Center for Medicare & Medicaid Innovation
Bundled Payments for Care Improvement

Understanding the Medicare LDS Denominator File for CMS Bundled Payments for Care Improvement (BPCI) Initiative

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Please note: The transcript for this activity is based on the actual webinar recording. Minimal editorial/formatting changes have been made to the transcript text.

PAMELA PELIZZARI: Hi, this is Pamela Pelizarri with the CMS Innovation Center and we are really pleased today to have with us Marshall McBean from the University of Minnesota School of Public Health and the Research Data Assistance Center. Marshall is going to talk about understanding the Medicare LDS denominator file for CMS bundled payments for care improvement initiative.

So I am just going to move to our schedule to orient everyone. So the first webinar we had on the date that is being provided as part of the bundled payments for care improvement initiative was this Monday, February 13th. And that was about technical aspects of data delivery and file processing. We had Buccaneer on the line speaking to that.

And today, tomorrow and Friday we'll have RESDAC on the line talking about these three different topics. Each of these webinars is going to take place from 12:30 to 1:45 p.m. Eastern Time and you can find out more on our website. So if you go to the CMS Innovation Center's website and you look at the bundled payments page, there is a learning and resource area which will direct you to the webinars for today. This is called the data webinar series.

All of the slides, as well as the audio and a transcript of these webinars will be available afterwards for people who aren't able to come today you will be able to download them from our website. That will take us about a week. And so if you could not email us about those within the next week, we are getting them up as quickly as we can. At this point I will turn it over to Marshall to start the presentation. Thanks so much, Marshall.

MARSHALL MCBEAN: Okay, and thanks to you, Pam and also to everyone else who helped facilitate today's presentation. And I also want to acknowledge the co-developers of this presentation and Jay Desai at CMS, as well as three of my colleagues here at the Research Data Assistance Center, Barbara Frank, Faith Asper and Beth Virnig.

As we get started here today, let me suggest for those of you who can do it, that you might want to go to the Learning and Resource area of the bundle payments for care improvement initiative website and click on the denominator file and download the LDS denominator record data dictionary. I know not all of you will be able to do that simultaneously to listening to this presentation, but for those of you who can or who have that ability, you might want to do that.

So our educational objective for today is to describe the information contained in the BPCI Limited Dataset Denominator File and then how you may use that in defining the bundled payments for care improvements initiative populations.

In the beginning, there was a single denominator file. It was created by CMS for researchers, it was based on the calendar year. It was a rather thin or narrow file. It only contained 80 columns, like the old IBM punch cards. It contained research identifiable information and we at RESDAC suggested that everyone who was doing a study get a copy of the denominator file.

Now in the past five years or so, there have been additional denominator files created and I mention these because some of you may be working at institutions or organizations who have received some of these other denominator files and I just, at the end of this slide will point out a couple of differences between them and the one that we are talking about today.

So the other ones that are out there, there is a Part D denominator file, there's a beneficiary summary file and there's being created a master beneficiary file. But again today we are talking about the limited dataset denominator file. And while there are a couple of differences, there really aren't very many between this file and these other files with which you may have had some experience.

In the LDS denominator file, the smallest geographic unit is the county rather than the zip code. And then secondly there is some omitted information regarding death in the LDS denominator file compared with these other files, and I'll talk about that more in a few minutes.

So describing this LDS denominator file, again, it is an annual file and it contains all beneficiaries entitled or enrolled in Medicare even if that's just for one day in the calendar year. Just to be clear, this is not a file that is limited to users of Medicare services, this is everybody entitled or enrolled.

The eligibility information that is contained in this file is determined by the Social Security Administration and something called the Railroad Retirement Board based on information which they have on the beneficiaries. In addition, other information in the denominator file comes from states, from some of the claims and also from the Medicare Advantage plans, Medicare Advantage being the current term for managed care for health maintenance organizations.

Now both the standard denominator file and the LDS denominator file for a particular calendar year such as 20XX, those files are based on information known to CMS in March of 20XX plus one. So as an example, for 2008 the information contained in that file is information that is known to CMS in March of 2009. And similarly for the 2009 denominator file, the information contained in it is information known to CMS in March of 2010 and we'll talk a little bit about this more in a few minutes.

One comment in terms of the balance bundled payments for care improvement initiative denominator file that you will get, and again the LDS denominator file that the organizations may have gotten previously, they are the same. And I repeat, they are the same except that the files that you will be receiving for this project will only have information for your hospital referral cluster.

Normally when you get a LDS denominator file, it might be for 5 percent of the United States population enrolled in Medicare or 100 percent. For the bundled payment initiative, it will just be for your hospital referral cluster.

Now the content of the LDS denominator file, and I just note here at the beginning that I have capitalized all of the variable labels as they appear in the denominator file data dictionary. Hopefully this will help you find these variables after this presentation. And so as you can see in this first bullet, there's a variable used to identify beneficiaries. This was talked about on Monday by the folks from Buccaneer, the DESY_SORT_KEY. So the DESY_SORT_KEY is the variable used to identify beneficiaries and for linking records.

In addition, in the denominator file there are variables that we can use to obtain demographic information, very basic information about beneficiaries, age, sex, the race code, the state code and county code. And in addition, there's mortality information specifically the variable's valid date of death switch and beneficiary encrypted file or death, date of death.

Beyond these basic variables, there are others used to identify and track entitlement and eligibility for receiving particular Medicare services, and I'll go into those in more detail in about five or so minutes. Perhaps beating on a dead horse, we've talked about the DESY_SORT_KEY a couple of times now. It is a unique variable. No people will share a DESY_SORT_KEY in your hospital referral cluster and, as I have said before, you will use this variable to link beneficiaries across files.

Before I talk about the specific demographic information in the denominator file – age, race, ethnicity, sex, state and county of residence, death and date of death – let me just make a couple of comments about the demographic information in the utilization or claims files.

Tomorrow we will begin our discussion about the information in the utilization or claims files, but let me talk quickly about the demographic information that is in those files and why you must pay attention and use the denominator file for the demographic information.

So reading this slide to you, there are variables about age, sex, race, ethnicity, state and county of residence in the LDS utilization files for 2008 and 2009. So you will see those variables. However, all but the sex variable have null entries or null values for an unknown number of records in one or more of these years.

Therefore, in order to understand and have accurate demographic information to calculate age groups and things like that, you must use the LDS denominator file information and not the utilization or claims file information. Again, as we have said several times, you can link the LDS denominator record to the appropriate utilization files using the DESY_SORT_KEY. It is just something that you will have to do in order, again, to have accurate demographic information.

So back to the variables, to go through some of the simple things first. The age, as it says in the data dictionary, is the age at the end of the prior calendar year. And if age is greater than 98, then age has been set to 98. Sex is also pretty simple. The sex variable is coded one for male, two for female and there are no missing values in this field.

There are rules at CMS in the processing of information that if there is unknown information for the sex field, if the person is less than 65 and sex is unknown, then sex is entered as male and if the age is greater or equal than 65 years of age and sex is missing or unknown, then sex is set to female. This slide here, perhaps again a little bit more information than you want to see, but just to demonstrate for two diagnoses and one procedure, that sex assignment is rarely in error.

So the first two items, so the diagnosis of prostate cancer in 100 percent of those records the sex was male. Ovarian or cervical cancer, almost 100 percent were found in women and then for breast reconstruction surgery, 100 percent of the beneficiaries were women.

In terms of race, ethnicity, things are not quite so good. In the Medicare data the beneficiary race code is a one column variable. I would assume that many of you on this call have worked with other data systems either private or federal or state in which the race ethnicity is defined using two columns, one for ethnicity, generally Hispanic or non-Hispanic and then one for race.

In Medicare, that is not true; only one column. Initially that column or that race was coded as White, Black, other and unknown. And then in 1994 the race codes were expanded to include White, Black, Asian, Hispanic, North American Native, other and unknown.

As part of the struggle to accurately identify people of minority groups such as Asians and Hispanics, there's been a lot of work done to get the best possible information, but studies that have looked at this have shown that for Hispanics the sensitivity of the Hispanic race designation is only about 40 percent and for Asians it's only about 60 percent.

So the validity or accuracy of this information is less than we would like. However, let me just add one piece of information. Because you will be linking the denominator file and the race ethnicity information in that file to the utilization file or claim records, at least you know that the race ethnicity for someone in your numerator if you're calculating rates will be the same for that person in your denominator. So the information may not be accurate, but there is consistency between information about the type of person receiving the services and the type of person who would be then in the denominator.

Moving on to geography – as I mentioned earlier, the two primary variables in the LDS denominator file are state code and county code. We do not have zip code. So as many of you may also know, these are the mailing addresses for official correspondence from CMS. Therefore, there is some concern about the accuracy for all beneficiaries because some persons may have their mail sent to another person – son, daughter or guardian who perhaps lives in another county or may in fact live in another state.

Now taking a deep breath and saying this slowly, the residency in the LDS denominator file for again calendar year 20XX is based on the information available in March of 20XX plus one. So it is possible that if someone moves after December and prior to April, they may have a different state and county of residence than during the period for which you have utilization information. There is no work around this, as far as I know. It's just part of the Medicare databases.

A couple of caveats which might seem a little bit confusing, so let me say them slowly, at least the first one. That the residency in the utilization files, so going back now to utilization, not the denominator file, but the residency – so state and county – in the utilization files is based on the residents known to CMS at the time the claim is processed.

So this is not the March state and county, this is the information known in January through December when the claim was processed. So, in fact, there may be a different state and county code for the same beneficiary in the utilization file compared with the denominator file.

One other comment about state and county codes, for those of us who know and love them, they are Social Security Administration codes, so SSA codes, not FIPS, FIPS standing for the Federal Information Processing Standards. Again, people who have used other databases within the federal government or outside, you may have used codes either knowingly or unknowingly for state and county based on the FIPS designation.

So if it turns out in preparation of your proposal to CMS you are combining information from sources that one, used the SSA codes and the other uses the FIPS codes, you will need a crosswalk. A crosswalk file is available as a public use file and the URL is indicated in this slide.

Mortality – okay. In terms of mortality and the LDS denominator file, there are two variables that we need to consider. One is the valid date of death switch and the other is the beneficiary encrypted file or BEF date of death. The valid date of death switch will have a value equal to V if the exact date of death has been confirmed and this confirmation primarily comes from the Social Security Administration.

If the person does not have a "validated date of death," then the value for this variable is blank. The person may be dead, but the death date has not been validated. So that's the first variable. The second variable is the date of death. This is an eight digit date variable and if the person is dead and the date of death has been validated, you will have an entry in that field.

However, it is blank if the beneficiary is still alive or if the valid date of death switch is blank. Therefore, in the LDS denominator file there will be beneficiaries who are dead, but you cannot know who they are because the exact date of death has not been validated. Or the other way of saying it, there are beneficiaries who you think are alive, but they are dead. Now the good news is that 96 percent of all deaths are validated so the information is there.

I put together this next slide just thinking a bit about this 4 percent and how we might have to deal with it or consider it in the proposals that you prepare. So in terms of a potential size of the problem, the annual all (unint.) mortality amongst all Medicare beneficiaries is about 5 percent. So if we multiply 5 percent times 4 percent it would turn out that about 0.2 percent of all of your beneficiaries might have incorrect information in a given year.

On the other hand, I mean that doesn't sound like very many. But on the other hand, post acute care patients obviously have higher mortality rates and in one of the documents that's been cited to you, again at the resource area, the learning and resource area of the website, the post acute care episodes expanded analytic file data chart book from June 11 and these are those series of chart books and other information that was prepared by the Research Triangle Institute for ASPE, the Associate Secretary for Planning and Evaluation within the Department of Health and Human Services.

Anyway, in that particular document chapter five they talk about mortality. And just as an example, for people whose anchoring event, if you will, the anchoring event was long-term care hospital, 17 percent or 13 percent of the people were dead within 30 days depending on whether it was a variable length or a fixed length episode. So again, the mortality rates in the populations you will be studying will be higher than the general Medicare population and you may want to consider the implications in your application.

So recapping, mortality, the date of death is present only for those persons with a validated date of death or when the validated date of death switch equals V. There are some variables in the denominator file, as I mentioned, that relate to entitlement. I'll go over those fairly quickly because I'm not sure how useful they will be to you, but they may be.

There are variables called original reason for entitlement and current reason for entitlement. The values for those variables are here on the slide. They are either old age eligible persons, they have a disability or end state renal disease. That information, this third variable I have on the slide here called Medicare status code is, the slide is not moving forward. May I have some technical assistance, please?

Alright, there you go – that's where we want it to be. So there is this Medicare status code variable that combines information about entitlement, as well as end state renal disease so that you can categorize patients into these five different groups, aged with or without end stage renal disease, disabled with or without end stage renal disease or end stage renal disease only.

In addition, there is yet another variable about end stage renal disease which is a yes, no variable. I mention these because again, it may be of interest to you to divide your populations or exclude certain populations because these groups are different. Here just looking at four different characteristics – gender, mortality, mean age and the most frequent DRG for inpatient care – you can see that the elderly are less likely to be male than the other two groups, that the people with end stage renal disease have the highest mortality rate.

Age, of course, higher in the elderly and that the top DRG, as well as other diagnoses and MSDRGs will be distributed differently in those populations. So again, my point is that these variables might be of interest to you in your proposals to help define certain populations. So if that is somewhat optional, what I want to turn to now is not optional at all.

If you remember back to the requirements set by TMS in the bundled payments for care improvement initiative, there are certain inclusion and exclusion decisions that are, shall we say, made for you but you need to pay attention to in terms of working with the data.

First of all, the inclusion required by the balanced bundle payment initiative is that the people be Part A entitled and Part B enrolled. Other requirements are that the beneficiaries not be in Medicare Advantage. Also they should not have end stage renal disease.

There is something that is mentioned in the various documents that say that people who receive benefits because they were workers in the railroad and receive benefits due to the Railroad Retirement Board or United Mineworkers Union should be excluded. However, the way in which these LDS files have been created, this is not possible to do. Do not try and you will not be able to use the denominator file to exclude Railroad Board members or United Mineworker Union members because the information is just not there.

However, talking with people at CMS, we are not concerned about that because within any health referral cluster, they would really only be a small number of individuals. So these are the inclusions and exclusions mentioned by CMS. I put another bullet in here in or out. Again, I think mortality is something that each of you and your organizations want to think about as a potential exclusion criterion.

So for the first inclusion criterion and the first exclusion criteria, what do we do? Our recommendation is to use monthly indicators. Now what do we mean by monthly indicators? First of all, Medicare participation is determined on a monthly basis and CMS gathers and maintains information related to each beneficiary's enrollment status including Part A entitlement, Part B enrollment, disenrollment.

And they do this on a monthly basis and this monthly information is available in the denominator file. So moving to Part A and Part B participation. Again, the bundle payments for care improvement initiative requires that you include Part A – sorry, that you assess Part A and Part B services and that the beneficiaries be Part A entitled and enrolled in Part B.

Just a reminder, for some of you that perhaps aren't aware, beneficiaries are not required to have Part B benefits. However, 94 percent of beneficiaries who have Part A also are enrolled in Part B.

I have put up a question here asking should you agree that only those beneficiaries with Part A and Part B coverage be included in your studied population? Our answer is yes, we agree with CMS. And the reason is seen in this next figure which shows hospitalization rates for 100 elderly Medicare beneficiaries by type of coverage for fee for service beneficiaries by age group.

And what you see here in red is that those beneficiaries who have both Part A and Part B are much, much greater users of hospital services than those who have only Part A. So these populations are different for whatever reason and so limiting your studies and your proposals to those who have Part A and Part B makes a lot of sense.

Let me go back up one. Well, the bottom of the, the prior slide said so okay, how do we determine Part A and Part B participation? And the way we do that is using the variable called Medicare Entitlement/Buy-In Indicator, often referred to as just the Buy-In Indicator.

So here you have on this slide the values for this variable. Repeating myself, for each month this variable appears so there are twelve of these variables in the denominator file record for each beneficiary. And reading through this with you, the person could be not entitled, they could be Part A only, Part B only, both Part A or Part B or have Part A with state buy-in, Part B with state buy-in or both Part A and Part B with state buy-in.

And now you are probably saying what is this state buy-in? Well, state buy-in means that a state has paid either the premium or the cost sharing for Part B for the beneficiary through either traditional Medicaid or one of the other Medicare savings programs administered by the state Medicaid program. These have wonderful acronyms called FLIMBY, QUIMBY, QDW dot and QDWI and QI.

Now the important thing is that as we showed in this figure twenty on slide 28, there is this difference between those who are Part A and part B entitled and enrolled and those who have only Part A. So we suggest that what you do is that you use the variable for state buy-in and that you select only those with the value of three or a value of C.

And we make one other recommendation is that you look at this value or this variable for the month of your anchoring event to determine whether they were A and B eligible at the time of

that event and then that you look at this variable for the subsequent months through your period of observation so you make sure that they continue to be Part A and Part B beneficiaries.

Here are some examples that you could quickly imagine, I think. This is for one calendar year so you have twelve entries, various examples of the first line here. A row of threes, so the person is covered by both Part A and Part B. The second one, a complete twelve months of C, so the person has A and B coverage; however this is a state buy-in person.

The third one, someone who was perhaps Part A entitled for five months and then decided that he or she would enroll in Part B, so became Part A and Part B covered. The next one, someone who throughout the whole year only had Part A entitlement and then other people here who have first four months of A and B coverage and then eight months where they are not entitled. Perhaps this person is dead and that information is communicated by this set of numbers.

The next to the last one, for ten months the person was not eligible, had neither Part A or Part B coverage, but then for the last two months did have coverage. And then finally someone who had state buy-in coverage for eight months followed by four months where they were not entitled. And again, this person might well have died.

In addition to these monthly variables, which we highly recommend that you use, there are some variables that I have called for this presentation number of months variables. These are annual summary counts of the number of months, so one through twelve of several of these variables that we have already discussed. So there is an HI or Hospital Insurance for Part A coverage variable, a SMI, Supplemental Medical Insurance which refers to Part B coverage, HMO coverage variable and a state buy-in coverage variable. All of which have, again, information indicating how many months the person had this type of coverage. Again, we recommend you do not work with these numbers of these variables, but that you work with the monthly variables.

Now the question of Medicare Advantage information for your projects. As I mentioned a few minutes ago, the bundle payment initiative projects are to exclude Medicare Advantage beneficiaries. The Medicare Advantage plans transmit to CMS information regarding enrollment. And disenrollment, this is generally - or not generally, it is on a monthly basis and the accuracy of these data is essential to ensure that the Medicare Advantage plans are paid appropriately and also to make sure that claims that are inadvertently submitted to the claims processor are rejected. So this information has high validity.

There is a monthly variable called HMO Indicator that tells you whether or not a beneficiary is in a Medicare Advantage plan or not for that month. Here are the values for the monthly HMO Indicator. The letters A, B or c indicate that they are in a risk for lock-in managed care plan. The numbers one or two, a non-lock-in managed care plan, which are also called cost managed care plans.

And then if they are not in managed care, they would have either a zero or for a very small number of beneficiaries who are in demonstration program, they would have a value of four and you can see in the slide here that less than a half a percent of these people in 2006 had this designation for any month.

Now this indicator doesn't distinguish between people who are in fee for service and those who are not eligible for Medicare benefits that month. It only tells you whether they were in a managed care plan. Therefore the use of the HMO indicator variable is limited to excluding those enrolled in managed care plans, not for selecting those in fee for service. A person that has the designation zero, not in managed care would not get the entitled to Medicare for that month or they could be dead.

So using this monthly HMO indicator, should you use it at the time of the anchoring event? Well, as I have read through the documentation, it seems like it shouldn't be necessary and the reason is that in the LDS utilization files that you will be receiving, only fee for service beneficiaries are included.

So we don't need to worry about it in the anchoring event again, because the services are only included if they are for fee for service beneficiaries. However, after the anchoring event, we would argue that yes, you should use this HMO indicator because after the anchoring event if there's no utilization information, you do not know if they didn't use services or moved from fee for service to managed care. So you want to pay attention to this variable, perhaps during the entire period of your observation, but certainly for the period after the anchoring event.

Now let me just present this one slide here on using these two variables, the buy-in indicator and the HMO indicator to help you define your studied population. So using the Medicare entitlement for buy-in indicator, you can determine and include those with Part A and Part B coverage. Then using the monthly HMO indicator, you can then exclude those who were enrolled in Medicare Advantage as it occurs.

A final point here is that while these first two are monthly variables, the end stage renal disease indicator is an annual variable so you will be forced to eliminate these beneficiaries for an entire year even if the disease occurred sometime in the year, like in May or whatever.

Now I have put here one last slide just trying to think how could we try to reduce the number of people on whom we don't have non-valid date of death information. I am not sure this will be useful to all of you, but let me just go through it and then we'll be all finished.

There is another variable in the denominator file called the Part B Termination Code. The values here, not terminated, dead. But in order to be coded as dead, you need to have a validated date of death. So there is no new information here compared to the other mortality information I talked about earlier.

Then there are variables called non-payment of premium, voluntary withdrawal or some kind of other termination. It would seem that if you go back to the state buy-in variable, that people who change from a three or a C and go to zero, a likely probability would be that they died.

And if it turns out that there is no other explanation for termination and having a zero in the Part B termination code, it's highly likely that they have died and might be in the four percent. So you might try using the combination of these two variables. Unfortunately, the Part B termination code is an annual variable so the most precision that you can have is the month and while you will not know the date of death, but again, it might be useful to you in the preparation of your proposals.

My last slide shows where you may go if you would like additional technical assistance. We will be on the line now for the next half hour available to answer questions that you have submitted. Barb and Faith and Pam are looking at them and will sort through them, be happy to respond to as many as we can today. If you have additional questions, please submit them to RESDAC.

And as with the information requested by Buccaneer on Monday, please in the subject line refer to bundled payments and if you could indicate your DUA number and request ID, that would help us out. So thank you for staying with us and we are now ready to answer your questions.

PAMELA PELIZZARI: I'm sorry, this is Pamela Pelizzari. I just wanted to reiterate that we are not planning on taking oral questions during this session, we are planning on using the chat feature. So people have been asking questions throughout this time and if you have any questions, now would be a great time to get them in. So through the chat feature you can send us a question and we will start going through those.

While you are sort of composing your questions and typing them in, I would love to chat for a moment about our plan going forward. An email went out today regarding how we are going to provide technical assistance in the future. So we realized that this is a big task, analyzing this data that we are providing. And we are planning on hosting some sessions with RESDAC through Marshal and some other people in the office, to help you answer these questions on an ongoing basis.

Because we know that since you don't have the data now, you might not have all the questions that you are going to have. And an email about that went out today over our list serve, the same list serve that we use to announce these webinar sessions. And that is in regard to – I mean, it will tell you that we're only going to take questions via email and that we'll be answering them in sort of open forum so that other people can listen.

And if you have any questions about that, you should email us at bundleteam@cms.hhs.gov. We would really love for everyone to get on our list serve so you can stay updated on the issues. It does look like we have received some more questions. So I will turn it back over to Marshall and the RESDAC staff to see if there is any of those that we can get answered.

MARSHALL MCBEAN: Boy, yes – let me read the question and then I'll give a response. The first question was denominator is 100 percent of the hospital referral cluster. Yes, the answer is yes to that. The next question, do the beneficiary files include everyone who was eligible or enrolled in any Medicare plan, including Medicare Advantage? Again, the answer is yes, it will include in the denominator file people in Medicare Advantage and people in fee for service.

The subsequent question from the same person, will claims information include any of those with traditional Medicare coverage or will there be Medicare Advantage claims in there too? The way those utilization files have been created, they will include only fee for service beneficiaries, there will be no Medicare Advantage claims in there.

The next question, is the DESY_SORT_KEY unique for an individual beneficiary or only unique across a hospital cluster? I think the way to answer that is within any hospital referral cluster, the DESY_SORT_KEY is unique. I believe Susie Joe mentioned on Monday that because there is a finite number of DESY_SORT_KEYs, there may be in cluster six and cluster 29 someone who has the DESY_SORT_KEY, but you will not have people from cluster 26 and cluster 6.

Although I do remember some of you may be getting multiple clusters and so I suppose if you are in that situation, you might want to merge the files and see what you get. I would hate to do a merge of one million by one million, but maybe that's what I am suggesting. Or perhaps Buccaneer has a comment. Susie, do you want to comment on that seeing that that's perhaps more your area of knowledge?

SUSIE JOE: Thanks, Marshall. The DESY_SORT_KEY is unique for a beneficiary. Now one beneficiary or one DESY_SORT_KEY may be in more than one subserve. If they move from 2008 to another area, that would throw them in another cluster in 2009, then they would be included in both, for both years. But it would still be the same person. Did I explain that?

MARSHALL MCBEAN: Right. I think what you're concerned about is people moving. What I was more concerned about and maybe incorrectly, was when you make all of these hospital referral clusters, have you had to reuse a DESY_SORT_KEY value because there are just so doggone many of these people?

SUSIE JOE: No.

MARSHALL MCBEAN: No – good. Okay, so the DESY_SORT_KEY is unique for every person and it is unique across hospital clusters. Good, thank you.

SUSIE JOE: You're welcome.

MARSHALL MCBEAN: The next question was is there a way to determine is a person aged and has had end stage renal disease, the answer is yes. If you want to go back and look at the Medicare status codes, that will solve your problem.

Please confirm the groups that were listed as excluded populations will have been in the file, but they are not to be included in the bundle project. Yes. In other words, there will be people who are in the file who do not have both Part A and Part B. So you need to go find these people. In terms of utilization files, there will be no Medicare Advantage beneficiaries, but they will be included in the denominator file, so you will want to search and exclude those people most likely.

The next question, it was mentioned that a zero value in the buy-in field means not entitled or possibly dead. That's true. Does that mean that everyone will have twelve records for each month even if they were alive for only one month in the coverage year? Yes, so that for example in the slide 31, those examples I gave, each person will have a value for every month.

Alright, we are now searching for more questions. Will the zip code be included in the utilization files since it is not included in the LDS denominator file? The answer is no. All the LDS files do not have zip codes. Pam, are you seeing any additional questions? There are 30 out there and I am only seeing seven, let me get some more.

PAMELA PELIZZARI: So I see a couple that I can answer. I mean, one recurring theme again is if the slide for this presentation will be available and I can verify that the slides are currently available. So if you go to the website for this presentation, which is on the Center for Innovation's website and we sent out a link to that, then you can see at the bottom, at the very bottom there's a link that says you can download these slides for these presentations. And that will bring you to RESDAC's website. That's where the slides are posted.

There will also be audio files posted there and there will be transcripts, so written transcripts of everything that occurred will be available. They are not currently available, currently only the slides. I also saw one person asking if you're going to receive 100 percent of the claims for an HRC or only a random sampling of 5 percent. And I can verify that the files being provided are 100 percent files, they are not a 5 percent sample. Marshall, are you able to see the rest of the questions now?

MARSHALL MCBEAN: I have more, so until I finish these, I won't complain.

PAMELA PELIZZARI: Okay.

MARSHALL MCBEAN: There's one question asking is the death date incorporated into the denominator file? And just to repeat, the actual date of death will be there only if the valid date of death switch is turned on. And so again, for about 4 percent of the population, you won't know the exact death date and it will be unclear actually whether they are dead or not.

A question that I will take a crack at and Pam, you might want to jump in. Can you tell us if deaths are excluded from bundled payment, or is that up to the facilities to propose? I would think that it's up to you to propose. One comment I'd make is in looking at the document that RKI prepared for ASPE, there's quite a difference in the actual expenditure for people who died and those who did not die. And so it seems to me, and I'm not an expert in this topic, that it is something that you will want to consider, but maybe Pam there is something that CMS wants to say about that.

PAMELA PELIZZARI: Hi, this is Pamela. So at the current time, I mean, who are exclusions are stated sort of as you stated then in this presentation. And there's no specific current policy regarding that. If you have a question about mortality and you think it's significantly affecting your target price, we would encourage you to let us know that and we can respond to that through our inbox. So that would be a question you'd want to direct to us at bundlepayments@cms.hhs.gov just to make sure we're giving it sort of the fullest consideration.

MARSHALL MCBEAN: Okay. Another question is is the denominator file on the USB hard drive discussed on Monday? The answer is yes. Another question was on Monday we clarified that this Medicare claims data does not match to Oasis and MDS. Is that the case for data available for this demonstration or all data available for RESDAC?

If I'm understanding this correctly, I would say that the thing that controls the linking and the compatibility of data is your DUA. And so the information that you will get on this USB hard drive, all of that information can be linked, again using the DESY_SORT_KEY at the beneficiary level, it is possible that you might want to bring in other information, let's say from the area resource file which is generally organized on a county level, that could be linked.

But I think it would be fair to say at the beneficiary level, the DESY_SORT_KEY is unique to your DUA and there's no way that you would be able to link that, again, at the person level to any other file. Okay, I am searching down here. Oh, here's one maybe for you, Pam. What are the implications of people with partial period enrollment to how the bundled payment periods will be handled in terms of provider responsibility for costs of a bundled service? It's question 17 if you are scanning them, Pam.

PAMELA PELIZZARI: Hi, this is Pamela – sorry about that. So you are asking what the implications of people with partial period enrollment are in terms of how to handle provider responsibility for cost of a bundled service. So it's an interesting question.

I mean, I think it's important to go back to the RK that we've put out and sort of look at the exclusion criteria. Basically what is going to happen is that every individual who is initiated into one of the bundled payments based on the essence of those definitions of the RFA, in that case the awardee is going to be responsible for the costs of all of the parts of that bundle that is initiated.

But it is sort of an, essentially an all or nothing situation. The patient will either initiate a bundle and then the provider is responsible for all costs outside of those that are specifically excluded as designated in the RFA or the person will not be initiated into a bundle.

If you have more – I know that that might not have answered exactly what you were looking for. I can imagine a number of scenarios and I just really don't have time to go into them all. So if you have more specific questions about that, please feel free to email us in the inbox.

I think – Marshall, I see some more questions that are coming and that I am pretty sure you could answer in just the last few minutes. One of them is if age will be in the denominator file as ranges or as exact age. Do you think that you could answer that one?

MARSHALL MCBEAN: That's easy. The age will be exact age. Again, it's the age at the end of the prior calendar year. It will not be in five or ten year age groups. There's another one here, what is an anchor event? We'll talk about that a little bit more tomorrow when we talk about the utilization data, but I think the quick answer is it depends on which model of bundle payment projects you are addressing. So it could be a hospitalization or it could be the initiation of post-acute care. And that is your choice.

There's a nice question here, will there be summary reports such as simple as frequency counts on all the variables in the files? That would be wonderful. And my heart is with you asking that question, but unfortunately, the answer is no. Certainly doing proc contents and proc freqs I think, particularly if you're a new person to the data, I encourage you to do these very simple things because it will tell you a lot about what is going on. Again, unfortunately there is no place, particularly at the hospital referral cluster level, to have frequencies out there.

There was a question about which variables are monthly and which are yearly. If you go to the data dictionary, it's pretty clear. The ones that are annual, the ones that we recommend you don't work with, again, we're in slide number – I apologize. The ones that are monthly – well, there's hospital insurance coverage, SMI and something, medical insurance coverage, HMSO coverage and state buy-in variables or buy-in coverage.

And these, again, are in the data dictionary pretty easy to find. And the monthly indicators, they will say in the margin where parenthesis X close parenthesis ranges from one to twelve. So you can find those if you go to the data dictionary.

PAMELA PELIZZARI: Thanks very much. So I see there are a couple of logistical questions that I can answer that are coming in now that are actually quite important. So I am going to go ahead

and answer those. One of those, if you can use this data for analysis for other CMS initiative applications such as the Medicare Shared Savings program.

And the answer to that is no. So this data is being provided for the purpose of helping you develop episode definitions and target prices towards the bundles payments for care improvement program. Because that is integral in this data request process, it would state in your research request packet, that's the purpose for which this data is being released and so that's the only purpose for which your DUA covers the use of this data. So you should not be using this for that kind of analysis.

Another question that is coming up is sort of what the logistics are involved here in terms of how you are going to receive the files. So you will be receiving the files, as Buccaneer explained on Monday, on USB hard drive so you can connect to your machine. And you will be receiving those on or around February 28th, so that's the target date that we have for data dissemination and that's the date you'll be receiving the files.

The files will be password protected, and so you'll receive that password in an email. It's very important as such to make sure that you are checking your email and expecting that to come around the 28th of February. Marshall, do you have any last questions you would like to answer?

MARSHALL MCBEAN: I just found a bunch more. One question is please clarify, will the claims utilization file contain members that have services at a facility within the HRC but the beneficiary resides outside the HRC. Let me turn that around a little bit and remind you from what was said on Monday that the people in the hospital referral clusters are based on place of residence, not on place of service. So the HRC, again based on place of residence.

So number one, if you live in Maine, you are in that group even if you go to Boston, as many of those people do, to get some fancy shmancy procedure. So the question is or the answer is HRCs are based on place of residence and any treatment that person receives will be in those claims or utilization files.

Next question was will the claims beneficiary file contain utilization and members that are dual eligibles? The simple answer is yes. Dual eligibles, for those of you who don't use the term frequently, means people who are both Medicare and Medicaid entitled.

The simple answer is yes, your second question becomes probably how do we find these people. In the dataset that you will get, the state buy-in variable has historically been used to identify dual eligible beneficiaries. The problem is how do you define dual eligibles and what I mean is how do you personally define it?

Do you mean traditional Medicaid or do you mean traditional Medicaid as well as being enrolled in a Medicare savings program - those acronyms I mentioned, QUIMBY, SPLIMBY, QDWI and QI. You cannot know who is in traditional Medicaid and Medicare without also including these other Medicare savings program enrollees.

So I don't know if that helps. You can certainly contact RESDAC if you have more, need for more detailed information. Here we live in an area with winter visitors, so I guess I might say please send me an invitation suffering up here in Minnesota. How do we know if a beneficiary is readmitted, but in another state?

That's one of the wonderful thing about the Medicare data. No matter where the patient is readmitted, you will know. So a person treated in Minnesota goes to Scottsdale Arizona or Naples Florida, that readmission to a hospital in one of those areas is linkable to their anchoring event through the beneficiary or the DESY_SORT_KEY.

Are the non-valid data death cumulative? Right, yes. Someone is doing his math here and is asking if it's true that one year of non-validated death might equal 0.2 percent, in two years it would be 4 percent. Yes, that is true.

Can a person change DESY_SORT_KEY if say he was getting eligibility under spouse's SS and spouse dies and now gets eligibility under own SSN? This is a really good question that used to involve about a ten minute answer. As background for those of you who perhaps don't understand the question totally, people's Social Security benefits are paid based on someone's work history.

And that someone could be the person or a spouse and Social Security does something very nice. They pay you based on the maximum amount that you could get. And so frequently when men worked for higher wages than their spouses, a woman might receive her Medicare benefits under her husband's Social Security number. And then when he died, she might then have her benefits based on her Social Security or work history.

I am not going to go through all the details, but because of the work that Buccaneer has done with the DESY_SORT_KEY, you don't have to worry about this. The DESY_SORT_KEY is unique no matter what happened to their health insurance claim number or how they are receiving their Medicare benefit.

PAMELA PELIZZARI: Thanks very much, Marshall. It looks like we are about out of time. I would ask that anyone who is able, click on the survey link in the bottom center of their screen and take the survey that we have to give us some feedback about if this presentation was useful to you. Again, the slides, the audio and a transcript will all be available on our website soon and we'd really love your feedback. So anything you can provide would be great.

If you have a question that did not get answered, we would really appreciate it if you could email that to us, either our address bundledpayments@cms.hhs.gov or if it's a question for Marshall and his team, you can send it to RESDAC at the email address that is currently showing on the screen. Thank you so much for tuning in. We hope to see you all tomorrow at the Understanding the Limited Dataset Utilization Files webinar at this same time. Thank you.

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