Center for Medicare & Medicaid Innovation

Bundled Payments for Care Improvement Initiative
Model 3 Deep Dive

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ANDREW SHIN: Thank you very much, and thank you everyone for joining us. We're delighted to have you join us today for this exciting webinar. Today's webinar is part of an ongoing series of webinars designed to support providers in their redesign of care through bundled payments and participation in the Bundled Payments for Care Improvement Program. Over the next few weeks and months, we'll be offering a series of webinars to support your success in episode-based payments in the Bundled Payments for Care Improvement Initiative.

At the end of today's webinar, we'll provide a list of the upcoming webinars that can be found on our website, Innovation.cms.gov. So we designed this webinar in response to questions and requests we received from you for additional information and clarification specifically to Model 3 of the Bundled Payments for Care Improvement Initiative. Our staff and our leadership have been around the country, and we really heard from you about all the excitement related to all the models. But in particular Model 3 presents some unique opportunities that we'd love to go into a deeper dive today for.

So for the purpose of today's webinar, we will give – our intent is to give providers and particular post-acute providers an in-depth understanding of how Model 1 works – excuse me, Model 3 works, the services applicants will be at financial risk for, and then how the partnerships can mitigate these risks. Lastly, we'll review upcoming dates that we'd like you to be mindful of.

So moving over to the agenda, we're going to do a very brief overview of the Bundled Payments for Care Improvement Initiative before doing the Deeper Dive into Model 3. And then we plan to leave plenty of time for you to ask questions to the program's staff and presenters. Just as a reminder, questions may be submitted through the chat box feature on the webinar platform or telephonically. We will enable those features at the end of the slide presentation. Lastly, we'll review upcoming dates that we'd like you to be mindful of, and we'll of course have those on the website as well.

So at this time, I just want to do a brief introduction of the program team. The program team is a little larger than last -- for our last webinar, and it's important to know these people because they will be working with you in the coming weeks and months as we move forward towards the application date. And, of course, the program team is led by Valinda Rutledge who is Director of the Patient Care Models Group as well as Dr. Carol Bazell who's the Deputy Director of the Patient Care Models Group. Further, the program team is we have Lori Anderson, Dr. Jeff Clough, Jay Desai, Melissa Cohen, Sheila Handley, Rachel Homer, Elyse Pegler, Pamela Pelizzari and Elizabeth Troung.

This is so far –- I know it's a mouthful, but these people are all performing essential functions to really do the best job we can to provide as much technical assistance as well as all the other

information pertinent to you as we move closer to the application date. So at this time it is my pleasure to turn it over to Melissa Cohen. Take it away, Melissa.

MELISSA COHEN: Thank you, Andy. First off, I would just like to emphasize that the underlying mission of the Innovation Center is the three-part aim – better health for populations, better care for individuals and lower costs through improvement, and I'll talk a little more deeply about this in a minute. But first I just want to welcome you all and thank you for your presence here today.

The Letters of Intent for Models 2 through 4 of the Bundled Payments for Care Improvement Initiative closed just before Thanksgiving, and we were overjoyed with the response by providers across the country who want to partner with us to achieve the three-part aim. We – many of you on this webinar today are post-acute providers and their partners. We appreciate your leadership efforts to improve the health care delivery and care coordination in your own communities, and we look forward to receiving your applications for the Bundled Payments for Care Improvement Initiative.

For those of you applying to the Bundled Payments Initiative, we want to emphasize that the goal is to develop cost payment and delivery models that achieve the three-part aim. We are moving in this country from a volume-based to a value-based delivery system, and we no longer want to deliver care in silos.

The purpose of this program is to help redesign care delivery models across the continuum of care and not narrowly in a specific care setting. Therefore, we expect all applications for this initiative to show that commitment to the three-part aim. When we say better care, we want to see applications that demonstrate care quality such as evidence-based care coordination, patient safety, efficiency of service delivery, better care experience that demonstrates patient engagement and patient satisfaction and better utilization demonstrating the appropriateness of care. When we say better health, we want to see applications that demonstrate better health outcomes for our patients and our beneficiaries.

So before I pass it over to my colleague here, Rachel Homer, I just wanted to thank you all again for listening to this webinar and ask you all to apply for this initiative with applications that demonstrate your real commitment to achieving the three-part aim. Rachel?

RACHEL HOMER: Thank you, Melissa. As Melissa said, to achieve the goal of these initiatives, we actually have – the goal of this initiative, we actually have four different models, and I want to take a moment just to walk us through those very briefly.

Model 1 is inpatient focus. It's an opportunity to redesign care for the entire hospital. This model, we use an episode of care focused on the acute inpatient hospitalization and will include Part A inpatient hospital services for all MS-DRGs. It includes a discount on all DRGs that have stayed in over the three-year period.

Model 2 includes the inpatient hospital stay and care provided during the post-acute period following that inpatient stay. The applicant can propose the DRGs in a bundle and specify the length of that post-acute period. The applicant also proposes a discount to Medicare compared to historical payment rates for the services in that bundle.

Model 3 includes the post-acute period only. Applicants can propose an episode of care consisting of the post-acute care following an acute hospital stay. Applicants propose the conditions that will be included in the episode of care and the length of the episode which can be as short as 30 days after the episode begins or as long as the applicant wishes. Like Model 2, applicants for Model 3 will propose a target price that incorporates a discount on historical Medicare payments for that episode.

Models 1, 2 and 3 which I've just described are retrospective bundles meaning that Medicare will pay all providers using the regular fee for service payment system. After the episode, we must compare actual Medicare expenditures during the episode to the target price. If the actual expenditures exceed the target price, the awardee will repay the difference to Medicare. If the actual expenditures are less than the target price, Medicare will pay the difference to the awardee. Any gains arising from more efficient, more coordinated care including any payments from Medicare to the awardee for expenditures less than the target price may be shared among providers, physicians and other practitioners.

Model 4 is a little bit of a different payment model. Model 4 is built on the ACE demonstration. It includes hospital and physician services during only the acute inpatient hospital stay and related readmission. Applicants will propose the conditions that will be included in the episode of care as well as the included related readmissions. Applicants will also propose a price for that episode that includes a discount on expected Part A and Part B payments for all hospital facility and professional services during the episode. Model 4, however, is different than Models 1, 2 and 3 in that it's a prospectively bundled model where Medicare will set a single prospectively determined rate and pay that to the admitting hospital, and the hospital will then be responsible for distributing payment to providers as appropriate.

As you can see, applicants have great flexibility to propose the conditions that will be targeted, the length of the episode and the discount rate, the target price, the quality measures, the gain sharing methodology and other components of this initiative.

There are a variety of opportunities to partner in care redesign across the continuum of care in this initiative. This initiative creates the opportunity for post-acute providers to improve the way that care is delivered to patients by facilitating relationships and partnerships with physicians, hospitals and other post-acute providers across the entire continuum of care. These relationships create the building blocks of high quality, effective and less costly care including improved care transition, improved coordination of care, improved collaboration regarding best care practices, and improved efficiency and seamlessness of care again across the entire continuum of acute and post-acute care.

There are a variety of strategic and financial opportunities for post-acute providers in this initiative. The development of relationships with acute and post-acute providers within this initiative creates opportunities for post-acute providers to play a real leadership role in redesigning the post-acute care delivery model and the interface with their acute care partners. This initiative also provides the opportunity for post-acute providers to expand their financial stake in care redesign, to include efficiencies gained across again an entire continuum of care and to share in the savings achieved as a result of adopting more efficient and effective care processes across the continuum of care including providing only needed services, reducing readmissions, returning patients to the least intensive level of care that's most appropriate for that patient and post-acute care providers also have the opportunity in this initiative to position

themselves as attractive partners in a value-driven market and manage and enhance their referral networks.

For example, imagine that a skilled nursing facility has determined that its costs are higher than regional and national averages including longer lengths of stay and a higher number and intensity of services provided. Under current volume-based payment systems, post-acute providers have a disincentive to facilitate transition to less intensive alternatives even when there is a limited patient benefit from these more intensive services. Models 2 and 3, on the other hand, align the incentive of post-acute providers to the goal of improving the efficiency of care. Post-acute providers who participate in Model 2 and 3 may have the potential to share in gains from increasing efficiency including improvements in the appropriateness of care, reductions in length of stay, changes in intensity of services and reductions in the readmission rate.

Model 2 enlarges the financial stake for post-acute providers to the full episode of care –- that is, the acute inpatient stay and the post-acute period, increase opportunities to share in the gains of reducing readmission rates. Model 3, on the other hand, allows post-acute providers to take a leadership role in driving the redesign of post-acute care. Post-acute providers are rewarded in both models for better coordination of care across providers and to getting the patient safely home as soon as possible. Post-acute providers that improve the overall efficiency of care after discharge in both of these models will benefit strategically by becoming increasingly attractive clinical and business partners to acute-care providers.

There are several similarities between Models 2 and 3. Models 2 and 3 both address the current limitations in silo payment systems that reward volume at a given facility over coordination of patient care across multiple settings and facilities. Both Models 2 and 3 provide new financial incentives to coordinate care among acute and post-acute settings among the various different types of post-acute settings, and both Models 2 and 3 require new and stronger relationships among providers and organizations across the continuum of acute and post-acute care.

There are also several key differences between Models 2 and 3. In Model 2, the episode begins with the inpatient admission at a participating hospital for MS-DRG as proposed by the applicant. The applicant proposes the length of stay if there's a minimum length of 30 days following hospital discharge, and the applicant proposes the minimum discount rate. In Model 3, the episode begins with the initiation of care at a SNF, IRF, LTCH or home health agency, and that initiation of care must occur within 30 days of discharge from the hospital for an SM-DRG designated by the applicant. Note that in Model 3, unlike in Model 2, the services provided in the initial hospital stay are not included in the episode. The services provided after hospital discharge but prior to the beginning of the onset of care are also not included in the bundled payment. In Model 3, the applicant also proposes a minimum discount rate – I'm sorry, the applicant also proposes a discount rate. CMS has stated no minimum.

In Model 3, the applicant also proposes the length of stay. CMS has stated that the length of stay must be a minimum of 30 days following the initiation of the episode. In both Models 2 and 3, readmissions are included. The major different between Model 2 and 3 is the scope of the episode. As I stated, Model 3 does not include the hospital or physician services provided during the index acute inpatient hospital stay.

Model 3, as I said, also does not include any services which occurred prior to when the episode begins which is when the beneficiary initiates care with a participating SNF, IRF, LTCH or home health facility. Note that this episode in Model 3 includes beneficiaries discharged from any hospital with a specific DRG -- not just from a participating hospital.

Services that are included in Models 2 and 3. In Model 2, all Part A DRG-based payments for designated SM-DRGs, physician services, inpatient hospital readmissions, all post-acute care and other services during the episode are included. In other words, all Part A and B services note with the exception of hospice care. In Model 3, all Part A and B services provided during the episode are included including hospital physician services, all post-acute care and inpatient hospital readmissions and all post-acute care and inpatient hospital readmissions for the designated MS-DRGs. And again, this is with the exception of hospice services.

Note that CMS expects that all services provided by post-acute care providers as part of current fee-for-service and prospective payment services will continue to be provided as part of this initiative. SNFs, IRFs, LTCHs and home health agencies must continue to provide care to meet the comprehensive needs of the beneficiary as identified from their comprehensive residential patient assessment.

Applicants in both Models 2 and 3 have the opportunity to propose that some types of services can be excluded. These types of services are only unrelated Part A services such as certain unrelated hospital readmissions and some unrelated Part B services which are proposed by principal ICD-9 diagnosis codes. Note that the proposed exclusions must be justified clinically.

We want to highlight also that CMS has a strong bias toward inclusion. We would expect that most Part A and Part B services during the post-acute period would be included. An example of a possible exclusion might be accidental injury which is completely unrelated to the patient's condition prior to the injury.

We also want to highlight what physician services are included in the Model 3 bundle. Note that all physician services provided during the episode are included. Unless that physician service has been specifically identified and excluded, it must be identified by principal ICD-9 diagnosis code in the application. It must be proposed in the application and approved by CMS. Note that all physician services unless otherwise excluded are included in the episode regardless of whether the physician has a partnership relationship with the awardee.

I'd like to talk through who can apply in Model 3. There are several different types of provides who are eligible to submit an application. These include post-acute providers such as SNFs, IRFs, LTCHs and home health agencies, acute care hospitals, physician hospital organizations, physician practices and applicants who organize a group of partner providers under one application. These types of applicants are called conveners, and they can be many different types of providers. An example of a convener could include a health system or care company or an association of providers, for example, for SNF association or hospital association.

To walk through these different applicant types in a little bit more detail, the applicant type is determined by whether that applicant is taking risk and the kind of relationships that applicant has with its bundled payment participating organizations. Applicants can be either risk bearing or non-risk bearing applicants. They're the ones on the left side of this chart if you're looking at the slide. For risk-bearing applicants, there are two types: an awardee and awardee convener.

The awardee model is the standard model where the applicant is a single post-acute care provider, a SNF, IRF, LTCH or home health agency and the applicant would be a single awardee who takes financial and clinical risks for its patients.

The next type of risk-bearing awardee is an awardee convener. This is an entity that brings together other providers and assumes financial and clinical responsibility for all of the included beneficiaries and all of its bundled payment participating organizations.

The final type of applicant is non-risk bearing. This type of applicant is a facilitator convener. In this scenario, the facilitator convener submits a single application and in that application designates the awardees who would then be financially responsible for their beneficiaries. The facilitator convener would provide administrative and technical support to all the awardees it brings together under that one application.

To talk through the role of the convener a little bit more, conveners apply as organizers of care redesign submitting a single application on behalf of multiple organizations. As I mentioned, there are two different types of conveners. There's a facilitator convener who does not bear risk who supplies administrative and technical assistance for providers for the risk and the providers themselves are the risk bearing awardees. Applications from facilitator conveners must clearly identify the risk-bearing awardee or awardees.

On the other hand, we have awardee conveners. These conveners assume financial responsibility for all patients for each bundled payment participating organization included in the application. Awardee conveners may be a provider or they may not be a provider. They do not have to be an enrolled Medicare provider. It might be a provider association or a hospital system or parent company.

They must specify in the application the financial arrangements with the participating providers that allow the convener to bear that risk to make payments to providers in Medicare as appropriate. To walk through several examples of the different kinds of awardees, the first example in Model 3 is a risk-bearing awardee. For example, a SNF might apply as a risk-bearing awardee. The SNF assumes risk for all services provided within the episode. This includes services provided directly by the SNF and those delivered by other providers during that episode such as Part A and B services, i.e., physician services, DME services, services provided by another post-acute provider and related acute readmissions.

The SNF may establish working relationships with physicians and other providers including other post-acute providers and needed to enable the coordination and redesign of care across the continuum. Only services delivered by that SNF initiated within 30 days of discharge from an acute inpatient hospital stay can initiate that episode. In other words, the episode only begins once the beneficiary seeks services from that participating SNF.

There are no requirements that the relationship among providers be within the same organization as the awardee. That is, the SNF is able to partner with other organizations that may not be owned by the same company. To walk through an example of a risk-bearing awardee convener in Model 3, a SNF could apply as a risk-bearing convener. The awardee convener would assume risk for all services provided within the episode for all patients from each of the bundled payment participating organizations listed on the application. That includes related services provided by the awardee convener if the convener is a provider themselves,

other bundled payment participating organizations who are providers, physician services, non-participating post-acute care providers, and other related Part A and B services. The convener would establish the partnerships and other collaborative relationships as needed to coordinate and redesign care across the care continuum. And again, there are no restrictions that the bundled payment participating organizations be part of the same organization as the awardee convener.

An example of a Model 3 facilitator convener is a post-acute provider association applying as a facilitator convener. This facilitator convener would supply administrative and technical support for several post-acute care providers. Each post-acute care provider listed on the application would assume financial risk for episodes initiated by services provided to their own patients.

Support provided by the facilitator convener to risk bearing awardees to facilitate this care redesign may include data and analytic support, learning activities and learning collaborative to share best practices, internal communication and diffusion of best practices across its participants.

I'd like to talk through how a Model 3 episode is initiated because it's a little different in Model 3 than it is in the other models in this initiative. In the scenario where a risk-bearing awardee is the awardee, so that is a SNF, IRF, LTCH or an HHA is the awardee. The episode initiates when the beneficiary seeks care from the awardee's facility or agency. That must happen within 30 days of discharge from an acute-care hospital for a designated DRG.

If the awardee is a convener, the episode initiates when the beneficiary seeks care from a participating SNF, IRF, LTCH or home health agency. Again, that must occur within 30 days of discharge from an acute inpatient hospital for selected MS-DRGs. To talk through what we are looking for in all applications regardless of who the applicant is, we're looking for strong beneficiary protection, comprehensive quality assurance and quality improvement strategies and a clear gain sharing methodology that rewards improved care, episode definitions that are inclusive and include broad categories of conditions. Note that no minimum number of beneficiaries is required to participate. However, preference will be given to efforts that redesign care touching a large number of beneficiaries.

Note that CMS has not set a minimum required discount in Model 3. However, we will give preference to applicants that offer highly competitive discount rates while ensuring a high quality of care. And finally, to refer back to what Melissa said in the introduction, mere interest in understanding how this bundle payment model supports care redesign toward the three-part aim.

Now if you are a post-acute provider, there are several ways you can participate in this initiative. Post-acute providers may submit an application for Model 2, for Model 3 if they're represented on an LOI that was already submitted for this program. Note that in Model 3 risk-bearing awardees assume responsibility – risk-bearing awardees in Model 3 that assume responsibility for all patients will need to develop partnerships with other providers who may be caring for these patients, and these applicants will need to develop those partnerships prior to submitting an application. We look forward to seeing on the applications the list of partnering providers.

Post-acute providers who do not submit an LOI may develop and enter into partnership relationships with an applicant who is willing to assume financial risk for all participating patients. Again, those partnerships must be formed prior to submitting an application.

Post-acute providers may also establish relationships with hospitals participating in Model 1 and Model 4 in order to improve care coordination transitions and reduce avoidable readmission.

How will awardees in Model 3 be rated? Risk-bearing applicants will propose a discount target price and an absolute definition for each MS-DRG. Applicants and CMS will determine the final target price after reviewing the applications. In this model, there is no change in the payment method during the episode itself. Medicare will continue to pay all Part A and Part B providers for certain patients identified as participating in this initiative using the current fee for service payment system. Again, in Model 3 during the episode of care itself, all payment will continue as it currently does under standard fee for service payment systems.

After the episode ends, extended -- CMS will compare expenditures for the episode to the target price. If the actual expenditures exceed the target price, the awardee will pay the difference to Medicare. If the actual expenditures are less than the target price, Medicare will pay that difference to the awardee.

How can Model 3 participants share in gains? Gains arriving from care improvements in this model including any payments from Medicare for expenditures that are lower than the target price may be shared among post-acute providers, physicians, other practitioners and other providers. Model 3 awardees must have established partnerships with physicians and post-acute providers to share gains, and they must detail that methodology in the application.

How will CMS monitor quality of care during this initiative? It's important to note that it's crucial that awardees may not restrict access to necessary care. CMS will routinely analyze data on utilization and referral cards and monitor and evaluate the care provided by participants in this initiative to beneficiaries. Note that all awardees will be required to comply fully with CMS and its contractors' request for information including tracking and reporting performance measures and operational metrics, cost-saving information, incentive payments, clinical quality and patient experience of care so that CMS is able to fully and appropriately monitor the quality of care provided in this initiative.

Some applicants have asked if I partner with a risk-bearing awardee convener, will I lose my ability to make independent care decisions. We view really the crucial question here as providing the best care to the beneficiary in all applicants whether they're participating in an awardee convener relationship, whether they're providing on their own or whether they themselves are a convener bringing together other providers to be focused on that goal of providing the best care to the beneficiary.

All bundled payments for care improvement participants must be committed to increasing coordination with other providers involved in that patient's care, and this increased care coordination will foster best care practices and better patient outcomes.

Can awardees encourage referral of patients to participating post-acute providers? Yes. We expect awardees to explain the potential benefits to patients with certain care pathways and to disclose that the awardee is participating in this initiative. However, please note that the right of

beneficiaries to choose a different provider must always be preserved. Nothing in this initiative changes a beneficiary's right to choose their provider.

How does this initiative interact with other health reform initiatives? It's important to note that this initiative is not a shared savings program. We are of the belief that by providing incentives for care redesign and collaboration, this initiative provides synergy with other delivery system reform initiatives such as ACOs, partnerships for patients, value-based purchasing and community care-based transition. Note that policies, copies and/or rewards related to readmissions, hospital required conditions, and value-based purchasing programs are unchanged and continue to apply as appropriate to participants in this initiative.

And also please note that Bundled Payments for Care Improvement applications may be reviewed in light of participation in multiple programs to avoid counting savings twice in programs that may be interacting to ensure we make a valid evaluation.

CMS does encourage entities to participate in both this initiative and other initiatives including shared-savings initiatives. We believe that this initiative can be viewed as a tool for ACOs and medical homes to transform their organizations. The alignment and partnerships that this initiative builds between physicians and hospitals and between acute and post-acute providers could ultimately support organizations as they attempt to develop or they continue to develop their ACO models. Similarly, this initiative can be used in concert with other CMS initiatives such as the partnership for patients to improve outcomes in patient safety. Again, the alignment and incentive between doctor, hospital and post-acute care providers in this initiative provides a tool towards applicants in meeting their partnership for patients goal while decreasing hospital-acquired conditions by 40 percent and reducing readmissions by 20 percent by 2013.

We also believe that this initiative gives providers the opportunity to anticipate changes in Medicare payments in the future. This initiative provides an opportunity to realign care through bundled payment and focus on care transitions and quality improvement. This may give organizations additional tools when they're focusing on how to get ahead of new value-based purchasing, electronic health records and hospital readmission reduction program requirements.

The ability to incentivize care coordination across multiple provider settings is an invaluable resource and we believe an invaluable resource to participants in this initiative as we all work together to transform our health care system.

In conclusion, the Innovation Center is looking forward to receiving your applications and testing your approaches to redesigning care across the continuum especially for post-acute services. Note that the Innovation Center offers ongoing learning activities to support the success of applicants as you prepare submissions and throughout this implementation process.

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 about your tremendous interest in this initiative, and we are excited about partnering with you to redesign care. We look forward to receiving your applications, and we are here to assist with your questions. We have left additional time today for questions, and I'd like to turn it over to Pamela Pelizzari to begin the Q&A portion of this seminar.

PAMELA PELIZZARI: Hi. This is Pamela Pelizzari. I'm another member of the program team. Before we start on questions, I just want to give you an update on some of the upcoming sessions that we'll be having. So starting next week, we're having a series of data related webinars. So these sessions will be an hour and 15 minutes each, and they'll be on Monday, Wednesday, Thursday and Friday of next week starting on the 13th at 1:30 p.m.

More information on how you sign into these webinars will be sent out to the listserv and posted on our website. There's no need to register. So just wait on receiving that information. We'll send it out likely today and post it on our website.

We also have – and those four data webinars are targeted towards people who are going to be working with the data sets that are provided as part of this initiative. So those will be most useful for data analysts and anyone who's going to be working on your data analysis for your organization or anyone who's interested in learning more about the data.

We'd also ask you to stay tuned to our website for information about the accelerated development learning sessions number two and three that are coming up. The first number two is next Tuesday the 14th called Transform Care Today: Strategies and Tactics Across the Continuum, and number three will be on Tuesday, February 21st. So stay tuned for updates on those.

At this time, I think we'll have the moderator read the instructions to let you know how you can ask questions verbally. But just so you know, we'll also be taking questions via the chat. So I'll turn it over to Rachel to read those instructions.

MODERATOR: Thank you. The floor is now open for questions. If you have a question, please press star one on your telephone keypad at this time. Questions will be taken in order they are received. If at any time your question has been answered, you can remove yourself from the queue by pressing one. If you are using a speaker phone, we ask that while posing your question, you pick up your handset to provide favorable sound quality. Again, ladies and gentlemen, if you do have a question or comment, please press star one on your telephone keypad at this time. Please hold while we hold for questions.

The first question comes from Kathleen. Ma'am, please state your question.

KATHLEEN: Yes, Hi. My question is around the true up. You mentioned with the – after the episode completes, there's some analysis comparing the target to the expenditures that were spent on the episode. Is that an episodic true up, or is that done once a year for the organization?

JEFF CLOUGH: Sure. This is Jeff Clough, one of the program key members. So we haven't actually specified exactly how frequently that will be done. But we do recognize the industry's need to have that done on a frequent and timely basis. We're going to make our best efforts to make it as frequent and timely as possible, and obviously you'll have more information about that before we enter into an agreement.

KATHLEEN: Okay, thank you.

PAMELA PELIZZARI: Thank you so much for that question, Kathleen, and this is Pamela again. I just want to reiterate and I apologize for not saying this earlier. So they're going to identify

callers by their first name only. We would ask if your question is specific to the model that you're thinking of applying for, you let us know what kind of applicant you are and what model you're thinking of applying for. If you're comfortable, we ask that you not identify the specific organization that you work with just so that everyone can stay exactly as anonymous as they'd like to in this process.

We're getting a repeated question on the chat regarding how you can see these slides or listen to the presentations in the future. So I just want to address that proactively. The slides here will be available online, and you'll find the link on our website in about a week. So it might be there earlier. But if you don't see it, if you could wait about a week to contact us; we are putting up both the slide deck and the audio from this presentation as well as a transcript of the audio. So those will all be available to you. But it just takes a few days sometimes for us to that up.

Is there another question in the queue?

MODERATOR: We have a question from Lonnie.

LONNIE: Yes, hello. Thank you for a most interesting presentation. My question is that both the key providers generally do not – by the way, we're bidding on Model 3. Both the key providers do not generally have a lot of experience in risk taking. And since this particular model has – you cannot restrict the choice of Medicare beneficiaries to go to any participating provider and cannot have a stop-loss arrangement, et cetera, what top three risk management techniques do you think work in this type of an environment based on CMS's past experiences with bundling?

JEFF CLOUGH: This is Jeff Clough again. I'll try to answer that question. You know, we don't have a formal answer for sort of how to manage that risk. You know, obviously, it comes down to careful analytics, you know, really thinking about what your care redesign model is, really targeting opportunities where you seize your benefit. Certainly, as we enter the stage of final agreements, there'll be terms and conditions around, you know, if you're not doing well, there are ways to get out of the program. But ultimately, you know, it really is up to providers and their partners to manage that risk.

PAMELA PELIZZARI: Thank you for that question. I'll answer a couple more from the chat. One question that we've gotten again is that on the slide it was clear that hospice was excluded from Model 2, but some of you were unsure if it was excluded from Model 3, and we can say that hospice services are not included in Model 3 bundles. Those are the excluded services. Is there another question in the queue?

MODERATOR: I have another. The question comes from Wes. Please state your question.

WES: Yes, thank you. We're an acute care hospital, and I wanted to know if we would have the ability to waive the three-day qualifying stays so that we would not be affected and lose the transfer payment. And if this is the case, would it apply to all skilled nursing facilities that our patients go to, or do we have the ability to pick out certain ones?

PAMELA PELIZZARI: Thank you for asking. That is a great question. And we would encourage you, if you feel that that's an important part of your care redesign strategy, to include that in your application and request that waiver. We will be considering all waivers that are requested in the applications. But we can't make a determination at this time as to exactly how that would

work in your setting. But again our end goal really is care redesign. And so if you think that's an important part of your strategy, then we would love to hear sort of how you're going to use that tool.

WES: And if I could just ask one more along that same line. Would we have the ability to waive co-pays and administrative leave? Would that option be open only to bundle participant organizations, or would that be available to providers at all parts of the episode?

PAMELA PELIZZARI: So that's another good question, and it has quite a similar answer. We would ask that you include the request for those kind of waivers in your application. And it's important to note that while former demonstration projects at CMS have included things like beneficiary cost sharing. This one does not. And so we'd be interested in hearing sort of other ways that you're hoping to invent beneficiaries. But it's very important to us that beneficiary choice is maintained and that beneficiaries aren't confused about this program. So we'd really want to hear the details of what you're thinking of doing in your particular setting.

WES: So it's an option, but it's obviously different from, say, the ACE demonstration project where both beneficiaries get to get a piece of the savings.

PAMELA PELIZZARI: Now that is a significant difference between the ACE. There's no built-in sort of beneficiary cost share opportunity. But you can propose what waivers you would need to do whatever you're hoping to do within your application.

WES: Okay. Thank you very much.

PAMELA PELIZZARI: You're welcome. Thank you for asking. So we have a question about –- through the chat has come in about a SNF. So the SNF is an awardee and have a home health agency as a participating provider, does the episode start only when the SNF day occurs, or could it also start as the beneficiary begins acute care at that participating home health provider. So that's an interesting question, and it does depend on how you apply. So if the SNF is an awardee and it's not a risk-bearing convener like Rachel discussed in the presentation. If the SNF is the awardee alone, then the SNF is the only entity that would initiate the episode. However, if the SNF is an awardee-convener and has that home health agency as an episode-initiating participating organization, then those episodes would start in either setting.

Is there another question in the queue for?

MODERATOR: No ma'am, you have no questions. So, again, ladies and gentlemen, if you would like to pose a question via your phone, please press star one at this time.

PAMELA PELIZZARI: Well, luckily for us, we have lots of questions in the chat here. So we'll just keep going through that. Someone has asked who designs what unrelated services are. So that's a good question, and I think Rachel outlined it in the webinar. But that is something that you would propose in your application. So you can decide what unrelated services are both Part A at the MS-DRG level and Part B at the ICD-9 level. And so that's something that you would be including in your application.

Here's another chat question. Is the discount rate a target deduction based on the applicant's historical average cost, or is it supposed to be based on the entire partnership group in the

application or an average across the geographic region in the HRC? I'm going to turn that one over to my colleague Jeff.

JEFF CLOUGH: Sure. So I think it's very helpful to sort of list how the awardee and awardee convener models work. So it basically is at based on the specific provider. So if you're a single awardee, it would be obviously just that provider. If you're an awardee-convener, there would be a separate target price for the historical average cost for both the awardee and each one of its partners that are the types of partners that can bring patients into the initiative. So, for instance, a group on an application wants to know if a convener with several skilled nursing facilities, each skilled nursing facility would have their own target price.

PAMELA PELIZZARI: Thanks, Jeff. So, here's another question in the chat queue. What are the specific requirements around patient choice? I'm going to turn that one back over to Rachel.

RACHEL HOMER: Sure. Thank you for your question on that. We want to reiterate that patient choice is a central aspect of this program. Nothing in this program can in any way change or limit patient choice. So, as Pamela mentioned, applicants that are interested in asking for waivers for co-pays or other similar policies, you would need to detail very specifically how they would maintain patient choice. And we actually ask in the application for the applicant's proposal for how they will maintain patient choice, how they will engage their beneficiaries, how they will educate their beneficiaries about this initiative, and, again, how they will make sure that patients always understand that they have the choice to choose the provider that they wish.

PAMELA PELIZZARI: Thanks so much, Rachel. Here's another question that's come in, and I'll restate it a little bit. But if a patient in episode chooses to receive services given, as Rachel said, that patient choice is very important, if a patient prefers to receive services outside of the partnership that's participating in the initiative, are the cost of those services applicable to the awardee who's bearing the risk. I can answer that one. The answer is yes. So patients are allowed to receive their services in whatever setting they choose. We would anticipate that if you're participating in an SNF and implementing your care redesign tools that you would have a natural incentive for patients to go to your facilities because they would be having better outcomes, there would be higher patient satisfaction. That's what we would hope for.

If some beneficiaries choose to go outside of the network, however, those costs would be counted against your target price. We anticipate that you would see this when you're doing your data analysis and setting your target price respectively. So when you're looking at that data, you can see sort of how many of your patients choose to go out of the network that you're working with. That might make you want to say invite additional providers to join the network so you could all work together. But regardless of whether you choose to go that route or not, those costs should be built into your target price.

So unless sort of more people choose to go out of network than did before, you shouldn't see negative financial incentives there. Are there any more questions on the phone line?

MODERATOR: The next question you have comes from Paul.

PAUL: Yes, can – if you're an awardee that is taking risk, can you ask your other participating organizations to share losses as well as gains with you – completely share risk, or is it only gain share?

PAMELA PELIZZARI: Thanks for that question. I'm going to turn that over to Rachel.

RACHEL HOMER: Sure. Thank you for your question. You are welcome to propose a methodology to transmit risk to your partners as you wish. However, note that the awardee is still on – in the opinion of Medicare, the awardee will be the one who has an agreement with Medicare and will be at full financial risk from Medicare's perspective.

If on your end you choose to transmit that risk through contractual arrangements with your partners, you're welcome to do so.

PAMELA PELIZZARI: Thanks for that question. Do we have another question on the phone line?

MODERATOR: Your next question comes from Syid. Please state your question.

SYID: Hi. I'm a privately owned home health care entity from Michigan and would like to know how would we participate in this Model 3 model of bundled payments?

PAMELA PELIZZARI: So what kind of organization? I apologize. I –

SYID: Home health care private agency.

JEFF CLOUGH: So this is Jeff. I mean a home health care agency, you can apply for Model 3 either as a single awardee or you could apply with partners for the other models. You know, you be the right type of applicant for this model.

SYID: But you made it known that in our referrals that are coming from the hospital or the nursing home, if they have their own agencies, then why would they pick us to be part of them?

JEFF CLOUGH: Well, you want to reiterate that you would be, you know, the patients would not be assigned into the program based on the specific hospital they came from. They would be the patients that came to your agency. So – and again, you're welcome to partner with as many hospitals or providers that you like, and at the end of the day we'd hope that, you know, you'd be providing better care through this initiative and that would generate stronger partnerships.

MODERATOR: I think you have another question. Do you wish to take it from the phone or go to the web chat?

PAMELA PELIZZARI: So we have – we still have lots more chat questions. Here's one. On Model 3, if you're in an area where an LTCH doesn't exist, is it okay to participate in Model 3 without the partnership of an LTCH? I'll turn that one over to Rachel.

RACHEL HOMER: Sure. Thank you for your question, and that's a good question. We want to be clear that if you are of an entity that's eligible for being an awardee in this initiative so that an awardee convener or a provider that is a SNF, IRF, LTCH or home health agency, you are welcome to apply without any of those partners. You are not required to partner with all four of those types or even any of those types.

We encourage you to look at your beneficiaries and understand their care patterns and the places from which they are likely to receive care, and then partner with those organizations. And

if you're in a region where there is not an LTCH, then of course your beneficiaries would not be likely to receive care from an LTCH. So there's no need for you to partner with them.

PAMELA PELIZZARI: Thanks so much for that question. So here's another one. When formulating a target price, what is the base year that should be used? I think that Jeff can answer this question.

JEFF CLOUGH: Sure. In the application, you'll be able to input your target price in essentially calendar year 2009 dollars. Now we recognize that that's obviously not going to be a fixed price that you would want to propose during the years of the demonstration, and what will happen is we will basically take your episode definition and the good target you propose, and we'll be able to transform a new target price that we'll agree upon for the purposes of the demonstration or the program.

PAMELA PELIZZARI: Thanks so much, Jeff. So I think we can take another one that's in the phone queue.

MODERATOR: Your next question comes from Wes.

WES: Hi. Thanks for taking another question. This is going to be a two-part question. Again, acute care facility, if I submitted an LOI with a SNF as a participating organization, is that by definition make me an awardee convener? Second part of the question is if on that LOI we've applied or we will apply in the application for one DRG, that DRG presumably we would need to include on all our application – Model 2 application, then my question is what would the SNF need to do on their application for Model 3? Do they need to do anything, or do they just ride along on the Model 2? So if you could answer both of those that would be helpful.

PAMELA PELIZZARI: Thank you for asking. So I just wanted to get some clarification. If you're looking to apply for a Model 2 bundle along with a SNF, Model 2 does cover both acute and post-acute care. So they all seem to do sort of that same DRG, that would be one bundle and the SNF wouldn't need to apply separately, and they wouldn't need to apply for Model 3 if they're hoping to cover those same patients in that post-acute period. Is that what you're referring to?

WES: That's what I'm referring to. But then the other part of the question is does that Model 2 structure by definition make me an awardee convener or not?

PAMELA PELIZZARI: Not necessarily. If you are an acute care hospital or a hospital system, if you apply as one hospital sort of with one CPN and you choose to be an awardee, that means that you would then initiate into the episode all the patients that go through your facility with a specified DRG.

WES: Right.

PAMELA PELIZZARI: If you're partnering with a SNF, as long as you're applying as the awardee and not an awardee convener, the SNF is just there for sort of you're working on them with care coordination. You can include them in the financial incentives that you might have, and they would help you with sort of the care redesign. But they wouldn't necessarily initiate episodes. If that's what you would want just to have the patients that go through your hospital and be working with a SNF, then you would apply for Model 2 as an awardee.

RACHEL HOMER: And just to clarify for people listening on the phone, that question and answer we're regarding Model 2 – not Model 3. There's been some confusion regarding when an episode initiates in Model 3, and again that question and answer about the episode beginning in the acute-care setting was regarding Model 2.

WES: Thank you very much.

PAMELA PELIZZARI: Thanks for that question. Can we – I think we have time for another one from the phone. Is there another one in the queue?

MODERATOR: Yes ma'am. Your next question comes from Paul.

PAUL: Yes. If you are a post-acute provider that provides a very broad spectrum of post-acute services and you're applying as the awardee, is there a requirement that you have other partners? And if you do have other partners, is there a requirement that you gain share with them? I guess with the definition of a partner is a little bit confusing.

MELISSA PELIZZARI: Sure. So if I'm understanding correctly, you're asking if you're a post-acute provider that provides a broad range of services, are you required to have partners, and are you required to gain share with them. I'm going to turn that one over to Rachel.

RACHEL HOMER: Sure. So as I stated before and this is similar to the person who asked if they are required to partner with an LTCH. You are not required to have partners at all. Again, we are interested in seeing in your application how you would redesign care for the beneficiary who would be included in your model. So we would expect applicants to look at the care package to their beneficiaries and understand where those beneficiaries receive care. And, if appropriate, partner with anyone who the applicant deems sort of needed because that other facility is likely to be involved in the beneficiary's care.

If you're in a situation where your beneficiary really only receive care from your facility and not from other facilities, then it would make sense for you to not partner with other organizations. Now I thought I heard a second question in there which is if you have partners, are you required to gain share with those partners and the answer is no. You in the application are welcome to propose your gain-sharing methodology, and that could include no gain sharing methodology.

PAUL: So for purposes of the application, even if you're not gain sharing with another organization, if you are coordinating care with them, you would be expected to list them as a partner?

RACHEL HOMER: Yes, that's correct. And we would be interested in seeing how you will interact with that other organization to redesign care even if you will not be gain sharing with them.

PAUL: Thank you.

PAMELA PELIZZARI: Thanks so much for that question. Is there another question in the queue at this time?

MODERATOR: Yes ma'am. Your next question comes from Michael. Please state your question.

MICHAEL: Yes. The concept of partnerships, is there any formality to that, or is it really between the entities and downstream entities?

RACHEL HOMER: Sure. Thank you for that question. I assume you're asking do we have certain requirements in terms of what the contractual relationship must be between those partners, and the answer to that is as you assume. We don't have requirements there. So you can choose how to enter into that relationship. If you wish to do it in a formal contractual arrangement, you're welcome to do so. You're welcome to design those contracts in your usual manner.

JEFF CLOUGH: It's only in your interest to have as many partners as necessary to strengthen your application – at least as many partners that are relevant to the care redesign.

PAMELA PELIZZARI: Are there any more questions in the phone queue?

MODERATOR: Yes ma'am. Your next question comes from Brian. Please state your question.

BRIAN: Yeah, we're a post-acute health system that has all the components of post-acute with the exception of skilled nursing, and we're looking at Model 3. My question is we're going to need a skilled nursing partner for the DRG we specified. What would be the differences in the decision points for us to be an awardee accepting risk or an awardee convener accepting risk?

JEFF CLOUGH: Well, if you're an awardee accepting risk, then the only patients that would be included in the program are patients that basically for those given MS-DRGs are admitted to your facility within 30 days. If you want to include patients that partner with skilled nursing facilities, if you want to include patients that were admitted to partner skilled nursing facilities, then you would need to apply as a convener and include those skilled nursing facilities as your partners.

PAMELA PELIZZARI: You can partner with facilities without taking on the risk for that facility's patients if you're an awardee. If you're an awardee convener, you are agreeing to take on the risk for a partner facility that's also able to initiate episodes.

BRIAN: So it's up to – is there – from the perspective of CMMI, is there a preference for one over the other, or it's up to the applicant?

PAMELA PELIZZARI: I think that we're looking for things that affect sort of broad numbers of beneficiaries as much as possible. However, I think it depends on your application. If you have sort of a highly integrated system that doesn't include SNFs/IRFs, we're glad that you'd be looking for including SNFs in care redesign. It's really up to you if you'd like to take the financial risk for patients who may, say, go to that SNF but never use any of your other facilities. That would be sort of your choice.

RACHEL HOMER: And again, to underscore a point that Pamela hinted at there, we really are most interested in understanding how this will redesign care to be better for the beneficiaries and lead to better outcomes for the beneficiary. So that the sort of type of applicant that you would be really depends on who are your beneficiaries and what types of relationships are likely to best facilitate care redesign and will have better outcomes for the beneficiary.

PAMELA PELIZZARI: So we've been getting a couple more questions on the chat about the excluded services and the nuance of that. There's one here specifically asking about if someone

has ongoing treatment for, for instance, oncologic disease, would this have to be excluding application. The answer to that is yes, you have to explicitly exclude anything that you want to be excluded in your bundle. So from the party side, that would be going through all of the MS-DRGs that you would want to be excluded as readmission. And then on the Part B side, you would have to specifically exclude the services side for any diagnosis that you want to be not included in the calculation of your target price and the payment reconciliation. So, for instance, if it was an oncology patient, you would have to exclude their oncology-related visits from your bundle.

Another question we've gotten is whether IRF services – inpatient rehabilitation facility services are included in Model 3, and we just want to make sure very clear the answer to that is yes. Unless you explicitly exclude something which we wouldn't necessarily encourage you to do, IRF services are included in Model 3 bundle.

I think we have time for one more question on the phone if there is one.

MODERATOR: Yes, you have one last one in the queue. Syid, please state your question… [Pause]… Sir, please state your question.

SYID: Hello?

PAMELA PELIZZARI: Hello.

SYID: Yeah, this is Syid again from Michigan. I had the same question. We still did not get an explanation that how a privately held home health care agency can partner with the hospitals or the nursing homes when they have their own home health care agencies?

PAMELA PELIZZARI: Hmm-mm. So we understand that it could be a challenge as a privately owned home health agency in that geographic area where a lot of the home health agencies might already be networked. We would anticipate that there's a couple ways in this initiative in which you could participate. One of them would be sort of as a freestanding home health agency. So you are fully able to apply on your own, and whichever patients you now treat would likely be the type of patients that would be in your episode. So you can look at the patients that you're currently treating and say that it looks that a lot of them were discharged for these kind of SM-DRGs. I'll apply with those and set a target price. And then going forward, you can find ways to save cost on those patients. Particularly, we would look for some kind of care redesign and partnerships with post-acute care facilities. Reducing readmission could be a way for you to seize financial savings on the patients that you're already treating.

Another thing to think about is that if facilities – hospital-based facilities are available in your area are participating in this initiative. They're looking for partners who can deliver sort of high quality services at lower cost. So if you can sort of denote yourself as a provider who is able to do that, then you might be able to draw business from those facilities as they're also trying to find savings as part of this program.

So we're just about out of time. We want to leave a few minutes because we do have a couple polling questions. So we really want to learn from you about what you're interested in hearing. And this presentation was designed in response to your questions, and we're hoping to continue doing this. So we ask that you please take a few minutes to fill out that poll, and we'd also like to

remind you that if your questions did not get answered because we did get a lot of questions we weren't able to get to, please go ahead and e-mail that to our inbox which is BundledPayments@cms.hhs.gov, and we'll answer it as quickly as possible.

Thank you so much for participating. We really appreciate it, and I now ask that the moderator now push out those survey questions so that you guys can give us some feedback on this presentation.

RACHEL HOMER: Moderator, are you still on the call?

MODERATOR: I am.

RACHEL HOMER: And are you able to go ahead and push out those evaluation questions?

MODERATOR: The evaluation questions were pushed, yes.

RACHEL HOMER: Wonderful. Thank you.

MODERATOR: Thank you. This concludes today's teleconference. We thank you for your participation. You may disconnect your lines at this time and have a great day.

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