Public Listening Session: Defining an Episode Logic for the Medicare Population

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Goals and Purpose

- Goal: Define an episode logic that is transparent and designed for the Medicare population.
- Purpose of today: Solicit advice on approaches to defining episodes for the Medicare population

Background

- Concern over rising health costs and uneven quality
- Need to identify and encourage more efficient health practices
- Necessary tools:
  - Measures of resources used
  - Measures of quality

Background

- MedPAC, GAO recommended using resource use information for feedback and measurement and have analyzed the use of various tools
- CMS research
- MIPPA required a program to provide feedback
- MIPPA required development of a PVBP plan

Background

- Episodes one way to measure resource use
- The foundation: the logic to define episodes
- Much work has already been done, but need:
  - Focus on the Medicare population, payment system and care settings
  - Transparency

Physician Resource Use Measurement & Reporting Program

Physician Resource Use Measurement & Reporting

- Statutory Authority
  - Medicare Improvements for Patients and Providers Act of 2008, Section 131(c)
    - The Secretary shall establish a Physician Feedback Program under which the Secretary shall use claims data (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care. The Secretary may include information on the quality of care furnished by the physician (or group of physicians) in such reports.

Physician Resource Use Measurement & Reporting

Phase I

- Use both ETG and MEG to calculate episode costs; calculate per capita costs from all claims
- Assess several approaches for:
  - Risk-adjustment
  - Attribution
  - Benchmarking
- Produce resource use reports (RURs) for several acute and chronic conditions
- 1-on-1 individual interviews with small samples of physicians (3 rounds)
- Distribute RURs to a large sample of physicians (2 waves)

Physician Resource Use Measurement & Reporting

Phase I

- Medicare Physician Fee Schedule
  - Calendar Year (CY) 2009 Final Rule (73 FR 69866)
    - Interim Final Program Parameters
  - CY 2010 Final Rule (CMS-1413-FC 474)
    - Finalized Program Parameters

Physician Resource Use Measurement & Reporting

Phase I

- Acute conditions
  - Community-acquired pneumonia (CAP)
  - Urinary tract infection (UTI)
  - Hip fracture
  - Cholecystitis (may also be classified as chronic)
- Chronic conditions
  - Congestive heart failure (CHF)
  - Chronic obstructive pulmonary disease (COPD)
  - Prostate cancer
  - Coronary artery disease (CAD)/acute myocardial infarction (AMI)

Physician Resource Use Measurement & Reporting

Phase I

- Process Medicare FFS claims data to run optimally with each grouper
- Use only one grouper per RUR design
- Populate RURs with relative cost performance scores from either grouper
- Not evaluating which grouper is “better”

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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[FIRST NAME][LAST NAME], [TITLE]
[ADDRESS 1]
[ADDRESS 2]
[CITY][STATE] [ZIP]

Dear [Dr./Ms./Mr.] [LAST NAME]:

A few weeks ago, CMS sent you the attached Notice from Medicare to inform you that you had been selected to receive a confidential resource use report as part of Medicare's new Physician Resource Use Measurement and Reporting Program. The purpose of this initiative is to provide physicians and other professionals with confidential information on how the resources used in the care of their Medicare patients compares with that of their peers. Enclosed please find your confidential report.

The resource use reports generated for this program display aggregate resource use measures, as well as more detailed breakdowns of costs for individual physicians. The measures, based on Medicare claims data, have been adjusted to account for differences in patients' clinical, demographic, and socioeconomic characteristics. The measures have also been standardized nationally so that the reports do not reflect geographic or institutional differences in medical input prices or supplemental payments (such as graduate medical education adjustments).

As was indicated in the advance Notice, CMS is very interested in hearing your views about your resource use report, especially with regard to the following:

- How the resource use and cost information is displayed in the report
- How useful the per capita and/or per episode resource use measures are in helping you understand your overall practice patterns for Medicare patients
- How useful and actionable the breakdowns of resource use by cost of service categories are in helping you understand what is driving costs of care for your Medicare patients
- Whether the clinical conditions selected for the report are reflective of your practice

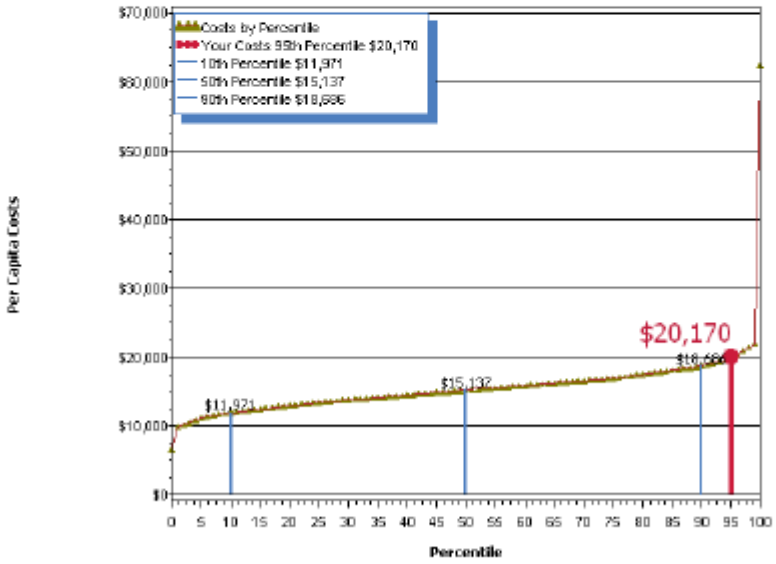
SECTION I: PER CAPITA COSTS

This section provides summary information on the per capita costs of your Medicare patients for 2005 through 2007. For an explanation of the costs included and attribution of costs to you and your peers, see **Exhibit A: Attribution of Costs.**

Exhibit 1 shows the per capita costs for Medicare patients for all General Internal Medicine physicians in IN in 2007, from lowest to highest, by percentile. The average per capita costs of your patients in 2007 were higher than **95 percent** of all other General Internal Medicine physicians in IN.

Based on all Medicare Part A and Part B claims submitted by all providers for your 792 patients in 2007 (compared to 852 patients on average among General Internal Medicine physicians in IN), average per capita costs for your Medicare patients were $20,170.

Exhibit 1. Medicare Per Capita Costs Among General Internal Medicine Physicians in IN, by Percentile 2007



The per capita costs for selected service categories for your Medicare patients compared to those of other General Internal Medicine physicians in IN are shown in Exhibit 6. Your per capita costs are based on all Medicare Part A and Part B claims submitted by all providers for your 792 patients in 2007. The costs for each category are averaged across all of your patients, not just the patients who received the service. For example, if you had 453 patients in 2007, and 148 of your patients had clinic or emergency visits, the costs shown are averaged across all 453 patients, rather than across only the 148 patients with clinic or emergency visits. In some cases, costs for a given category (e.g., E&M services provided by other physicians treating your patients) may be greater than the sum of the sub-categories (e.g., primary care physicians, medical specialists, etc.), because the category costs include other costs not broken out separately (e.g., nurse practitioners, physician assistants, etc.).

Exhibit 6. Your Per Capita Costs for Selected Services Compared to Your Peers, 2007

Service Category	Average Costs for Your Patients	Average Costs of Median General Internal Medicine Physicians in IN	Comparative Score
Costs of Professional Evaluation & Management Services			
Provided by YOU for your patients	$1,736	$5,491	0.3
Office, Outpatient, or Emergency Visits	$361	$3,850	0.1
Inpatient Hospital Visits	$1,173	$1,444	0.8
Consultations	$202	$41	5.0
Provided by OTHER physicians treating your patients	$1,860	$1,022	1.8
Primary Care Physicians	$866	$393	2.2
Medical Specialists	$248	$139	1.8
Surgeons	$124	$35	3.5
Emergency Room Physicians	$621	$104	6.0
Costs of Hospital Services			
Inpatient Hospital Facility Services	$10,481	$3,811	2.8
Outpatient and Emergency Services	$655	$200	3.3
Clinic or Emergency Visits	$86	$80	1.1
Procedures	$283	$20	14.2
Laboratory Tests	$93	$46	2.0
Imaging Services	$193	$54	3.5
Costs of Procedures in All Settings			
Provided by YOU for your patients	$210	$219	1.0
Provided by OTHER physicians treating your patients	$350	$365	1.0
Primary Care Physicians	$88	$91	1.0
Medical Specialists	$116	$91	1.3
Surgeons	$29	$30	1.0
Emergency Room Physicians	$117	$152	0.8
Costs of Services in Ambulatory Settings			
All Ancillary Services	$1,179	$1,243	1.0
Lab Tests	$240	$531	0.5
Imaging Services	$220	$334	0.7
Durable Medical Equipment	$719	$378	1.9
Costs of Post-Acute Care			
All Post-Acute Services	$3,698	$3,370	1.1
Skilled Nursing Facility	$2,379	$3,182	0.8
Psychiatric or Rehab Facility	$152	$38	3.8
Hospice	$92	$7	14.7
Home Health	$1,075	$143	7.9

SECTION II: PER EPISODE COSTS FOR SELECTED CONDITIONS

This section provides information on the per episode costs of your Medicare patients for selected acute and chronic health conditions, based on episodes of care in 2005 through 2007. For an explanation of the costs included and the attribution of costs to you and your peers, see **Exhibit A: Attribution of Costs**.

The costs of your Medicare patients treated for selected acute and chronic conditions and those of your peers are shown in **Exhibit 9**. These costs are based on all Medicare Part A and Part B claims submitted for episodes of care associated with these conditions in 2005-2007. Only **statistically-reliable cost information** is displayed in this report. If the number of episodes attributed to you for a given condition is insufficient to ensure statistical reliability, the exhibit entries for that condition are blank.

The pages following Exhibit 9 provide more detail on your per episode costs for each of the conditions for your Medicare patients.

Exhibit 9. Per Episode Costs for Your Medicare Patients for Selected Conditions, Compared to Your Peers, 2005 to 2007

	Your Medicare Patients		Median Per Episode Costs of Other Physicians in IN	
	Number of Episodes	Per Episode Costs	General Internal Medicine Physicians	All Other Physicians Treating This Condition
Chronic Conditions				
Congestive Heart Failure	45	$5,094	$2,211	$2,058
Chronic Obstructive Pulmonary Disease	46	$6,351	$3,189	$3,290
Coronary Artery Disease	34	$3,257	$2,129	$2,244
Malignant Neoplasm of the Prostate				
Acute Conditions				
Cholecystitis and Cholelithiasis				
Acute Myocardial Infarction				
Hip Fracture	28	$18,283	$16,892	$16,700
Community-Acquired Pneumonia	49	$9,749	$8,824	$8,151
Urinary Tract Infection	30	$7,715	$1,911	$1,712

Physician Resource Use Measurement & Reporting

Outreach and coordination

- Presentations to stakeholder groups:
  - Providers
    - Including report recipients
  - Consensus-based organizations
  - Consumers
  - Payers
  - Purchasers
  - Accreditation and standards organizations

Physician Resource Use Measurement & Reporting

Phase II

- Medicare Physician Fee Schedule
  - CY 2010 Proposed Rule (74 FR 33589)
    - Two proposals:
      - Reporting on Cost and Quality Measures
      - Reporting to Groups of Physicians
  - CY 2010 Final Rule (CMS-1413-FC 474)
    - Finalized reporting of quality measures from the Physician Quality Reporting Initiative (PQRI) and the Generating Medicare Physician Quality Performance Measurement (GEM) Results Project
    - Finalized reporting to groups of physicians, including: formally established single or multi-specialty group practices, physicians practicing within a defined geographic region, and physicians practicing within facilities or larger systems of care
    - Added diabetes to the list of episodes of care

Physician Value-Based Purchasing Plan Report to Congress

- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
  - Section 131(d)
    - Plan for Transition to Value-Based Purchasing Program for Physicians and Other Practitioners
    - Report to Congress due May 1, 2010
- Emphasis on:
  - Measures
  - Incentives
  - Infrastructure
  - Reporting

Episode Logic Considerations

CMS Research On Episode Groupers

- In 2006, Acumen, LLC began studying commercial grouping software: INGENIX Episode Treatment Groups (ETG) and the Thomson Medstat Medical Episode Grouper (MEG)
- Using a 20% sample of 2003 Colorado data, Acumen assessed functionality of these products
- In 2008, CMS contracted with Kennell and Associates to explore grouping issues from the clinician's perspective

Logic Considerations

- Multiple chronic conditions
- Length of chronic conditions
- Physician services
- Post Acute Care and Re-admissions
- Risk-adjustment
- Other

Multiple Chronic Conditions

- Consideration: How to create discrete episodes when beneficiaries often have multiple conditions
- Possible options
  - Separate episodes
  - Recognize as co-morbidities
  - Create logical clusters

Length of Chronic Episodes

- Consideration: Chronic episodes by definition do not resolve. How long should an episode that is considered chronic last?
- One way that various groupers have addressed this is to make chronic episodes 12 months long. Is this the right approach?
- Should acute flare-ups be included within the episode, separated out, or both?

Physician Services

- Consideration: Physician services may or may not have the same diagnosis as the claim for the setting in which the beneficiaries is receiving care, in particular hospital care.
- Should physician services that occur within the same time period as the setting-based services be included in the same episode regardless of the diagnosis on the physician claim? Or be grouped into another episode?

Post Acute Care and Re-admissions

- Consideration: Skilled nursing services, home health, inpatient rehabilitation, long-term care hospitalization, and outpatient therapy are often related to the preceding hospitalization. However, diagnoses are often different between the hospitalization and PAC.
- Under what circumstances should these types of services be grouped to the same episode as the hospitalization?
- Re-admissions are also often related to the preceding hospitalization. Under what circumstances should re-admissions be grouped to the same episodes as the hospitalization?

Risk-adjustment

- Consideration: Episode costs should be adjusted to account for the severity of a beneficiary beyond that captured in an episode.
- Using indicators of services, such as the presence of a hospitalization, to adjust risk may remove the variation in episode costs that should be captured.
- What are some suggestions for adjustments that could be made to adjust out the underlying severity of patients?

Other Considerations for Using Episodes

- Use of quality measures
- Level of accountability
- Attribution methods
- Benchmarking
- Composites
- Transparency of logic and availability of the software

Questions or Comments?

Where to find out more:

- CMS Physician Center Website:

http://www.cms.hhs.gov/center/physician.asp

- Prototype Resource Use Report:

http://rurinfo.mathematica.mpr.com/_documents/RURPrototype508.pdf

THANK YOU!