that be the hospital's base rate for physician services, or the base rate plus incentive payments, is considered gainsharing.

The second question we'd like to discuss is Question B-14 in the awardee application, B-15 in the awardee-convener application, and B-16 in the facilitator-convener application. In response to this question, applicants should address the following two issues. First, applicants should address what care redesign interventions gainsharing payments are associated with.

Second, applicants should address what entities are overseeing these gainsharing arrangements and the making of these payments. For example, what entities make decisions on who may become an enrolled BPPO or a BPPP, and what entities are making decisions on which enrolled BPPOs and BPPPs have met the gainsharing requirements, and are therefore able to receive gainsharing incentive payments.

The final question in this section that I would like to discuss at this time is Question B-15 in the awardee application, B-16 in the awardee-convener application, and B-17 in the facilitator-convener application. In response to this question, applicants should address the following two issues: first, applicants should address the process, including quality metrics and other criteria, to become an enrolled BPPO or BPPP, and second, applicants should address the gainsharing requirements, including the quality criteria, for an enrolled BPPP or BPPO to receive a gainsharing incentive payment.

Moving on to the next section in our presentation, I'd like to discuss Section B, Model Design/Provider Engagement. CMS is asking about BPPP engagement for a variety of reasons. CMS is interested in letters of agreement from Bundled Payment participating practitioners, to demonstrate physician and practitioner support and involvement in this initiative.

In addition, CMS has interested in understanding the applicant's plan to continue to build physician and practitioner buy-in after the application is submitted, if the applicant is selected as an awardee. Regarding letters of agreement, these letters are an opportunity to demonstrate commitment from Bundled Payment participating organizations and Bundled Payment participating practitioners, who will be engaging in care improvement, and from those who will be enrolled in gainsharing arrangements.

Again, not all BPPOs and BPPPs will necessarily be enrolled in gainsharing. We are interested in understanding of engagement of both of these type of participating practitioners and participating organizations. As we have mentioned several times, all eligible beneficiaries are included in the episode payment model. Therefore, physicians and non-physician practitioners are not able to opt out.

Therefore, when reviewing the application, it's crucial that we are able to gauge physician and practitioner buy-in. This is especially important in Model 4, where all physicians and practitioners, who could treat including beneficiaries, will be paid directly by the participating hospital.

We'd like to note that there is no required format to these letters. Applicants may create form letters and distribute these form letters to the BPOs and BPPPs, if they request, if they wish to do so. There is no minimum number of required letters. Applicants may seek letters from representative of large groups of physicians and practitioners, for example, from a chief medical officer.

And for bundled payments, participating practitioners who are or who will be enrolled in gainsharing arrangements, please note that these letters are not binding contracts. These practitioners may opt in or may opt out later, and the letters do not need to detail the terms of the gainsharing arrangement.

With that, I'd like to turn it back over to Elyse, to discuss Section B and Section C, Episode Definitions in Table C-1.

ELYSE PEGLER: Thank you so much. So now we'll talk a little bit about episode definitions. In Models 2 through 4, in all clinical conditions, we are seeking broad episode definitions. Therefore, we do hope to see relatively few proposed exclusions, and we've noted in our Frequently Asked Questions you must include the full MS-DRG family in your episode definition.

At a minimum, the MS-DRG family includes the duplicate or triplicate MS-DRGs without comorbidities and complications, with comorbidities and complications, and with major comorbidities and complications. However, depending on the clinical condition, there may be additional highly related MS-DRGs and their respective duplicates and triplicates that together would constitute an episode.

We are also seeking model designs that lend themselves to rapid scaling. Therefore, CMS may request changes from applicants to promote commonality around, among awardees. Regarding excluded services, in Models 2, 3 and 4, applicants may propose excluded readmissions to acute inpatient hospitals by MS-DRG. In Models 2 and 3, applicants may propose non-IPPS Part A and Part B services to propose to be excluded during the post-discharge period, using principal ICD-9 diagnosis codes. This could include, for example, excluded SNF services, excluded outpatient services.

It's important that we wanted to reiterate that there is a difference here between the way that applicants should exclude these services for Models 2 and 3 versus Model 4. In Model 4, all Part A and Part B services during an included readmission are included. All Part B and Part A services during an excluded readmission are excluded. It is not possible to propose any exclusion criteria by mechanisms other than these.

Moving on to a further discussion about model definitions and the target price; the episode parameters are to be defined in Section B of the application. That includes an anchor MS-DRGs, the length of the episode, proposed exclusions and the rate of discount. The target price is proposed in Section C of the application, and in the next two slides I'll discuss, there are some nuances among these areas between models and between applicant roles.

So in this slide, we're discussing a nuance for awardee-conveners that in Model 2 and Model 4 for awardee-conveners, the episode parameters may not vary by Episode-initiating Bundled Payment participating organization, but the target price will vary by Episode-initiating Bundled Payment participating organization.

For Model 3, the episode parameters and the target price will be set at the awardee-convener level. This is a really key point that we want to emphasize, that these may not vary by Episode-initiating Bundled Payment participating organizations. I'll just reiterate it again. The target price for Model 3 will

be set at the awardee-convener level, and not the Episode-initiating Bundled Payment participating organization level.

For Models 2, 3 and 4 facilitator-conveners, the same is true in that episode parameters are defined in Section B of the application. They are defined at the facilitator-convener level, and so the facilitator-convener would define the anchor MS-DRG, the length of the episode, the proposed exclusion and the rate of discount, and then the designated awardees and designated awardee-conveners may choose which episodes to participate in.

So if the facilitator-convener proposes two or three different episodes, the designated awardees and/or designated awardee-conveners may choose one, two or all three of those episodes to participate in. Those episode parameters, which are defined by the facilitator-convener, may not vary by designated awardee or designated awardee-convener, but the target price will vary by designated awardee and designated awardee-convener, and then within the designated awardee-conveners, the target price will vary by their Episode-initiating Bundled Payment participating organization.

This section of the application guidance document contains several additional technical details and clarifications regarding calculating your target price for bundled payment amounts, and we do encourage you to read this section of the document very closely.

And now I'd like to move to the next section of our agenda, which is the quality of care and patient-centeredness section. We would like to provide additional guidance about the quality metrics that applicants must propose to CMS that set of quality metrics that is used to measure quality in this initiative. We'd like to point out that CMS will synthesize these proposed metrics into a consistent set that may be used across many awardees.

These quality metrics are distinct from the gainsharing specific quality metrics, which enrolled bundled payment participating organizations and bundled payment physicians/practitioners must meet to receive gainsharing payments. That information is contained in the gainsharing section of the application guidance document.

We would also like to clarify that regarding the minimum quality standards, that awardees and their bundled payment purchasing organizations and bundled payment physicians/practitioners must maintain or approve their aggregate performance on hospital and patient quality reporting system measures, hospital outpatient quality reporting program measures, and physician quality reporting system measures.

RACHEL HOMER: Thank you, Elyse. At this time, we'd like to continue on and conclude, by reminding everyone of our upcoming webinars and key dates. To conclude, we'd like to once again thank everyone for the work you are doing to redesign care. The Innovation Center looks forward to receiving your applications and testing your approaches to redesigning care.

To review some key dates, as a reminder, the online application portal will be available the week of April 23, 2012. We will soon announce a technical assistance webinar to assist people in understanding how to access this online application portal, and most importantly, the applications for Models 2 to 4 are now due on June 28, 2012 by 5:00 pm, Eastern Time.

We'd also like to remind everyone all the resources available on our website. We would encourage you to review the application guidance document, which we have been discussing in our webinar today, as well

as the non-fillable PDF application. The online application portal will contain the actual application, but it will include the same questions that are available in the non-fillable PDF application.

We also have a document with technical clarifications for the non-fillable PDF application. This includes information such as the size of text boxes and whether attachments are permissible. We'll also have a Frequently Asked Question document available on our website, and if you have further questions after reviewing those documents and listening to this webinar, as well as recording from past webinars, we would invite you to email us at BundledPayments@cms.hhs.gov.

At this time, we'll begin answering your questions. I'd like to turn it over to Pamela.

PAMELA PELIZZARI: Hi. This is Pamela Pelizzari with the Center for Innovation, and we'd like to encourage you at this time to type in any questions you have into this Chat box. We'll be reading questions we've received and answering them in this format. If there are questions at the end of the webinar that you still have that haven't yet been answered, if you could please email those to your inboxes, as Rachel mentioned, and we'll get those answers to you as quickly as possible.

So the first question, just to make sure everyone's on the same page, is someone has asked us to please review again the definition of a BPPP.

RACHEL HOMER: Sure, this is Rachel. We'd be happy to answer that question, and this is on Slide 15, if you have a printout in front of you and you'd like to refer to it. A bundled payment, a physician or practitioner, are physicians and non-physician practitioners who are expected to participate in this initiative, including those who may be separately paid by Medicare for their professional services.

Please note that a subset of bundled payment physician practitioners will be enrolled bundled payment physician practitioners. Those are the BPPP who are participating in gainsharing arrangements.

PAMELA PELIZZARI: Thanks, Rachel. So the next question is can you please explain the difference between what's an unrelated DRG and what DRG exclusions are, and how each impacts the episode?

ELYSE PEGLER: Sure. I'd be happy to clarify that. So when we refer to unrelated MS-DRGs, we are really referring to excluded MS-DRGs for readmissions. We're using unrelated and excluded as the same term.

RACHEL HOMER: To build on that response, we've noted in the request for applications the types of services that applicants may propose to exclude from their episodes of care. We would encourage you to review our request for applications, as well as our application guidance document and Frequently Asked Questions document, to determine what types of exclusions are permissible in each of the four models.

PAMELA PELIZZARI: Thank you, Rachel and Elyse. So the next question is pertaining to the model for awardee-convenor. That is that a model for awardee-convenor has several hospitals, each having their own provider numbers. The questioner understands that each hospital must bid separately for a DRG-anchor episode that is treated at all of the hospitals, but with respect to gainsharing, do they use a common pool to identify and distribute cost savings according to standardized measures, values and rules, or is the gainsharing on the individual hospital level?

RACHEL HOMER: We would encourage you again to review that section of the application guidance document, and at this time we are not able to provide more specific guidance on sort of gainsharing

arrangements would be permissible. Rather, we would hope that you would describe in your application the exact details of your gainsharing arrangements.

So if you wish to pool these internal hospital cost savings together across your hospitals and then distribute them, please describe that in the mechanisms for that in detail in your application.

ELYSE PEGLER: And I would like to just clarify too that awardee-conveners that have multiple hospitals, would all be if it's an awardee-convener application, it would be included as one application, where the applicant would list the provider numbers for each of the hospitals. But that would be one application.

PAMELA PELIZZARI: Thanks very much, Rachel and Elyse. Here's another question. Rachel, if you could just clarify, if when and how and the slides and audio will be available for this webinar. We have a couple of people asking about that.

RACHEL HOMER: Sure. Within two weeks on our website, on the Learning area of our website, the slides, audio and transcript will be available. I'd like to point out that at this time; you are able to download only the slides. You can do that by going to the bottom right-hand corner of your screen and selecting the tab labeled 'Documents.' In that folder should be a PDF file that contains the slides.

PAMELA PELIZZARI: Thanks, very much Rachel. It seems like we have several more questions here. Here's one regarding the DRGs that you are being asked to exclude. Are the questions about which DRGs are being asked to exclude directed towards the hospital as a whole, or only specific departments?

So it seems like what this person is asking is if they're doing sort of a specific bundle and really they're involving certain parts of the hospital more than others? Do their DRG exclusions only apply to those parts of the hospital, or do they apply to everything that's going on at the hospital, even if it has to do with providers who aren't necessary directly involved in the specific services being bundled as part of this initiative?

RACHEL HOMER: This application is asking questions about the entire applicant organization. So if you are a hospital, you should respond on behalf of the entire hospital, even if you're only proposing episodes of care that relate to specific service lines or departments within your hospital.

PAMELA PELIZZARI: Here's another question. Aside from BPPPs, are applicant-awardees required to have BPPOs other than the awardee identified in the application, and as a part of the initiative? Basically, they're asking if their application can still be considered a strong application without engaging Bundled Payment participating organizations?

RACHEL HOMER: Sure. This is Rachel. Thank you for that question. We're interested in supporting care redesigns that improve the quality of care for beneficiaries throughout the entire course of an episode. So it's up to the applicant to determine which organizations, if any, they would need to partner with, to provide that improved care for the beneficiary across the entire course of the episode. We would encourage applicants to consider the other care settings that their beneficiaries might receive care in during their episodes.

However, it's again up to each individual applicant to make their own determination, based on what they understand about the care pathways for their beneficiary.

That means it's likely, again dependent on your applicant and your service lines and the nature of your network of care providers, but it's likely that for a strong application you would need to include other Bundled Payment participating organizations.

PAMELA PELIZZARI: Thanks very much, Rachel and Elyse. Someone says we're calling this a former, the application form that you may have previously looked at, had a 90-page limit. Someone is asking if there are limitations to the length of the responses, now that the application has moved to this online format.

ELYSE PEGLER: Sure. We can provide an answer to that. The online application format removes the issue of page limits. Each of the questions that has a text box will have a character limit for each of the text boxes of 4,000 characters. So we do believe that that will be sufficient to provide your responses.

PAMELA PELIZZARI: Thanks very much. Someone has asked about sort of episode definitions. Now we've discussed a little bit about what you can exclude from you episode definitions, and someone is asking a question regarding whether or not their application will be at risk for being rejected, if they exclude a lot of services, or if it's better to only exclude a few services.

ELYSE PEGLER: So as we've stated, we are expecting broad episode definitions, and we hope to see fewer exclusions. But of course, we welcome all kinds of proposals, and they will be reviewed during the course of our review process.

PAMELA PELIZZARI: Thanks very much, Elyse. Here's a question about quality metrics. We've described minimum quality metrics, many of which are hospital-based. Are there specific minimum quality metrics for Model 3 for post-acute providers that are different than those ones, or do you have any specific guidance about... [Audio cuts-off]

[Please note: Due to technical difficulties experienced during the live presentation, the audio recording cuts-off at approximately 0:40:30 to 0:42:25; audio will return at approximately 0:42:25. We apologize for the inconvenience.]

PAMELA PELIZZARI: ... [Audio returns] ...let me know, that would be very helpful... [Additional pause]

PAMELA PELIZZARI: Thanks, very much. So it seems like we had a little technical problem there, but people are indicating that it's fixed now, so please don't hesitate to let us know if you have that problem again, and thanks for letting us know so quickly. That was very helpful.

So here's a question about the letters of agreement. What are providers committing to in a letter of agreement that indicates their endorsement and engagement in the BPCI initiative?

RACHEL HOMER: So as we have noted, the letters of agreement from bundled payment participating physicians or practitioners are non-binding. These letters are an opportunity for the applicant to demonstrate that they have done significant engagement with their population of physicians and practitioners.

Letters of agreement from Bundled Payment participating organizations are meant to indicate that that organization understands they are participating in this initiative, and they are committed to partnering with the applicant to redesign care.

PAMELA PELIZZARI: Thanks very much, Rachel. Here's another question. Someone's asking if they provided an LOI or a letter of intent for both Models 2 and 4, can they be a facilitator-convener for both of those models, Model 2 with some of the providers and Model 4 with the balance of providers that were listed on their letter of intent?

ELYSE PEGLER: The answer to that is yes.

RACHEL HOMER: But it's worth pointing out that that would be a separate application. That facilitator-convener should submit one application for Model 2 and another facilitator-convener application for Model 4.

ELYSE PEGLER: And one of the questions that I think would be helpful to respond to is that....The question is whether an awardee-convener would need to submit more than one application, if the organization is looking at, for example, cardiac episodes and orthopedic episodes? The answer to that is that if you're looking at various episodes, those can fall under one application, and that is what we would expect.

PAMELA PELIZZARI: Great. Thanks very much, Elyse. Here's another question. Does the post-acute care episode into a SNF still require a three-day hospital stay, or can an applicant decide an episode by DRGs, even if that DRG's hospital stay is less than three days?

RACHEL HOMER: If applicants wish to request waivers of other Medicare rules and regulations, they are welcome to do so. There's a question in the application that allows the applicant to identify the waivers they are requesting, and explain why that waiver is essential to their episode design. It's worth noting that unless a waiver is explicitly requested and explicitly granted, all other standard Medicare fee-for-service regulations still apply.

PAMELA PELIZZARI: Thanks very much, Rachel. So here's another question. Can you confirm whether or not risk adjustment is allowed; is still allowed as indicated in the request for applications?

ELYSE PEGLER: Yes. We are still asking applicants to propose whether they are including risk adjustment in their methodology or not.

PAMELA PELIZZARI: Someone else has asked if the Q&A that we're currently doing will be available on the website? Rachel, could you let folks know how they can find information that we're discussing on the website?

RACHEL HOMER: Sure, and thank you for that question. The slides, transcript and audio of this entire webinar, including the Q & A, will be available on our website. If you go to the Bundled Payments for Care Improvement website and select the Learning area link on the bottom of the page, you'll find a listing of all of the webinars we have conducted for this initiative. If you select this webinar, that's where you'll find the slides, transcript and audio. Please also note that on our website is the application guidance document that we are talking about today, as well as a running list of Frequently Asked Questions and the non-fillable PDF of our application.

PAMELA PELIZZARI: Thank you, Rachel. Here's another question relating to all this discussion we're having about DRGs and exclusion criteria. Do we recommend including the DRGs related to what's being applied for in your application? Actually, this is sort of not—do you recommend, in terms of when you're

proposing a certain DRG, that we also propose DRGs related to that? I think this relates to the discussion we had of the severity family earlier. I think that Elyse can answer this one.

ELYSE PEGLER: Sure, and as we stated, yes, we do require that the, what we are calling the family of related MS-DRGs, all be included in the episodes, and that would include the, with complications, without complications, with major complications.

PAMELA PELIZZARI: Thanks very much. Here's another one. Can Model 4 be something that folks apply for as a retrospective model rather than a prospective model?

RACHEL HOMER: No. Model 4 in this initiative builds on the past acute care episode demonstration conducted by the Center for Medicare and Medicaid Services. Model 4 is a prospectively paid Bundled Payment model.

PAMELA PELIZZARI: Thanks, Rachel. Here's another one. Will CMS create standard episode definitions after receiving and reviewing the applications, that awardees will be expected to adhere to? Perhaps you can give some insight as to what we'll be doing there, what the process will be?

ELYSE PEGLER: Sure. As we've discussed a little bit today, we will be taking in all of the proposed episode definitions that the applicants are proposing to us, and we will be looking for commonalities, because in the end we are looking for a replicable, scalable program. So we will be considering all of the information that comes in, and then as an iterative process, we may request changes from applicants, again with the goal of promoting commonality and seeking designs that lend themselves to rapid scaling.

PAMELA PELIZZARI: Thanks very much. Here's a question about facilitator-conveners. Can a facilitator-convener complete one sub-proposal for two designated awardees in the same HRC, if all episodes in the discount will all be the same, or does a facilitator-convener need a separate sub-proposal for every designated awardee?

ELYSE PEGLER: I can answer that, sure. So the way that the facilitator-convener and designated awardee/designated awardee-convener application works, is that because the risk-bearing entity is the designated awardee and/or designated awardee-convener, that is the organization that, if accepted, CMS would engage in a partnership with.

So if that is the organization that would bear risk for the initiative and would hold an agreement with CMS, then we would need a separate sub-proposal for each of those organizations.

PAMELA PELIZZARI: Thank you, Elyse. Someone has asked if we have a target start date for this program.

RACHEL HOMER: At this time, we do not have further information available about target start dates or implementation time lines. However, I'd like to take this opportunity to remind applicants that as we have stated in our request for applications, CMS is interested in proposals that are able to be implemented on aggressive time lines.

PAMELA PELIZZARI: Thanks very much, Rachel. Someone has asked if their organization submitted a letter of intent, but did not submit a data use agreement or research request packet, if they're able to submit those documents now and receive data?

Unfortunately, the answer to that question is no. The data use agreement and research request documentation was due in November, and at this time, we're not accepting additional requests for data.

Someone else has asked in terms of the 4,000 character limit that we referred to earlier, does that include spaces or only text characters?

ELYSE PEGLER: That includes spaces.

PAMELA PELIZZARI: Okay, and can you shed some more light on the quality metric list and how that will be entered into the online portal? Will that be subject to that limit, or is it in a different format? I think some folks have asked the quality metric lists are rather long and they're wondering how those will be entered.

ELYSE PEGLER: That's a great question. They will be entered in as a table, and there will be a table as part of the application system. So it will not be a table that applicants would upload separately or attach. Applicants would be expected to enter the information directly into the table, and they will be able to add as many rows as they would like.

RACHEL HOMER: To build on that, tables do not have character limits.

ELYSE PEGLER: They actually have a 255 character limit.

PAMELA PELIZZARI: Is that for every cell?

ELYSE PEGLER: That's for every cell in the table.

PAMELA PELIZZARI: So it looks like for quality metrics, you should be all right. Can anyone speak to how or how often the Center for Innovation will be reconciling episodes?

RACHEL HOMER: Sure. Thank you for that question. The exact periodicity of those reconciliation payments is not yet available. However, we anticipate making that information available prior to signing agreements with the awardees who will be participating in this initiative. We understand the applicants' need for a regular reconciliation, and we hope to meet that need.

PAMELA PELIZZARI: Thank you very much. A few different folks have been asking if we're going to share data during the course of the program, and I think that that is a question that we would be willing to accept your feedback on at this time, so we're aware that some folks think that there might be a need for certain kinds of data to come to them, in order to administer the program once it's operational.

As you can see that there might not be a space for that on your application, but we would invite you to email us at BundledPayments@cms.hhs.gov, and if you could be as specific as possible, sort of letting us know what kind of data you might need, and why, that would be helpful for us, just to get a sense of sort of what the needs are of our constituents.

Here's a question. When someone is completing the online application, after they start, can they save it and go back later, or does it have to be completed all at once?

ELYSE PEGLER: I can answer that. Applicants will be able to start, save it, and go back later.

PAMELA PELIZZARI: Sure, thank you. So here's a question about how folks will be paid. Someone has asked if the reduced rate, I think they're referring to the discount they take as part of this program, apply for all the entities, including physicians, post-acute providers, or just the participating entities? If someone could perhaps describe the difference in how providers will be paid in Models 2, 3 and 4, I think that would be helpful.

RACHEL HOMER: Sure. Thank you for that question. This provides a good opportunity for us to clarify how payments are made in each of the different models. Model 2 and 3 in this initiative are retrospective payment models. In those situations, CMS and the awardee will agree ahead of time on the total target price. However, during the episode itself, Medicare will continue to pay all providers according to standard fee-for-service payment policies that would otherwise apply.

Therefore, there will be no discount taken out of those payments. At the end of the episode, in Models 2 and 3, CMS will engage in an episode reconciliation with the awardees.

At that point, if the total spending for all of the services during the episode exceeds the target price, which includes the discount, the awardee will be responsible for repaying to CMS any expenditures over that target price. If the total payments during the episode are below the target price, CMS will pay the difference to the awardee.

In Model 4, which is a prospective bundled payment, CMS will make a single bundled payment to the hospital participating, and that single bundled payment will include the discounts. That is, it will be at a discounted rate.

PAMELA PELIZZARI: Thank you, Rachel. That was very comprehensive. So here's a question about gainsharing. Someone was asking if their clinicians and other providers are employed, do they have to do gainsharing?

RACHEL HOMER: Thank you for that question. This is a good opportunity to clarify that gainsharing is never a required part of this initiative. If applicants wish to propose a gainsharing methodology, they are welcome to do so, and if they wish to include their employed physicians or their independent physicians, they are welcome to do so. But if applicants choose not to do so, that is perfectly acceptable.

PAMELA PELIZZARI: Thanks very much, Rachel. Someone has said that they didn't understand our answer about whether or not spaces are included in the 4,000 characters. We can say yes decisively. Spaces are included, so you should count your spaces when you're counting your characters.

Someone else has requested for us to comment on the difference between a price and proposed discount, sort of what folks are presenting in their application. Is it a discount or a price?

ELYSE PEGLER: So in Section B, where applicants propose their episode parameters, they will be expected to provide the discount percentage. In Section C in Models 2 and 3, where applicants will propose a target price, that will be a dollar amount that will include the percentage discount. In other words, the percentage discount will be taken off, and that is what will be represented as the target price.

PAMELA PELIZZARI: Thanks very much, Elyse. That's helpful. So someone else has asked if CMS is going to disseminate or publish any risk adjustment methodologies related to readmissions or other parts of this application.

ELYSE PEGLER: At this point, we're asking that applicants propose to us their risk adjustment methodologies.

PAMELA PELIZZARI: Thanks very much. Are there any character limits for the attachments in the applications?

ELYSE PEGLER: There are going to be just a few attachments in the application, the online application system, and there are no character limits required in the attachments. However, there is a size limitation in that, only documents that are five megabytes or less will be allowed to be uploaded to the system. But again, there are very few attachments.

PAMELA PELIZZARI: Thanks very much. Someone's asked for further clarification regarding that discussion we just had about how folks get paid under Models 2 and 3. So for instance, if a post-acute provider chooses not to participate, but they're in maybe a region where there's some Model 2 episodes going on, what role does that non-participating post-acute provider play?

Will the hospital maybe that's participating, where some of those patients may go to this non-participating post-acute provider, be responsible for losses, or is this non-participating provider in some way responsible for that?

RACHEL HOMER: Thank you for that question. Again, this is a good opportunity to clarify the basic payment model associated with this initiative. We would also encourage you to review the documents on our website, as the details vary slightly by model, and include a fair amount of detailed technical information. So we would encourage you to go back to the request for applications, for further information in response to this question.

In this initiative, the awardee or the episode-initiating bundled payment participating provider, and because this person is asking about Model 2, that would be a hospital, takes risk, takes financial risk for all of the care that their beneficiaries receive during the episode period. That means if a beneficiary is discharged from the participating hospital, and assigned an included DRG, the awardee would then take financial risks for all of the care that that beneficiary receives during the post-acute, post-discharge period.

If that beneficiary receives care from a post-acute provider, whether nearby or whether across the country, who isn't participating in this initiative, that doesn't change the fact that the awardee still bears financial risk for that care.

ELYSE PEGLER: And that the—and any of the post-acute providers are still paid as per usual, under fee-for-service Medicare.

RACHEL HOMER: Yes. Thank you for that clarification, Elyse. Providers who are not participating in this initiative do not bear risk for any beneficiaries associated with this initiative. It is always the awardee that bears full financial risk for their beneficiaries in this initiative.

PAMELA PELIZZARI: Thanks very much for that discussion. It looks like someone has asked if the target price they're proposing is specific to each DRG within a family, or are they proposing one price for the whole MS-DRG severity series?

ELYSE PEGLER: Thank you. That's a great question. Yes, the target price in Models 2 and 3 is specific to each MS-DRG within the family.

PAMELA PELIZZARI: Thanks Elyse, and sort of on a related note, after this target price is set for the MS-DRGs, what happens if Medicare changes the payment rate for that DRG during the life of the initiative?

RACHEL HOMER: So the target price, excuse me, the discount will remain constant over the performance years of this initiative, and will be indexed to the standard Medicare fee-for-service payment rules. So if the Medicare payment rates for the DRGs change, the discount rate will remain the same, but the target price would therefore change as the Medicare fee-for-service payment rates change.

PAMELA PELIZZARI: Thanks very much. Someone has asked if CMS is allowing an outlier exclusion? So in people's applications, can they, for instance, exclude beneficiaries if their care costs beyond a certain threshold?

I can answer that question. The answer is no. We're not allowing beneficiary exclusion such as that in the application. So those particularly expensive beneficiaries should be factored into your target price.

Let's see. Someone has asked in the applications, there's one field that's called 'Organization Type', and one that's called 'Type of Entities', and they don't understand which one, what the differences between those two things is.

ELYSE PEGLER: Sure. That will actually become clearer in the online application system, because there will be drop-down boxes for each of those. One will refer to whether an organization is a non-profit, for-profit, publicly traded or not, and the other organization type will refer to whether an organization is a acute care hospital, a long-term care hospital, an inpatient rehabilitation facility, a skilled nursing facility, etc.

PAMELA PELIZZARI: Thanks very much. So here's a question that I think would be useful for some folks to hear about. If CMS sees a significant change in costs for a certain service, for instance, post-acute costs, but it happens in 2009, because we know that you all are proposing your target prices based on 2009 data, what would happen? Is CMS going to change the target prices or negotiate them in some way to more appropriately reflect current costs?

ELYSE PEGLER: So yes. There will be a process, and this is stated in our documentation as well, that we will—I'm hesitant to say try, but we will create the target price in 2012 dollars.

PAMELA PELIZZARI: So I think that the important message is that we are thinking about and we are aware of sort of these nuanced payment changes that may have happened under this payment system since 2009. We're aware of them, and we do anticipate taking them into account when we're setting target prices.

However, we really don't want you to try and do that trending or that change in your application. We would just much prefer that your application, and in fact we are requiring that your application reflect the 2009 number.

If you have a particular concern, you think something very specific happened in your area with wage adjustments or something happened to a payment system that's really driving your costs, and you think they inaccurately reflect the reality of the situation; you can describe that in the question immediately following those tables.

But just do know that it's not just you, that we are taking that into account and are considering it. But we appreciate sort of the detailed-oriented nature of all the folks who are applying here.

So here's a question. In Model 4, if a patient is readmitted to a different hospital, one that is not participating, will the awardee have to pay them at their current Medicare rate, including IME and dish?

RACHEL HOMER: Thank you for that question. In Model 4, if a beneficiary is readmitted to a hospital that is not participating in this initiative, we do not expect the awardee to directly pay that hospital. That second hospital would be paid by Medicare, according to standard fee-for-service procedures, and then CMS would recoup those costs from the participating awardee hospital.

PAMELA PELIZZARI: So I think it's important to remember when you're setting your target price, it seems like what Rachel is saying that the awardee is still responsible for those costs.

So those should be included when you're setting your target price, but you shouldn't be concerned about sort of actually making payments from the awardee to that other hospital. You should factor it into your planning, though, that you will be responsible for that, from a financial perspective.

Someone has asked for further clarification on the question about attachments, that being which questions have attachments and can they attach as many attachments as they want, as long as each attachment is under the limit, or if the question allows an attachment, can they only have one?

ELYSE PEGLER: It's actually the latter, that if a question requires an attachment, they may only attach one attachment to the question that requires the attachment.

PAMELA PELIZZARI: Thanks, and what form can those attachments take? Can they be Excel tables or what can they look like?

ELYSE PEGLER: They can be Word, Excel, PDF. We've got a variety of options.

PAMELA PELIZZARI: Thanks so much. From a broader perspective, someone's asking for details about future models of this—so models beyond 1 through 4. Do you have any more information at this time about those models?

RACHEL HOMER: Thank you for that question. We really appreciate how engaged the applicant community in both the current bundled payment offerings and any potential future bundled payment offerings. So we really appreciate the engagement and excitement that we found in the stakeholder community around this payment model innovation.

At this time, the only models available are Models 1, 2, 3 and 4, as announced in this request for applications. We don't have any further information at this time about any potential future activities related to bundled payments. But again, we do appreciate your excitement, and please feel free to continue sending us your input and feedback on potential future bundled payment activities.

PAMELA PELIZZARI: Thanks very much, Rachel. Someone has asked us to speak specifically to something that is on page 15 of the application clarification document, and that refers to home health agency services specifically. They've asked how to deal with this problem, which is highlighted on page 15, that some of the services that may have been provided in the later months, in November and December, may not be reflected in the claims data that was distributed.

Could one of you just help folks out and say how they should deal with that home health potential problem?

RACHEL HOMER: Sure. I would like to just read from page 15 of the application guidance document:

‘In Models 2 and 3, we know that due to the time period of the claims data distributed in conjunction with this initiative, many of the claims for home health services, starting after November 1, 2009, are not in the files.’

‘As such, episodes of care, constructing for beneficiaries who may have received home health services beginning in November and December of 2009, may not include all relevant home health agency services rendered to those beneficiaries.’

‘The failure to include Medicare payment for home health agency services furnished during the episode of care could result in proposed target prices that do not include all services that were historically rendered to those beneficiaries.’

‘If there is a concern that this is a significant problem in constructing episodes for beneficiaries, please only include episodes of care that start on or after January 1, 2009, and end on or before October 21, 2009, when calculating target prices or bundled payment amounts. Please indicate this on the application in response to the question that asks about limitations to the data used to construct target prices or bundled payment amounts.’

PAMELA PELIZZARI: Thanks very much, Rachel. So hopefully folks will be able to sort of use that information to help them decide what to do there. Someone has asked, sort of in follow-on to that question, if they can use imputation techniques to determine a reasonable number of home health agency stays, and this goes back to my comment earlier.

We really—the answer is no, and we don’t want you to use mathematical or statistical or actuarial techniques to adjust the numbers you are entering into these tables.

We do understand that might be desirable specifically to those of you who have that capacity, that sort of you see this risk arrangement being concerning, and I think that this sort of all falls back on that. We understand. We’re aware of that this is the problem, and we would prefer that the numbers you give us reflect what’s in the data we’ve distributed, or whatever data you’re using, and not reflect sort of mathematical techniques to adjust what is reflected in the actual data.

Please do feel free to explain to us, and in that instance we would really like you to tell us what you did in that question after the financial table. Let us know if you decided to drop episodes that start at the end of the year or not. But we do think that we’d like to see sort of those numbers reflected in your data that you used.

Someone has asked on the application, there’s an episode number. Is this number something that you’re supposed to assign, or is it the number of the DRG? What does that mean, the episode number?

ELYSE PEGLER: Sure. I can clarify that. It is, will be assigned by the system, and it’s actually something that applicants do not need to worry about at all.

PAMELA PELIZZARI: Great. That makes it easy, doesn’t it? So I think that we have just a few more questions. Someone asked again for Model 3, if the initial episode—does the episode anchor have to have that three-day length for someone to initiate a Model 3 episode or not?

RACHEL HOMER: Sure. Thank you for this question and this is one that we received earlier as well. If you wish to request a waiver for any existing Medicare payment policy rules, you are welcome to do so. You should indicate this in your application, and you should explain why this waiver is essential to your model design.

Please note that unless a waiver is explicitly requested in the application and then explicitly granted from the awardee agreement, unless that occurs, all existing fee-for-service payment policies remain the same.

PAMELA PELIZZARI: Okay. I think we have time for just one more question. I think I see a good one, so if someone's applying for Model 3 as an awardee-convenor, and they have Episode-initiating Bundled Payment participating organizations that include both SNFs, skilled nursing facilities and home health agencies, are they supposed to set that target price for blended across those different settings as a Model 3 awardee-convenor?

ELYSE PEGLER: Yes. For Model 3, as an awardee-convenor, the target price would be a weighted average of the Episode-initiating Bundled Payment participating organization's historical payments, including—and the discount, with the discount applied to it.

PAMELA PELIZZARI: Thanks very much, Elyse. That's really helpful. So we hope that this has been a useful exercise for you folks, and we would encourage you, if you had your question that was not answered, to send it to our inbox at BundledPayments@cms.hhs.gov. At this time, I believe we do have a survey that we'd love for you to fill out. So I'll turn it back over to the host, to describe how to access that survey.

OPERATOR: Thank you. At this time, we would appreciate your feedback. Please take just a minute to complete a brief survey. As a reminder, the slides from today's webinar are available in a Documents folder, in the bottom right of your screen. Thank you for your attention today. This concludes the Bundled Payments for Care Improvement Application Guidance webinar.

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