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**Centers for Medicare & Medicaid Services
Medicare Program; Listening Session Regarding: Defining an Episode Logic for the
Medicare Physician Resource Use Measurement Program
Moderator: Karen Milgate
November 10, 2009
9:00 am ET**

Operator: Welcome to the Medicare Program; Listening Session Regarding: Defining an Episode Logic for the Medicare Physician Resource Use Measurement Program. There will be opportunities for comments at various points throughout the Listening Session.

Priority for making comments will be given to people who are in-person in the CMS auditorium. As time allows, people participating by phone will be given opportunities to comment.

An audio download of the Listening Session will be available through the CMS Physician Center website within 72 hours after the completion of the Listening Session at <http://www.cms.hhs.gov/center/physician.asp> .

We will now join Jon Blum, on-site, in the main auditorium of the Centers for Medicare & Medicaid Services in Baltimore, Maryland.

Jonathan Blum: Thank you very much. Good morning. I'm Jonathan Blum, the Director of the Center for Medicare Management.

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I want to thank everybody here in the audience and also folks on the phone for joining us today. I want to apologize for folks that had to bear through our security screening here in Baltimore and hopefully it wasn't too onerous.

Today's session is really, I'm really excited about it and I think it's going to be a very important discussion and, if you are here, and I want to thank you again for taking time to help us and provide CMS valuable insight on ways that the Medicare program can improve quality and lower the overall cost to the program.

All of us here and on the phone know that health care spending is growing at an unsustainable rate and health care costs and costs for the Medicare program are also growing faster than the general economy.

We have to find solutions to improve quality, to lower the cost of the program and to me, these two go hand-in-hand. So it's not just about lowering costs but it's also to improve the overall quality of care that is financed by the Medicare program.

Talking about the Medicare program, I know that Secretary Sebelius, and the new administration and myself believe very strongly that the Medicare program has to lead by example.

We have to re-think the way that we provide care, that we pay for care, and we need to continue to create the focus and promote the focus on paying for value, not just simply the cost or the volume of services provided.

We need to continue to ensure that the Medicare program, both the fee-for-service program and also the private plan side of Medicare, promotes the

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concept that the patient should always receive the right care every time, that care is patient-centered, safe, effective and efficient.

We need to move the system. We need to move the Medicare program to ensure that it's focusing on the right care for the right patient at the right time.

But we have a lot more work to do here at CMS to ensure that the goal is achieved. We need to do a better job. We need to have more tools. We need to have greater tools to assess quality, to assess the resource of care that physicians, hospitals, and other health care providers are providing.

And there is really an exciting discussion going on. This has been going on for quite some time and it's really going on right now on the Hill and in the health care reform context to really, you know, develop a new way to assess episodes of care, to assess resource use, to assess quality and that's the focus for today's discussion.

There has been much discussion and much work and much research that this agency has conducted and I know that it's also been conducted throughout the field but, you know, I think we're really here to discuss ways for us to set the foundation for how we measure quality; for how we measure episodes of care; and how we think about a broader episode of care going forward.

CMS through its research has, you know, come to several conclusions. The first is that we need a way to define an episode of care, to define grouper logic that accomplishes two goals. The first goal being that we have to establish an episode, have a grouper logic that focuses on the Medicare population.

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We know that the Medicare population is unique. The Medicare population has more co-morbidities, and so we need to define episodes of care that are reflective of the conditions that our beneficiaries have.

We also need to make sure that it's transparent - that the physician community, the hospital community, the health care research community understands the logic and it's transparent to all.

And I think about the DRG system and what a value that has produced for the health care system throughout the country and throughout the world, and I think we're seeing this as a public good to ensure that we have a foundation for the Medicare program but we also set a foundation for the entire health care delivery system.

CMS is planning on developing a publicly available grouper that will define episodes of care and we intend to put out a Request for Proposal sometime next year. That's why we're here, gathered today, to provide the agency, to provide our staff advice, input, thoughts, concerns; but we really want to hear from all of you that are here in Baltimore and also on the phone today.

The staff here will identify some of the key issues that we have identified in helping the agency think through these issues, but we also seek your input. We also seek other concerns that you may have, feedback, questions, what have you.

There - today's audience, I'm really excited about the fact that it is very diverse. We have clinicians, we have researchers, we have folks from out the country that have come here today, really, I think, in the spirit of helping the agency develop the best possible tool that will help the Medicare promote its

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goals to promote value and quality throughout the health care delivery system but also to lead by example.

Please give us all feedback. Please give us all questions, all concerns, all input. It is tremendously valuable for us, for the staff here; and again, just want to thank everybody for coming, for coming to Baltimore, for spending the time on the phone and I think I'll turn it to Karen to get us started.

Karen Milgate: Thank you, Jon. Before we go through a couple of other presentations, just to set the stage I want just do a little bit of logistics. So for people who haven't been here before, the restrooms are out the door, down the hall and just to the left before you turn to where you came in at the guard's desk.

There's also, if you keep going to the back of the building, a cafeteria downstairs if people, you know, need to have drinks or food. We will have a break at one point in time for about 15 minutes, so there's no need to feel like there won't be a time to do that throughout the session.

What - the format is that we will have a couple of presentations laying out issues that we want to discussed and then have a fairly lengthy public comment period. The first public comment period - there'll be two public comment periods. The first period will be primarily focused on specific advice you have for us on logic considerations for groupers.

We'll have public comments from the auditorium and then also take questions on the phone; so those of you on the phone will also have a chance to ask questions or provide comments.

The second comment period will be more focused on the use of episode groupers, so some of the issues beyond what logic you, we need to create the

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episode, issues such as attribution and benchmarking and that will also be a time for people to talk a little bit about their thoughts on transparency and the concept of transparency in a grouper.

And so that'll be the format for the session today. Is there anything else people think I need to cover with this or? Okay. Then let's go ahead and get into the background. I'm going to do just a brief background. Jon actually covered a lot of what I think is important for people to understand is the context here.

Lisa Grabert then will go through describing how we've currently used the grouper technology as well as per capita measures for the physician confidential feedback program; and then we'll get more specific into the logic issues that we would greatly desire your feedback on.

Are we on background already? Okay.

So as Jon said, clearly there's a concern over rising health care costs and uneven quality in the country as well as in the Medicare program; and that raises the need to identify and encourage more efficient health practices.

So the question is, what does efficient really mean? So to define efficient, we really need measures of quality and resource use to be able to determine what - determine the practices that result in high quality care that cost less than other practices.

The Medicare Payment Advisory Commission and the GAO have recommended using resource use information for feedback to practitioners as well as measurements that may be used beyond just feedback and have also analyzed the use of various tools.

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In addition, CMS research has focused through our Office on Research that Renee heads on looking at the various tools for measuring resource use and various approaches for doing so.

We've also done some research that in particular, Lisa, has been working on to look at how we might display the information as well as physician reaction to information when it's displayed in certain ways.

The MIPPA required CMS to develop a program to provide feedback to physicians and so there's been a lot of work on that and Lisa's going to describe that in just a moment; as well as that legislation also required the Secretary to develop a plan for physician value-based purchasing, so the agency is also doing a lot of work to determine what that plan might look like and part of that is discussions around what resource use measures might be used.

Now clearly that plan will also interact with what's going on up on the Hill, so I don't want people to think that we would necessarily put out a plan that wasn't a part of the legislation but, so the legislation is, if it passes, what we will, of course, implement.

So episodes of care are one way to measure resource use. There are other ways - we don't want to suggest it's the only way; but what it, episodes do is create clinically similar patients so that the comparisons for the resources used for those patients are actually more valid and also more discrete so that if we're providing feedback to clinicians or other practitioners, it's easier for them to understand, you know, the types of patients that may be driving the performance measures that they are looking at.

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The foundation though for using episodes is really how do we actually define those episodes; so what services that a beneficiary uses actually get grouped together in something that's called a discrete episode of care.

Clearly, as we said before, much work has already been done by policy analysts, either through CMS research or MedPAC and GAO but we also want to recognize there's work that goes way beyond that that some of you have been involved in for years to actually define what episodes of care mean and the clinical logic to group claims into those episodes.

However, we - more work needs to be done. We need a focus, as Jon said, that's more specific to the Medicare population, as well as the unique payment system and care settings that Medicare beneficiaries use. And another critical criterion for Medicare is that the logic be as transparent as possible.

So I'm now going to turn it over to Lisa, to go through the Physician Resource Use Measurement and Reporting Program that we've already been operating for, what at least a year - thanks, Jon.

Lisa Grabert: Thank you, Karen. As Karen mentioned, I'm the Program Manager for the Physician Resource Use Measurement Reporting Program and I'd also like to recognize my colleague, Colleen Bruce, who's sitting right over here who also manages the program with me.

Today I'm going to be giving you some background on the program, cover the legislative history and some of the reports that we have distributed to physicians to date.

The program uses resource use measures including both episodes of care and we will also be planning on using some of those measures within a physician

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value-based purchasing program and putting together our plan for that which I will also touch on at the end.

For those participants on the phone, I'm now on slide 7, in the slide set.

The statutory authority for the program came from the Medicare Improvements for Patients and Providers Act, or MIPPA, of 2008, Section 131(c).

It gave CMS the authority to provide physicians with peer comparisons of resources for Medicare beneficiaries. CMS is currently implementing the program in phases.

To date, we have completed Phase I of the program and I'm going to cover, on slide 8, what we have included in Phase I. In addition to providing per capita measures of resource use or total cost of care for any given beneficiary, we also provided episode of care measures using two commercially available episode grouper software packages - the ETG product, which is the Episode Treatment Groups, and the MEG product, the Medical Episode Groups.

The first phase consisted of both distribution of reports to physicians on a one-on-one interview basis that we distributed reports to physicians individually and interviewed them one-on-one to test what we call the look and feel of the reports, to make sure that the reports were easily understood by the recipients. Then we took feedback from that first round of distribution and we mailed reports out to physicians.

The basic parameters of the program are included on slide 9, and they were also discussed in the Medicare Physician Fee Schedule in both the Calendar

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Year 2009 and 2010 Final Rules; and those citations are provided for you for additional background on the program.

The basic parameters of Phase I included the conditions of interest, which I will also be covering later; the geographic sites that reports were distributed to, we focused on 12 different geographic sites for the first phase of the program; and then we also included several different aspects of the methodologies that we used in the first phase of the program.

Phase I covered eight different clinical conditions. Four were what we considered to be acute conditions and four were chronic conditions. And those conditions are listed on slide 10, and include community-acquired pneumonia; urinary tract infection or UTI; hip fracture; cholecystitis; and the chronic conditions were congestive heart failure; COPD or chronic obstructive pulmonary disease; prostate cancer; and coronary artery disease with acute myocardial infarction, or AMI.

Slide 11, lays out the overall process that we used in Phase I. We processed Medicare Fee-for-Service claims data to run into each grouper and for the per capita methodology.

One of the things that we do in pre-processing before it enters one of those two methodologies is we standardize for price; so we adjust across all of Medicare's claims type for different price considerations.

So for example, in the hospital setting, we would adjust for any DSH payments that are made. In the physician setting, we would adjust for GPIs or Geographic Price Indexing; so we would remove those factors because we're just concerned with sheer resource use and not those additional factors.

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We only use one grouper per report that's sent to a physician; so a physician will not receive a report that's based on two different products. So it will be one grouper product and the per capita methodology in the report that a physician receives.

We populate the resource use reports with relative cost performance; so after we run the Medicare claims data through the grouper or for the per capita methodology, we also risk adjust.

We attribute costs to physicians. We benchmark the claims and then we also have an algorithm for determining what the minimum threshold needs to be in order to get us statistical accuracy.

So we do those, all those portions of methodology for the claims in the program before they're put into a report. And we also, in this program, are now evaluating which grouper is better; we're just using both products that are available right now.

The next couple of slides include some screenshots from the reports that we've distributed to physicians to date. This first is from a publicly available sample resource use report that - and the URL to access the full report is available on the last slide in the slide presentation.

At first, physicians are sent what we call an advance notice letter. So a few weeks prior to receiving the resource use report, we send them a letter that says, this will be coming in a few weeks; we'd appreciate it if you look through it and give us your feedback on it because this a very important value-based purchasing initiative for CMS.

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This is an example of the first page of the report, which explains the resource use program and CMS' efforts in value-based purchasing. This next page of the report is a sample for the per capita methodology.

This type of graphic is also used for the per-episode methodology; and it's just a distribution curve of a peer group of physicians. It depicts the 10th, 50th, and 90th percentile of performance and for an individual physician shows where they are in terms of their peer group on that distribution curve.

So the graphic - for the people in the room - that is, colored in red, is where this physician's performance is in the total distribution of his or her peer group.

In addition to providing distribution curves, that's sort of the highest level of resource use; we also provide participants with a cost of service category breakdown.

So in order to make the information more actionable, we provide different breakdowns in different service categories. We include both your costs, or the physician's individual cost, as well as the cost of other physicians who are also treating patients attributed to them.

We include a breakdown for hospital service categories for many of our post-acute care services and then we also do a peer comparison. In this example, it's a peer comparison to all other internal medicine physicians within a given state.

On slide 15, we provide an example of a summary table for episodes. As I mentioned, the episode analysis is the same as the per capita which I just

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referred to. This is a summary table that includes all of the episodes we have been focusing on for the program.

There are a couple of episodes in this example that do not have any data populated in it. That's because for this individual there was not enough statistical reliability in order to populate data for all of those episodes.

Throughout the first phase and into completion and as we go into the second phase of the program, it is critically important for us to speak with and work collaboratively with the stakeholder community.

We've had various presentations including individual interviews with physicians who are receiving reports as well as consensus-based organizations, purchasers and accreditation organizations.

We've had many conversations in addition to rule-making on this topic and your feedback today will inform the future phases of our program so we really appreciate hearing all of your ideas today.

On slide 17, we summarize the plans going into Phase II of the program that were just recently finalized and the Calendar Year 2010 Medicare Physician Fee Schedule Final Rule.

We proposed two different options for the Phase II of the program. Those options were to include both cost and quality measures in the program moving forward and reporting to groups of physicians. Both of those options were finalized in the Final Rule.

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We mentioned possibly using PQRI, or Physician Quality Reporting Initiative measures, or measures from the GEM program, Generating Medicare Physician Quality Performance Measurements, in the Final Rule.

And, for groups of physicians, we finalized giving reports to single or multi-specialty group practices, physicians practicing within a defined geographic region, and physicians practicing within facilities or larger systems of care.

So we will be looking for your feedback as well as we move into Phase II and implement those two new proposals for the program. In addition, we've also added diabetes as an episode of care for one of the conditions that we are focusing on in Phase II.

Finally, I want to say just a bit about our process in planning the MIPPA mandated Section 131(d) Physician Value-Based Purchasing Plan Report to Congress.

As we are also managing the ongoing implementation of the resource use report program, we're also planning on that program and many other value-based programs can be folded into a physician value-based purchasing initiative.

In December 2008, we held a publicly, a public listening session on issues related to the Physician Value-Based Purchasing Program. That was a very valuable session for us and we've taken many of those ideas into consideration as we are currently planning and putting together the Report to Congress.

And as the slide mentions, we are focusing on different aspects that cover measures - both cost and quality measures; incentives that will be available in the program, the infrastructure and how to both collect information and put information back out to professionals, and then reporting of information

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through either public reporting or confidential feedback as I've just described in the Physician Resource Use Program.

And now I'll turn it back over to Karen, and Renee, to talk about episode logic considerations.

Karen Milgate: So, in this part of the morning, we're going to be laying out some of the issues that we would appreciate feedback on that have to do with how episodes are created. So up until this time, it's primarily been background for this discussion.

There are about five or six issues that we have identified specifically that come out of our experiences in the last few years looking at episodes of care but also ask if there are other issues that you want to comment on related to developing logic that you also, you know, have, are open to do that.

We debated whether to take each one separately and have comment on each one; but they are somewhat interrelated to some extent, so we're going to go through all of them and then ask that you hold your feedback and comments until we're done sort of laying out what we've identified as the primary issues.

Renee and I are going to do a bit of a tag team on this. It's - her group have been the primary folks doing the research so she's going to provide a little bit of context for some of the issues related to the research that we, that her office did.

So having said that, let's move it, in slide 20 and then - go ahead - Renee's going to describe a bit of the research.

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Renee Mentnech: Thanks, Karen. My name is Renee Mentnech. I'm the Director of the Research and Evaluations Group here in CMS in the Office of Research Development and Information.

And I want to acknowledge a few folks who really have made this work possible, that work within my group and those are Fred Thomas - you can put up your hand there, Jesse Levy, Curt Mueller, and Craig Caplan, and they have largely been leading this effort in our shop and I just get the privilege of presenting their work.

The work that we're going to refer to has been primarily done through two contract vehicles. One is by Acumen, Tom MaCurdy is the Principal Investigator, and in that contract, they did an analysis of the two commercial products that are out there, the two commercial products that are out there, there are more, but they looked at the ETG and the MEG grouper products that Lisa referred to in her talk.

And then also, using a 20% sample from one particular state, looked at the functionality of those two products as they relate to the Medicare program and the Medicare population.

Then finally, we also have a contract with Kennell and Associates where they explored the grouping issues from the clinician's perspective. The studies from, or the reports, from those studies are all available on the website.

There are some additional reports that will become available, particularly out of the work being done by Tom MaCurdy, at Acumen and our goal is to finalize those reports and get them up on the web for people to have at their disposal hopefully sometime in early winter, after, sometime in January.

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Karen Milgate: The next - it's on, okay - so the next slide, slide 21, is a list of issues and then we're going to go through each of them individually. Here are the issues that we've identified through our research that are particularly important to the Medicare program.

I want to note at the outset though, really with the exception of the fourth bullet down on post acute care, these are issues regardless of the population. It's just that the Medicare population compounds the issues with creating episodes at least in part because they often have multiple chronic conditions.

So I don't want to suggest these are new issues or that no one has done work on these issues. These are issues regardless of the population; they just happen to be more prominent when you're dealing with the Medicare population.

So let's take each in turn. So as I said, one of the underlying issues for the Medicare program is how to create discrete episodes when beneficiaries often have multiple conditions. So there's a variety of different options that one could use to address this issue.

One is just to create separate episodes and have some logic around which claims will go to which episode and which ones won't. The other would be to recognize those explicitly as co-morbidities and to have a logic that would then acknowledge their presence in that manner.

Another might be to create logical clusters of conditions so you wouldn't necessarily just call it a co-morbidity but you'd actually create a cluster that there seems to be a variety of different types of conditions that often cluster together so you could create episodes that are clusters of conditions.

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So we throw those out for discussion purposes to see if people have input on any of those three approaches or others.

Rene Mentnech: So, I'm going to take a minute to elaborate on some specific data to reinforce what Karen covered in her slide. A 2009 Rand study using the same grouping methodology as the Acumen assessed the level of co-morbidities in the Medicare population.

They found substantial co-morbidities in the sample of nine conditions. For example, of the beneficiaries who were grouped into an acute myocardial infarction episode, 63% also had a hypertension episode, 54% had a CHF episode, 35% had a diabetes episode, and 22% had a CVA episode.

Another example is for beneficiaries grouped into a hip fracture episode. Of those, 67% also had a hypertension episode, 30% had a congestive heart failure episode, 36% had an ischemic heart disease episode, and 27% had a fungal skin infection episode.

The point is to drive home the message that for the Medicare population, this issue around co-morbidity is particularly relevant and will need to be addressed in the development of any grouper that we use programmatically.

Karen Milgate: So clearly related to that is the issue on the next slide which is, so we know that many Medicare beneficiaries have chronic conditions and have more than one, so if you're looking at episodes of care, what is an episode for a chronic condition given that by definition, chronic conditions will not be resolved particularly in the Medicare program. They're often conditions that people will live with until the end of their life.

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So one way to define chronic episodes, that various groupers have used, is to make the chronic episodes 12-months long. A question that we'd put forth to this audience is, is that the right approach? If you're making them 12-months long, is it a calendar year? How might you measure that? Is really the 12-month long episode the right way to do it?

Another question related to that is whether acute flare-ups that occur during that time period should be included within that episode or should it just be separated out as a separate episode, or would you do both? These are again a question we'd like some feedback on.

Rene Mentnech: To elaborate on this point here, I would draw your attention to the study that was done by Kennell and Associates and it's nicely summarized in an article on a web exclusive on our website that was co-authored by the folks I mentioned here and the title of the article is *Clinician Feedback on Using Episode Groupers With Medicare Claims Data*.

Essentially what they did is they took the two, the two commercial products. Then, for a variety of large, multi-specialty group practices out there that participate in our Physician Group Practice Demonstration, we ran their claims data through the two products and then picking a particular set of clinical conditions, walked through with clinical panels at each of those sites their reactions to these reports that we were able to generate, so that the next few slides will give you some flavor for the clinician's reaction to the reports that they saw.

Again the purpose of those interactions with the clinicians at those group practices was not to assess which grouper was better than another; it was simply to get their reaction to how these products work with the Medicare population.

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So current approaches, as Karen said, tend to truncate chronic care into fixed 12-month intervals with most common type intervals being a calendar year. Episodes for a chronic condition can be described as being for maintenance such as ongoing evaluation and management, office visits and/or can include acute exacerbations or flare-ups such as hospitalizations.

One approach is to separate acute exacerbations from the chronic maintenance episode while in another claims for acute exacerbations are grouped with the maintenance episode. The clinician panels were asked to opine on this and on the design, this particular design feature.

In support of separating them, panel members stated that acute exacerbations are frequently not treated by the physician responsible for a patient's chronic maintenance; however, the majority of clinicians favored leaving flare-ups in the same episode as the chronic condition because part of physician's role should be to minimize flare-ups and inpatient re-admissions.

Now these, you know, obviously are a sample of multi-specialty group practices, so it doesn't necessarily represent the universe of physicians out there; however, the majority did feel that the, they should be kept together.

Karen Milgate: So, moving from how you define or address chronic conditions, the next two topics have to do with specific types of services. So, one is physician services. Physician services may or may not actually have the same diagnosis as the claim for the setting in which the beneficiary is receiving care.

In particular, this is true in the hospital and so therefore one of the questions is whether physician services that occur within the same time period as the setting-based services should be included in the same episode regardless of

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the diagnosis on the physician claim or should it be grouped into another episode that is more specific to the diagnosis on the physician claim.

Again, this is an issue in general but in particular problematic for the Medicare program given that physician - given that beneficiaries may have multiple issues when they are seen within the hospital setting in particular.

Renee Mentnech: So regarding this, Medicare pays for daily evaluation and management services by a physician during a hospitalization and we looked at this issue in the Acumen study and found that 69% of inpatient stays had daily E&M hospital visits over the length of stay of the hospital, over the hospital stay. However, less than 42% of inpatient stays had daily E&M visits grouped into the same episode as the inpatient stay.

The reason for this difference is that diagnosis codes are primarily used to link claims in constructing episodes. If the diagnosis claim on the hospital facility claim differs from those on the physician claim, the claims will not necessarily group into the same episode. That's using current, the current technology.

A design option might be to group all claims occurring between the admission and discharge dates into the same episode as the inpatient stay. Using this option, for example, the internist claims would be grouped with the hospital claim into a hip fracture episode.

The design issue was posed to the eight clinician panels in the Kennell study. In support of the date of service method, the clinicians thought that much of care would not have been done without a hospitalization; therefore all physician services should be grouped into the same episode as the inpatient stay. They also argued that the diagnoses and physician claims may not be

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accurate since physician payments are not determined by diagnosis, as they are for inpatient stays.

Countering these arguments, however, was the notion that multiple inpatient consults likely will be required for patients presenting with co-morbid conditions.

These conditions, which are identified through physician claim diagnosis, would be recognized in multiple concurrent episodes. So the physician panels were mixed on their reaction with how to, with respect to how to do this.

Karen Milgate: Then the issue that is probably the most unique to the Medicare program is the issue of post acute care. Now re-admissions I would not suggest are unique to the Medicare program; however, there is a higher rate of re-admissions in the Medicare program generally speaking.

So in the Medicare program, skilled nursing services, home health, inpatient rehabilitation, long-term care hospitalization, and outpatient therapy are often related to the preceding hospitalization. In fact, it's particularly the case in skilled nursing services.

However, diagnoses are often different between the hospitalization and the post acute care, so any logic that relies heavily on diagnoses to determine whether the post acute care should group to the same episode as the preceding hospitalization is likely to not necessarily capture all of the post acute services that might be related to that hospitalization.

So the question we're posing to you all today, and we would appreciate advice on as well as we would be asking, we feel need to be addressed for a grouper

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for Medicare is under what circumstances these types of services should be grouped to the same episode as the hospitalization.

The same issue, although clearly it has its own unique issues as well, is whether re-admission should be considered related to the preceding hospitalization as well. And so another question is under what circumstances re-admission should be grouped to the same episodes as the previous hospitalization.

CMS has conducted some research to look at what logic might look like for grouping post acute care and re-hospitalizations to the previous hospitalization.

We had a contract with RTI and the findings are final now and just about to be posted on our website and they came up with a proposed logic that was based primarily on looking at time gaps between the hospitalization and the post acute care setting as well as re-admissions, and then if there were subsequent post acute care or re-hospitalization, additional logic came out of that contract. So that's information that will be available very soon on our website.

Rene Mentnech: Regarding the SNF stays, skilled nursing facility stays, a characteristic of the Medicare population is the prevalent use of post acute care services. In our analysis, we found that about half of the SNF claims did not group into the same episode at the inpatient stay because of the different diagnoses that Karen alluded to a minute ago.

The clinician panels in the Kennell contract commented that a SNF stay immediately following a hospitalization is usually related to the same medical condition as the inpatient stay.

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They thought that including SNF claims in the same episode as the inpatient hospital stay may give physicians an incentive to manage the inpatient stay better in order to avoid a SNF placement. However, a SNF stay may not necessarily relate to the immediately preceding inpatient stay.

The SNF stay may reflect the patient's underlying condition or frailty rather than the acute condition that required hospitalization. So in going forward with anything that we develop, this is an issue that we're going to have to be sensitive to and figure out how to deal with.

Regarding re-admissions, the orthopedic surgeons in the clinical panels - this is just one example - asked if re-admissions that resulted from a complication of surgery should be grouped into the same episode as the original surgery or grouped into a new episode.

The clinicians thought that if the original surgeon had no control over the re-admission, then a new episode should be opened. Otherwise the complication should be included in the same episode as the initial surgery. By separating the problem re-admission from the initial procedure, the accountability for the re-admission would be lost.

Karen Milgate: So finally, the issue that will probably vex us all for a long time to come is risk-adjustment of episodes and I would suggest here there's not necessarily a perfect way to do this but that episode costs need to be adjusted to account for the severity of beneficiary beyond that captured within the episode that is being measured.

One issue though with trying to define a risk-adjustment method is that using indicators of services such as the presence of a hospitalization - one factor that is often used for risk-adjustment - if you use that to adjust the risk of the

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beneficiary, you may remove the variation in the episode cost that actually you're trying to capture through measuring episodes. So this is kind of the conundrum of risk-adjusting episodes.

So again, what are some suggestions for adjustments that could be made to adjust out the underlying severity of the patient so that we are actually comparing apples to apples of clinically similar episodes?

Rene Mentnech: So in our analysis, looking at actual data to try to tease out this issue around variation, we found considerable variation in cost across the episodes and within episode types.

For any of the top five highest cost acute and chronic conditions, the level of cost - which is defined to be Medicare payments exclusive of copays and deductibles - demarking the most expensive 10% of an episode type always exceeds the level demarking the cheapest 10% of the episode types by at least five times and in many instances is more than 100 times larger.

This cost variation may be due in part to the complex mix of co-morbidities of the Medicare population even within an episode type. So a central research question concerns whether the construction of episodes yields sufficient cost homogeneity to make comparisons feasible across providers, or are additional steps in risk-adjustment needed.

This, as Karen said, is an area that I don't think any of us have sort of successfully tackled yet but will be the part of the solicitation that Jon mentioned, so it will be looking at how to construct the clinical logic but we can't separate the risk-adjustment issues from that task as well.

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Karen Milgate: So I'm going to go back to the slide on page 21, and which is a list of what we just described - that it, yes, okay - and open it up to public comments on any of these topics, all at the same time on these topics or other issues that we may have overlooked.

So again, just to be clear, the - what we're hoping to get from this session and the next public comment is advice, identification of issues that need to be addressed in particular for the solicitation that we're planning on issuing in the coming year.

So with that I want to open it for comments here in the auditorium and then we'll allow some time also to get those on the phone.

Rene Mentnech: And if you would identify yourself.

Karen Milgate: And what organization you're with - hold on a moment, yes, Kelly.

I'm sorry, we're coordinating with the phone people, so just hold on one moment.

Operator: And we will now open the lines for comments. To make a comment, please press star followed by the number 1, on your touchtone phone. To remove yourself from the queue, please press the pound key.

Please state your name and organization prior to giving your comment and pick up your handset before speaking to assure clarity.

Please note your line will remain open during that time you are speaking; so anything you say or any background noise will be heard in the conference.

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Renee Mentnech: Okay. Thank you.

Doug Emery: Hi, my name is Doug Emery with Prometheus Payment and Bridges to Excellence. We've been studying this listening session and the issues that you put up there particularly. In fact, we've written out a little piece to answer each of these.

Every single one of these issues, whether it comes to multiple chronic conditions right down to risk-adjustment, we've had to undertake under the Robert Wood Johnson Foundation to do two things.

One, not just resource measurement but connecting it to payment, because we feel strongly that if the unit of analysis is fundamentally disconnected from the way we pay for care, there's not very much that can be done with it.

So for instance, if you look at it from that point of opinion or from that point of view, you have to include multiple chronic conditions. But if you look at a diabetic patient and they have hypertension or they're chronically obese, those must be factored in.

The other thing has to do with length of chronic conditions. If you look at the 40 years of research in episodes of care, it has always been settled that an episode of care is as long, in a chronic condition, as the patient's life. The reason we settle on 12 months is because of the difference between biological time and calendrical time.

Because fiscal years and plan years are divided into these artificial 12-month periods, you don't really have much choice but than to go with a 12-month period. Obviously if we had a different way of pooling our finances, then you

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could look at much longer periods; so that right there kind of binds us to a 12-month period, especially when you're looking at reimbursements.

As with post acute care and re-admissions, they must be factored in and our methodology does this. The solution is not to look at strict delineations between this episode and that, but it's to understand the episode through evidence-based medicine and divide costs that are reflected through typical care as would be defined through evidence-based medicine and those types of events and costs that come from potentially avoidable complications.

And when you do that, you find out that you can group all of these into the same patients. So remember the whole point of an episode of care is to focus care and clinically homogeneous pathways around the patient; not around institutions, so that way you can solve that problem.

And when you put all those together, the risk-adjustment technique that we've put together is very powerful. Now the R-squares are around 70 to 75% which is, I think, far and above what's been achieved elsewhere.

So the answer to these is that all of them are yes and they become yes when you have to turn this into a payment system which we now have up in four RWJ-funded pilot sites plus the New York State Healthcare Foundation, and there's many, many other comments and I don't want to monopolize the time but the answer to all these is yes, we've solved them and they can all be done. Thank you.

Karen Milgate: I'm sorry, I won't - I don't know if we have time for too much follow-up but can I just ask you to say a little more detail...

Doug Emery: Sure.

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Karen Milgate: ...on the risk-adjustment.

Doug Emery: Right.

Karen Milgate: Not, you know, there's lots and little, but if you give an overview of kind of how you approach it.

Doug Emery: Right. The power of risk-adjustment is once you understand the clinical homogeneous, clinically homogeneous pathway as described by evidence-based medicine, then what you can do is apply a rigorous form of regression analysis where the variables themselves are the predictors.

So what we can show you - and this is why this methodology's so powerful is because it's very, very actionable; it doesn't just tell you what something costs or the number of episodes but breaks down in terms of clinical variables which are the factors that have the most explanatory power.

So you can do that for inpatient care, you can do it for chronic episodes and produce a list with all the distributions from 5th percentile up to the 100th percentile of where these indices lie.

And the one thing I didn't note is that when you put these together, the main thing you want to do is also be able to create the possibility of bringing in clinical data that is not claims-based and we've been able to build that as well.

Ultimately, that's what will make the real power of risk-adjustment. Unfortunately, we're stuck with CPT-4, ICD-9. As everybody knows, the claims system we have now was not designed for outcomes measurement which doesn't make it particularly amenable for risk-adjustment; but it's all we have right now.

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Karen Milgate: Thank you. I'm sure those comments got others interested in commenting.

Dan Dunn: Hi. Dan Dunn, Ingenix, and as Karen and others mentioned, we were one of the methodologies that were included in some of the CMS research, in particular the Episode Treatment Group methodology.

So we worked, you know, in some ways around the edges to help CMS understand our methodology and they've shared with us some of the challenges and issues and I think they're very well summarized and presented today.

Maybe as a first point; thank you for holding this session, a very useful and given the emphasis on standardization, transparency, consistency, and the role of measurement and how do we, how we change how medical care is practiced - a very important topic especially given the way how care is delivered, episodes really play an important role; so thank you.

Maybe just to get to a few of your points; you know, definitely a mutual, multiple chronic conditions and agree in many ways Medicare populations are different although, you know, in some of our work and some of the work of other folks who use our methodology, there are these types of patients in a commercial population and there are some challenges in the same way but also some solutions.

Like the idea of clusters of episodes especially for conditions like diabetes, which to be honest, a diabetes episode in and of itself is not really that useful for understanding how that patient's being managed.

Some cardiovascular conditions, but also you need to recognize that those clusters will work best for, you know, primary care docs and cardiologists and

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endocrinologists but some of the sub-specialists involved in those clusters you'll need to think of how to measure them separately.

In terms of grouping physician services within an inpatient admission, I know you threw out two options. One is, you know, put them all in within the timeframe; secondly, let them go where they will be based on the existing methodologies.

I'd suggest that you probably don't want to do the first, but maybe you want to think of something in between the first and the second. Maybe add some, some more intelligent methodology which helps really within that timeframe understand what's clinically related beyond the, using information beyond the diagnosis, again rather than an either or; because I think you will see, as you mentioned, a good number of inpatient consultations within a stay that really have nothing to do with the primary reason the patient is in the hospital.

Finally on risk-adjustment, maybe even more challenging is the skewness of cost data within an episode, across episodes. You know a lot of the methodology, I think Doug Emery was just touching on, is that we can define the clinical factors which drive costs, we can figure ways to weight them.

I think, you know, one focus of your research was taking the tools as they were currently developed rather than the possibility of how you can make them better fit Medicare populations, Medicare data. So I would argue the methodology is there, it's just making it, you know, fit your unique circumstances.

In terms of the skewness, you know, there are a lot of techniques people use in the market, you know, dealing with outlier episodes, how you trim the, you know, the lower end of costs or even drop those low cost episodes which don't

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make any sense, how you truncate the higher costs and I think a lot of the variation would be tempered by those types of steps.

You know, the idea of in some ways, you know, we're stuck on this concept that you need to weight all the costs within an episode given we have a dollar for them in the same way.

You know, actually if you think of what goes on within an episode at different sort of strength of the relationship between what happens in a physician's control over what happens is random events. You know, sometimes you relate it to things like an inpatient stay.

When they happen for a physician, for significant in some ways, noise versus signal and how they're performing, so, you know, we have - you do see in the market some folks who actually weight services differentially within an episode which addresses some of these issues and really tries to focus on that part of the care that really signals that a physician is practicing well.

Maybe just a couple of other quick ones related to - one is, you know, procedural episodes are another consideration. Most of your research has focused on episodes either using ETGs or MEGs from a diagnostic perspective, which works well for most medical specialists, but, you know, proceduralists, you know, looking at that part of the care they provide within ischemic heart disease episodes, a CABG surgery, what not; so I think you need to consider different methods if you're going to measure surgeons versus medical specialists.

And then finally, I think there's a lot of, you know, good ideas in some of the reform legislation, some things you've been thinking about around payment based on episodes of care and I think if you look at it closely, episodes of care

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from a measurement perspective are likely going to be somewhat different than from a payment perspective, just the mechanics of how you pay a claim and how you, you know, work and provide the right, appropriate methodology for triggering an episode and handling claims as they come in and how you deal with them versus having the luxury of looking back over two years and building an episode from a measurement perspective.

So again, thank you and as we, I know you talked with us before, very interested in what you're doing and very willing to work with you to help you be successful. Thank you.

Karen Milgate: Thank you, Dan.

Rene Mentnech: Want to go to the phone?

Karen Milgate: Anyone else in the audience? Go ahead.

Niall Brennan: Niall Brennan from Brookings. I'll just make a couple of very quick comments.

The first one is to applaud CMS for their leadership in this field and taking what I think is a very important step for cost of care measurement generally.

Second, I sort of have a comment or a question that may not be answerable at the moment but I would hope that at the end of this process what we don't end up with is an episode logic for Medicare and an episode logic for everybody else.

I would hope that we, you know, we come to, you know, national, you know, standards around cost of care measures and cost of care measurement that can

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be widely applied, that can, that are flexible enough to take account of some of the specific needs and quirks of Medicare population, of the Medicare population more generally.

I'd like to echo the comment of the gentlemen from Prometheus regarding 12-month chronic care episodes. To a certain extent, it's an artifact of working with what you have. Medicare might be an interesting case study because once you're in, you're in.

Karen Milgate: Right.

Niall Brennan: But the problem that we face with most of our commercial populations and commercial analyses is there's so much fluctuation in enrollment from year to year that if you require, and we have found this out in our own episode development work, that if you require length of time more than 12 months, you start to see some pretty serious attrition fairly quickly.

And I know that in Lisa's presentation earlier, you know, several rows in the table were blank because physicians didn't meet certain thresholds. So again, maybe not as big an issue for Medicare but if we're going for one standard, it will be an issue for the commercial population even though with everything in flux due to health care reform that problem may get a little bit less in severity.

And then finally you noted in your presentations and I'd just like to again stress that I do think transparency in the development of this, you know, episode logic will be key.

I think the physician community really does want to learn more about their care and improve the way in which they practice care and if we can make this

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as open and transparent as possible it will help build physician acceptance of this type of measurement going forward.

Karen Milgate: Thanks, Niall.

Steve Bandeian: Hi, Steve Bandeian, from AHRQ. Let me just mention three points which I have unfortunately not have a chance to research yet but I think these three points may underpin some of the points as you posted there.

The first point would be what I would refer to as accuracy of grouping, and what I mean by that is you have two records where the same patient within a certain particular time period and they have different diagnoses on them. Do they really belong to the same episode or not?

It turns out that there are many, many different ways that a clinician can code the same sort of service and if one - a danger of the episode building process, and I'm not referring to any particular product but I'm just simply saying looking at the data, if one says given a particular time interval for a patient who has diagnosis A, what other types of diagnoses do we see for that same patient within a time interval.

One sees a whole variety of things; and so if one's not careful what one can do is create too many episodes and then each - a false episode, so to speak, that is to say something that should actually have been joined to another episode, will have very low cost and utilization associated with it because it only represents a piece of the care that was provided for that illness.

So to some extent some of the difference that you were citing tenfold, hundredfold variance between costs for the same condition, I would suspect

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that a good chunk of that is related to what I would refer to as episode fragments.

Another point - and actually that's, in my opinion, the hardest problem to tackle - another problem or another issue that relates to risk-adjustment or severity is ensuring that the episode itself is clinically homogeneous.

So to use an example, there are all different sorts of ankle fractures. Some require a relatively minor level of care. Some require very complex care. So for some conditions, you almost need to sort of have as your reporting level down at the ICD-level because there can be considerable variation in the resource requirement if one looks at groups of ICD codes.

The final point I'd make is complications. One can get a very misleading understanding of what the cost of care is if one does not link complications back to an initiating episode.

Now you don't necessarily need to - you might still want to have the complication be a sort of a freestanding episode for purposes of analysis of how well that complication was treated; but one still wants to have the ability to link it back to a source, an initial illness or treatment because again, just to restate, you can have a very misleading impression about the cost of care if you don't take into account the complications that might have occurred.

So those are the three points that I would make.

Karen Milgate: Could I ask you a follow-up on the...

Steve Bandeian: Sure.

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Karen Milgate: ...complications point because I think our first questioner also raised it. So how easy or hard is it to identify what is a complication of a, in a particular episode.

I mean, I guess it's easier if it's a hospitalization, possibly; but how, you've done some work on this and I would just be interested in your thoughts on that.

Steve Bandeian: Well, I mean for some conditions it's, for some situations it's just sort of a matter of clinical logic. There are some statistics that one can run to identify likely conditions that are complications, but I mean, for example, if one's talking about a cancer that metastasized to bone, then a pathologic fracture is part of the cancer episode so to speak and one might want to have that at least as what I would refer to an optional link.

Similarly, again taking cancer as an example, nausea, vomiting, dehydration are common complications of chemotherapy, so one at least would like to not - or for example, fever and leucopenia are all complications of chemotherapy.

They're not necessarily evidence of substandard medicine or what have you, it's just that a lot of medical care involves side effects but again if one - there actually could be variation in coding.

In other words, one clinician might put dehydration or nausea or vomiting on the claims for the nausea or vomiting related to the chemotherapy or they could just put a chemotherapy diagnosis on.

So one wants to look at these sorts of issues because I expect, particularly in the Medicare population, these conditions that are quote, related, to what one might refer to as a primary condition are probably quite prevalent.

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Karen Milgate: So I guess I hear from that, as well as our previous speaker, one thing to look at would be what the evidence says about what diagnoses would be considered complications for a particular condition.

Steve Bandeian: Sure. I mean obviously a clinical expert panel for a particular specialty, you know, could probably rattle off, you know, a list of...

Karen Milgate: Right.

Steve Bandeian: ...things to think about, you know, pretty easily.

Karen Milgate: Okay. Thank you.

Mary Patton: Hi. Mary Patton, from the Association of American Medical Colleges and I just want to say, you know, the AAMC supports really trying to understand more of what's going on with variations of care. We've actually started some initiatives to try to understand, at least some of our academic medical centers, variations for a subset of our members.

We've also done some preliminary work, not on episode groupers but on just trying to understand what's going on with different re-admission analyses and since re-admissions can be a significant driver in episode groupers, we just wanted to let you know two of our preliminary findings.

And one is that we did, we noticed an increase based on people who, an increase for people with a lower economic status. So to the degree that you can include socio-economic status, we think that would be really valuable in your risk-adjustment methodology.

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We also noticed a really high volume of re-admissions for patients with mental illness and substance abuse. So to the degree again that you include those co-morbidities and separate them out or, you know, include that in some kind of a risk-adjustment methodology or some kind of measurement, we think that that would be useful. Thank you.

Karen Milgate: Thank you.

Renee Mentnech: Regarding your last point on socio-economic status, if anyone has an opinion on two points: one is making sure that we don't build a system that is gameable and that we don't necessarily build a system that creates a disincentive to take more difficult, disadvantaged populations. If you sort of keep that in your minds and have any comments on it, we'd appreciate hearing that as well.

Karen Milgate: Other comments in the auditorium?

So I realize this is a little bit of an awkward format in a sense because we're dealing with some fairly complex issues; so as people who know me, I've got about, you know, ten questions I could ask all the various people that just spoke.

But what I'd like to do - and there may be some nice interaction we could encourage - but I'd like to take the comments from those on the phone first and then to the extent - and then I have a few questions to dig in a little bit on some of the commenters and we can have a little bit more interchange if we have some time at the, after we've heard the comments or questions from the phone.

So are we ready to open it up?

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Operator: You have a comment from the line of Dr. James Kennedy.

Dr. James Kennedy: Good afternoon or good morning. I'm Dr. Jim Kennedy. I'm with FTI Consulting based in Atlanta, Georgia. My background is that not only am I a physician but I am also a certified coder and have been following the ICD-9 codes from an inpatient perspective and how they apply to the Diagnosis Related Groups that are used to reimburse inpatient hospitalizations.

I've been following the episodic treatment grouper discussion and the MEG discussion because physicians currently are not incentivized to be, to define their conditions accurately, not document them in the chart, such that a coder can code them and create a good database by which diagnosis-related groups are constructed.

My fear of the episodic treatment grouper methodology is that it will be based solely on ICD-9 codes and not on any clinical abstraction of the records.

There's some inherent problems with ICD-9 codes such as, whereas on an inpatient basis, uncertain diagnoses, those that a physician may say possible, probable, likely, suspected can be coded if documented at the time of discharge.

Outpatient coding does not allow uncertainty to be coded and this is reflected in a - the problem with the codes was reflected in an article in the September/October 2009, Health Affairs where the IHA pay-for-performance folks in Oakland are not using episodic groupers because the coded data is just not good enough for California pay-for-performance.

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The second is that there are limitations in the volumes of codes that are submitted. The UB-90, the, on inpatients we can submit up to 25 codes per interaction. On outpatients, there's only four on paper, eight electronically.

And the third is going to be this whole concept of DRG, or what I'll call episodic grouper creep. When there was an increased emphasis upon diagnosis specificity with DRGs, there was a - Medicare noticed an increased, what one might call a case mix index, once the diagnosis and the coding mattered.

I predict that with episodic treatment groups, once the general physician population recognizes that documenting and coding better will improve perhaps their report card, for lack of better words, that we're going to see coding creep with the outpatient phenomenon like we see with the inpatient phenomenon.

So I'm going to keep my comments brief on that and I thank you very much for listening to what I have to say.

Karen Milgate: Could I just, could we ask how many people are in the queue?

Operator: We have one other.

Karen Milgate: I'm sorry?

Operator: One other.

Karen Milgate: One other, then let me ask a follow-up to the gentleman who was just speaking?

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Dr. Jim Kennedy: Yes, ma'am.

Karen Milgate: I'm just wondering - so you've certainly outlined some really key issues. I'm wondering if you've thought at all about how to address any of those within the context of grouping generally?

Dr. Jim Kennedy: Well, one thing is again, we, there will be a transition from ICD-9 to ICD-10 that will be implemented on October 1, 2013, and thus this is a, you know, and how that is going to impact this given the higher specificity of the codes, not that that might solve the problem, you know, given the data that we have today but there, that is going to be a conundrum, you know, of what will be the specificity of the codes.

The second is the inclusion of laboratory studies. We know in the inpatient arena with the various studies and I can - Alex, Hauser, Pine and such - that if laboratory, that clinically abstracted charts, you know, have higher c-statistics than those that are just based on coded data and you might even want to consider adding some laboratory metrics to this.

For example, if we're following the diabetic population, we might want to look at the hemoglobin A1c's that are run by Medicare because to the extent that the hemoglobin A1c is above seven would indicate that the patient is likely, their diabetes is likely uncontrolled and those would have higher resource utilization than a patient with perhaps controlled diabetes.

Another is in the treatment of cancer patients looking at their hematocrit or hemoglobin and that, or what their white count might be, would have some predictors in to outcomes rather than making the physician take those laboratory studies, translate that into a diagnosis which then has to be

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translated into a code, you know, and then goes into the grouping mechanism here.

So you, I would say, I mean I'd obviously spend more of my time on the inpatient side and not that I'm not interested in this but what I do believe is that we do need to look at some laboratory values.

And then there has to be a partnership, since ICD-9 is a cooperative relationship between the American Health Information Management Association, CMS, the CDC, and the American Hospital Association, really holding them to, accountable for does the physician language that most physicians use translate into the codes that would be used to drive this database.

Did I answer your question, ma'am?

Karen Milgate: Yes, yes. You gave us some additional ideas. The ICD-10 one is one that I think we'll all have to think very carefully through as to how that might address how we would create episodes of care.

So thank you and for the, as for the lab data, I guess what I hear you're saying in addition to possibly using lab values as outcome measures for the quality piece of the calculation, you're suggesting that those data might also be used for risk-adjustment purposes.

Dr. James Kennedy: Yes, ma'am.

Karen Milgate: All right. Thank you.

Dr. James Kennedy: Thank you, ma'am.

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Operator: Your next comment comes from the line of Amita Rastogi.

Amita Rastogi: Hello. This is Dr. Amita Rastogi, with Prometheus and you already heard from Doug Emery earlier today; but I wanted to reiterate some of the comments that he made and as you may know that I've been working with the episodes of care system for over a decade now.

And the first point that comes to my mind is when we develop an episodes of care system, what is the purpose behind it? Is it for payment response or is it for physician performance measurement? Or is for both?

And one thing noted why they are doing it, the episode of care logic can be modified or built according to this goal and you know within Prometheus, we are building it primarily for payment reform.

And the way we have solved the problem of risk-adjustment here is that we develop it at the population level. As you know, when we look at individual physicians, the sample size may be too small and any kind of risk-adjustment there would be dangerous.

But when you think in terms of population, whether it's a health plan data and like in our case, the whole CMS population, that would exactly be right. When you think in terms of the entire population for diabetes, and later on go on to attribute it to physicians.

Now when we start thinking in terms of developing an episode of payment logic for risk-adjustment, we have to be clear why are we doing the risk-adjustment. The risk-adjustment is done primarily to adjust for co-morbid conditions and not give more incentive or more payment for complications that may happen.

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So when we think of the entire episode, say for diabetes, and if the patient had an amputation in the setting of diabetes, that really is a complication or if they had urinary tract infection, they had pneumonia, they had decubitus ulcers, these kinds of things are clear-cut complications.

So when you are developing the risk-adjustment model, we should be able to separate out the complications from typical and reliable care of diabetes. Then when you develop the risk-adjustment model, then it will be based on the co-morbid conditions that the patient has such as obesity, coronary artery disease, hypertension. These are the co-morbid conditions that coexist with diabetes rather than accounting for, or more money for complications.

When we built our risk-adjustment system, we had our dependent variables as the allowed amount, so we are developing resource use or cost models rather than end point being mortality or end point being any particular patient outcome.

Here we are talking about resource use and the risk-adjustment model then factors in various co-morbid conditions that are so to say, cost drivers. So I don't know if you would call them as risk factors but rather those that are increasing the cost of care for that particular patient given the fact that these are co-morbid conditions.

So very important when we start treating an episode of care logic, we should separate these so-called potentially avoidable complications, areas, you know, that physicians can control and take them away from the pool for the risk-adjustment models.

And as Doug had mentioned that we had a very good R-square. Part of the R-squared attribute was good because he created separate models for the

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physician services and separate for hospital-based services, partly because the factors that go on in a hospital setting, the facility files are very, very different than the professional files.

So all the professional services were grouped together in a separate risk-adjustment model and we also included pharmacy over there and, as you know, much of the cost variability that we see is because of pharmacy.

We could not include lab data but that's a very, very important piece of evidence because we have clinical information that can be very easily linked to member records and using line codes, et cetera, it is very easy to bring that information in and that would definitely be an additional channel of data that should be structured into the thing.

Of course, the risk-adjustment model would really get enhanced if we had more outpatient information like patient demographics including access issues, you know, the geographical place, the socio-economic status and level of education and understanding of their condition; so many of these situations it would be nice to be able to link a patient-level file in doing this.

So this is a little bit that I wanted to talk about from the risk-adjustment point of view because we have done quite a bit of work there. As you may know, you know the PFC folks have a ready strong risk-adjustment models in the Atlas database using the lab data and, you know, we built these models using the help of MassPRO and the QIO in Massachusetts and the person behind the risk-adjustment model, Steve Kurtz actually worked at MediQual and helped develop the Atlas Database Risk-Adjustment Model.

So now we have a fully automatic, automated method by which the programs can run any health plan's data and be able to create an automated bootstrap

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validation kind of practice in creating the coefficient that drive costs in a given setting.

So the episode logic, very important to define the conditions, to define the boundaries of the condition, what's included, what's not included, what's relevant to that particular episode and then what's typical care and what's really a variability that is driven because of improper care or inadequate care or as we call them, as gaps in care.

And this whole thing we built these episodes, 21 different conditions including 10 procedures and 10 medical conditions; that's how we did and of course pregnancy, so that's how 21 came to be.

And for both of them, chronic care you have to define the episode length differently, for procedures you have to define it differently because for procedures you want to capture the look back period and the pre-op care that happens and then the post-op follow-up and then the re-admissions that happened after the initial care.

So each episode that you build has to be structured based on the condition that you are building and once the whole piece is structured, at that point you can think of, okay, does this patient have multiple episodes that are happening simultaneously.

For example, a coronary artery disease patient also has AMI; or also has coronary bypass surgery; or had an angioplasty and then bypass surgery. Then how will it factor in and so the whole piece becomes like a, like a practice. It starts building on each other and episodes can latch on from one episode to the other and build a whole series of episodes there.

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So there's a lot to talk, I'll stop here because this is kind of a life that we've been living for several years. Thank you, thanks for the opportunity.

Karen Milgate: I think others can commiserate with your life you've been living the last several years.

Were there, are there any other callers on the phone?

Operator: Yes, ma'am. We have one other comment at this time.

Renee Mentnech: Open it up for comments after that.

Karen Milgate: Go ahead.

Operator: Your next comment comes from the line of Sarah Tong.

Sarah Tong: So this is Sarah Tong, from the American Academy of Neurology. I missed the discussion about some of the risk-adjustment variables so if you could repeat that a little bit.

As well as I'm looking at the Dear Doctor letter regarding feedback on the reports and I'm wondering if you are considering stratifying when giving the feedback as well; because, for example, when you look at service category and you, the position reads provided by you for your patient and then it says provided by other physicians treating your patients.

And then to the right there's a comparative score and you go down and of course, you typically look at the high score or low score depending on where the outlier is so immediately if you go to the high score you see, you know, 5 on consultation and then 6.0 on emergency room physicians, so basically you

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can say, oh, yes, that makes sense; I refer out; but if you could break that further down it might be useful.

I don't know if it's either for the physician receiving the report to give feedback or - what's confusing about this is then how do you use it because if you know you refer out but you know your patient base, what are you supposed to do, not refer to consult, consultations, or if you broke it out by SES, for example, you might find that a lot of people go to emergency room because of health, no health, urgent care, that kind of thing, so if you could comment on those two pieces, that would be great.

Karen Milgate: I can comment on the cost of service category breakdown. Your comments are very helpful. We always looking at how to refine that category to make it more actionable, going deeper into any of those specific categories even down to the service level for example, it may be more actionable for people who are receiving these reports so that's very helpful feedback and we're going to continue to revise that methodology there. So thank you for that.

And we didn't really go into too much detail on the different factors that we're using for risk-adjustment, which I believe was your other question, and we're just looking for feedback from the audience on different things to take into consideration.

Sarah Tong: Well, my understanding is that when we go to SNOMED and LOINC codes which is 2015, which is not too far off, is that by adding four elements, forty elements to the database that you'll be able to risk adjust based on complications and co-morbid.

And I'm not quite clear on how far we along, we are along with adding those into the administrative database but I'm sure it would change your risk-

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adjustment methodology and so I'm wondering about currently how your risk-adjusting - if it's age, sex or beyond that; and then secondly, looking to the future, which I think it's two years away, is where these forty elements to the database are going to be able to adjust by complications and co-morbid.

Karen Milgate: So, thank you for those comments. Are there others on the phone?

Operator: There are no further comments at this time.

Karen Milgate: Okay. Let me just follow-up a little bit on the last conversation on risk-adjustment. There've been several comments about that.

So, a question, I, that I would throw out to the audience, and this can include CMS people as well, but so, the ICD-10 transition and then, then the last caller mentioned SNOMED; so has there been work done on how risk-adjustment might be changed, enhanced, et cetera, related to episodes and I want to be specific on episodes so it's not necessarily a per capita adjustment. It's not necessarily a in-the-hospital adjustment but if you're looking at creating discrete episodes, is there thinking, logic, et cetera, around how we might need to transition given the new coding systems?

Tom Lynn We're - I'm Tom Lynn, from Ingenix - and we have been starting to look at ICD-10 and how it's going to affect all of our grouping products, particularly ETG and we have not done a comprehensive analysis but what we really have done is a gosh, you know, what the thing that we needed was, we really need cancer stage and we looked at ICD-10, not there.

You know, gosh, we'd really like to know some range of a patient's blood pressure. No. You know, we'd really like to know the extent of coronary artery disease and coronary vessels, you know.

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So every time we sort of thought, this is what we really need and let's go look at it, it's not in there. So we've been pretty disappointed by it.

Karen Milgate: Okay. Steve?

Steve Bandeian: What I was originally going to say is somewhat related to what Tom was just saying, so I'll take advantage. I would recommend that as sort of as a by-product of what you're doing that you give very careful consideration to, as a by-product, an important by-product, is what needs to be done to improve the data that is used for the measurements.

One of the virtues of going down this road of thinking through these issues is it ultimately becomes kind of an engineering problem, that is to say, I need to measure this; now can I with the data that I currently have.

And not to be too flip about it, I do sort of wonder what was in the mind of the authors of the ICD-10 when some issues that appear relatively basic do not appear to be addressed, and so having that feedback where there is sort of not just reporting for reporting's sake but also reporting data so that we can do certain measurements, that that loop is closed.

Now as a suggestion along those lines and it, I would at least wonder, is it really clear to clinicians what they are supposed to code? In other words, look at the ICD, the UB-90 or whatever it's called these days, does have some fairly detailed instructions and I did look at the instructions on the HCFA 1500 some while ago and actually I can't, unfortunately, remember what they say but I would pose this specific question.

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It would be really nice if we knew that, take for example for coronary disease. We see some diagnoses, diagnosis codes for a particular patient with coronary disease. That doesn't mean that they have coronary disease.

In fact, one can look at the data and persuade oneself that this individual person does not have coronary disease simply because they do not receive the type of treatment after the initial coronary codes that one normally would expect for coronary disease.

So in that regard, it would be really helpful if when, and imaging studies in particular are done, that rather than being as sort of rule-out coronary disease or what have you, that the diagnosis that's reported actually on the claim for the imaging study reflect what the radiologist thought was actually there.

Now I understand that that probably raises a whole long list of issues and it would be probably difficult and maybe even controversial but my point really is, we're requesting the physicians to provide us the diagnosis codes; what is it exactly that we want them to provide and is that really made clear.

And I would think that it would be extremely helpful if imaging studies gave not the rule-out diagnosis, not the diagnosis thought of by the referring physician; but actually ideally what was found on the imaging study.

I realize again that that's sort of controversial. My larger point though is create a feedback loop where as you version the software that you have, part of the versioning of it is trying to think of how to improve the accuracy through changing and enhancing the source data.

Karen Milgate: Yes, clearly an important point on this. Are there other, anyone else done any work on ICD-10 or SNOMED? Sounds like at least the initial look that the

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two that just commented, were that it wouldn't necessarily give us, at least in what they've looked at, a whole lot more for risk-adjustment.

I would think it would be important to take a more, a comprehensive look at it but...

Okay.

Renee Mentnech: Just as a follow-up to that if anybody has any comments on how registry data might be used to address some of these issues that have been raised around the accuracy of codes in our claims system.

Niall Brennan: Hi, Niall Brennan, from Brookings again. I have a couple of different comments. I mean I'm sort of - just to go back to ICD-10 very quickly - I know I'm sort of stating the obvious here but I think it is important, implementation and operational issues for the development of your episode logic because it seems I mean this isn't going to happen overnight.

There's been a lot of foundational work by, you know, Ingenix, MedStat, Prometheus, you know, Brookings, ABMS, and others that could hopefully be built upon but it seems that, you know, by any normal timeline you're almost looking at a complete reworking it a couple of years in.

And then another naïve question, and I haven't followed the ICD-9 issue very quickly, will we just flick a switch on October 1, 2013, and all physicians will magically start coding ICD-10? I don't have an answer to that.

Specific to this whole issue of clinically enhanced data, obviously it's hugely important. The Brookings Institution and some of our partner organizations are very active and exploring a range of ways to enhance claims data, be it,

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you know, regular linking of that laboratory results to claims data or exploring linking to registries to get more clinical data.

Everybody knows that, if there was more information on ejection fraction for CHF patients or SAMI/nonSAMI for AMI patients, it will be great. The one problem is that even if you can successfully do it and link to administrative claims setting, you generally are only linking to a subset of administrative claims data because registries, most registries lack the universality that claims have.

And I know that people, it's, you know, sort of a favorite like thing to bash claims data but, you know, I'm always the one saying, it's like we have it, we have it for everybody except the uninsured and, you know, most other data sources, be they registries or, you know, the promised land of EMRs, I mean A, it's not going to happen, you know, any time soon even with all the ARRA money; and B, you know, if you want to measure everybody or as close to everybody as you can, I think the initial focus at least needs to be, you know, taking claims and figuring out innovative ways to make them a little bit, you know, to make them better.

Get the laboratory outcomes, get the staging information, you know, get key conditions.

Karen Milgate: Thanks, Niall. Could I ask a - did you have a question or - Dan, I wanted to follow up with you on the one comment you made and then someone else raised this as well.

If you could go into a little bit more detail, you had said something about, I think it was in the context of a strategy but is to possibly think of procedure,

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procedural episodes separately. So could you talk a little bit more about what you were meaning there?

Danny Jennings: Sure, Danny Jennings, again. I think the - it's not as much status in either/or procedural episodes versus diagnostic-based episodes. It's that depending on the focus of your measurement. One may make more sense than another.

So example, with ischemic heart disease episode which, you know, would work well for a primary care physician, a cardiologist. But if you were interested in measuring a cardiothoracic surgeon on the procedures that occur say within the context of the ischemic heart disease episode, actually I think Amita Rastogi, covered this a little bit in her comments early.

But the idea that you can go within the ischemic heart disease episode maybe even to other episodes use the coronary artery bypass graft surgery as the trigger for that and then only gathering claims related to the performance of that procedure are likely concluding some pre-imposed operative window.

But, you know, with the idea being that there are a lot of things that go on during the course of that, patients with larger diagnostic-based episode that the cardiothoracic surgeon just isn't involved in.

Karen Milgate: So does that - so we had teed-up the question of whether you would pull particular acute flare-ups out of a broader episode. So are you suggesting you would pull it out or are you suggesting you'd leave it in but also pull it out?

Danny Jennings: Yes, I think that's in this case I would leave it in potentially for the cardiologist. Although they're actually some schools of thought that you potentially treat episodes that have a surgical intervention differently than

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non- surgical ones with the need then obviously to measure to the incidence of surgery across all episodes for a physician.

I'm getting into another point here, but one other risk-adjustment tactic which is tricky because you are then potentially rewarding over surgery. But there's other ways to measure over surgery than to lump surgical and no surgical episodes together.

So I think in some cases it makes sense to leave them together. But if there's some specialties and physicians that you should definitely pull them out and look at them as a subset of the whole.

Karen Milgate: Okay. And then one other thing you said that may relate is also there may be some waiting that you might do if you didn't want to have the full cost of that surgical piece of the episode in. Is that a connected comment or not?

Danny Jennings: No. But it's, I think are one worthy of repeating. You know, I think, and this includes, you know, some of the things we've done in measurement around physician care.

The idea that a dollar is the best signal of how efficient a physician's care is may not be the best way to go. It's easy to measure it's on the claim whether allowed amounts or standard priced.

And some of the most challenging services within an episode to risk adjust that are things that are often infrequent like an inpatient stay for some episodes. And when they occur they carry significant amount of dollar weight.

So you can almost think of it as, in some ways, more like a quality composite where you are looking for, you know, potentially different dollar-based

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measures within an episode. Maybe even things like sequence of care overuse measures.

But putting them all back together in a way that makes sense rather than trying to force everything to work from a - and match up to the total cost of the episode which given sample size and given the amount of control doctors usually will taken in the incidence of random events in their consequence may be the better way to go.

Karen Milgate: Thank you, helpful. Is there another caller on the phone that had a comment?

Operator: Yes, ma'am, you have a comment from the line of Dr. James Kennedy.

Dr. James Kennedy: Hello. This is Dr. Jim Kennedy again. I was just listening and just again just want to suggest that the answer is on October 1, 2013, there will be a switch flipped. You know, the day before we'll be using ICD-9, on that day there will be a flip to ICD-10.

We predict that most people will not be prepared for the flip. You know, we - even though it's only four years out.

And part of the push-back that physicians are going to have, you know, even now all you have to do is look at the complaints regarding the consumer purchaser disclosure project and the physician rankings on the various insurance sites like United HealthCare and Blue Cross in Tennessee and such.

And physicians are just very upset, you know, regarding the quality rankings and the cost efficiency rankings that are on the Internet.

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I know that MedPAC has done some work. And yes they found some physicians that have been early adopters. And these tend to be the larger academic groups. You know, those that are forward-thinking and such.

Yet have many physicians or the rank and file or, you know, even now as I do my lectures with the Medicare DRG, the inpatient work. I'm here in California today speaking to some physicians. And they're still having transition to what they need to do for the inpatient side.

I would highly encourage that we figure out some way to enhance the claims reporting. One way might be is this, you know, is the uncertain diagnoses. And, you know, whether or not those can be coded as an outpatient versus an inpatient.

You know, expanding or changing the CMS 1500 form which only has eight codes that can go in electronically allowing the physician to submit the same number of codes like you would on an inpatient as to better categorize the characteristics of the patient.

And in fact, put this - start putting this in the physician rules, you know, that are coming out now just Medicare's interest in the quality of the outpatient data and that codes are not just to meet medical necessity to get that individual claim paid. That the code is actually being used in the episode grouping methodologies.

And so I'm - I know that this is - I'm - please understand I am not an expert. You know, I tip my hat to the Ingenix folks and everybody in the work that they've done.

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But I'm going to tell you that practicing physicians, you know, they're involved in that face-to-face patient encounter. And the last thing they're thinking of is what a office clerk is typing in when they're submitting the claim. Thank you for listening to what I have to say.

Karen Milgate: Thank you. Dan, did you have a...

Danny Jennings: Just a quick comment. I agree with the points about improving coding. And Dr. Bandeian's ideas I think we're right on that as well how you can proactively do it.

Maybe just - it may seem like an obvious point but, you know, when the switch is flipped on I-10 in 2013, given the fact most of these approaches are likely going to have, you know, a couple year look-back. Your living in a - not only are not all physicians going to move to I-10 immediately you're working in a hybrid world for at least a couple of years.

So I think, Niall's, point is right. You need to anticipate I-10 but you probably have a little longer to deal with it than you think.

Obviously, you also need to develop the data and the experience to, you know, build new models risk-adjustment or otherwise. And just one way to think about is potentially you may be in a world where you've built your methodology around I-9.

But the first couple of years of I-10 you're actually mapping I-10 codes back to I-9, leveraging your I-9 methodology. And then at some point you're ready to basically flip your system to I-10.

Karen Milgate: Yes. That'll be a complication. Significant.

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Dr. James Kennedy: I have another comment. And I hope it's not too down in the weeds. But it pertains to prescription drug claims. And the fact that there are no - I just wanted to keep in mind there's no ICD-9 coding in prescription drug claims.

I think it's most relevant for this multiple chronic condition issue where right now sometimes you have to make judgment calls as to whether it belongs to episode A, whether a given belongs to episode A or episode B because clinically it could be indicated for condition A or condition B.

So that maybe A, it's something to think about and B, maybe a reason to think more about, you know, maybe clustering a little.

Renee Mentnech: So one of the complications on the use of the drug claims that you send on the Medicare side is that we don't necessarily have the universe of claims. And sort of the responded to the notion that one of the advantages of claims data is that it's universal. But we don't have that necessarily in the drug world, in the drug-claim world.

Dr. James Kennedy: That's right.

Man: Can you actually tie up. Can you actually provide a little bit more detail as to what is in the Medicare? In other words you say it's not universal. Just what exactly is there?

Renee Mentnech: Well, for example, we don't have the drug data on people that have creditable coverage.

Man: Have what?

Renee Mentnech: Creditable coverage.

Karen Milgate: Not all beneficiaries are in Part D programs.

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Renee Mentnech: They may have drug coverage, for example, through a retiree plan and that data doesn't get reported to us in our system. I believe that's the case.

Karen Milgate: I believe that's the case, yes. So for that you would have to subset those folks out or if you were to be able to, you know, create - be able to use the DDE data.

Man: I mean I think the drug data is pretty important. If you could get it on those people that would be desirable.

Man: I was going to say (unintelligible).

David Hirsh: If they could use the mic.

Karen Milgate: Do you have a - I can't believe there's no other comments on this. But if there aren't we could take our break at this point and time. Is there anyone on the phone that had any other comments? Otherwise we're going to take a 15 minute break.

Operator: We do have one comment.

Karen Milgate: One comment, okay. Go ahead.

Operator: Your comment comes from Dr. Amita Rastogi.

Amita Rastogi: Yes and thanks for taking my call again. Amita Rastogi from Prometheus. And I just wanted to follow up on Dan's comments about the procedures. And that's exactly right.

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The thinking is exactly in those lines. That if a major procedure is done then would it be carved out of the original chronic-care episode.

So for example if a patient had arthritis and then they had hip replacement done then if you're looking at their cost of care for chronic osteoarthritis for one year it would be very different in patients who had hip replacement done with those who did not.

And the only way to handle whether be encouraging overuse. So to say treating an incentive to have more hip replacements would be by appropriateness of case studies by doing some propensity analysis, et cetera which would be a completely different realm.

But at the current time in the current fee-for-service system there is no way to control overuse again. So in an episode of care logic the best way to handle, I guess, at the time would be to carve out some of the major surgical episodes, create their own episode time window and then the balance of the chronic-care episode would be the episode minus the procedure that has been done. Thank you.

Karen Milgate: So for this session we just have one primary slide and then the last slide is really for information for people to - we have two URLs for people to go to for additional detail on the research that's been done on the groupers as well as prototype resource use report.

So this part of the session what we wanted to do is just raise a variety of other issues that we know are on your mind or certainly on anyone's mind who tried

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to figure out how to use episodes and tried to figure out how to do some relative resource use measurement.

And we have one slide that lists them all and are interested in hearing your feedback advice on any of them that are up there on the slide. But I would call your attention in particular to the last bullet because we know that we will struggle with the question of transparency and what's meant by transparency.

So let's assume that we have figured out a strategy for grouping claims into episodes of care. And then once we have those episodes of care we'd like to use them to do some measurements.

So the first bullet, just note that there is clearly a commitment on this agency's part to not only look at resource use but also to combine those with quality-of-care measures. So a variety of different questions come up when one tries to do that. How did they get combined?

Do the quality metrics, for example, need to be specific to the particular episode? Is it okay to create what some have called kind of a footprint for whatever unit of accountability you're measuring so that you have sort of a cost of care measure on one side, quality on the other and then combine them into some of overall efficiency metric?

So those are the kinds of questions we throw out for your consideration on that one.

The second bullet is the level of accountability. So we talk about physician resource use measurement, but what exactly is meant by that? And is that really the unit of accountability we want to look at?

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There are a variety of ways to do that. We could try to attribute episodes to individual physicians. We could attribute episodes to small groups of physicians, multi-specialty practices.

We could say no it's really more an overall network of care. Many people are currently in the current debate talking about Accountable Care Organizations. That's another unit of accountability potentially. In addition, we could even look at regions of care and look at variability in resource use using episodes at that level.

Once it's determined what level of accountability we are looking at, then there's a variety of different ways to attribute episodes to whatever unit of accountability.

We can look at some methods that have been used are to look at the preponderance of evaluation in management codes to see who seemed to touch the patient the most from a management perspective and attribute the episode to that particular physician or group of physicians.

Some have said no, it's really better if the physician, him or herself or the practice defines who their patients are. And then we would attribute those patients and their episodes to the physician.

Other ways to do it are to have the patient choose, which is clearly not something that happens much in the Medicare program, although to some extent Medicare Advantage but in the private sector that sometimes there's a physician or a practice that's identified as the primary practice. And then whatever episodes were created would be attributed to that group.

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Once we decide who the unit of accountability also then there's the question of how would you benchmark? So are you looking at that physician, practices, episode, resources for a certain episodes compared to other practitioners in the same specialty?

Are we talking about comparing the cost to other practitioners in the same specialty in the same region? Do we want to look at averages? Are we looking at where what we think is an efficient practice? Those are the kinds of questions we're seeking advice on in that particular bullet.

The next bullet of composites, so they're many different ways of combining metrics both episodes, but also then thinking back to the first bullet on how you combine scores on episodes or relative scores on episodes with quality metrics. So how do you want to complete your composite measures?

Obviously there's a lot of detail within the individual metrics themselves and so both for the consumption of the practice as well as just for describing it, creating higher level aggregation scores are also helpful. So composites there is a - so what the best mechanism is to create composites is also a question.

So those are all somewhat technical, although there's some policy related to it in terms of what you're actually trying to achieve.

The last one is the transparency of the logic and the availability of the software. So, as John laid out in the beginning of the day, he said one of the goals for what we're planning on doing is to make sure that whatever logic is created is as transparent as possible. And one of the subquestions underneath that is then also how available would the software be.

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We recognize there is a real important balance here between making sure that whatever's created is as transparent and usable as possible, but also understand that there are many people that have spent decades working on this type of logic and want to make sure that we can build on that research to the extent possible.

So that's the balance we're trying to achieve within this request for proposal. So having laid out what we're meaning by those different bullets up there, I'd like to open it now to comment here in the auditorium. And then we'll open it, as we did before, to the phone.

Doug Emery: We're okay now? Everybody's on board with the phone and all that?

Renee Mentnech: I'm sorry? Oh, should we take this off ?

Doug Emery: No, no, no. I just want to make sure that the people on the phone can hear us and...

Operator: Yes, sir. And just as a reminder we will now open the line for comments. To make a comment, please press star followed by the number 1, on your touch tone phone. To remove yourself from the queue, please press the pound key.

Doug Emery: I just want to do down these lines, these bullets, bullet by bullet. Use of quality measures - healthcare, I am by background an economist. It's the only form of economics I know that bifurcates efficiency from effectiveness. I think that comes as a world of fee-for-service. I don't know why, but that's the way it is right now.

When you're working with claims data, you're essentially stuck with process measures. And that's a highly impartial world.

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So as we move forward in this model, once you give a great deal of consideration to the types and measures that can be derived from areas that are not of claims and we've been able to set this up with each and every one of the episodes we've built to have the ability to pull, for instance, quality measures like hemoglobin A1c levels in diabetes from electronic medical records and all of our pilot sites we're going to be able to do that.

The level of accountability goes back to look, if this is just a retrospective grouper like the commercial groupers that's just designed to look over fee-for-service claims in a fee-for-service world. Level of accountability at some point becomes unsolvable.

But if the model is to move towards a payment methodology, then level of accountability - it becomes solvable because now you're thinking about okay, who is the person delivering this? Who is accountable? Who is contracted? Who's on the hook for the episode of care?

But that's something that should be definitely worked out over time and we have that worked out through Prometheus as well.

Attribution methods are a little bit difficult. One of the most interesting uses of Prometheus for attribution is done by Medica where they've use the world attribution method which is a way of saying, who touched - I think it's as you said earlier, who touched the patient most in a primary care setting for chronic care.

On an inpatient setting, it's much simpler. Especially for things like total hips, total knees. But I really want to emphasize benchmarking. There's a very simple way of doing this and that is, if the episodes are modeled on evidence-

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based medicine and the statistical and risk-adjustment model are credible, you have two things to look at.

The dollars associated with the typical care of sound care that's evidence-based and the dollars that flow out through potentially avoidable complications. We've done this analysis across the country right now and I guarantee when we do it in the CMS data your eyes will pop open.

In some areas, for certain chronic episodes we're seeing 75 to 80 cents on the dollar going out to potentially avoidable complications. That turns out to be a very big ripe target for physicians and other professionals to go after.

But it also shows you where the intrinsic problems are in our system and makes it very actionable because then we can break down this data and show in clinical terms what that will bring those potentially avoidable dollars down.

And then finally on transparency, we offer this to you as our opinion. That unless this is fully transparent, totally in the public domain and not based on available commercial groupers, it will never receive adequate credibility among providers.

And I give that to you as somebody who's worked in the business for twenty years and knows what the plans have been doing with the commercially available groupers and how doctors and hospitals feel about them.

But more importantly, it has to be built in an open architecture setting or what's done today is amenable to evidence-based medicine and new discoveries as we move down the line so that all parties have the ability to contribute to its evolution and it's accountability over time.

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And if it doesn't achieve that, I doubt very much whether it will receive a sort of acceptance and credibility that is required. This is why RWJ funded us to do this so that nobody owns it. It's fully public domain. Everything we've built, as I've told Frank, is up on the web or up on the sites and you can tear it all apart. And nothing is hidden about it.

So no black boxes, no proprietary algorithms. It's fully built for all parties to be able to work with. And I think that will be a quintessential component of success. Thank you.

Karen Milgate: Other comments? Thank you. Let me ask a follow up for that then. In terms of your last comment on transparency, so when you say open architecture, one issue that comes to my mind is so are you saying that the actual sort of software program is available and people could take that and change it if they wanted to?

Doug Emery: Not change it. No.

Karen Milgate: Okay...

Doug Emery: You'd want definite quality control over it. But the algorithmic structure by which it works is not only fully transparent. Anybody could go into your website and see how it works. But it is not owned by - it's not proprietary in that sense. It's fully in the public domain.

Karen Milgate: But could someone else use it, I guess, maybe that's what I...

Doug Emery: Anybody could. Like for instance, we offer the software we built for free on the web. Except for the predictive model, but that's because too many people can mess around with it.

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But the point is that all institutional parties should be able to work with CMS in developing it and co-creating it and evolving it over time. And that no one party, especially in the private sector, own it.

Karen Milgate: Okay, thank you. Go ahead, Sharon.

Sharon McElrath: This actually is a question. I'm Sharon McElrath, with the American Medical Association. I was wondering, with the feedback that you've gotten back thus far from the reports that you've sent out, it seems like there's a trade-off between attribution and then the numbers of physicians that you can actually find enough data for to send a report out.

And we seem to be heading down a road in congress where they seem to think we're going to have to have reports on every single physician, whether or not that's really doable or not.

But my question would be I mean it seemed like that the attribution method that you used with the, I think, with 10% is - if you were responsible for at least 10% of the E&M and that seems to me that it's probably something that physicians might have a problem with.

But I wondered if you did that because you had to do that in order to have adequate numbers of patients and physicians to look at. I mean, could you sort of comment on the interplay there?

Lisa Grabert: Yes, I can comment on the interplay there. We did receive specific comments on the minimum threshold of 10%, but then an episode of cure - for our patient and we're looking at that methodology both to increase it and to

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decrease it because it's directly related to the number of people you can get reports out to.

In addition to just the attribution methodology, many of the other methodologies that we look at, the benchmarking and how wide those peer groups are is also directly related to how many people you can get reports out to.

In addition to the minimum threshold of episodes someone needs, in order to have enough statistical reliability in the numbers. So we have many different factors that are all at play at the same time that limit who we can actually get into the sample.

So we will continue to test all those different methodologies in order to both engage and educate people and get more reports out because there's always that trade-off that exists.

Tom Lynn: This is a follow-up on the threshold comment. The NCQA sets that threshold at 30% and you really don't lose a whole lot of cases, although you do lose some high cost cases when you go from say 10% to 30%.

I also wanted to make the point that the episode treatment grouper specifically which is a commercially available grouper, does have a website that's available to the public where we lay out exactly what the methods are, how the grouper works, what the relationships are between codes and diseases. So I just didn't want to leave that unsaid.

Karen Milgate: Thank you. I'm sorry, Tom, could I ask you, on the 30%, 30% of what? I'm not familiar with your method.

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Tom Lynn: Well, it depends on the metric that you use to do attribution. If you use a count of E&M visits, then in order to attribute a case to a provider, that provider has to have at least 30% of those visits.

So if the highest provider has 25% of the involvement, then you basically don't attribute that episode to anyone. If you're using surgery management cost, then that's the denominator. If you're using total cost, then you use that as the denominator.

Karen Milgate: Okay, so there's just basically minimum 30% regardless of whether it's the E&M visits, E&M dollars, Part B or...

Tom Lynn That's correct.

Karen Milgate: Okay.

Tom Lynn That would be my interpretation, you know, given the Medicare Part B concept.

Renee Mentnech: Is that a model where you could have multiple proportional?

Tom Lynn It is not.

Renee Mentnech: It is not.

Woman: Every episode is uniquely assigned to one provider?

Tom Lynn I don't guess a requirement. But I think you do assign the entire episode to a provider, then you have to have a 30%...

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Renee Mentnech: Because I should clarify thinking the approach that was taken in our project was multiple proportional attribution. So any given episode could have been proportional if assigned to more than one provider. Is that correct, Lisa?

Lisa Grabert: Yes. We actually have two different attribution methodologies. The multiple proportional where you divide the cost of the episode among all of the different professionals who have treated the patient.

Tom Lynn Right.

Lisa Grabert: And then also a single rule that takes the highest number of E&M services and assigns that to a physician. The NCQA is kind of on the high end of the attribution with the 30%.

There are also several private plans that are on the lower end that use a team based approach that assign an episode to every physician that touched the patient for a single service.

there's a wide range of different attribution methodologies that we'd like to recognize in this program and can continue to test...

Tom Lynn: Yes.

Lisa Grabert: ... to see which attribution methodologies are appropriate for which episodes as well.

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Renee Mentnech: I should probably clarify, when we do issue the solicitation to develop the public grouper, the solicitation will be focused on the clinical logic and the risk-adjustment piece in terms of the development work.

Now clearly the decisions around attribution, benchmarking and such will largely have policy decisions behind them and that the contractor would be asked to simulate or model what the impact of various decisions are. But those kinds of decisions I think will be made more at a policy level.

Steve Bandeian: Hi, Steve Bandeian for AHRQ, again. Just a couple of comments that really relate to certain implementation issues I suppose which you've got.

First, it's obviously very - I mean, I know you know these things, but pardon me for repeating them anyway. It's first of all obviously very important that the report be actionable.

I would imagine that if - I am a physician but I would imagine I received one of these reports and was flagged in some way as an outlier, unless I could understand what I can do differently, I would just get frustrated.

And I would not assume that the answer of what I should be doing differently is going to be self-evident. In other words, the process of care is very complicated; a lot of things are going on and so if one sees that one has more hospitalizations for a particular condition that does not necessarily translate into an immediate answer of what to do differently.

The second point is a little bit more nitpicky or technical, but again it relates to how the physicians would respond to this. And there's a trade-off which again I imagine you've encountered in your pilot project work thus far.

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And that is ideally one would want to have reports occur relatively frequently. And if a physician actually is able to change the problem, one ideally would like to see that in the next report.

It would be a little distressing, I would imagine, to have an adverse report, make corrective action, and not being able to see the impact of that corrective action for two years.

And there are some technical issues that are involved in trying to kind of compress the tale that's involved in this type of analysis. But I just simply put it there as something that's likely to be important to how this process is received because, again, obviously if I do something, I change, I like to see that reflected in the numbers.

Lisa Grabert: That last point clearly gets at the source of the data because the current data we're using, I can't even quite imagine how that would happen. Do you have a thought on that or...

Steve Bandeian: Well, I don't mean, actually my recollection is that Medicare has got very good turnaround time in terms of date of service, processing, et cetera. And so, again, I don't know where the bottlenecks are in terms of, you know, getting the claims data into the analytical engine.

But it's also a question of exactly what measures you're calculating and how you're calculating them and whether you can devise the measures in a way so as to minimize some of the tale that would otherwise be there, lag time that would otherwise be there.

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Lisa Grabert: I was just going to comment, Steve, that if the lag time in the data has, you know, been shorten over time and it does relate more directly to the other points you made which is the engine that you have to put in place.

You know, how quickly that can sort of absorb the claims engine off the report. But the other piece of it is that a lot of measures are annualized measures and so there's always that complication.

Steve Bandeian: Well...

Lisa Grabert: In terms of lag of claims, typically within, somewhere between, you know - there's still a lag, but around six months after a run out period the data is fairly complete.

Steve Bandeian: In any event, I just flag those issues.

Kara Sutor: Hi, Kara Sutor, from Moran Company. Second to that note about the data, just to make the point that while it - certainly six month lag for you internally at CMS for the other stakeholders who may want to have not only access to software but they will need data and a usable and like the LDS format in order to be able to make assessments and evaluations of any resource use software programs going forward.

And so for instance, if there is some sort of time built in, time process measure or discharge measure for instance in the LDS, the claim dates are rolled up to the quarter. So that would not be possible under current format. So considerations like that would be helpful.

Lisa Grabert: Let me just make sure I'm clear on your comment. Your comment is that in addition to wanting the availability of the software, you're saying you would

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also want to make sure that Medicare's data are available for - I'm not exactly sure what your company does, but for others to actually apply it to the Medicare data?

Kara Sutor: Well, if other stakeholders, as an example physician groups, industry hospital associations, et cetera. If they were interested in not only understanding the logic but how the logic may affect them versus their...

Lisa Grabert: I see, okay.

Kara Sutor: Let me just comment on the LDS issue. I know one of the complications is the limited data - you're referring to the limited data sets, is balancing that with privacy.

And so the statute's pretty clear around - on the privacy act around the things that have to be stripped off of a file or fuzzed up in order to protect privacy.

And so it's actually something that the department is actively - it's an active dialogue around right now because the goal is to try and get more data out to and be as transparent as possible. But the balance of trying to figure out how to do that while, you know, ensuring that the privacy is protected.

Lisa Grabert: Certainly it is a challenge and I don't have a solution. That I would just say that in addition to the software being made a public, think about the data you'll need to be able to make the software usable to the stakeholders and all.

Kara Sutor: Thank you.

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Niall Brennan: Niall Brennan, Brookings Institution. Obviously each one of these bullets could be, you know, the subject of a two-day conference in their own rights, so to try and do them justice in public comment period is very difficult.

I think the other commenters have been very helpful. You know, regarding the use of quality measures, definitely, you know, you don't want to measure cost in isolation from quality.

Again, a lot of this is sort of stating the obvious. And there are suites of process measures the vast majority of which have, you know, been endorsed or accepted by, you know, the multiple stakeholder community.

You know for certain conditions it may be fairly straightforward. Diabetes is off the quality measures for other conditions that may, you know, the necessary, you know, parallel quality measures that may not exist.

Also just a general observation that I think as we move forward, you know, in cost, quality, patient satisfaction, whatever and you know, this ties back to some of the work that Lisa has been doing with the resource use reports.

I think we may be in danger of getting towards the how much measurement is too much measurement scenario and overwhelming, you know, the various different groups via providers or consumers, you know, with information that obviously ties into the whole notion of competent measurement, but you know, and actionability.

We need to advance from where we are now, but we need to be careful that we just sort of, you know, lose perspective and, you know, people get 50 page reports with 500 different measures and then we post them on a website that consumers go to and log off after five minutes because they can't make head nor tails of it.

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That's not to say it shouldn't be done, but we need to be very careful and I think always keep that at the back of our minds.

Attribution methods, you know, it's a mechanical discussion. I will tell you that from our work in developing episode logic, also funded by the Robert Wood Johnson Foundation, that it's a very big issue for physicians and that it's probably the single issue defining the episode logic and we should be included - we should be excluding follow-up services.

We can usually, you know, bang through that like in a morning or an afternoon and eventually get back to them on the details.

But attribution, it's a really sore subject. I think based in part because of, you know, a lot of physicians may have a history with, you know, getting episodes or a score they didn't like or quality measures that they felt weren't reflective of their care.

And it ranges from physicians who literally think they should not be responsible for what happens outside the four walls of their office to physicians who are, you know, more open to the notion of a team-based care and accountability. So that's more of the, you know, quasi-real world anecdote, if you will, about attribution.

And again, on benchmarking, I think for right now they firmly believe that even regardless of risk-adjustment systems, they do treat different types of patients.

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So for example, the work that I did when I was at MedPAC and I think many of the approaches in the field right now do, you know, within specialty comparison as opposed to a cross-specialty comparison.

That's not to say that cross-specialty comparison should never be made. I think all these efforts should ultimately move towards cross-specialty comparisons. But again, from a - I think a real world stakeholder buy-in perspective, you know, that might be something yet to consider.

Finally, on transparency. Obviously, it's very important. Our effort is fully transparent as well and we have our measure specifications up on our website.

You know, practically speaking, you know, doctors aren't going to log on to a website and look at, you know, very complex clinical algorithms and say well, I don't think that, you know, CPT 90110 belongs in, you know, an episode of care for diabetes.

So again, I think it's the process that is important and, you know, we have to respect the fact there are multiple stakeholders' perspectives, be it folks like Doug and Tom from Ingenix who feel that we have, you know, knowledge in this area to consider, but also, obviously sufficient groups are going to be at the center of this.

But I think - what I'm trying to say is you need some kind of leadership level buy-in by physician groups whether you tie that to, you know, some form of, you know, NQF endorsement or something so the physicians know that these have been developed transparently. They have been developed openly.

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You know, their peers are a leadership group of their peers that said you know what, if we're going to have cost of care measurements, these are cost of care measures that we can live with. And you know, that should be enough.

And, you know, just have the specs, you know, somewhere for the people to look at and to constantly improved. I mean you can, you know, almost imagine sort of a Wikipedia type thing maybe.

And then on the availability of the software, obviously very important to make it freely available, but it does raise a whole other series of issues.

So will all the decisions on attribution and benchmarking be hardwired into the software so you can only do it one way? Right now, you know, that's not really what happens.

And people have a little bit of leeway. What do you do if somebody takes your software package and, you know, uses it inappropriately in some way? Will that, you know, ramification for, you know, did the acceptance of the methodology and the software package in the community more broadly? I think that's it for now.

Lisa Grabert: Thanks Niall. Great comments. Can I ask you one follow-up? In part this is because I like just get this out in the discussion a little bit on your attribution comment.

So one question that I did not explicitly layout which I think is actually implied by what you said and I just wanted to clarify, is that you - the Brookings Institute has listed cost of care measures around certain conditions, correct?

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So one question, at least in previous times has been would you use the same attribution method regardless of the episode?

And I just wanted to ask you, did you find that for the different conditions that you came up with different ways of attributing so it's really episode-specific or was there some general rule of thumb that did seem to apply when everyone finally got down to yes, this is okay?

Niall Brennan: That's a really good question. We're actually testing that right now. I can say that the vast majority of our episodes conform to this, you know, accepted notion that you look at some threshold of E&M care, generally visit-based and use that to attribute an episode to a provider.

And we are testing some of our more exotic attribution approaches which, you know, were developed with physician inputs because they felt that model didn't work for a given condition. We will see if the two different methods result - how many times the two different methods result in the same physician being attributed to the episode.

But you actually raise another point that I wanted to talk about and this refers to the link to link the quality measures and quality measurements.

Obviously another thing that you have to think about when you bring those two things together is right now it's not inconceivable that physician A could be attributed somebody's diabetes quality measures while physician B could be attributed somebody's diabetes cost of care measures.

I mean, you can make it work so it doesn't happen that way but the way things are set up right now it could happen and that's something that you have to obviously try and take into account.

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Maybe it's okay and you, you know, make sure the physician A and physician B, you know, get the same reports and, you know, talk to each other and, you know, try and work together or maybe it's not okay and, you know, there needs to be some higher-level decision that for certain conditions you need to sort of integrate the quality and the cost measurement and look at them together.

Karen Milgate: Thanks. So if there are no other comments in the room, let's open it up for comments from the phone.

Operator: You have a comment from the line of Robert Weiss.

Robert Weiss: Yes. I am a consumer or a beneficiary patient advocate, particularly in the area of lymphedema. I take it at face value that you want input from all stakeholders including the beneficiary and so I am going to brazen it out and give you some comments based on my hearing of the issues involved in the DRGs, the system and the episode logic development.

I am concerned - I'm going to give you these comments on the basis of a very specific medical condition. That is lymphedema.

But I think that many of my comments are generalizable and maybe points up some problems of the patient and ways to make the system better for not just the bean counters, if you will, but for also the patient. This is indeed a Medicare population focused issue.

Comments on diagnostic-related groups. They're based on the accuracy and the completeness of the diagnostic codes. And in the case of lymphedema, diagnostic codes are woefully inadequate.

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They do not go down to the levels where it's necessary to go down to. They're very high level. It's either breast cancer related or mastectomy related or its other. And that's really the extent with the exception of genetic or congenital lymphedema of the lower limbs.

Those are about the only lymphedema codes you have. And yet it's very vitally important to reflect the codes, both for body site since this is a condition that occurs in just about any body site and also codes representing the length and the etiology of the lymphedema.

None of these issues are being ported into ICD-10. ICD-10 only took the inadequate diagnostics from the ICD-9. This is a - your diagnostic groupings are only going to be as good as your diagnostic codes.

So this is an issue that really has to be addressed. I know this is not the place to do that. There are other ways to change that, but I just want to mention that in passing.

Now there are co-morbidities that are very closely related to lymphedema. And here again, the issue of co-morbidities and how they get grouped is, I think, very important because any measurement of quality has to look at the interrelation of these co-morbidities.

A very blatant example is that cellulitis is both a cause and a sequela of lymphedema. And so there is a vicious cycle here that if you don't treat the lymphedema, you're at high risk for cellulitis.

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You get admitted to the hospital for cellulitis. Very often the lymphedema isn't even noted and yet that's the cause of the cellulitis. Or cellulitis is the cause of the lymphedema.

So these must be grouped. Chronic wounds and lymphedema, obesity and lymphedema, these are all closely related and hopefully will be reflected in an appropriate DRG for that group of conditions.

Now having done that, you have to then make the measurements of quality measurements that include all of the co-morbidities. For instance, when I see the few analyses of the cost of treating lymphedema, all I see is the doctor's cost, the physical therapist's cost and the DMEPOS cost. I very seldom see - in fact, I never see the savings in the reduction of the risk of cellulitis.

And so any measurement of quality in this area has to reflect not only the size of the arm or the size of the leg as a measure of the quality of the lymphedema treatment, but it has to reflect how often does the patient come back to the hospital or back to the doctor's office for a treatment for cellulitis?

And is the treatment of cellulitis adequate? Has the doctor prescribed a long enough course of antibiotics or a prophylactic course of antibiotics, which is done extensively in Europe but not done here in the United States, and as a reflection of the quality of the treatment of that lymphedema and cellulitis?

So the return to the hospital is a very commonly used measure of quality but it's a return to the hospital not for lymphedema. People don't get admitted for lymphedema. They get admitted for this co-morbidity of cellulitis. So somehow this is a fairly complex kind of thing that I'm sure occurs in other medical conditions.

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The measurement of cost I think has to always include the cost of DMEPOS. And I believe it currently is reflected. But the cost to the patient of the uncovered medical supplies I think is also a very good measure of the total cost of treatment of any given condition.

In the case of lymphedema, Medicare currently does not cover the cost of compression garments and bandages and yet that is the mainstay of the treatment of lymphedema.

And so if it's not covered, the patient then will not comply. The patient will come back to the hospital very frequently with cellulitis. They'll have disability issues having to do with the uncontrolled growth of a limb, a leg or an arm. And these are usually not included in the costs of treatment or not treatment or any measure of the quality.

And some comments about attribution. Lymphedema sometimes takes a visit to in some cases as many as eight or ten doctors before it's properly diagnosed.

And these are all costs that I think are associated with the diagnosis and then the ultimate treatment of the condition. I'm not sure how one would capture that. It usually takes a few years for a patient to be diagnosed for lymphedema. So this is another issue about how to capture this information in terms of the quality of the care and also the cost of the care.

I guess I'm going to stop here because as I say I'm just giving you some reflections of issues that I hear and maybe I can just give you some suggestions as to things you should look at in the development of these diagnostic groups.

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Lisa Grabert: Thank you for that comment. It - you raise a very important example of how co-morbidities interact that I think will need to be addressed as we move forward.

Can I just ask you somewhat of a specific question? You just said that it sometimes takes eight to ten physicians to diagnose this condition. So once it's diagnosed, does the patient tend to have a primary physician or not?

Robert Weiss: Ideally the patient would have a group of physicians. Very often, lymphedema is caused by - it's a sequela of cancer treatment. Roughly 25% to 30% of the patients treated for cancer - and this is not just breast cancer. This is testicular cancer, cervical cancer, and melanoma. Roughly 25 to 30% will come down eventually with lymphedema.

The team that treats a lymphedema patient usually includes an oncologist, a primary care physician and almost always a physical therapist. And it - very often because of the link with cellulitis, it'll also include an infectious disease specialist. So that's sort of the team that treats a typical lymphedema patient.

Lisa Grabert: Thank you. So that also raises some questions about for other conditions would it be possible to identify a team as one way of doing attribution.

But wouldn't necessarily be the example that I think now you pointed out where - or others have talked about - where you would possibly attribute the episode to anyone that touched the patient but perhaps some intelligent attribution in the sense that you might look at the type of specialty that was involved in terms of one of the physicians seeing the patient as well.

Robert Weiss: Absolutely. That's the only way that makes sense for a lymphedema patient as far as I'm concerned.

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Lisa Grabert: Okay. Other comments on the phone?

Operator: You have a comment from the line of Amita Rastogi.

Amita Rastogi: Yes this is Amita Rastogi, from Prometheus and I just wanted to comment on a few of these discussion points.

I really enjoyed Robert Weiss' discussion, taking one specific episode and walking it through and relating all the issues. That's exactly the right way of thinking of things.

So talking - building up on the physician attribution, just a small comment there. That we have to think about why are we doing the provider attribution?

The main reason for provider attribution, is it a retrofitting based on current claims data trying to say who should be given certain portion of this episode and how much responsibility or if there's a gap in care who is to blame? Is that the whole point about attribution?

Or is the point about attribution being about prospective, proactive patient accountability? So a physician or a physician team takes on accountability for a patient and moving forward we have not only a measurement but also payment systems structured around that particular, you know, accountable physician, so to say, or the team.

This issue is quite important when we think in terms of how are we attributing an episode to a provider? Because up front if a patient - oh, sorry - if a physician takes on responsibility for the patient's care, the payment is structured around that particular episode.

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The physician either treats themselves or allocates certain portion of the care to an infectious disease doctor or somebody else. That's one way of doing it.

But, as you know, in America all kinds of systems exist. And it's a free country. Each kind of system can take shape. So within Prometheus we have seen that, you know, our four pilot sites are very differently structured.

Each one has their own system of attribution and own system of accountability and just requiring an accountable care entity or requiring that one particular physician should take responsibility doesn't work.

In Rockford, Illinois, it works one way. In Pennsylvania it works another way. In New York it works another way. And then within the same state there is - it works differently.

So I agree with CMS when they said that it will be ultimately a policy decision which may be structured differently based on the different communities that you reach out to.

Okay, talking a little bit about when he was - when Doug mentioned about open architecture. So the current, you know, model that Prometheus has developed we were very fortunate because, you know, (unintelligible), our CEO, has reached out to several groups and people have heard about our work and so physician groups started contacting us and wanting to help build episodes for the payment structure.

So the GI physicians from Minnesota affiliated with the American Gastroenterology Association, they reached out. The CMQCC [California Maternal Quality of Care Collaborative] the, you know, for maternity and, you

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know, delivery care, Dr. Elliott Main and Debra Bingham, they reached out. They all wanted to help me build these episodes.

So, you know, and then we were talking about physicians may or may not know the codes. They are the ones who really know those codes. They really know this CPT code is billed and what is paid and what's going on.

So they went down the code books and they said this is what you should include. This is what's not part of this episode. This is what we would consider as potentially worried about complication. This is what we want our colleagues not to do.

And so we could not only build models in describing typical care versus, you know, what are complications within a particular episode, but also build core pricing, care coordination issues, where are the gaps in care and underuse, that kinds of issues.

Because really the whole idea behind episodes of care is to build a system that will bring value to our system, that will look for underuse that will prevent overuse and that will prevent all these complications that are happening.

So when we talk about actionable data and actionable information, that's exactly what we are now being able to produce. We can tell in the setting of diabetes how many patients had a preventable hospitalization.

How many had an emergency room visit that could be avoided? How many had a pneumonia problem or a urinary tract infection? We bring out actionable reports which lift out these complications and we tell them the frequency and the cost associated with it.

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And like I told you, this is a population-based analysis so we can tell in that whole population this is the percentage of, you know, potentially avoidable complications happening and each physician can then see for their patients what is the most important, you know, complication that they should be working on to improve processes of care, to practice engineer in such a way that their efforts will be most rewarded by decreasing this waste within the healthcare system. So I'll stop there. Thank you.

Karen Milgate: Thank you. Could I ask a follow-up and either you could answer or perhaps Doug in the room on attribution. So it sounds like what you were describing is that there are some group of physicians that have agreed to be paid on this basis and so they have prospectively identified for you the patients that they consider their own. So that's kind of a question. Is that correct?

And when you think of the Medicare program, have you thought about how that might work within that context?

Amita Rastogi: Okay. Doug, do you want...

Renee Mentnech: Another point to that. When you answer Karen's question, in the Medicare context, one thing that we are concerned about is not building a system where a provider can sort of cherry pick the ones that are most likely to do well. This gets back to my comment before about not building a system that results in providers refusing to treat a more disadvantaged or difficult populations.

Amita Rastogi: Right. Coming to the second point first and then I'll let Doug describe the first one because he's really working in the implementation teams across the country.

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But coming to the second point, what is ideal and how we would incent, you know, CMS providers not to cherry pick. When I look at physicians, you know, say working in the community, it's something like how Robert Weiss was saying.

Quite often it's not a solo physician who's responsible or taking care of a patient. It's usually a patient - or a doctor team that forms where they - it is, you know, unwritten team because physicians have referrals happen. They work in a group setting quite often.

So on the weekend it will be the colleague who takes care of or sometimes you take care of your colleague's patients. So it's a group but then if the patient has other problems that come up, then you reach out to other specialists. So it's a joint accountability or joint kind of care.

And it's not a matter of cherry picking anymore because here is a patient who needs help and you're looking at the full patient and you're looking at different aspects of care.

The place where the whole system starts to break down is because nobody is taking full responsibility for this patient.

So when the patient gets discharged from the hospital, nobody is really kind of seeing that they don't get re-admitted back, that the pharmacy for the next two, three days is covered, that, you know, they don't have to rush to Walgreens the same night that they are going home because there's too much to take care of.

All those processes are the places where nobody is really working in that medical home kind of idea or the whole care coordination kind of idea which needs to happen, which we need to incent.

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And through episodes of care we are trying to build that kind of thinking, very different from encounter-based thinking. But when we start thinking about an ideal world, it may be a while coming.

And in the interim, you know, we have to do with what we have. We can't suddenly change everything. So we'll have to build on the people service system that we have and start moving towards episodes of care for initial kind of, you know, retrospective reconciling so to say.

So at the current time that the - what we are doing is when physicians have decided to take on the role for an episode-based payment. We, you know, proactively look at the information but that at the end of the year we retrospectively reconcile and say, you know, looking at your data, this is what happened, this is what the predictive model suggested that the episode-based payment should have been.

This is what actually got done. And I'll let Doug build up on that implementation side of things.

Doug Emery: ...attribution from clinical logic and risk-adjustment because the one is policy and so I think you've pursued the right course on that.

As I said earlier, most problems of attribution begin to take care of themselves when you consider this as a payment tactic especially contracting technique. For the nearly 50 years that episode theory's been around, remember this is always a way of shifting the current system which is all institution based and putting the patient at the center and making a new institution.

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So that all forms of episode logic whether it's ETGs, 3M, MEG, Prometheus, Brookings, they're all cognitive proxies as a way of tricking claims into working as if the system were actually organized correctly and paid for correctly, right.

So attributions, so long as it's just this claims-based system looking back, without any link to payment, that's why I said it, it becomes pretty much irresolvable. But once you start moving towards payment, then it becomes resolvable.

And as Amita said, in every site we're implementing, it's a bit different. In Rockford, Illinois it's going to be done by largely hospital physician aligned systems.

When you look into Crozer-Keystone affiliation, it's going to be built in total hips and total knees around orthopedic surgeons but within the Crozer-Keystone system.

In Minneapolis, and I wish I could show you the Prometheus data in Minneapolis. They look better than anybody in the country. They essentially have the potentially avoidable complication and cost problems solved there.

Why? Because they have a strong community commitment to measuring care and making it transparent which is where I hope this process is leading. So in that sense there, there's a couple of payers just looking at how do you structure episode payment around supporting the medical home.

So in each and every instance, it's a bit different. So I think you've come to the right conclusion in saying that if you structure an episode logic, it's really about the clinical logic and the risk-adjustment methodology.

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Attribution, you could take the same clinical logic and attribution processes and apply multiple types of - wait a minute, the same clinical logic in risk-adjustment techniques and apply multiple types of attribution processes to the same.

That's the part that has to be gotten right. And then just to emphasize something that Amita and I believe Steve said, this has to be actionable.

One of the things that drives me nuts about most of the episode reports I've seen and some of what I saw up there is that you see somebody along a Bell curve distribution or you see them as a ratio in comparison with other providers.

It has to be actionable and that is whatever you develop, a clinician has to be able to look at it and say okay well I understand I'm to the left or the right of here, but here's the stream of data that tells me what I need to do to get myself over there.

And that would be invaluable. And that's why when we talk about transparency, if physicians and their groups at hospitals are key to the development of this methodology as a means of understanding how they can improve their care processes, they'll adopt it, especially if you make it worth their while and make it profitable to adopt it.

Karen Milgate: Stream of data, so when you use those words, what are you thinking about? You said if they had a stream of data, they could use to change what they're doing. I think some of those stream of data type things we're thinking about are services to a level of specificity that, you know, however would be useful. So what are you thinking about with - I mean, is there other aspects or...

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Doug Emery: No, no, you're right. It's the reporting mechanism. It's how you organize the incoming data, how it's processed and what the outputs look like. And the outputs are in the - are all in the reporting process.

And as I said earlier, if you can link this to outcomes measures, not just process measures, but outcomes measures that are all underlying tied to evidence-based medicine, then you'll have something that has never existed in American health care before.

And that is the gradual envelopment of our darkly opaque system by light of actionable pieces of information that all parties, especially in the patient-provider-payer triad, that's the most important, right.

Patients don't have information, physicians don't have information, you don't have information and yet we pour \$2-1/2 trillion into what is essentially a black hole.

Karen Milgate: Okay, thank you.

Steve Bandeian: Hi, it's Steve Bandeian, again. I'm not sure I'm necessarily disagreeing with people have said. But I mean, you phrase it a somewhat - in the perspective that I would advocate. I fully agree that there are many policy, political and organizational issues surrounding attribution.

So I think separating that from the basic analytic structure and allowing - and having flexibility to do multiple different approaches of attribution for a given analytic structure is advisable.

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Notwithstanding what I just said though, I think that ideally for any given patient, if we look and we see for the care of that patient through our analytic tool that something went wrong or some - there were some avoidable cost or avoidable adverse outcome.

Ideally we want to know not just we, but the physicians should ideally want to know well what were the one or two or three things that could or should have been done differently and who was in the best position to do it differently.

So I think that the issue of attribution in some regards really can be rephrased as what might have been done differently with this patient specifically, e.g. to make the analytics actionable. And who was in the best position to have done it differently.

And if the physicians choose to be organized as some group and to get some sort of group payment or whatever, that's fine. But at the end of the day, that group also would need to know what specifically needs to be done differently and who needs to be doing something differently.

And it's sort of unfortunate that these things tend to get to be sort of negativity associated with these reports but at the end of the day, you really need to see what are the things that are being done in the process of care that are not ideal and who can change it.

So I would argue that you ideally in one way or another want to be able to link the variants in the care to who could change it.

Karen Milgate: Steve, are you suggesting a model where sort of even after you work out the kinks around attribution and let's say a given patient or their episode is

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assigned to a particular physician that a useful piece of information back to that physician is what other care was provided to that patient and by whom?

Steve Bandeian: Well it's not exactly what I was saying but that does seem to me extremely useful. In other words, I wouldn't assume that any of the doctors or clinicians involved in the, you know, our care process has become complicated.

But there's a good reason for that which is to say that there are different physicians and different clinicians that are expert on doing different sorts of things.

And so I wouldn't necessarily assume that one person or one group of doctors who are focused on one aspect of the care of the patient necessarily know in a comprehensive what happened once the patient leaves the care process.

And so yes, I think that ideally - in the ideal world, I wouldn't just be talking about a single report that goes out once a year.

I would be saying that ideally, different providers who are focused on different aspects of the care process would have access to reports that would be relevant to what they are doing so that they can see what they could've done differently.

So I used to work as an emergency room physician and I never knew what happened to the patients after they left the emergency room. And it would've been useful to know how many, you know, saw their primary physician within a recommended period of time, how many did or didn't take their medicine to follow the course of action.

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You get some - emergency room is probably about the worst in terms of continuity and follow-up, but I wouldn't necessarily assume that any clinician has a comprehensive or global understanding of what happens to his or her patients once the patient leaves the exam room.

So I was actually making a different point, but I actually do agree that it would be valuable. I tend to be of the view that actually to the extent that our system is less than fully effective, it's largely because the clinicians do not know and have no way of knowing in a systematic way what actually is happening to their patients.

I'd say it's simply not possible for even the most, you know, conscientious and dedicated clinician to really understand what has happened to the patients given the - I wouldn't say fragmented nature of care because that's the negative phrase. I'd say care is split into different pieces for logical reasons.

The problem is that that makes it hard for anyone to really understand what's happening and where the opportunities for improvement are.

Barbara Tomar: Thanks. I'm Barbara Tomar, from the College of Emergency Physicians. I think I wanted to follow up because even though it is a problem for emergency physicians to have any idea what happens to the patients after they leave.

I mean, more than 50% of Medicare admissions come through the emergency department and we certainly would assume on the re-admission issue that the bulk of patients who are readmitted are also going to come through the emergency department.

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And, you know, in terms of attribution, it might be an easier thing if physicians work for hospitals, but 2/3 of them are independent and don't - and are not hospital employees.

But I would hope that as a policy consideration, what we hope to see out of all this attribution and the episodes is that the physicians will be able to work together to find out if in the case of an emergency visit, what did go wrong, what was the exacerbation?

And be able to sort of close the loop back with the primary like attributed physician and all the other physicians that are involved. I mean that seems to be the bottom line of where we are trying to go with episodes. Thanks.

Lisa Grabert: Yes, thanks for that comment. Actually as Steve was talking I was thinking that it would seem like one positive outcome of thinking about episodes and providing information to physicians on episodes would be the ability to get a better sense of over some period of time what actually happened to the patient.

I mean, there's clearly negative aspects to that if physicians feel like they really weren't a part of that episode. But I do think that that is potentially some positive outcome of this.

I don't know if there's other people, clinicians, or those representing clinicians in the room, but I was wondering your thoughts also on the comment that Steve made that - and I wasn't sure if he was actually saying we, CMS or Medicare should provide information on what went wrong for making a judgment statement and then, you know, sort of who has responsibility for doing something differently.

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I would think that would be an area of discussion at least as to how much the clinicians would want to sort of judge that versus an external entity kind of making a judgment about what went wrong. So are there - is anyone interested or willing to comment on that?

Karen Milgate: Sure.

Steve Bandeian: It's not, you know, I don't really know any other way of saying what went wrong, other than to say what went wrong.

But what I'm really trying to say is unless somebody pulls the analytics together, then if one gives a report saying there's some adverse variance with regard to a particular patient and if you don't provide sort of connect the dots, how would people know what to do differently?

So the - there's a dilemma because if you do connect the block - the dots it looks like your assigning blame. On the other hand if you don't connect the dots then the clinicians have to sort of scramble to figure out what to do differently. And it's not obvious to me that it's easy for clinician to do that.

Lisa Grabert: Okay.

Liz Hoy: Hi, I'm Liz Hoy. I'm with the American College of Surgeons. I actually interpreted Steve's comment a little differently, not that CMS should be the one doing the analytics necessarily. Working for a physician group I was thinking that becomes our responsibility. And to some extent it's the communities responsibility as well and I think that this is an area where accountable care organizations as they evolve are going to be able to bring a lot of value to the system in terms of having a team-based

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approached that integrates the caregivers within a community to take responsibility for the care of that community.

Karen Milgate: Thank you.

Steve Bandeian: Can I respond to that? Actually I think that is a wonderful approach. The problem is right now, the Accountable Care Organizations would not necessarily have access to the data. In other words, think about the - suppose an emergency physician group wanted to assemble data to track what happens to their patients.

Well that's - patients are seen in other settings, other physician offices, what have you. So, you know, if you know if there is a way of making the data available, then that's fine.

But if one dumps a report on ones desk - pardon me for saying it that way - and do not at the same time empower them to be able to figure out what to do differently. Then I think you have an issue.

Liz Hoy: Right, so the point being that to get to the point where there is a good discussion amongst providers about what needs to be done, there needs to be actual information.

I mean - that sounds like what you are getting at and what you were getting at and what you were saying as well. And so we need to be real conscious about what actual means.

Karen Milgate: Okay. Are there any other comments on the phone, I actually think that we didn't get through. I didn't make sure that there weren't anyone else on the phone that wanted to make a comment?

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Operator: Yes, ma'am you have a comment from the line from Sarah Tong.

Karen Milgate: Okay so I think we'll take one more and then end the session.

Sarah Tong: Yes, this is Sarah Tong, at The American Academy of Neurology and staff. This statement really reinforces something that the Brookings Institute representative said.

It also comments and makes suggestion on an approach both to standardize or promote the standardization of use and interpretation of ETG methodology and also an acceptance in the physician community.

I see here that this listening session is being promoted and all these ETG efforts are being worked on by CMS Office of Policy, CMS Office of Research Development and Information.

And the point of reference with quality measure development has all come out of PQRI and Contracting for measure development work through Dr. Michael Rapp's office.

So what I'm trying to bring to light here - maybe hear how you might take this suggestion is that when we hear of the term quality measures, there's a total existence that has grown for a number of years now of measure developers.

And, such measure developers include Physician Consortium for Performance Improvement, National Clinical - NCQA and then of course specialty groups that are coming into measured development.

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And CMS on the other office side decided not to be a measured developer except, they got engaged with it via contract with Mathematica, for example.

And so now CMS is developing - maybe not - their announcing a call for public methodology using existing vendor methodology, ETG, MEGs, through Ingenix and MedStat processes and then there's a lot of mention of physician acceptance and this is paramount and we talk a lot about this.

And I think a great concern of the specialty societies - and then you also discussed physician action. So in order to be engaged, physicians need to understand the methodology. And in order for them to act on it, they're going to need to understand it.

They should be acutely, intimately involved in the development and decision of these methodologies. Furthermore, developing public methods focused on clinical logic and risk-adjustment as was clearly stated earlier, you need upfront physicians involved.

And who better to go to or consider for involvement and including via contract with your ETGs vendors but the measure developers.

There's a huge physician community that has rallied around the Physician Consortium for Performance Improvement. They already have standard methodology for incorporating developing measures and even moving to outcomes and interim outcome measures.

And I'm wondering if there's been a consideration of working with these measure developers to incorporate in or as a standard sub process where you can actually get clinical input to help you discuss these pieces of benchmarking attribution methods level of accountability.

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In addition, you can use those groups to provide feedback on the reports that they'd see and not that you should report out, you know, bad behavior based on where the attribution lies, but the physicians can give you council on what kind tools to be developed and monitored and how the physician community can use those tools.

So specifically involvement of measure developers in your process here.
Thank you.

Renee Mentnech: Thank you for the comment. I should probably clarify that when we issue an RFP to build this clinical logic grouper or whatever it turns out to be, we don't have in mind any particular vendor or approach. So it's not that necessarily, you know, we have one particular one in mind.

And for that reason when we issue the RFP we're actually anticipating sort of an open competition as opposed to going to one of our master contract vehicles, so that any bidder is free to respond to it and we will evaluate the bids in a competitive way accordingly.

The mention of the vendors that are currently out there is simply because we took a look at those products separate and apart from this effort to see how they worked with the Medicare population and the Medicare data.

So the research that has been done took advantage of sort of the products that were already out there in the market, but our intent, as I said, is to do this in a competitive way.

Clearly as this is developed we will be seeking clinical input and we expect that clinical input will be a big part of this.

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Sarah Tong: Well, but I'm - what I'm suggesting about the clinical input is to actually, in your RFP, make mention of work with measure developers. I'm not suggesting PCPI develop the methodology.

There's, you know, good products out there, but to have the RFP describe stakeholders and I'm suggesting that huge stakeholders already in the system include PCPI and NCQA as well as NQF. Thank you.

Karen Milgate: Thank you for that comment. So just two other points. One, we will be happy to take written comments. So if you'd like to put anything you've said or haven't said in written form, feel free to send that to us. There is an e-mail that I'm going to give you now, so it's physicianvbp - VBP is for value-based purchasing - @cms.hhs.gov.

And then the last page of the slides had, again, two website links. One, the first one was to the website that has the Federal Register notice, the background paper, the slides for this particular session. And then the second one that was there is where you can get the prototype resource use reports that Lisa described.

And then also in the background paper, there are links to the findings from the research that Renee has described as well, if people really want to dig in to some of the research that's been done on the groupers.

With that I'd like to thank everyone for coming to this session. I think it's both illuminated some nuances of issues we've already discussed. It's outlined and raised to the light some issues that I think we hadn't been as aware of.

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It's also, at least for me, made me think about how we can get this kind of input as we move forward in this process. So we'll need to take that back and talk about that to some extent.

And also wanted just again note - I guess I just feel very appreciative of the people who came to this meeting who've spent many years looking at this issue and really acknowledge the work that's been done in this area already.

So thank you very much. Are there any other parting comments from my colleagues here? Okay. Otherwise, thank you so much.

Operator: Thank you for participating in today's conference. You may now disconnect.

END