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

**Payment Variables Useful for Costing Bundled Payment Initiative Services**

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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:** Hello, this is Pamela Pelizzari from the CMS Innovation Center and thank you so much for joining us today. We're very excited to have Barbara Frank from the Research Data Assistance Center at the University of Minnesota here to talk about CMS Payment Variables Useful for "Costing" Bundled Payments for Care Improvement Initiative Services. So I think this final session in our data webinar series is going to help us tie together what we talked about in the past several days.

So I'll just move to the overview and as you can see, this is the final in our four-part series of data webinars. We really appreciate everyone who's been able to come and hear what we have to say and we hope it's been helpful. We'd encourage you before you sign off today to take the survey that you can access from the survey link at the bottom center of your screen and we want to remind you that all of these four webinars will be available in their entirety on our website very soon. So that would include both the slides, which are currently available as well as an audio recording of the entire presentation and a transcript of what was said during the presentation.

We will have those posted as soon as possible on our website and you can find them through the Bundled Payments portion of the Innovation Center website, which is located there at the bottom, innovations.cms.gov. At this point I'd like to turn it over to Barbara. Thank you so much.

**BARBARA FRANK:** Thank you, Pamela. And I'd also like to thank Jay Desai at CMS as well, as well as my colleagues here, Faith Asper and our Director of ResDAC, Marshall McBean. But before we get started with the slides, I kind of would like to take you through the ResDAC website for just a minute to point a few things out. So if you want to minimize the webcast screen, be sure that you don't close out, but please do minimize it and open up another page on your web browser and if you could, go to www.resdac.org.

And then once you're there, you'll be at the homepage. On the right-hand side in the very first blue box of our home page, you'll see something that says "Find more information about." Go to the second bullet point that says, "Payment bundling." And then once you're there, it has some information I want to point out that we do have some FAQs posted on our website that will answer a lot of questions about the initiative.

But under the overview in that very last paragraph, there is a link to the CMS website. If you could, please click on that and that does take you to the CMS Innovation Bundled Payments for Care Improvement website. On this page I'd like you to scroll down all the way to the bottom until you see the heading "Additional information on the bundled payments for care

improvement initiative." Under that click on the fourth bullet point that says "Bundled payments learning and resources area." And then yesterday Marshall McBean had referred to a metadata document. For those that did not go there and download it, it's under the heading "Data resources." And then it's about the third link down, "Metadata on the CMMI LDS files."

If you could, go ahead for those that have not downloaded that, open up that document because I want to briefly talk about the files and how they are listed because I will be referring to several of these different files. So how these datasets are set up are that for one plane, you have information that could potentially be spread across five different actual files. So on page 2 of the meta document, you'll see where it says, "LDS Extract" heading and go and see a file called "Inpatient claims." When I refer to claim level variables, those variables will be in this inpatient claims file. And anything that I have highlighted as a variable name, I use the description that is on the far right-hand side of this document.

For those that are using Marshall's slides, he used the description that was listed under the column heading called "Column name." And the other files that will get broken in the different pieces of the claim get broken into, if you go to page 4 of this document, you'll see something called INPATIENT_INST CONDITION and that's a related Condition Code file. The next one under that is the Inpatient Institutional Occurrence Code file. And then there's a file called INPATIENT_INSTVAL. That's the Value Code file. That's one of the other files that I will be referring to today that has information that's important for you to analyze the payment variables.

And then lastly the last file that puts all the claim pieces together is the file named Inpatient Revenue. Now, you have those same files for all of those institutional types of claim files. The inpatient, outpatient, skilled nursing facility, and home health. Therefore, the Part B files, the Carrier file, those start on page 8 of this document. And I will be referring to the B CARRIER_CLAIMS. Marshall referred to that yesterday as well. That will contain the information for what we call the claim level variable or the header variables that he discussed. And then the second file for that is non-institutional claim type is the B Carrier Line. And that contains information from the line item part of the claim. And I will be referring to both of those claim files as well.

So that was just an overview real quickly of how a claim is parceled out to these different five types of files or two types for the non-institutional and you may be needing information from one or more of the files to conduct your work.

So for today's presentation, I'm going to be giving an overview of the CMS payment systems so you can understand how the variables for the payment information were derived from the different types of payment systems that CMS pays off of. And then I will also be talking about the specific variables that are in these bundled payment care improvement initiative files for determining your cost of services. These next two slides are just acronyms that I tend to use quite a bit throughout the slide presentation.

So I'm going to start off with the Inpatient Hospital Services and for this bundled payment initiative, for the episode of care, the anchor event for Models 1, 2, and 4, you'll be looking at acute care hospitals as well as critical access hospitals for those anchoring events. Marshall talked about it yesterday how to find those specific types of hospitals. Acute providers will be

the last four digits of the provider number variable at 0001 through 0879. And critical access hospitals are in 1300 through 1399.

And then for those that are going to be submitting proposals for Models 2 and 3, you'll be looking at post-acute care events that might also include inpatient rehab hospitals as well as long-term care hospitals. For the inpatient rehab hospitals, those provider numbers are 3025 through 3099 as well have an R and T in the third digit of that provider number. And then the long-term care hospitals are in the range of 2000 through 2299 series. So getting back to the acute inpatient hospitals, they are paid on the Inpatient Prospective Payment System, IPPS.

And as you probably are aware of, it's a payment classification system for all of these types of hospitalizations are the MS-DRG, the Medicare Severity Diagnosis Related Group. MS-DRGs were just implemented in fiscal year 2008. How DRGs are created, they are run through a grouper and the variables... Excuse me just a second. The variables that are used from the claim information to create what the MS-DRG is is the principal diagnosis. You can have up to eight secondary diagnoses; up to six ICD-9 procedure codes; the age of the beneficiary; the sex as well as the patient discharge status.

So once CMS has calculated what that MS-DRG is for that hospitalization, they will calculate that MS-DRG payment. And how they do that, they calculate the prices based on both operating and capital costs so that they start off with a base payment rate that is the standardized amount and it's divided into labor and non-labor shares. The labor share will be adjusted by a wage index for where that hospital is located. For the non-labor share, it's only adjusted for hospitals that are located in Alaska and Hawaii for the cost of living. And then that base payment is multiplied by the MS-DRG weight.

Additional payments can be made to a hospital that serve a disproportionate share of low-income patients or what I refer to as the DSH adjustment as well as to teaching hospitals that incur indirect costs of medical education. So these are further adjustments that could be made for both the operating and capital costs.

So how the actual formula for an MS-DRG payment for the IPPS operating payment. Again, you have the standardized labor share. So for example, for fiscal year 2009, the standardized labor share was $3,654 for hospitals that were located with wage indexes of greater than 1. And you would take that amount and multiply it by the operating wage index for that hospital. An example of one would be 1.0224. And then you would add in the standardized non-labor share. And for example, for fiscal year 2009 that amount was $1,553. If there was an adjustment for a hospital, you would also multiply that by the COLA adjustment.

And then if the hospital again had any kind of IME or DSH adjustment factors, you would multiply that amount by adding 1 plus those adjustment factors. An example for an operating IME adjustment factor would be 0.042 and for a potential DSH operating wage adjustment factor, it would be 0.4495. And then you would take that amount and multiply it by the MS-DRG weight. An example of MS-DRG weight for a stent placement would be 3.22 and you would get that amount for the IPS –- excuse me, IPPS operating payment part of the MS-DRG.

Then if you want to calculate the price or the cost, the payment for the IPPS capital payment, that again starts with a standard federal rate. An example again of that amount for fiscal year 2009 was $461. And that gets multiplied by the geographic area factor for that hospital. An

example would be like 1.0869. Again, another adjustment for hospitals located in Alaska, Hawaii. And again, adjustment factors for DSH and IME if they happen to have them. And then that total amount gets multiplied by the DRG weight. And that amount gets for the capital payment would get added back with the operating payment for the full MS-DRG payment that you would find in the claim payment amount. It doesn't hold the full amount, but I'll talk about the claim payment amount later.

If you are interested in calculating a hospital base MS-DRG payment, all the information and tables that are needed can be found on the CMS website. I've just given you the link for the tables for fiscal year 2009 for example.

The reason why I showed you the detail of what goes into calculating the MS-DRG payment is because under the Bundled Payment Initiative, they do have some exclusions. So you are expected to offer a discount to Medicare from the usual Part A hospital inpatient payments, specifically the MS-DRG payment that's calculated to include all the payment adjusters and any applicable outlier payments except you're supposed to exclude DSH payments, hospital capital payments, and IME. So if we go back to that MS-DRG payment for the operating portion, you'll want to remove the amount of the payment portion for that operating IME and operating DSH adjustment factor that I've highlighted here in red.

Likewise, for the capital payment, you'll also basically want to remove all payment that's related to that IPPS capital payment portion. So it's the entire formula for that piece of the MS-DRG. So how will you be able to do that? There is a variable in the Inpatient file and it's in that Inpatient Claim file that will adjust for the hospital capital payments. So the variable is called Claim Total PPS Capital Amount. This variable contains the capital portion of that inpatient PPS capital payment and so you can use it to adjust for your acute care IPPS payment that you'll see in the claim payment amount and remove it. This capital total PPS amount includes any adjustment factors that had IME or DSH capital payment adjustments.

Likewise, for the portion that was in the red that you needed to eliminate for the operating disproportionate share amount and the operating indirect medical education IME amount, you will have to use the file that's called the INPATIENT_INSTVAL or Institutional Value Code file. And then what you will want to do is look for the variable claim value code and then associate it with the dollar amount for the particular claim value codes of interest. That amount will be located in the Claim Value Amount variable.

The two code values of interest for DSH and IME are code values of 18 and 19. Eighteen is the operating disproportionate share amount and 19 will indicate an operating IME amount. And likewise you will then be able to take those amounts and adjust the claim payment for that. And that's how you would adjust for anything related to the MS-DRG payment for your calculations.

Now, the next type of anchor events that you can look at may also come from critical access hospitals. Now, they are not paid on a PPS basis, on a prospective payment system. But instead Medicare reimburses critical access hospitals based on each hospital's cost and not on that calculated DRG that I just reviewed. They are reimbursed for inpatient, outpatient, lab, therapy services, post-acute care in swing beds. However, as Marshall stated yesterday, we wanted to reiterate, you can still find that anchor event using the MS-DRG because even though they're not paid on it, it is still calculated and populated in the file.

But because of how critical access hospitals are paid, you will not find any capital payment amounts that I just referred to. They also have no per diem amounts. CMS is aware that there's no way to exclude any kind of capital payment amounts for critical access hospitals. Critical access hospitals also are not paid directly for any kind of disproportionate share or IME so you will not find those value codes of 18 and 19 for critical access hospital providers.

So moving on to the post-acute types of payment system that you'll find for the models. The first one is the long-term care hospital payment system. And they are paid as well under long-term care prospective payment system. It's very similar. Payments are based on a single standard federal rate for both inpatient operating and capital related costs. But keep in mind that long-term care does not include a certain pass-thru cost. And I'll be talking about some pass-thru costs when I talk about the payment variables.

But they do not get paid for bad debt, direct medical education, and technologies. However, they also do not provide adjustments for a DSH or IME so you won't have to worry about that. They do have adjustments though to the payment that may occur due to a short stay outlier, interrupted stays, high-cost outliers, the wage index, and cost of living adjustments.

The next post-acute care that you'll find in the inpatient claim type is the inpatient rehab hospitals. They, too, are paid under a prospective payment system. And the payment classification system for IRFs are the Case-Mix Group. And so this payment is again based on a standard payment amount for operating and capital cost for that facility. And it is adjusted for wage, the percent of low-income patients, locality, transfers, interrupted stays, short-stay cases, deaths, and high-cost outliers. So some or all of those could apply. They do have a DSH and IME payment amounts in the Claim Value file if you're interested in that.

The next payment system I'm going to talk about is the outpatient hospital payment. They, too, are paid on the prospective payment system. The payment classification system is the Ambulatory Payment Classification, APC. And it's based on HCPC codes that are reported and classified into an APC. Some APCs have composites that bundled HCPCs that are reported. The information that you'll look for payment because in the HCPCs will be in the Outpatient Revenue file unlike being in the Claim file. And I'll talk about them both, but the HCPCs are found in the Revenue file.

The next payment system or systems are the skilled nursing facility and home health payment systems. Again, both of these are paid on a prospective payment system. The payment classification for skilled nursing facilities is the Resource Utilization Group or RUGS-III. And then for home health, their classification system is a case-mix category for the Home Health Resource Group or HHRG. If you want to know what that classification or the RUG or the HHRG for each one of these, for the SNF, you will find it in the Revenue, the SNF Revenue Center file with the Revenue Center code of 0022. And for the home health, you find it the 0023 in the HCPC field or if it was downgraded in an APC field.

For both of these, they are prospective payment systems and again the reason why I refer to them as overall prospective payment systems is that as Marshall kind of stated, you won't be able to get to specific type of services necessarily to price those out but just the overall payment for that stay or the home health care episode.

Now, getting into the specific payment variables that are in the files, each type of a file, Inpatient, Outpatient, SNF, Home Health, Carrier, and DME, I'm going to talk about three overall categories of payment variables. The payment variables that are related to what was paid by Medicare or what Medicare directly reimbursed that provider for or the payment that was made for beneficiary. We like to refer to it actually as the beneficiary responsibility because you never really know did that come out of the pocket of the beneficiary or did they have a Medigap policy or did someone actually pay for it else but it was the beneficiary's responsibility?

And the third type of payment variables that we will refer to is the primary payer. Why we're talking about the primary payer is because that is another exclusion under the Bundled Payment Care Initiative. You are not to include any services that are paid for by another primary payer. So you'll want to look for those variables as an exclusion.

So the category for Inpatient, SNF, and Home Health for the claim variables. You really can only analyze at that claim level. So you may only need to use the Claim Inpatient Level file or the claim SNF or home health. But for the outpatient carrier, the physician type services, and the durable medical equipment type services, those types of services can be analyzed both at a claim level. So you would find potentially for a physician claims that in that B Carrier Claim file, the claim level information.

And then for the specific HCPC and what was paid for specific service, you would look under the B Carrier Line file. So you may be using both files for carrier and DME. Outpatient, again it would be the Outpatient Claim file and the Outpatient Revenue file that you will be looking at. You don't have to worry about the Value Code files like you do for the inpatient.

So going back to the inpatient payment variables, the variables that are important to know about are the claim payment amount, the claim pass thru per diem amount, the claim utilization day count, the NCH beneficiary inpatient deductible amount, the beneficiary Part A coinsurance liability amount, the blood deductible liability amount for the beneficiary, and then lastly that primary payer claim paid amount.

So going back to the specific variables now for the inpatient claim payment amount. This payment amount includes that MS-DRG payment, any outlier that approved payment amount. It does include that disproportionate share in the IME, the total PPS capital amount. And then after April of 2003 it now also includes any amount that is a new technology add-on amount. So what is not included in that claim payment amount field. It does not include any pass-thru amounts that were not part of the MS-DRG. And again, that claim payment amount is only what Medicare reimbursed. So it would not include anything that the beneficiary paid such as their deductible or coinsurance or anything that a primary payer would have reimbursed. So it is truly just what Medicare paid for that MS-DRG.

Now, if you are interested in getting the total amount that was reimbursed by Medicare, you might want to also look at that claim pass-thru per diem amount variable that is in the Claim Level files. And what gets included in this pass-thru per diem amount are items that are reimbursed that are not included in the MS-DRG. They might include direct medical education and typically acquisition costs for organ donations. It also includes bad debts that some hospitals may get reimbursed.

So, to calculate the total payments made to a hospital, you would take that claim payment amount that includes any outlier payments plus the MS-DRG portion. If you want to get the total amount, you would take that claim pass-thru per diem amount and multiply by the number of the claim utilization day count. So that amount actually has to be multiplied by how many days CMS covered for that stay. So for instance, if there was a utilization day count of 5, you would multiply the claim pass-thru per diem dollar amount by 5 to get the total amount and sum that to the claim payment amount for the total amount reimbursed by Medicare for that inpatient stay.

I know that you may not be concerned necessarily in looking at what is made by the beneficiary or what the patient responsibility is, but there are three variables and I'm going to highlight them simply because I'll be talking about things to consider later on. But there are three variables that get the total amount that the patient is responsible for. And that is the beneficiary inpatient deductible amount. And that is charged regardless of how long a beneficiary is in the hospital. It's a set amount for each fiscal year. And then for the beneficiary Part A coinsurance liability amount, you typically only see coinsurance amounts paid by the beneficiary when you get into long stays and coinsurance starts to kick in.

You do see some blood deductible amounts for beneficiaries, mostly in the Inpatient files. But if you ever wanted to know the total patient responsibility, you would sum those three variables. And all of these are at the Claim Level file.

And then lastly, the total amount that may be included for any kind of payment is that primary payer claim paid amount. Again, if you want to exclude the claims, the easiest way is to find any claim that has an amount greater than zero in this field to make that exclusion.

For the inpatient payment variables, the revenue center payment amounts are not in the inpatient CCWB files. So you can really only use claim level calculations. If you are interested in what revenue codes are billed by the hospital, you could still use that inpatient revenue center payment information just to look at the revenue codes that were billed, but you won't find any exact payment amount for each of those revenue center codes.

For skilled nursing facility payment variables, they're essentially the same as the Inpatient files, but you don't have any claim pass-thru per diem amount in these EPI files. So you only have the claim payment amount at the claim level. And likewise for the skilled nursing facility, there's no payment information at the revenue center line item necessarily. Potentially if you're interested in how they calculate that payment for the revenue center code, it's 0022. They do take that revenue center rate amount times the units count to get the total payment for that. But you'll have that in that claim payment amount so there's really no need to go to a Revenue Center Payment Amount file.

Moving on to home health payment variables, again I recommend really only using the Claim files, Level file for the home health care. And you'll only have to worry about the claim payment amount for the home health care because that's the only one that is populated in the files. Again, you'll want to remove any that had payments made by a primary payer. The variable name is the primary payer claim paid amount.

For the payment made by beneficiary, there is no claim level variables. Why not? Because home health really does not have any copays or deductibles for beneficiaries so it was never included.

You might find a few copays at the revenue center, but it's very, very rare and that field is not in your file so you don't have to worry about it. Now, there are some revenue center payment amounts in that HHA Revenue file that are found. The reason being is for LUPA. LUPA are the low utilization claims. In other words, they were home health care episodes that had four or fewer visits and because of that they'll pay it on a per-visit versus PPS episode of care. And you can find revenue center payment amounts populated in that variable revenue center payment amount field if you want to look at specific things. But the total will still be at the claim level for that claim.

Moving on to the outpatient hospital facility payment variables. Again, at the Outpatient Claim Level File Variable file, the variables for payment made by Medicare, you only have to worry about one and it is the claim payment amount. Again, this is what Medicare reimbursed. Only it does not include any primary payer amount or any beneficiary amount that they were responsible for. So you still have to exclude any claims going to that primary payer, claim paid amounts to find those, and then the payment made by the beneficiary or payment responsibility. There are three variables: the beneficiary Part B deductible amount, the beneficiary Part B coinsurance liability amount, and there's also a third, the beneficiary blood deductible liability amount. It's rarely populated in the Outpatient file, but if you just want to set up your program to be all-inclusive, there are the three variables.

Now, as I stated, if you're interested in looking at specific services, you can do that with the Outpatient Payment file even though they do use the APC for payment. It is actually paid on the APC, but you'll typically see payment amounts for almost all HCPCs unless a particular HCPC is bundled with another one for those consolidated APCs. And in that case you would find a zero payment amount for a HCPC that might be rolled into a consolidated APC. But the payment variables are found in the Outpatient Revenue file. So for these revenue center variables, it's the revenue center payment amount, which is what Medicare reimbursed.

Then you have that payment amount for the primary payer. That variable is called Revenue Center Medicare Secondary Payer Paid Amount. And then the payment that is responsible for by the beneficiary is the Revenue Center Patient Responsibility Payment.

Moving to the Carrier file, which would contain physician services, nurse practitioner services, those types of services that Marshall referred to yesterday, as well as the durable medical equipment services. At the claim level again you would use the claim payment amount to determine what Medicare reimbursed. Again, that is not the full amount due to the provider, but it's only what Medicare reimbursed. And then you have the Carrier Claims Primary Paid Amount so that would indicate there was another primary payer other than Medicare.

And then the payment that is responsible for the beneficiary, you actually have to go to the Claim Level file and sum up two line item variables: the line coinsurance amount and the line beneficiary Part B deductible amount. So if you want the total amount that's responsible for the beneficiary, you'd have to go to both the Claim Level file as well as the Line Level file that you will receive.

But if you just wanted to use the Line Item file, you could do that very easily with these two different types of files, the Carrier and the DME because that is where the HCPC... In that Line file is where the HCPC is located. So you would know exactly what service it is. You would know

who the performing provider is as well as the payment amounts on these line items. So if you were looking at the calculations in the Line Item file, again the variables are the lines, payment amount, the line beneficiary Part B deductible amount, the line coinsurance amount, and there is also a line beneficiary primary payer amount.

So that is all the variables that you will be wanting to use in these different files to account for what Medicare paid to think about what the beneficiary was responsible for and to determine if there was another primary payer. So again, other things to consider when you're doing this, you will find some zero payment amounts in line item services that are allowed. So why would you find something that Medicare, a zero Medicare reimbursement amount? Well, it's usually because the deductibles are paid by the beneficiary.

So let's say it's the very first claim of the year and that line item reimbursement for Medicare was only $60, but their deductible for the very first claim was $120, you would see a zero amount in the line payment field for what Medicare reimburses because it's all in the Part B deductible that's the beneficiary's responsibility. So things to consider when you're doing this that you will have some zero payment amounts that are legitimate.

Other things you might want to consider when you're looking at payments are the denied claims at a full denied claim level or a particular line item. Particularly for the Carrier file, you do get claims that the full claim can be denied or you could get a claim that is partial denied where some line items are approved and paid for and some line items are denied. And if you want to completely get rid of them at the claim level if the full claim's been denied, the variable to use is the Carrier Claims Payment Denial Code, but if you go down and only use that part, the B Carrier Line Item file to look at your services and payments, you can use the line processing indicator code to determine if a line item was allowed or approved or denied.

Why you might want to consider that is because if you just look at what the average cost for a particular service would be, if you included denied claims for a particular service, it might be $36.95, but if you removed any denied claims or line items, that same service would have an average cost of $42.82. So that's something to consider in your analysis. For the institutional files not very often do you see denied claims, but the variable to use to find any denied claims is the Claim Medicare Non-payment Reason Code. And that is in the –- for each institution in the Claim Level file.

Other things to consider. Negative payment amounts. In the Inpatient file particularly you will find negative payment amounts. Why would you do that? Well, it's because the beneficiary is charged the full deductible and during a short stay that deductible may actually exceed the amount that Medicare reimburses for that hospital claim stay. It can also be due to a transfer so that beneficiary deductible is on that first hospital's claim and then you would not find a deductible on that second hospital claim that that beneficiary was transferred to because the beneficiary is only charged one deductible per episode stay.

And then you can also find negative amounts when it gets to the point that the coinsurance during a very long stay exceeds the amount that Medicare is responsible to pay. So for an example, with psych hospitals you often find long stays where you have high coinsurance amounts.

So in summary, just wanted to make sure that you have an understanding of the payment system that would drive what payment variables are available in the CCW files and understand that really

for only the inpatient SNF and home health would you probably want to use the Claim Level file, but you can analyze Service Level information in the Outpatient, Carrier, and DME.

Lastly, just to wrap things up, if you have any questions, please feel free to contact the ResDAC help desk at resdac@umn.edu. When you do, please put in the subject line reference bundled payments and also include your DUA number and your request ID in your email. That concludes my presentation.

**PAMELA PELIZZARI:** Thank you so much, Barb. So at this point we're going to take questions. We're only going to take them via the chat feature. So if you have a question, if you could type it in and we'll be answering questions that have come in through the chat. I'll give Barb and the ResDAC team a couple minutes to sort of look through the questions that are there at this point. I do see a couple that I can answer from the perspective of the Center for Innovation.

So I think there's a couple things that it might be important to clarify. One of them is regarding critical access hospitals. Some people have asked about critical access hospitals. And you're correct in your understanding that the request for application does specify that only hospitals paid under the IPPS are eligible to apply for this program. So that means that critical access hospitals wouldn't be initiating bundles. So if you're doing say a bundle for major joint replacement, DRG470, you won't be initiating patients at a critical access hospital. Patients who have that surgery at a critical access hospital will not be in a base payment.

But if you're working say at another hospital, you realize that in several of the models you're at risk for readmissions and those need to be calculated in your target price. So those readmissions even if they happen at a critical access hospital, will need to be taken into account and that's why it's important to understand what Barb has said about identifying costs for those institutions because you'll need to take into account sort of everything that happens in that episode period when you're calculating your target price.

Another area that we got a lot of questions about so far is how you deal with IME and DSH payments. So Barb explained some really useful things about these files and how IME and DSH present themselves. In the Bundled Payments for Care Improvement Program, in Models 2 and 3 all Medicare fee-for-service payments are paid at their usual rates, but you should be proposing to us a target price that excludes IME and DSH payments. So those payments should not be included in your target price and they won't be included in payment reconciliation. So that's important to know.

In Model 4 as well IME and DSH payments will be calculated based on the non-discounted base operating payment that would otherwise have been paid for the applicable MS-DRG for the episode that you're doing. So in all of those models, it's important to note that your target price is not meant to include IME and DSH payments and they won't be included in the payment reconciliation calculation. I hope that clears at least a couple of things up. I did see questions about those things sort of repeatedly. Barb, do you see any questions that you and the team would like to answer at this point?

**BARBARA FRANK:** There may be one other question that you might want to address and that's why you might want to exclude payments that other primary payers paid.

**PAMELA PELIZZARI:** So I'm not sure if I exactly understand the question. I know that we've discussed a bit about primary payers on this webinar and it's important to note that patients who –- beneficiaries who don't have Medicare as their primary payer won't be initiating service –- won't be initiating episodes under this program. So for instance, that would be a beneficiary who has another private insurance. Maybe they're still employed and so Medicare is the secondary payer. So it's important to look at that when you're deciding who will be initiated into an episode, which beneficiaries for instance at the institution will be initiated. But I think that I'm not necessarily in a position to comment on the theoretical underpinnings of that policy at this time.

**BARBARA FRANK:** Okay. And just to explain who can be other primary payers. As Pamela said, I may be 65, still working so I have my employer as my primary payer. Some questions came in wanting to know if Medicaid was a primary payer. That is the one example where if you're dual-eligible and you have both Medicaid and Medicare, Medicare is the primary payer. However, you might have a hospitalization that might have been related to an auto accident and in that case an auto insurer would be the primary payer versus Medicare. So that's another example of what a primary payer may be.

Another question about how do you figure out which hospitals are critical access hospitals. Again, you would use the last four digits of the Medicare Provider Number of 1300 through 1399 to determine that.

Another question, are SNF payments daily or monthly? In essence they're actually a per diem payment and so they'll take the number of units times that payment rate to determine the overall SNF payment amount that is located in that Claim Payment file.

A lot of the questions were related to primary payers. There's a question is the claim payment amount for the MS-DRG the number we need to fixate on our projects? Yes. So for whatever projects for whatever MS-DRG that you're looking at, the claim payment amount for that inpatient stay would be the amount. But if you wanted to look at total amounts that Medicare reimbursed, you would also have to include a pass-thru per diem. Some hospitals do have approved pass-thru amounts. And then you would have to multiply that by the Claim Utilization Number to include for the full amount. But maybe, Pam, on a program note, I could be wrong whether or not they want to include any of those pass-thru payment amounts. [inaud.] you want to address that or not.

**PAMELA PELIZZARI:** Yeah. I think that that's a good question to pass to our inbox because I think we would need a little more information from sort of the questioner regarding what situation they're specifically in that we can't sort of elicit during that setting. So we would encourage you to send that question to our inbox at bundledpayments@cms.hhs.gov.

I see another couple of questions here. One of them is regarding how long-term care hospitals or LTCHs are hundred under this project and if you'll be receiving data for those. And I can verify that you will be receiving data for long-term care hospitals under this initiative. The payments to long-term care hospitals will be included when you're calculating your target price. So since some of these episodes do include post-acute –- the post-acute period, the post-discharge period from the index MS-DRG admission, you would need to include payments to LTCHs for those patients. LTCHs are included in the claims data you're receiving as an institution. They will

be in the Inpatient file. And so you will need to include those in your target prices. They work a little differently. They're different models because of sort of who's applying for Model 2 versus Model 3. But I can verify that LTCHs are very much included in these episodes.

**BARBARA FRANK:** There was a question on Slide 29, should the plus sign actually be an equals sign? No. It is correct. Those are all different variables and if you want the pass-thru payment amounts are not included in a claim payment field. That's right. It's a plus and not an equal.

**PAMELA PELIZZARI:** I see another question here regarding if Medicare Advantage plans will be included in the bundling program. And I can verify that patients, beneficiaries who are in a Medicare Advantage situation would not be initiating bundles. So the bundle is only initiated by the sort of target MS-DRG that's explained in your application for Medicare fee-for-service beneficiaries, not for Medicare Advantage beneficiaries.

**BARBARA FRANK:** The next question, does the claim total PPS capital amount specified on Slide 17 include the capital portion of any outlier payment? The answer is yes. As long as you use that total.

**PAMELA PELIZZARI:** I have a clarification. So it looks like someone was confused, at least one person was confused by my comment regarding IME and DSH. So they are excluded from your discount calculation and they're excluded, but you will still receive IME and DSH payments. Essentially you'll receive IME and DSH payments as though this program wasn't happening. So your IME and DSH payments should be reflective of what they would be in the absence of this program. And exactly how that occurs is explained in the FAQs on the bundled payments website. So you're not losing IME and DSH. That's not what's happening.

**BARBARA FRANK:** Another question, will we be able to identify specific physicians by an NPI number? You will be able to know which physicians did provide services to beneficiaries. However, the NPI number or any identifiers in the Carrier File for physicians will be encrypted. So you won't be able to know that it's Dr. John Smith, but you will be able to know that this physician had this level of services.

**PAMELA PELIZZARI:** Thanks so much. I see another one, which is can the bundled model include pharmacy costs post-acute discharge? So I think that this means after someone is finished with whatever post-acute setting they go to, whether it's a SNF or an inpatient rehab facility, would you include pharmacy costs? I can verify that Part D pharmacy costs or outpatient pharmacy costs will not be included in the bundled payment model. Part B drugs, which we've discussed in these webinars, Part B drugs will be included. So those are more of your provider-administered pharmaceuticals. They're not the kind that patients would be getting at their outpatient pharmacy. Those are included. But Part D drugs that patients would pick up when they are discharged sort of on their own at their pharmacy covered by Medicare, Part D, those are not included.

**BARBARA FRANK:** Another question is will the NPI for the inpatient hospital be encrypted? The answer is no for all institutional providers. Those are the providers that would be in the Inpatient, the Outpatient, the Home Health, and the Skilled Nursing Facility file. You will have the true six-digit Medicare Provider Number. That will not be encrypted. You could request a provider service file or download a hospital name and address file from the CMS Cost Report page. If you have questions where to get those, you can email ResDAC.

**PAMELA PELIZZARI:** So, I see an interesting policy question that someone is discussing that yesterday we talked about the patient data being based on the HRCs of people's home address. So sort of when I'm looking at these episodes, how do I ensure that the correct individuals are being triggered into DRGs so that I'm capturing everyone that will be captured during the program? And what we can say again is that you have individuals at your institution that maybe are having a target. Let's say you're a hospital and you're doing a certain MS-DRG. So every individual who triggers that MS-DRG, who has that procedure, who isn't excluded for one of the reasons we've discussed regarding Medicare Advantage, they'll all be included in this program and so you'll have the ability to look at their care pattern regardless of where they go afterwards.

So if they have the procedure at your institution and then they do their post-acute care somewhere else in a different state, you'll still have the information because all the information is based on their home address. If their home address is not in a hospital referral cluster that you have received, then you won't have that data. So that's why we asked you to break down your patient population by their home address and that's how we determined which HRCs you'd receive.

So we understand that a small percentage of your patients you may not have in the data you receive because of these things, that their home address is sort of far away or that they live in a region where you only have sort of .1% of your patients coming from and so they won't be included in the data you receive. And we would ask that you propose a target price based on the data that you have available. So if that only covers 95% of the beneficiaries that you would be initiating episodes for, that's fine. And we'll be looking at the visit you bring in and we'll help you to understand if that's going to be a problem, but we recognize that that's sort of, that you can only work with the data you received. And it is not possible to sort of request little bits of data from other regions that you've not already been approved for.

**BARBARA FRANK:** And again another question, what resources can I find with dollar in the calculations? Again, in the MS-DRG claim payment amount, it does include the amount that Medicare reimburses for capital payments of that MS-DRG as well as any adjustments made for the disproportionate share, the hospital as well as an indirect medical education. So if you need to –- want go to exclude the capital portion, there is a variable, that capital PPS amount variable that I referenced in the slide, as well as you need to go to the Inpatient Claim Value file and find value codes equal to 18 and 19 for any DSH or IME amounts that were included in that claim payment amount field.

**PAMELA PELIZZARI:** There's a couple of good questions regarding if the provider identifiers will be encrypted in the files that we're providing even if certain providers are employed by the system requesting the data. And we can verify that yes, the NPIs are not going to be identifiable in these files. You can identify institutional providers, but you cannot identify those individual physicians even if they're employed by the system requesting the data. As you can imagine because this is geographically specific data, if we have identifiable provider IDs only for physicians for instance, that would be available to everyone else in the region. So the system I imagine wouldn't agree to that. So in these research files, that's the way they're constructed. You'll be able to identify institutional providers but NPIs for individual physicians will be encrypted.

I see another question about the length of the episode. Does the bundled payment sort of have to include this full 30 plus day post-acute period? And the answer is yes. So you can see in our

RFA the exact way that that applies to each of the models, but it's important that you keep in mind when you're constructing your episode the length that it has to be. And there is some leeway in the RFA that you can go to depending on which model you're interested in applying for. So we're not telling you necessarily exactly how many days the episode has to be, but it does always have to be longer than a certain period of time which you can see in the RFA.

So I think that the stream of questions is starting to slow down and we're glad that you've all been engaged throughout this presentation. We've gotten some really good questions. And as we mentioned on the line there are some that we would really encourage you to email us at bundledpayments@cms.hhs.gov. We recognize that these are not simple issues and we are here to help you work through things that you don't understand or problems that you're having as you're analyzing this data.

I think it's important to remember that all of these presentations have been recorded and they will be available online for you to listen to again if you need to or to read a transcript of what transpired throughout the presentation. We will be putting those up within the next few days. They're not all currently available. I think today only the first one has been posted on the ResDAC website. But we're working to get those files up. It takes a little bit of time on our side. And we apologize for that, but we will have them up within the next week, all four of them so that anyone who wasn't able to attend is able to.

If you have any questions that weren't answered during this presentation, please email them to us. And we can make sure they get to the right outlet as long as you sort of get us your question. So the ResDAC individuals who participated in these calls for the last three days are the best source for information like we've been discussing today. And you can see their email address, resdac@umn.edu. And what you need to include in your email, that's up on your screen right now. If you're not sure where to direct your question, you can send it to us at bundlespayments@cms.hhs.gov and we'll be happy to get back to you as soon as we can.

Remember that the target date for dissemination of this data is February 28th, 2012. So if you've requested and received approval for data through the bundled payments program, that's when you can expect to receive it. And if you have any questions about that process, those you should direct directly to the Center for Innovation at bundledpayments@cms.hhs.gov. We are working to get you that data of course and we hope that you feel better prepared for it now that we've had this opportunity to discuss the files.

From now on as referenced in an email that we sent out this week, we're going to start having open-forum calls. So if you submit a question via email, we're going to answer them on a phone call. So it won't be a webinar like this but just a phone call. And those we hope will be a good opportunity for ongoing discussion about this claims data analysis. We look forward to that and if you have any questions or if you're not on our list and you want to join, please email us at bundledpayments@cms.hhs.gov and we can help you out. Thank you so much. This concludes our presentation for today. And please take that survey before you go just to make sure we understand what your learning needs are and how we can better assist you in the future. Thank you and have a nice day.

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