BPCI Winter Open Period

Final Transcript
Prepared by: Healthcare Management Solutions
Webinar Date: March 4, 2014

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PRESENTATION

Introduction:

Moderator: Thank you for joining us today for the BPCI Open Period Webinar, hosted by the Bundled Payments for Care Improvement initiative. Please note that during today's webinar, we will be accepting questions via the Q&A feature. To ask a question at any time during the webinar, simply click on the "Q&A" button located at the top of your screen and enter your question within the text box provided and then click "Send." All lines will be muted for the duration of the call.

And now, the CMS Bundled Payments for Care Improvement Team will begin the webinar.

E. Sutton: Good afternoon, everyone, this is Erin Sutton, and I'm the Director for the Division of Payment Models here at CMS. I'm joined by colleagues Isaac Burrows and Lela Strong and a host of other team members from CMS. We just want to thank you for joining our webinar today.

This is to address process and background for the Bundled Payments for Care Improvement Winter Open Period 2014 for Models 2, 3 and 4. So again, thanks for joining us today.

We're going to cover a couple things on today's call. First, just to review the principles of the Bundled Payments for Care Improvement initiative, and then we're going to give an overview of Models 2–4 and go through ways that you can engage in the Bundled Payments for Care Improvement initiative.

We're really excited to have the opportunity to open this pathway for both new and current entrants to engage in the Bundled Payments for Care Improvement program. We've done this because we've gotten a lot of interest from the community in joining the initiative to date, and so we're really pleased that we have an opportunity to offer a way to enter the initiative.

First, we announced this opportunity, again, for additional organizations to be considered for participation in BPCI and for current participants to expand their existing activity. This was announced in the Federal Register on February 13th, and CMS provided background documents for Models 2–4 and intake forms located at the link listed on your screen.

Submissions due for consideration are due by April 18, 2014 via email to the address listed on the slide. We've got a lot of questions and interest so

far into this mailbox and encourage you to write if you have questions throughout the consideration period.

So with that, I'm going to turn it over so we can discuss principles of the program, and I'm going to turn this over to my colleague, Isaac Burrows.

Program Principles:

I. Burrows: Thanks, Erin. BPCI episode parameters allow providers to select clinical conditions, time frames and services with the greatest opportunity for improvement. By grouping the DRGs together, it enables episodes that have sufficient numbers of beneficiaries to demonstrate meaningful results, but it also assures enough simplicity to allow rapid analysis and implementation of episode definitions.

MS-DRGs represent an established, annually refined bundle of inpatient services and comprise a large portion of episode expenditures for most models. Target prices or prospective payment amounts rely on historical MS-DRG payments as a significant component of bundles that include inpatient care.

Using these MS-DRGs, which we look at as kind of anchoring these episodes, it builds on a widely accepted methodology for grouping clinical conditions for appropriate payment. There is prior experience for grouping these clinical conditions using MS-DRGs as building blocks for episodes in CMS demonstrations and research.

Previously what we had was an RFA period. Entities could suggest any episodes possible. We went through all of these possibilities through what we consider a convergence in 2012, and we came up with the 48 I'm about to show on the next slide.

Each episode includes a family of related MS-DRGs, and episodes are linked to an inpatient hospital stay for one of the included MS-DRGs. The hospital admission that triggers or initiates an episode of care is referred to as an anchor DRG, and you see through the different models how they relate to the inpatient stay. Episodes are designed broadly with few exceptions and include most services covered under Medicare Part A and Part B that are provided to a beneficiary throughout the duration of the episode.

So you can see here the 48 defined clinical episodes. We strongly encourage testing longer episode lengths, 90 days for instance, to promote awardee responsibility for coordinating care through return of the beneficiary to kind of like a pre-hospitalization status.

In your intake spreadsheet, again, please include as many as you could project to potentially implement on January of 2015. Some folks look at this list here and divide it up, medical versus surgical. Again, there are different ways to group these, ortho, cardiac. I will say this, a common exclusion of the DRGs are cancer. There's a full list of inclusion and exclusion DRGs on our website under the Open Period Documents.

So I'm now going to go into some of the specifics of Models 2, 3 and 4. You might be asking why we have different versions of these models for BPCI. We really wanted to engage a range of participants and give different types of entities the opportunity to engage in care redesign activities and cost savings coming from different angles.

In Model 2, the episode of care begins with an inpatient hospital stay for the anchor DRG and all related care covered care under Part A and Part B and extends 30, 60 or 90 days following discharge from the acute care hospital. Participants choose to participate in one or more of the 48 episodes, and they must elect the length of the episode and a few other things we won't talk about here.

For each clinical episode and for each episode initiator Model 2, CMS sets a target price based on a three-year span of historical claims, incorporating a discount of 3% for a 30- or 60-day or 2% for a 90-day. That's for Model 2. Claims flow as normal, the episode base is reconciled later on and potential payment happens retrospectively.

Model 3 is similar to Model 2, but the episode begins at initiation of a covered Part A post-acute service within 30 days following discharge from acute hospitalization. Again, it includes Part A and Part B services that occurred during this 30-, 60- or 90-day period, except services specifically excluded. The same as before, the target price is set by the DRG and incorporated, for Model 3, a discount of 3%. Again, claims flow normally and reconciliation happens retrospectively.

In Model 4 the episode-based payment is prospective. CMS makes a predetermined bundled payment to the episode initiator, which is an acute care hospital in Model 4, instead of the IPPS payment. The bundled payment includes all Medicare Part A and Part B covered services furnished during the inpatient stay by the hospital physicians, non-physician practitioners, as well as any related readmissions that occur within 30 days after discharge.

The Model 4 target price is set per MS-DRG, incorporating a discount of 3% for non-ACE, that's non-ACE demonstration MS-DRGS or 3.25% for ACE MS-DRGs. Episode initiators submit what's called a Notice of Admission, an NOA, when a beneficiary expected to be included in a model is admitted.

So just to kind of summarize the models, a Model 2 episode includes the inpatient stay plus 30 to 90 days. Model 3 begins at the point of the post-acute admission and lasts a hard 30 to 90 days. And Model 4 is the inpatient stay plus 30 days, but the hospital—again, it's prospective payments that replaces IPPS.

Again, we have the background documents posted on our Open Period page, as well for each of the models, so please feel free to go to the link and the slides there and check those for additional information.

Right now my colleague, Lela Strong, is going to speak a little bit more about specific types of roles.

Description of Roles:

L. Strong: Thanks, Isaac. So now we'll discuss the various roles and awardee types that are available for BPCI participants. This diagram provides a high-level overview of each role.

The basic submission types are risk-bearing, who are responsible for the financial risk associated with the model, and they also enter into an agreement with CMS, and non-risk-bearing. The non-risk-bearing role is called a facilitator convener, and we'll discuss this role in more detail momentarily.

The risk-bearing participants are called awardees and include single awardees, awardee conveners, designated awardees, and designated awardee conveners. And as you can see from the diagram, designated awardees and designated awardee conveners partner with or take risk under the facilitator convener.

Also, each risk-bearing awardee either partners with or is itself an episode initiator. An episode initiator is a Medicare provider or supplier that provides services in the clinical episodes.

As mentioned, BPCI participants who are facilitator conveners will not bear any financial risk or receive payments for CMS; however, they do coordinate the BPCI activities of other health care providers that do take risks for redesigning care under the episode payment model.

So who should submit an intake form to be considered for participation in BPCI as a facilitator convener? These are organizations who have the capacity or are interested in fostering the participation of multiple providers.

These organizations serve in an administrative and technical assistance function for their designated awardees and awardee conveners. An example of a facilitator convener could be a hospital association. Each designated awardee and designated awardee convener that the facilitator convener partners with is responsible for their own beneficiaries.

And just an additional note about the facilitator convener partners, a designated awardee essentially functions in the same role as a single awardee with the exception of a collaboration with the facilitator convener. Designated awardee conveners operate in the role similar to that of an awardee convener.

Now moving on to risk-bearing awardees who are not associated with a facilitator convener. A BPCI participant is a single awardee if it's a Medicare provider that bears risk for only episodes that it initiates, while it's an awardee convener if it applies with partners and bears risk for all episodes of its episode initiator partners and its own episodes, if it is a Medicare provider.

So an example of an entity that could submit an intake form to be considered for the role of single awardee is an individual hospital. Single awardees are responsible for all of their own bundled payment beneficiaries, regardless of the other providers where these patients received care during the episode.

Parent companies, health systems, and other organizations that wish to take financial risk should submit an intake form to be considered for the role of awardee convener. Awardee conveners are, again, responsible for all of their own bundled payment beneficiaries, if they are Medicare providers, and also the beneficiaries of the episode initiators that they partner with.

As mentioned previously, episode initiators are Medicare providers or suppliers who provide services in the clinical episodes. Episode initiators will vary based on the model that you choose to participate in.

For Model 2, episode initiators include acute care hospitals and physician group practices. For Model 3, episode initiators include post-acute providers, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, and also physician group practices. And for Model 4, episode initiators include acute care hospitals paid under the inpatient prospective payment service.

So we just mentioned that physician group practices can be episode initiators, and we just wanted to provide a bit more information regarding the definition of PGPs for the purposes of BPCI. We define a physician group practice as follows.

First, there should be a unique EIN/TIN for the PGP. There should be more than one practitioner associated, and all the practitioners have assigned their individual NPI to the PGP for billing purposes.

At this point I will turn the presentation back over to my colleague, Erin Sutton, to discuss the phases of BPCI.

BPCI Phases:

E. Sutton: Okay, thanks a lot, Lela. So we are now on slide 17 here, and I just wanted to sort of break these two terms up a little bit for those that have reviewed this and are wondering why we have two phases for BPCI.

First and foremost, following the November 2014 submission, new participants are selected for Phase 1, and we often refer to Phase 1 as "ensure the preparation period." Selection for Phase 1 is based on CMS' review and acceptance of proposed care redesign plans and associated program integrity screening. Phase 1 represents the initial period of preparation, as I mentioned, for implementation and focuses on the assumption of financial risk.

There are many things that CMS provides in order for Phase 1 participants to start their preparation to move to Phase 2. First and foremost is monthly beneficiary-level claims data for episodes of care. This is used to inform both planning and sort of in the preparation for moving to Phase 2, which we'll discuss, an engagement in webinars like this and a variety of learning activities with other BPCI Phase 1 and Phase 2 participants through a collaboration site that we have.

We actually had a webinar last Friday, but there will be many other opportunities to engage in various content areas and deep dives as participants proceed from Phase 1 to Phase 2, also, target pricing information to inform assessment of opportunities under BPCI. So all these things collectively are provided to participants once they are selected through the screening process in order to better prepare participants for Phase 2 of the program.

Phase 2 of the program, we often collectively refer to this as our "risk-bearing phase." In order to move from Phase 2 as an awardee, participants must be selected by CMS following a comprehensive review and enter into agreements with CMS.

The agreement allows several important key items. First to bear financial risk for the model and affords the waivers of certain fraud and abuse authorities that are available in Phase 2 for specified gainsharing incentive

payments and patient engagement incentive arrangements in connection with Models 2 and 3 of BPCI.

We're going to talk a little bit more about those specifically, but at a high level that's what is afforded through Phase 2. And then also waivers of certain Medicare payment policies are available in Phase 2 of BPCI Models 2 and 3.

Again, we'll go through those specific payment policies and waivers, but the real difference is Phase 1 being the initial preparation phase and Phase 2 being the risk-bearing phase.

Episode Payment:

E. Sutton: So moving along to episode payment, this is a very high level, and again, as Isaac mentioned earlier, this is described in more detail in our background documents that are found on our website.

But essentially, how we calculate target prices for Models 2 and 3, the episode cost of Medicare is calculated for each episode, for each episode initiator using three years of historical data. That would cover the periods of July 2009 to June 30, 2012. The claims are then used to build episodes based on the included and excluded services for individual beneficiaries.

If the minimum threshold of historical data is not available for the particular episode initiator, regional data are used to supplement the episode initiator's historical data to calculate the episode cost. Episode costs are trended to 2012 using a national episode-specific growth rate so that CMS can determine the cost of the episode in 2012 dollars.

The final step in this here is that CMS would then trend the 2012 episode cost to the participation year and apply a discount that resulted in the target price for the bundled payment amount. And again, this is a high-level description. We have a little bit more detail in our background documents on the website.

Moving on to Models 2 and 3 payment reconciliations, again, at a high level, the total Medicare spending for included services for an eligible beneficiary during the length of the episode is compared to a predetermined bundled payment amount, or what we call the target price, following the conclusion of the episode.

This then would determine the payment to the awardee, the risk-bearing organization. So if the actual spending is less than the target price, the awardee would receive the difference from CMS, and if the actual

spending exceeds the bundled payment amount, the awardee is responsible for paying the difference to CMS.

Moving on to Model 4 payment, as Isaac mentioned previously, we're calling out Model 4 payments specifically because it is a prospective model and things flow a little bit differently given that it is a prospective model.

So a couple of important points under Model 4 payment, upon submission of the NOA, hospitals are given a $500 payment amount and receive the balance of the prospectively established bundled payment amount when the hospital claim is processed. The Model 4 hospital is also paid indirect medical education, or IME, disproportionate share hospital, or DSH, outlier and capital payments as usual under the fee schedule, and physicians and non-practitioners. Claims for physicians must be processed as "no-pays" and not submitted differently. So I just want to make that point on bullet point three here.

If any Medicare fee-for-service claims are paid by CMS for services included in the episode, as part of the initial inpatient stay or any related readmissions, the awardee is responsible for repaying those amounts to CMS. And finally, beneficiary coinsurance and deductibles are affected by the Model 4 payment methodology.

So again, that's a high level. We do have more information on this in our Model 4 background document that is on the BPCI website.

Evaluation and Monitoring:

E. Sutton: Moving from payment to evaluation and monitoring, this is a key aspect, obviously, of evaluating the initiative, and there are a couple of things, again, at a high level that happen as a part of the evaluation monitoring process. CMS intends to monitor and is in the process of monitoring numerous aspects of the model, including structural and organizational characteristics, patient case-mix, clinical care and patient safety, patient experience, and utilization and cost.

We do this through an outside contractor and through other ways, but primarily through an outside contractor. And that is a part of the awardee agreement, should you engage and are deemed appropriate to participate in the BPCI program.

Just a little more information on the evaluation monitoring activities, some of those could include interviews, surveys, focus groups with stakeholders, review of abstraction of charts, medical records and other data, and also in the form of site visits or phone calls.

Participants are also required to collect a subset of measures included in the BPCI continuity assessment record and evaluation tool, or what we refer to as the B-CARE tool, to evaluate beneficiary condition at discharge from the hospital. CMS would also monitor utilization and compliance with agreements and Medicare payment policy waivers, which we're going to talk a little more about.

So with that I'm going to turn this back over to Isaac Burrows to talk about some of the specific waivers they're afforded under the BPCI.

Overview of BPCI Waivers:

I. Burrows: Thanks, Erin. So we just wanted to touch real quickly on some of the waivers that are associated with BPCI. As part of the BPCI initiative, participants may be offered waivers to allow them to share funds that result from cost savings with approved physicians, practitioners, and other entities engaged in care redesign.

These are limited funds from internal cost savings that result from care redesign and CMS payments to ensure the payment of target prices. Providers must support care redesign to achieve improved quality, patient experience, anticipate cost savings, and also must meet quality thresholds and engage in quality improvement to be eligible to receive payments.

Also, within the fraud and abuse waivers is a payment engagement incentive waiver. Incentives may not exceed $1,000 in value for any one beneficiary, for any one episode. Items of technology exceeding $50 must remain the property of the awardee or provider and must be retrieved from the beneficiary at the end of the episode.

There are a few payment policy waivers as well. You can see those here. Again, you'll have copies of these slides.

But essentially there is a three-day hospital stay requirement for SNF payment waiver. And to use this, the SNFs that the awardee's partnering with must have a three star or better overall quality rating under the CMS 5-Star Quality Ratings, as reported on the Nursing Home Compare website, for at least seven out of twelve months immediately preceding the performance period, and all the other provisions apply as well.

There's also a telehealth waiver here where the originating site CMS waives essentially the geographic area requirements.

Next is the post-discharge home visit. CMS waives the direct supervision requirement for incident to services, given the certain provisions shown here. I'll say that given the complexity of this fraud and abuse in the

payment waivers, we'd ask that you email any specific questions you have to the Bundled Payment inbox, and we'd be happy to respond to those.

I'm going to turn it back over to Erin now for some of the more specifics of the open period.

Winter Open Period Recap:

E. Sutton: Great, thanks, Isaac. I know we're almost at 12:30. So we want to make sure there's plenty of time for questions at the end, but just a couple of other points I wanted to make about just the Winter Open Period.

Again, additions that can be possible, and this is just sort of responding to frequently asked questions we've already received through the inbox upon announcement of the Winter Open Period. New episodes can be added to existing single awardees, awardee conveners, designated awardee conveners and those submission types, and new episode initiators can be added to existing single awardees.

So those are just a couple of key points to pull out, and here are some quick questions and answers that we've gotten already that I just wanted to pull out.

"Can new hospitals or post-care providers join BPCI independently without working with an existing convener?" And the answer to that is yes.

"Can new conveners join BPCI? Yes, they can.

"If I'm an awardee convener do I need to submit with an episode initiator as well?" The answer is yes. As we reviewed earlier, you need to at least submit with one episode initiator.

And another one that we frequently got is, "If I am a facilitator convener, do I need to submit to participate with a designated awardee or a designated awardee convener?" And the answer to that question is yes.

So the purpose of this is just to sort of demonstrate some scenarios and questions that we've already gotten through our inbox. We're always happy to take those questions on a rolling basis, as well.

So just to point you to the Winter Open Period documents that we referenced throughout the presentation and in the beginning, that interested organization must submit an intake form and accompanying spreadsheet found at the address displayed on your screen under, "New Awardees."

Background documents are also available at that website as well for Models 2, 3 and 4. We've also, as Isaac mentioned, made available the Part A and B exclusions list in an Excel document that you can also use to inform your decision to participate in BPCI.

As next steps, CMS will review information provided and screen organizations for suitability and for participation in Models 2–4. And again, just to reiterate here, all forms are due to CMS April 18, 2014. Submissions, again, will only be processed for consideration as both the intake form, which is a Word document, and the accompanying intake spread sheet, which is an Excel file—again, just two files there, so we've streamlined—these documents are submitted to the BPCI inbox at the address listed by the April 18th deadline. Be sure to include your organization's name in the file's name so we know who you are and we can follow up if we have questions.

Just to quickly describe what the intake form contains, and that's the Word document that I described. It contains several narrative questions that must be completed by the organization in order to participate in BPCI.

For submission to CMS you would replace your new participant name in the file name, again, so we can sort of keep track of all these documents. So if you are X Hospital post-acute care facility, or convener or other type, just make sure to name that as your file name.

The intake forms attached to this document are separated by role for single awardees, awardee conveners and facilitator conveners. So answering that question about who you are, again, plays an important role in this. You would fill out as such depending on which submission type you are.

Only complete the questions for the submitting organization's intended role, so single awardees would respond to the questions starting on page four; awardee conveners would respond to the questions starting on page six. Facilitator conveners would respond to the questions starting on page eight of this intake form.

Going to the next slide, just to briefly discuss the accompanying spreadsheet that is available—again, we have really streamlined this. The intake spreadsheet is what participants must list for each proposed new awardee, convener, episode initiator and episode. There are instructions on the spreadsheet that are provided in the intake spreadsheet on tab one titled "Instructions."

If you're unsure of your submitter type, we would refer you to the background model documents and the instruction tab, which contains more detail, both of what we have discussed during today's presentation

but just a little more in detail about how those different submitter type roles are organized.

Just please, we ask that you correctly enter information and pay careful attention to not enter duplicate NPIs. As we work quickly to review and screen and process these documents, that will help the process to go more smoothly.

So to quickly go through the timeline, we've talked a little bit about when the Winter Open Period was announced, and we're really excited that we're able to talk to you about it more today. Again, the big date is April 18th, the organizations must submit a request to participate in BPCI.

And there's a host of activities that happen between the summer and fall of 2014. Episodes for new prospective single awardees will be added to Phase 1. As we've described earlier, data use agreements so that you can get that monthly data will be sent.

Awardees and facilitator conveners will be notified of new episodes for new prospective single awardees, and additionally, episode packets and historical data files will be provided in order to allow the replication of target prices. So that's just a little bit of a preview of what's to come.

And flipping to the next slide, just a continuation of this, in November of 2014, awardees will commit to entering Phase 2 for episode initiators by signing an awardee agreement. And then extending this out through January, all BPCI episodes must begin in Phase 2. Phase 1, the preparation and BPCI will end at this time. So that's January of 2015 that organizations have to move from Phase 1 to Phase 2.

For current participants that we afforded the opportunity to add new episodes and episode initiators, the timeline is largely the same. So obviously those are due the same date, April 18th. You submit the request to add new episodes and episode initiators that are also on the intake form and the intake spreadsheet.

Through the summer and fall, a couple of activities will take place. First, in July new episodes and episode initiators will be adding to Phase 1, following CMS' preliminary review. At this time, the new episodes and episode initiators will begin to get that ongoing monthly feed received by Phase 1 participants.

In some scenarios, new entities may be required to submit additional data use agreements or addenda. If that's the case, CMMI will obviously reach out to get that information from you.

In September 2014 CMS will notify awardees of the outcome of CMS' full consideration of the proposed new episode initiators for participation

in Phase 2. Where applicable, CMS will offer the opportunity to amend awardee agreements or sign new agreements for the inclusion of these episode initiators in Phase 2, and CMS will distribute the episode packets and historical data files to allow replication of target prices for new episodes and episode initiators that are offered participation in Phase 2.

So again, just the opportunity, timeline for current participants is here. It largely follows that of new participants, but in November of 2014 awardees, again, committing to enter Phase 2, the risk-bearing phase for new episodes and/or episode initiators, by amending the existing awardee agreement or signing a new one.

And then in January 2014 all BPCI episodes, again, moving to Phase 2, and that's initiative-wide. Phase 1 of BPCI would end at that time. So that's an extended period of time, of which prospective participants can move from Phase 1, the preparation phase, to Phase 2, the risk-bearing phase.

Questions:

E. Sutton: So with that, I know that we have got about 20 minutes left for questions. I just wanted to say that if you don't have questions at this time but you think of them later, please feel free to submit them to the email address that's listed on the slides, the BundledPayments@cms.hhs.gov, "BundledPayments," one word. And just to remind everyone that the open period documents can be found at the address that's listed here.

We just want to thank everyone for dialing in and for your time and your interest throughout this process, throughout the announcement through February, for submitting your questions already through the mailbox and for participating in the webinar today. And with that, we're happy to take questions at this time.

So it looks like we've got a couple questions already. The first one is from Paul. Hi, Paul. The question is, "Can an entity be an awardee convener for certain episodes and a facilitator convener for other episodes?"

I can take a crack at that and also turn it over to my colleagues to elaborate. I think the answer to that question is no. Paul, we can definitely talk offline about different scenarios here, but I'm going to turn it over to Isaac for a little more explanation of why that is not possible.

I. Burrows: We can definitely elaborate on that. So essentially the facilitator convener role is meant to be a role in which they would facilitate the process in BPCI. We're looking for those folks to help with the process of

submitting forms, to be contact point people. And by definition, those folks, a facilitator convener wouldn't be necessarily initiating any types of episodes. I think an awardee convener is possible. They could initiate episodes.

I'm happy to speak—it's difficult to kind of answer that question without knowing specific organizations. If you have any questions about your specific organizational structure, how that relates with your parent organizations and partners, please send those specific to our Bundled Payment inbox.

E. Sutton: All right, so the next question we have here, "It appears that ASCs," and I'm assuming you mean ambulatory surgical centers, "do not fit into this program. Is that correct?"

I think, Crystal, if we could potentially answer that question offline, we'd like to understand a little bit more about what you're asking there and sort of the arrangement that you're considering. So we can definitely follow up with you on that question.

I should also mention that there's going to be a transcript available of this, and that we can follow up with these questions and make them publicly available.

Another question we have is from someone who asks, "Once a convener enters Phase 2, are they correct in thinking the convener can continue to add new episode initiators and new bundles?"

The answer to that question is yes. We do have a quarterly process in which you can add new episodes and episode initiators to the program. We're happy to sort of answer that in more detail offline, but just at a high level that is the answer. I don't know if we want to add…

C. Bazell: This is Carol. I'll comment on that to elaborate. If you're a new awardee convener, we're estimating a hard stop of January 2015 for any episodes and episode initiators that you bring in.

So in fact, if you're coming into this period, you want a trajectory to start everything that you're going to start on January 2015, and nobody bringing other episode initiators or episodes in through this open period request would be candidates for starting any of those before January 2015.

We do have a process currently in place for those entities that we're working with that are awardee conveners, where they have episodes or episode initiators already in Phase 1. They are beginning some of those episodes and episode initiators on a quarterly basis.

So I want to take a step back to the ASC-related question. I can provide a little bit more clarity for the group on the group call. And I think it's important to understand this, that all of the models here, Models 2, 3 and 4, are related to an inpatient hospital stay in some fashion as the triggering or anchor DRG.

So if a beneficiary only has a procedure performed in an ASC or only has a procedure or care in a hospital outpatient department, they would not be a beneficiary under any of these models on that basis. Having your procedure, even one of the episodes that might be here, like a percutaneous coronary intervention in the hospital outpatient department, would not trigger an episode.

You must have had an inpatient hospital stay. We understand this can result in some beneficiaries not being part of the model even though their care may resemble those of beneficiaries who could be in an episode.

The sort of additional point I want to make is that these are inclusive episodes that extend anywhere from 30 to 90 days in relationship to the inpatient hospital stay. So if in fact the beneficiary had ongoing care or care during that period of time in an ASC, especially in Models 2 and 3, less the case for Model 4, the care in that ASC would be part of the care attributed to the bundle that's occurring for the beneficiary because they're in the episode already.

The episode was initiated based on their inpatient hospital stay for Model 2 or based on the initiation of post-acute care following an inpatient hospital stay, but they had ASC care at some point during the episode period, again, ranging from 30 to 90 days. That ASC care or hospital outpatient care for that matter or therapy services or physician visits, much of that care would be attributed to the episode, and really whether it is or not would be dependent upon the diagnosis that is associated with that care.

There is a posted list of exclusions on our website where you can get more information about the types of diagnoses that would lead to excluding other care there. So I wanted to elaborate for the group; again, to provide a little further detail on the ASC question. We'd be happy to review further anything you have to say, any further questions you have after that, through questions submitted to the inbox.

E. Sutton: We have another question that is, "For an awardee convener, do they need a contract with an episode initiator by April 18th or is an LOI sufficient?"

I think the answer to that question is that we would have to understand more about your arrangement to answer that question. In some instances

we have seen that LOIs have been in place by the time that you submit the actual open period documents.

I don't know if any of my colleagues would like to elaborate on that question at all.

We realize that it takes some time to get arrangements in place. So we're not necessarily specifying that you need to have particular contract LOIs in place by that time. We do anticipate, however, that would be sort of in progress, but we did not specify that that would need to be accomplished by the April 18th deadline, because that is just the original intake and submission period, but we would anticipate that that would be in progress as you're pursuing a path into the BPCI initiative.

So we have a question about how to contact us offline. I think you can just send an email to the address that we have on the final slide, BundledPayments@cms.hhs.gov. We do monitor that and provide timely responses to those questions. So feel free to reach out to us, if you have more detailed questions, there.

I'm just going to take a pause here for a moment.

We have a question about when new participants will receive their data and what data they're be receiving. I'm going to turn this over to my colleague, Jane Valuzzi, who's here with us to talk a little bit about when they might receive that data.

J. Valuzzi: Sure. We have assistance with developing data files for people, and as you go through the application process and are admitted into the program we would anticipate that we would work with you to develop a claims data file and that that would be available sometime during the summer months. We don't have a specific date at that time, but we would keep you informed as to when it would be available.

E. Sutton: Yes, and that's on the timeline that we have for our slides, but roughly this summer.

So I'm not seeing that any new questions have been asked here. Maybe we'll just give folks a minute or two more in case there are some that come up.

Okay. We have another one that says, "Are there additional application requirements that new participants will have to complete after the April deadline?"

Beyond the April deadline, we don't specify application requirements here, but yes, as I mentioned, there will be additional levels of information. As participants progress from the initial intake process to

Phase 1 and then Phase 2 of the initiative, we will be having additional education on those next steps.

But at this point, this sort of initial April 18th deadline, the information that you have in those two documents are what's needed. That said, we will be making more information available about different phases, what is needed through different phases of the initiative.

C. Bazell: This is Carol. I'll just supplement that by saying that if the question really focuses on when would we be needing more information about your plan, in fact we wouldn't expect to receive any substantive additional submissions from you about that until the point at which you've actually signed an agreement with us to participate in the model and move your episodes and episode initiators to risk.

At that point—prior to that point, we would of course share the agreement and the applicable provisions you would have time to review that in conjunction with your data. When you sign the agreement, at that point in time, you would have 30 days to develop or to finish, to submit to us what we would call an implementation protocol where you would describe your specific plans in more detail.

So that's work, if you were moving towards signing an agreement, that you would need to be doing along the way, because 30 days is not sufficient to fully develop all that. But that substantive submission to us with more detail about your specific plans would not be due to us until after you'd actually signed an agreement which committed you to entering the risk period for certain episodes and episode initiators.

E. Sutton: Thanks, Carol. I know some folks came in late. We're getting a couple questions about the availability of a recording of the webinar.

We will not have a recording, but we will have a transcript available along with the slides on our website. Certainly you can write into the Bundled Payments mailbox to request that specifically, but we will have it available on our website, as we do with all previous webinars with a detailed transcript.

So I think we have time for a couple of other questions. One is, "How do we keep current with all announcements and webinars for the program? Is there an email distribution list?"

We do send this out broadly to partners and post this information on our website, as well as send information through the federal register, but if you'd like to receive these announcements and information about future webinars, please do write us at the BundledPayments@cms.hhs.gov mailbox and we can add you to our distribution list for future announcements and email distribution. So we've had quite a few people

write into that and have added them to date, and we can communicate with you moving forward through that.

I see a couple of questions about different scenarios in participating in Model 2 and Model 3, and we want to be responsive to those. If you wouldn't mind please sending those questions to the mailbox, again, provided at BundledPayments@cms.hhs.gov and we can sort of handle those specific scenarios through that venue.

I don't see any new questions at this time. I'm going to give maybe one more minute for questions to come in, but I think we'll start to wrap up. Again, I don't want to say this is the end of answering questions. We can certainly answer your questions through the mailbox.

Okay, well we just want to thank everyone. We're going to end just a couple of minutes early today. I haven't gotten any new questions at least popping up on the screen here, but I did just want to thank everyone once again for your time and your great questions during the webinar.

Again, communication with us doesn't stop here about the Winter Open Period. We really appreciate your interest in this and please do email us at BundledPayments@cms.hhs.gov for further information and with specific questions.

And again, I think this concludes the webinar, and I want to thank my colleagues today and co-presenters and those that have answered questions, and thank you for attending. So we're going to sign off now. Thank you.