[Classical music plays]

Hello, and thank you for joining today's Listening Session on Cost Measure Development. Today Dr. Theodore Long, with CMS's Center for Clinical Standards and Quality, will give a brief presentation on cost measures and the role stakeholders play in the cost measure development. Following his presentation, he will ask for feedback on different topics related to cost measure development. The audio for today's session will be available through your computer speakers. You can provide feedback through the check box or use the phone number provided later in the webinar to provide feedback by phone. The speakers will answer as many questions as time allows. Any questions not answered on the phone should be directed to QPT Service Center. The slides, recording, and transcript for the webinar will be posted on the Quality Payment Program website in the next week or so. And now I would like to introduce today's presenter. Dr. Long, you may begin.

All right. Thank you, everybody, for taking the time to join us today for this Listening Session. I want to cover four topics today -- first, an introduction, second, what is a cost measure, third, opportunities for stakeholder engagement, and, fourth, the feedback session itself. Next slide, please. So, by way of introduction, again, I am Ted Long, Senior Medical Officer at CCSQ, or Center for Clinical Standards and Quality, here at CMS. Next slide, please. I want to start with a broad overview of the Quality Payment Program. The Quality Payment Program policy --

Sure. Thank you.

I'm sorry. Somebody's trying to say something? Okay. The Quality Payment Program policy reforms Medicare Part B payments for more than 600,000 clinicians across the country and is a major step in improving care access or care across the entire healthcare delivery system. Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population, and there are two tracks to choose from. The first track -- Advanced Alternative Payment Models, or APMs. If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model, or the second track, the Merit-Based Incentive Payment System, or, as you've heard it referred to as, MIPS. If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS. Next slide, please. Talk a little bit about the Merit-Based Incentive Payment System. There are four categories for performance evaluation in MIPS. The first is quality, the second is cost, the third is improvement activities, and the fourth is advancing care information. The Merit-Based Incentive Payment System, or MIPS, moves Medicare Part B clinicians to a performance-based payment system. It provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice. And reporting standards align with Advanced APMs wherever possible. Next slide, please. So, what are the performance category weights? Note the weights I'm about to describe are default weights. The weights can be adjusted in certain circumstances. For the first year of which we are currently in the performance year, the weights are as follows -- quality, 60%; cost, 0%; improvement activities, 15%; and advancing care information, 25%. Next slide, please. In terms of cost measure development and as a backdrop to this, the cost measure development work that we're currently undertaking pertains to the cost category, which is one of the four MIPS categories. Cost measure development builds upon our December 2016 posting for public comment that included two key features. The first is a paper

describing our approach to cost measure development, and the second was a draft list of episode groups and trigger codes. Today we will cover what is a cost measure and what role do stakeholders have in developing cost measures. At the end of this presentation, we'll offer a forum for stakeholder feedback where we will feature several key questions, but, also, we welcome any verbal feedback now, as this is a Listening Session on feedback for the December 2016 posting. Public commentary is open through April 24th of this month. Next slide, please. So, to go in to the second topic for today, "What Is a Cost Measure?" Next slide, please. A cost measure represents the Medicare payments for the medical care furnished to a patient during an episode of care. Cost measures are based on episode groups that identify items and services furnished in addressing a condition, serve as a unit of comparison. For example, an episode group for meniscus repair identifies care services furnished for this procedure and enables comparison of clinicians providing these services. Cost measures inform clinicians on the costs of their patients' care for which they are responsible. Cost measures can be aligned with quality-of-care assessment so that patient outcome and smarter spending can be pursued together. Finally, cost measures are calculated using Medicare claims data so no additional data submission is required. In other words, there is no additional clinician burden. Next slide, please. There are five essential components of cost measures. The first component is defining an episode group. The second is assigning costs to the episode group. The third is attributing episode groups to clinicians. The fourth is risk adjusting episode groups, and the fifth is aligning cost with quality. On the next several slides, I'll be going in to a little bit more detail for each of these five components. The first component is defining an episode group. An episode group focuses on clinical conditions requiring treatment, the condition itself, or procedures to treat the condition. For example, a procedural episode group that is surgical in nature could include preoperative services, the surgical procedure itself, anesthesia, follow-up care, services related to complications, and readmissions. An episode is a specific instance of an episode group for a given patient and clinician. For example, a clinician might be attributed 20 episodes or instances of the episode group from the episode group for, say, heart failure in a given year. Episode groups can vary in scope. They can be narrow and precise or broad and general. For example, an episode group for cataract removal with insertion of interocular lens prosthesis has a narrow scope. In comparison, an episode group for gastrointestinal hemorrhage has a broad scope. Episode groups can also be divided into subgroups to define more homogenous patient cohorts. An example of this would be thinking about gastrointestinal hemorrhage. This may be divided into subgroups for, for example, upper and lower gastrointestinal hemorrhage. There are three types of episode groups listed in the December posting. These are the boxes on the lower part of your screen. The first are acute inpatient medical conditions, the second are chronic conditions, and the third are procedural. Next slide, please. The second component of cost measures is assigning costs to the episode group. Assignment of items and services determines what is included in episode cost and depends on the role of the attributed clinician. The episode window determines the period of time during which claims are eligible to be assigned to the episode. There are two boxes in the bottom portion of your screen. On the left-hand side, items and services that are assigned to the episode group can come in two varieties -- direct services and indirect services. Direct services are provided by the attributed clinician. Indirect services are provided or ordered by other clinicians in the same clinical context -- for example, post-acute care, ancillary care, or consequences of care, like complications. The box on your right-hand side, items and services that are not assigned to the episode group -- these

are unrelated services, unrelated to the clinical management of the patient's condition or procedure that is the focus of the episode group. Next slide, please. Elements of an episode of care for a given patient and clinician are shown in the figure at the bottom of this slide. The black arrow represents a trigger service or a service such as identified through, for example, a CPT code that can rule the clinicians into an episode group or cost measure. The blue triangle shows services assigned to the episode, and the white triangle shows services not assigned to the episode. In terms of the attributed clinician, at the top portion of the figure here, there is a series of blue triangles and the black triangle, which shows the trigger service. The blue triangles for the attributed clinician are the services assigned to the episode, and you can see here that they all are included in the episode. However, on the bottom of this figure shows the services provided by other clinicians or providers. Now, as you can see, some are blue triangles, which means some are services assigned to the episode. However, some are white triangles. These are services that are not assigned to the episode. Overall, at the bottom of the figure, you can see the episode window encompasses all of the triangles together. Next slide, please. The third component of cost measure is attributing episode groups to clinicians. Attribution is the assignment of responsibility for an episode of care to a principal or managing clinician. Attribution should be transparent to clinicians and only hold them responsible for outcomes they can reasonably be expected to influence. Patient relationship categories and codes being developed under MACRA can be used in conjunction with claims-based rules to assist attribution. The figure at the bottom portion of your screen shows the development timeline for patient relationship categories and codes. On the left-hand side, in April 2016, an initial list was posted for public comment. We received many public comments and revised the list and again posted a revised list in December of 2016, again asking for public comments. In April 2017, an operational list will be posted. Next slide, please. The fourth component of cost measures is risk-adjusting episode groups. This adjusts for factors outside the clinician's control that can influence cost -- for example, age, comorbidities, illness stage or severity, other aspects of patient's clinical history, et cetera. Risk adjustment aims to avoid penalizing clinicians who treat either unhealthy or complex patients. The selection of risk adjustment method will be informed by analyses, Technical Expert Panels, clinical committees, and public comment. Next slide, please. The fifth component of cost measure is aligning cost with quality. Alignment with indicators of quality is necessary to compensate for information not adequately captured by episode costs. A quality assessment might include the following -- complications, rehospitalizations, unplanned care, and other consequences; outcomes of care; overuse, underuse, misuse; processes of care; the functional status of the patient; and a patient's experience. Next slide, please. I'm now going to go into the third portion of this presentation, which is opportunity for stakeholder engagement. Next slide, please. This slide shows the stakeholder input gathered to date, and we've broken it up into five different boxes or categories. The first box, on your upper left-hand side, is postings related to existing CMS episode groups. You may have heard these referred to before as Method A and Method B. These postings are CMS Episode Group's postings, first of which was October 2015, then supplemental CMS Episode Groups, the second posting of which was April 2016. Moving to the right, rulemaking is another vehicle. The Quality Payment Program proposed rule, which came out in May 2016, received many public comments which were taken into careful consideration in construction of the final rule, which was the Quality Payment Program's final rule with comment period again in November of 2016. Moving to the bottom portion of the screen, another venue for stakeholder

input has been our Technical Expert Panel, or TEP. This served a high-level advisory role and provides guidance on overall direction of measure development. It includes representatives from specialty societies, academia, healthcare administrations, and patient advocacy organizations. There have been meetings thus far in April 2016, December 2016, and March 2017. Another vehicle has been our clinical committee. This committee makes recommendations about clinical specifications for episode groups. Initial input activities occurred in August-September of 2016. This included 70-plus clinical experts from 50-plus professional societies. The clinical committee provided expert input to develop the draft-listed episode groups and trigger codes that are part of the December posting and part of our current comment period. Finally, on your bottom right-hand side, posting related to cost measure development -- this is the December 2016 posting I referred to of cost measure development -- both approach and draft-listed episode groups and trigger codes. We are seeking comment to this posting both today during this Listening Session but especially through our public commentary, which ends April 24, 2017, and we have information about how to submit those comments in this presentation, as well. Next slide, please. I'm on slide number 20 now. This is "Key Points from Prior Stakeholder Feedback." I will now outline a few key points, bringing together those different vehicles for stakeholder feedback that we have received and listened to thus far. First, defining episode groups and cost measures must yield actionable information that can guide improvements to patient care. Second, assignment of costs to episode groups should only hold clinicians accountable for patient outcomes that are within the scope implied by their clinical role. Third, attribution of claims and episodes to clinicians should be clear and credible at the time of service. Fourth, cost measures should account for patient complexity through appropriate risk adjustment. Fifth, cost measures must be aligned with quality measures. And, sixth, broad stakeholder feedback is crucial to the development and implementation process. Next slide, please. Our cost measure development approach has directly incorporated stakeholder feedback on every component thus far, but there are several key areas which I will outline here where we have not yet received stakeholder feedback but we seek to and we are soliciting it starting today. First, defining an episode group. For this component, our first TEPs provided guidance on essential concepts for defining an episode group. Our first clinical committee identified conditions and procedures for episode groups and selected trigger codes. Moving forward, we are forming clinical subcommittees which will refine the draft list of episode groups and trigger codes, which is an essential component of this first component of cost measures defining an episode group. For the second component, assigning cost. Our second TEP provided input on approaches for assigning costs to the episode groups and moving forward the clinical committees when they're formed. We'll select which claims are counted in each episode cost. The third component, attributing to clinicians. Our second TEP provided feedback on potential rules for attributing episode groups to clinicians, and our clinical subcommittees moving forward will recommend rules to assign clinician responsibilities for episodes. The fourth component, risk adjustment. A future Technical Expert Panel, or TEP, will provide feedback on potential risk-adjustment approaches, and future clinical subcommittees will identify relevant patient characteristics for use in statistical models. The fifth component, aligning with quality. The first and third TEPs provided feedback on approaches for aligning cost and quality. Moving forward, clinical subcommittees will share feedback on aligning cost and quality, as well. So, a takeaway from this slide is that there are many areas where we very much want stakeholder feedback, and we hope to solicit this feedback from you moving forward. Next slide, please. In terms of opportunities to provide

input on the December 2016 posting, CMS is currently seeking comments on the document which outlines the approach to cost measure development, including specific questions for stakeholder feedback at the end of that document, and CMS is currently seeking comment on the draft list of care episode and patient condition groups and codes collectively referred to as "episode groups."

[Speaking indistinctly]

The draft list incorporates stakeholder feedback on Component 1, defining an episode group. These came from detailed clinical review from, as mentioned, the Clinical Committee, feedback from earlier postings relating to existing CMS episode groups, and a Technical Expert Panel. The draft list serves as a starting point for future development. The comment period, as I mentioned, is currently open until April 24, 2017, so of this month. Next slide, please.

[Speaking indistinctly]

Please hold for a moment. Next slide, please.

[Speaking indistinctly]

Thank you. Just to reorient, I'm on slide number 23 here, for everybody listening. Upcoming stakeholder engagement and activity is built upon the prior feedback we've received so far. Technical Expert Panels provide conceptual input on measure selection and specifications for all five components. Clinical committees provide detailed clinical input on the five components for each measure with upcoming input focused on two of the components. The first component -- this is in terms of immediate upcoming input -- refining episode triggers from the December 2016 draft list, and the second component, recommending what services should be included in episode costs. The way that we will do this is that the overall clinical committee will be structured into subcommittees with seven subcommittees starting activities this spring for procedural and acute inpatient medical condition episode groups. The call for nominations is open until April 17, 2017, as listed here, but we've given an extension until April 24, 2017.

[Speaking indistinctly]

Please hold for one moment. In case anybody is hearing feedback from our line here, I'm going to ask anybody else with a speaker line to let me know if the feedback is still being heard. Otherwise, we will quickly redial in to avoid any pauses.

You sound better now.

Thank you. Okay. We're almost there.

[Laughs] All good.

Okay. So, as I was saying a moment ago, we will be forming a clinical subcommittee moving forward. We've extended the call for nominations, as we very much want to have as many nominations as people are interested in making, so we've extended the call by one week, until April 24, 2017, so this month. The way that we're doing this is that the clinical subcommittees, which are based on the episode groups in the first posting,

cover the following seven clinical areas, and I'll read these out loud here, because this is where we're seeking nominations for initially. Then, moving forward, we're going to be having future clinical subcommittees focusing on the additional episode groups that are listed in the December 2016 posting. So, the initial set of subcommittees for which we are currently receiving nominations are the following seven areas -- cardiovascular disease management; gastrointestinal disease management, medical and surgical; musculoskeletal disease management, nonspine; neuropsychiatric disease management, ophthalmologic disease management, peripheral vascular disease management, and, finally, pulmonary disease management. Next slide, please. So, we've now talked about the Quality Payment Program, what is a cost measure, and the way in which we've received stakeholder feedback so far and how this helps to guide our approach and processes, and I hope one of the things you've taken away is the ways in which we very much want to receive a great deal of stakeholder feedback moving forward. What I want to do now is go into the fourth part of this presentation, which is really the core of it, which is the Listening Session. So, on the next slide, we're going to describe how you can call in and start giving us comments. Then I'm going to read off a few questions to set the stage. So, I'll turn it over to our moderators here to read the information on the feedback session.

Hello.

In order to --

Go ahead, Stephanie.

In order to ask a question or provide feedback, you will press *1 on your telephone keypad. Again, that's *1. Or you may use the chat feature on your webcast.

Okay. Thank you. As we get started here, next slide, please. What I want to do to set the stage for our conversation is please take this as a moment to gather any thoughts you might have. I'm going to go ahead, and I'm going to read six questions. I'm going to pause on the latter three of the six questions, and the slide will continue to have the phone number and conference I.D. on it, and then I'll turn it over to start receiving your comments. So, I'm going to read the six now. First, are the criteria proposed for prioritizing the development of episode groups -- cost share, clinician coverage, opportunity for improvement, and linkage to quality) appropriate? Are there other criteria to add? Are any of these criteria more important than others? To be clear about this, as I read these questions, including this first question, the basis for these questions is described in a great deal of detail in the December 2016 posting. Second question -- should the focus of episode development be on comparing discrete events, such as acute hospitalizations or procedures? Alternatively, should the focus be on the clinical conditions for which these events occur? How can cost measure development take into account multiple options that might be available in the care of a particular clinical condition? Third question -- we intend to inform you on the resource use of each member of the clinical team. Direct and indirect service assignment enables one clinician's directly performed services to be considered as another clinician's indirect services when performed in the same clinical context. How can this concept be used to determine accountability for each member of the clinical team as an alternative to the entire episode being attributed to a single clinician? Next slide, please. The fourth question is considering the cost of clinical services needs to account for the effects of those services on the quality

of care. What options are available now that enable consideration of quality? Also, what infrastructure improvements can be considered over time to improve the linkage between cost and quality? The fifth question -- measuring the cost of caring for chronic conditions remains a challenge in terms of linking discrete services to specific clinical conditions when treating patients with multiple comorbidities. This challenge is compounded by the relatively short time frame of episode windows compared to the ongoing nature of chronic conditions. How can we best overcome this difficulty and capture the cost of caring for chronic conditions? The sixth question -- how can cost measurement best account for medical complexity and other factors? Now, the last thing I'll say before I turn it over to everyone on the line is we've listed six questions here which we very much welcome your input and feedback on. However, much more importantly, we would love for you to tell us anything in terms of any feedback that you think is most important or any feedback based on this presentation, as well. If you have questions, we're happy to entertain those, as well, and with that, I'll turn it back to the moderator. Thank you for your time.

Our first question or comment is from Kim Sweet.

Yes. Hello. My name is Kim Sweet, from ScrogginsGrear, and I have a question to present. I'm not sure if this is something that's being entertained currently or how this is gonna be handled, but when cost is assessed on the quality that's performed or quality measures that's performed, will the cost -- Do you know if the cost will be assessed on the quality measures that were actually reported, or will the cost be assessed on quality measures that CMS has determined through the administrative claims that could have been reported, as well? Does my question make sense?

It absolutely does, and that's a great question. What I will do, if it's okay with you -- Hang on the line with us for a moment. I'm gonna give you a brief programmatic answer, and then, if it's okay, I'd like to ask, maybe, you a question based on that. So, the programmatic answer is that there are four different performance categories for the Merit-Based Incentive Payment System. The cost category and the quality category are discrete categories. In other words, they are, as of now, programmatically independent. You can report on several quality measures, let's say, for a certain type of surgeon. The cost measures that would be calculated for said surgeon would be based on the claims that this surgeon has submitted to us in Medicare and, at this point, may or may not be directly aligned with the quality measures that we have. This is where the issue of how to best align cost and quality comes up, and you do not have to, but I did want to give you the opportunity, if you have thoughts based on your question, about a recommendation for us. I would love to hear it.

I'm not sure that I do. I'm just seeing more with the value modifier, how that was working, and I just am curious how it's going to pour over to the cost program -- whether it'll be the same or not.

Sure, and I'll say one more thing about it, and, again, I very much appreciate the question, because this is a very important, critical area. The relationship between the cost measures that we're developing and the quality-of-care assessment is something that we really want to get right, and there are many questions about that in the December posting, and we recently had -- This was the topic of the Technical Expert Panel we had a couple of weeks ago. So, what I can say is we're thinking about it a lot and we continue to welcome feedback on that, so thank you.

Thank you.

We received one question. The majority of comments coming through the chat are questions, not comments. One is can you compare/contrast the episode group model with DPCI?

I'm sorry. This is a question through the chat here?

Yes.

So, for this question, I'll see if our Acumen colleagues, who is our contractor that is our team working on the cost measure development side of this, would like to answer that.

Sure. Thanks for the question. This is Sri Nagavarapu from Acumen. The key differences between the measures that are discussed here and the episode-based construction that's in BPCI are along three dimensions. One is the method of attribution. Two is the grouping rules that are used in order to construct the episodes. And there is the way that the actual episode-based costs that are constructed or calculated are used in order to effect payment. The third item has been fleshed out for BPCI but is a decision up to CMS and going forward in MIPS. I wanted to spend a little bit of time on the second item in terms of grouping rules. There the BPCI episodes tend to work based on excluding particular services, so inpatient stays of particular DRGs, for instance. The exclusions are meant to be sort of a narrow set of exclusions. Here when we discuss grouping rules and the presentation that Dr. Long gave, what we're envisioning is a process in which stakeholders can participate through the clinical subcommittees to define grouping rules from the ground up in the sense that, instead of excluding services, they would start by saying, "For a given condition and trigger event, what are services that are clinically related to that trigger event?" and group that. And that would tend to result in a smaller share of costs being grouped than you might expect in a model like the two model.

We have an audio question from Dr. James S. Kennedy.

Thank you very much. Excellent presentation. A number of these procedures are done an inpatient basis and on an outpatient basis, and one measure of cost efficiency today for the inpatient environment is the Medicare Spending per Beneficiary calculation, which uses Hierarchical Condition Categories as a risk adjustment. Do you anticipate the risk-adjustment methodology to be the same for inpatient versus outpatient, or do you believe that they may be separate?

This is Ted Long from CMS. That is a great question. I want to give a quick backdrop to our approach to risk adjustment thus far, and that is that we anticipate having a Technical Expert Panel on this. We anticipate receiving much more public comment on this, and we anticipate it including our clinical committee, which will have many clinicians on it to assist us in this, as well. We have not made any firm determinations yet, and if I may, if you have any recommendations you'd like to make to us or any key points over the phone now, we'd love to hear them.

I don't. I am not an expert on outpatient risk adjustment. It is my understanding that Medicare has used a Hierarchical Condition Categories-type algorithm for its Medicare Advantage plans, the calculations of the

cost-per-patient attribution currently in the value-based payment-modifier-type environment. I'm just assuming that it's gonna be the same, but if you're going to go different, given that certain procedures can be done inpatient or outpatient, like transurethral resection of the prostate, cholecystectomies, you know, and the like -- some mastectomies or cataract surgeries. Having these cost-efficiency measures as close as possible, I think, would help physicians be more understanding of what you're trying to do.

Yes. I think you said, in other words, you would favor the risk-adjustment approach taken into account -- things that really sort of clinically matter to clinicians, like the setting that the care is performed in. And what I can say about that is that we have -- The reason we really want to be clear about the three different venues that we want to receive feedback on risk adjustment for is that we really want to get this right, and the only way that we're gonna get this right is to ask, so you can look forward to hearing more about that from us moving forward. But the risk-adjustment area is one. You're correct in terms of how we've historically done -- used HCCs, or Hierarchical Condition Categories, for risk adjustment in other CMS programs, but we do want to take this as an opportunity to really listen to see if there are any other priorities or thoughts about ways to really make sure we get this right, so thank you.

And one final comment. One of the challenges in the risk adjustment you will have is in the outpatient environment, you will find a paucity of comorbidities that have been documented by physicians since they don't have the clinical documentation improvement programs on the outpatient environment like we have on the inpatient environment. So, I just caution you that using historical data may underrepresent the patient risk, given that the documentation integrity in the matching of clinicians speaking coder speak and the capture of the codes may not have been as robust on the outpatient environment as we see in the inpatient environment.

Mm-hmm. I appreciate your comments. I'm a primary care physician myself, and I do appreciate that. Thank you.

Thank you.

I can read a couple of questions that have come through the chat box. One is -- These are questions, again, via the chat. Sorry. We haven't received too many comments, but the first question is, "Is CMS planning on incorporating indirect or incident-to services provided by pharmacists on patient-care teams when determining the assignments of episode groups? Will pharmacist services count towards helping physicians meet their cost measure requirements under MIPS?"

Yeah. Thank you for asking that question. I will ask our Acumen colleagues to see if they have any thoughts on that.

So, this is Jay Bhattacharya from Acumen. So, the determination about whether to include drug costs in the episodes is still under consideration. We've had a couple of Technical Expert Panels examine this, and CMS is still in the process of making that decision. As far as other eligible conditions, whether -- I take the question to mean, "Do pharmacist services that are billed to Medicare -- will they count as eligible?" My understanding is that they actually are included in that set, but there's been no determination yet as to how those costs will be included to the extent that they will. And

any decisions about that will come from clinical communities and will be informed by stakeholders, including pharmacists to the extent that they will be included.

Okay. Thank you. We did receive two comments. First is, "Please assess how cost measures will impact groups affiliated with CAHs." So, I'll say that again. "Please assess how cost measures will impact groups affiliated with Critical Access Hospitals. The current cost-assignment methodology hits them hard because their outpatient primary care is provided via Part A, not Part B. As a result, their only assigned patients are those that they treat in local SNFs." And do you need me to read that again? I have another comment that I can read, as well.

Oh, we can answer that question first. I think that, actually, I would appreciate our colleagues at Acumen taking a stab at that, too.

Okay.

So, this is -- Thanks for the question on the Critical Access Hospitals. This is a consideration in terms of hospitals and in rural areas, for instance, that has come up in the previous Technical Expert Panels that we've had, and there are multiple ways that we could potentially approach this question, and within clinical subcommittees, we hope to assess, one, whether group services should reflect these types of considerations by setting so that group services are chosen by the clinical subcommittee members for each setting separately, and then the other element of this has to do with risk adjustment and whether there should be consideration give to geographic or rural or other differences across hospitals in risk adjustment, so that would be something that we would get input on from a clinical subcommittee as to whether Critical Access Hospitals should be treated differently in some senses.

Okay. Thank you. I can read another comment from the chat. "Hi. Dr. Long. Thanks for your work on this. The cost proposal is too --" I'm sorry. I think I read that one already. Actually, I'll go -- Let me read that again. "Thanks for your work on this. The cost proposal is too complex. Sometimes the best designs are simple. How can the structure of this program be simplified? Thanks."

Yeah. We very much appreciate that. Our goal here is to figure out what the right balance is between thinking about how we can make this as simple as possible but also allowing clinicians to be as involved and engaged in our processes as possible so that they can feel that these measures accurately reflect what they do and that they can find the information helpful. I'll give you an example here. One of the most complicated parts about cost measure development is for a given episode of care -- let's say for knee surgery. There's many different costs that could be a part of both the surgery itself and then after the surgery. Now, there's not really a simple way to know, of all the different costs the patient might have, which ones should be included in the episode-based cost measure and which ones should not be included without having clinicians be there with us to help make recommendations to us about what to do. So, instead of having an overall rule that we would sort of absently carry across all of the different cost measures that we're developing, our approach here, which may err towards having a little bit more input of time and effort up front, is to really have these clinicians run by, recommended by, and made by the clinicians themselves so that the clinicians themselves can be the ones that are

building the measures that then will be used to evaluate them and give them feedback back, but I think you can see my example there. I mean, think about all the things that can happen to a patient after surgery. Pneumonia on post-op day 4 -- is that related to the surgery or not? These are things that we want clinicians to give us feedback on, and it does add complexity, but it also is the way to really, we hope, have clinicians really be the partner that they deserve to be with us. So, I hope that answers your question, and I do appreciate your point about how we can try to make this as simple as possible moving forward. But, again, I just wanted to emphasize that our balance is simplicity on one side but also making sure that we're really engaging stakeholders to make the important decisions with us at every step along the way. So, thank you.

Great. I'll read another comment from the chat, and then, Stephanie, you can take callers from the phone lines. The next chat comment is, "It's difficult to determine if new cost measures are appropriate and helpful until we see how they appear in a clinician feedback report and determine if they are meaningful and actionable. Prior cost reports within the Value Modifier Program were dense and near impossible to understand and, even worse, very difficult to take actions on."

Thank you for your comment. A quick note to that is that what I'm taking away from this is that it will be very important for, as we're developing the measures and after they're developed, to have the feedback given to clinicians be as clear and helpful as possible and to have the feedback given to them in a way that they can understand it to be able to make actionable changes. You will hear more from us about this as we move forward, but I have taken that away from your comment, so thank you.

Thank you. Stephanie, I think you can take a phone caller now.

Our next comment is from Dale Schumacher.

Thank you very much. Very interesting session. I believe in the legislation it talks about the per-capita costs for all beneficiaries and that there would be an alignment of that number to certain physicians, usually primary care physicians. Today we're talking about episodes, and is there going to be a critical proportion? For instance, if the episodes cover 40% of the care or maybe even 50% of the care, how is the gap between what the episodes might cover and the per-capita costs that are accrued through all the claims paid?

Yeah. That's a good question. So, to state that in a different way, there's different types of cost measures. There are measures that can be more aggregate, like a total per-capita cost measure, which we currently will be giving feedback on in the first year of MIPS, and there are episode-based measures. The episode-based measures that we have proposed in terms of the subcommittees to build out first into cost measures are procedural and acute inpatients. The other, the third, type of episodes would be chronic-disease episodes, and these would be where there would be potential overlap with total per-capita cost measurements. Now, the extent to which we can then construct chronic-disease-based episodes will inform the relationship between the episode-based measures themselves and things like the total per-capita cost measure. Moving forward, what you can expect from us is that we will be focusing on chronic conditions after we've had a bit more experience with the initial procedural and acute inpatient medical condition episode-based measures, because we want to be, to the greatest extent that we can,

learning from our experiences as we go. I hope that answers your question about sort of what you can expect moving forward that will inform the precise answer of what the status of the total per-capita cost measurement will be moving forward, and I'll put it back to you that if you have thoughts or recommendations for us based on what I just said, we'd welcome them.

Yes. Well, certainly. So, it sounds like, as we begin with MIPS, we're gonna have total per-capita costs, we're gonna continue to have the Medicare Spending per Beneficiary, and we're gonna have some rolling out of these more substantive episode measures that we're discussing today.

That's exactly right.

Okay. Thank you.

You're welcome.

Our next question or comment is from Hope Clinic.

Hi. Yes. This is Hope Clinic. We're very new to the MIPS. We're just now jumping on to the bandwagon, learning about the changes in the upcoming rollout. We're a federally qualified health center. So, I'm curious also -- Maybe backtrack a little bit. When will this all be in place, and is this relevant to FQHCs, as well?

Yeah. Thank you. That's a great question. So, I will say a few things about our timeframe, because one of the important things about our timeframe is -- as you said, you're sort of jumping on the bandwagon now -- is that we hope that you may want to work with us to continue to develop these measures, as that's what it will take before they're going to be ready for full implementation. So, right now we're in the phase of perfecting our approach, and that's why we have our public comment period open until April 24th of this month. What we want to do then is take stock of the comments we've received and to learn about the changes we should make based on all of the feedback that we anticipate hearing from you. Then, after that, we are concurrently putting together clinical subcommittees which we hope will, again, be that different vehicle for getting the input we desperately need for developing the cost measures themselves. In terms of our timeframe moving forward, for that, right now, we have an open-nomination period for that, for the clinical subcommittees, and that will close on April 24th, as well, of this month, and then the clinical subcommittees -- we will work with them to help to develop the cost measures, and then we anticipate having basically a feedback run of the measures that are developed after that. But what you can expect is that the first thing you'll be hearing from us will be sort of this feedback run of what we've developed to see what clinicians think and then thinking about how those measures would then, once we've received feedback, be rolled up into the program. The precise timeline for exactly when the new measures will be enrolled in each year of the program I can't comment on because it depends on a few variables in terms of our development process for them. But as soon as we know, we would love to share our plans with everyone about that. It just depends a little bit on how things go in the near future. So, I appreciate the question.

Thank you so much. I have one more question. I'm so sorry.

Yeah.

For the nomination, if we actually have a clinical team that is probably gonna be valuable, do we just click onto the slide? Is there any type of link or anything that we can nominate these clinicians?

There absolutely is. So, I think it's at the end of these slides. There is an e-mail address for Acumen, who's joined us on the call here, and they're the ones that are soliciting and collecting the nomination materials. I'll ask -- and this actually would be a good segue -- our moderator here to maybe go to the slide with that e-mail address so you can see it immediately on your screen now.

Thank you again.

You're very welcome.

There are no additional comments on the audio portion.

Okay. Thanks. I'll read a couple of comments that have come through the chat. The first is question-5 feedback. "How can we best overcome this difficulty and capture the cost of caring for chronic conditions? You could tackle this initially by focusing on the most costly procedures or treatments and how to use resources wisely for the highest-dollar therapies." Let me know if you want me to say that again.

No. That's a very helpful comment. Those are exactly the type of comments we're hoping to hear, so thank you. I appreciate it.

Okay. Great. The next comment says, "Dr. Long, thank you for your presentation. Has CMS considered how it might use social determinants of health in its risk-adjustment model?"

Yeah. Thank you for that question, as well. So, I'll go back to the former question that was asked about risk adjustment, too, just to emphasize that the risk-adjustment piece of this or the risk-adjustment component of cost measure development is something that we are actively thinking about and that we will be asking for a lot more feedback on before we finalize anything. That feedback will come in a few different forms, the first being a Technical Expert Panel in the future, the second being clinical committee work with clinicians, and the third being comments like this opportunity here and also any public comments received for the December posting, where we asked for that specifically by April 24th of this month. So, if that listener would like to offer any further comments in the chat box, we can read them out loud so everybody can hear, and I would very much welcome that.

Great. Thank you. Another comment is for question 6. The comment is, "Need codes specific for episodes. For example, there is no HCC code for surgical difficulty or for complex eye conditions that make lens procedures more expensive. Need to be able to code for chronic conditions, even after a procedure happens. For example, emergency might not have the opportunity to code prior to procedure or during hospitalization. Need to specify if chronic conditions from end of one calendar year can be applied for 12 months."

Mm-hmm. Yeah. I understand the comment. Yeah, that's something we definitely want to think about, so I appreciate it. Thank you.

Okay. We also received the following list of comments and concerns. The first is, "Quality can't be measured on claims alone. Need clinical-data registry." Two, "ASC-versus-HOPD cases not under physician control, especially in certificate-of-need states, should be evaluated separately." Three, "Attribution, concern that current protocols are unable to correctly attribute care to the appropriate physician, subspecialist surgeons, attributed costs of unrelated COPD admissions on QRUR." Four, "Lack of time to teach, implement patient relationship codes." Five, "How to differentiate episode-related versus unrelated services?" Six, "Bilateral surgery within the episode period." Seven, "Modifier recognition, unrelated versus related, RT versus LT, more extensive procedure co-management." And, finally, eight, "Risk adjustment, use of ICD-10 codes to exclude cases from denominator."

Mm-hmm. Yeah. This is Ted Long from CMS. Thank you for all your comments. We've written them down. This is exactly what we were hoping to get out of this Listening Session, because this is what we really want to hear about. I did want to make a quick note on your comments number three and number five, both pertaining to related and unrelated costs. I wanted to note this is one of those really critical areas where, as we form our clinical subcommittees, we want to -- and this is something that Sri from Acumen had talked about earlier with an earlier question -- we want to have as much clinician feedback in determining what are related and unrelated costs as we possibly can, and that will be one of the main goals of the clinical subcommittees, will be to go through what the costs are and say, "Hey, this one is related to the episode group we're developing, and this one is not." So, our hope is that through enough clinician input, we can really get this right in terms of getting it as accurate as possible. And that's going to be work on our end, and we hope clinicians will be with us there to help us. But that's really our intent, is to really focus on getting the related/unrelated costs right. So, I appreciate that comment very much. Thank you.

Okay. Thank you. I think I have one more, and then, Stephanie, we can check in on the phone. "Practitioners in the long-term-care setting have a longer timeframe for episode tracking of chronic conditions. They also have a unique need for specific quality measures, given that many of these patients are at the near end of life. Given most of these patients are dual-eligible, how can this population be categorized separately?"

Mm-hmm. So, I think your question here has a few different parts to it. One is about the long-term-care setting, and one is about some of the specific clinical attributes or characteristics of the patients in these settings, and this cuts across a few different aspects of quality-measure development, not the least of which is risk adjustment, for which the purpose is to, when the patient hits the door of any sort of episode, to have anything that they bring with them, which could be comorbidities, could be the setting they're in, potentially, but adjusted for to offer a fair and equal comparison to other patients and being seen by other clinicians. So, as we move forward with our risk-adjustment discussions, again, through a TEP that we will hold in the future, through our clinical committee input, and through comments like yours, we hope to really do our best to get this right. If you have any specific recommendations for us, we welcome them through the chat here, the chat box here, or especially through the public comment period on the December posting, for which we asked questions about this, which is open through April 24th of this month.

Great. Stephanie, are there any commenters in the phone lines?

Not at this time.

Okay. I can read another one that came through. They said, "Exclude co-managed surgical cases."

Yeah.

And that was a follow-up to the previous list I had read.

Excellent. Yeah. That's very helpful for us. So, again, for everybody on the phone, we're writing all of this down, and this is really what we'd hoped to get out of this time with you all, is recommendations to us about what we can do, so thank you. Very much appreciate it.

Okay. Thank you. You may have already gone over this, but we did receive a couple of questions about subcommittees. I think it might be helpful to -- Specifically, one question says, "Is this one round of nominations for all five of these waves of clinical subcommittees, or are there nomination periods for each of those listed on slide 21?"

Mm-hmm. So, I'll give an answer here, and then, in terms of some of the logistical aspects moving forward and in terms of any other comments they might have, I'll then turn it over to our Acumen colleagues to add on to this. So, you can think about the different episode groups in the December 2016 posting as sort of the ocean of options for what cost measures we could develop. We've broken up that ocean into different discrete clinical areas, and the subcommittees are for each of those clinical areas. So, the first seven subcommittees are for the first seven clinical areas that we've prioritized, and the nomination period is specifically for those seven. Now, for the rest of the episode groups, all the other clinical areas that are not part of those seven, we'll be holding separate nomination periods for in the future. The current nomination period is singular for those seven. So, you can expect for us to be in touch. What I will also say, finally, before I turn it over, though, is that when you go on the nominations form, there is an opportunity to put yourself on a list to show that you're interested in hearing about when the additional nomination periods for the other areas are made available, and we'd love to be in touch with you at that point, too. So, I'll turn it back over to Acumen for any further thoughts here.

Yep. Thank you, Ted. So, as you said, this current call for nominations reflects these seven clinical subcommittees, and there will be future calls for nominations for the other ones. In terms of timeline, what we have in mind is that once this wave of seven subcommittees starts, the subcommittees can choose which episode groups to work on and how to prioritize the episode groups within their clinical area and then progressively work through those episode groups with a goal of constructing episode-based measures for one or two episode groups by the end of August or early September. But then, after doing that, they would continue to work through other episode groups as they saw fit in terms of their prioritization. At that point, sometime in late summer or fall, depending on how the first wave has gone, we would initiate subsequent waves of subcommittees for the remaining clinical areas for waves 2 and 3. And to the extent that we obtain feedback from everyone about the structure of the subcommittees or potential adaptations of the existing subcommittees in order to address chronic conditions or new episode groups that people are interested in, then those new subcommittees or revisions to

subcommittees could happen in the future. And I will add that the link to the form is on the slide that is currently showing.

No, not yet.

Great. A couple of other comments that have come in are, "Why not begin a campaign directed toward the patient community to adhere to visits so their chronic conditions can be controlled?" The next comment is, "Instead of acute care, how does a managed condition --" This is actually a question. I'm sorry. "Instead of acute care, how does a managed condition like diabetes fit in to the episode model?"

Thank you for the comment and question. So, for your comment, we appreciate that. We do want to involve patients in this work to the greatest extent that we can, and what we've done so far are things like we've intentionally included patients in our Technical Expert Panels because they are technical experts in patient care. We hope to continue to do that moving forward. So, in terms of the ways to do that, we do welcome any further comments or feedback, but that is definitely a key interest of ours, so thank you. I believe the second question was about how we would include the chronic condition of diabetes in the episode-based cost measure development that we've been discussing, and I'll say two things about it. The first is that diabetes itself is a comorbidity that, of course, affects everything, whether it's a procedure, whether it's an acute inpatient medical admission, so it is something, one of the key things that we would take into consideration in terms of how we would think about risk adjustment for the episode-based cost measures that we're developing. As I said, that's a work in progress, and we're going to continue to be asking for feedback about the best way to do that, so we look forward to being in touch further about that, and if you have recommendations for us, please submit them via the chat box here or via the public comment period to the posting. The other aspect of how diabetes would pertain to this work is that a chronic-condition episode for diabetes could be created in the future, and we've proposed considering this. The way that this would work would be basically an episode-based cost measure focused around the chronic-condition issues of diabetes, and that's something that we're going to be asking for a lot more public comment and feedback on about the best way to do that. Right now our focus for the initial set of measures we wish to develop is on procedural and acute inpatient, and we hope to learn from that and to be able to ask you even more pointed questions as we move forward about how we should be evaluating chronic conditions, so I appreciate the emphasis you're bringing on this.

Great. I think this question is very similar to the one before. I'm not sure if you want to add anything. I can read it quickly. "Could you give some examples of how this should work? Surgical procedures seem easier to understand, but when I take a diabetic patient with a lot of comorbidities, how would episode-based cost work?" So, I think that may have just answered that.

Mm-hmm. Yeah. I think I just gave a few thoughts on this, and I will also say I do appreciate that. Again, I am a primary care physician myself. I clinically practice, and I definitely understand the challenges there, so thank you.

Okay. Next comment -- "It's difficult to determine if new cost measures are appropriate and helpful until we see --" Okay, sorry. I think I read that

one already. Next comment and question -- "Is there a way to tie a provider's quality data that was submitted through PQRS and now MIPS to the episode? In other words, if I am an anesthesiologist and provided anesthesia care to the patient in the O.R. and they went to the unit and developed pneumonia, is there a way to look at the data and conclude that the anesthesiologist performed well on their component and the failure point and thus cost adjustment should not be attributed to the anesthesiologist?"

Mm-hmm. So, the relationship between what we want to do with cost measures and the different ways to assess quality of care is something that we are thinking a lot about right now. Again, we had a Technical Expert Panel on this two weeks ago, where we thought about this exact issue. I think what I'd like to do for this is because we're very curious to hear more of your thoughts on this, I'll take this as a recommendation to us in its own right, and then I'll also ask if you or anybody else has any further recommendations about either ways to do this or some key considerations. Please let us know either now or, again, before the end of the comment period, because we care a lot about this.

Okay. Question-5 feedback -- "How can we best overcome this difficulty and capture the costs of caring for chronic conditions? You could tackle this initially by focusing on the most costly procedures or treatments and how to use the resources wisely for the highest-dollar therapies."

I'm sorry. Can you repeat the middle part and the last part of that one more time?

Sure. I can repeat it. "How can we best overcome this difficulty" -- and this is related to question 5 -- "and capture the costs of caring for chronic conditions? You could tackle this initially by focusing on the most costly procedures or treatments and how to use resources wisely for the highest-dollar therapies."

Thank you for reading that. I think we may have captured that comment already, but I still appreciate it, so thank you.

Okay. Stephanie, anything on the phone?

Not at this time.

Okay. We did get a couple of questions about commenting, Dr. Long. I don't know if you want to just repeat how long you're taking comments to and where folks can go to submit comments formally.

Yes, of course. So, we're taking comments through April 24th of this month, and the location for submitting comments, I believe, is on slide number 2, if you want to go back to there. And I'll pause to let our moderator go back to slide 2, but this should have the e-mail address and all the information you'd need to make comments. Also, as we're going back to slide number 2 here, I'll just note that we are noting all of the responses that we're getting here, and that was really our intention of this Listening Session. If you have made any comments that we did not get to during this session or may not be transmitted to us if we don't read them out loud, for whatever technical reason, please, it would be great if you could take a moment to go ahead and submit those -- via e-mail might be the easiest way -- as part of our comment period because we want to make sure that we capture all of your thoughts.

And we did have an audio comment from Julie Lundberg.

Hi. Thanks for the call today. We really learn a lot from these sessions, and we appreciate the time you give us. I have some feedback on discussion topic number 4 regarding the alignment of quality to cost. You know, in the early days here, you know, we're all looking for, "How can we get the best MIPS score for our docs?" And we love the ability to report our quality measures through our EHR technology to get the bonus points. We also look at, "Okay, here are the 25 measures available to me for the E.C. bonus. Oh, now here's the deciles I'm gonna look at. Where are the ones that I have the best chance at being successful? You know, I'm gonna avoid low back pain, you know, the radiology exam for someone with low back pain, because that's kind of topped out. I'd have to be, like, super-perfect to get a good 9 or 10 points out of that." So, the things that are currently going into my selection of my quality measures -- if that was then hampered by what would be illogical to measure me on cost -- ooh! -- that would be tricky. The intention of it sounds really great, but right now, that would be extremely restrictive, so that's just my comment about that.

Mm-hmm. Mm-hmm. No, I think your comment is very helpful, and, you know, our goal here is really to figure out what the right way to think about cost equality in the same context is, but also, I think you very astutely point out, not to the detriment of what you're already doing and the processes you've developed to be responsive to improving your quality overall, so I think that's a great point, so thank you.

There are no additional audio at this time.

Okay. A couple more have come through the chat. One commenter says, "Prior risk adjustment in the value modifier program was opaque, and where it wasn't opaque, it was difficult to ascertain and verify. This model should be clear, including its dependency on hospital coding." I think you've spoken to that before, so I can read the next one.

Well, I'll just say, before, you move on, we've received a few comments on the importance and need for transparency in risk adjustment for these cost measures, and I very much appreciate that, and that is certainly our intention.

Great. The next commenter says, "I have a concern about the accuracy and attribution of information and data. When PAs and NPs deliver care, their information is often lost or hidden due to Medicare billing provisions, such as incident-to. How can CMS assure that there is appropriate clinician identification in these circumstances?"

Yeah. I appreciate that question. So, attribution is a critical piece. It's one of the five components that we've discretely and clearly listed in terms of our cost measure development work, and there's a few different aspects of attribution which are important. One I'll mention here which gets, I think, the intent of if you have different types of clinicians with different claims, how do you know who was doing what? And an aspect of this which is required under the statute, but we're looking forward to having this be helpful, is defining the patient relationship with the clinician. This is an opportunity to say, "Hey, just because you're a clinician 'X' specialty, it doesn't mean that we can, with what we now know, assume that we know what your relationship with each of your patients is." And I'll give you an

example here. Let's say if you're an orthopedic surgeon, you have patients with chronic hip pain. Say for a given patient with chronic hip pain, you may see them every three or four months, evaluate them, talk about different options for care. Another patient with hip pain, you may see once and say, "Hey, you need to go to the operating room." If we don't know what your relationship is with that patient in terms of, in the first instance, it being more of a continuous relationship and the second instance it being more of a punctuated relationship, it very much behooves us to know what your relationship is with your patient in terms of us thinking about how to attribute different episode-based cost measures to you. So, we're going to be including on claims an ask for the relationship between a clinician and their patient to be more well defined so we can learn from it and we can make sure, I think getting to your underlying question here, that we get it right in terms of attribution to a specific clinician.

Great. The next comment is, "Concerned that attribution of beneficiaries to attend based on plurality of ACP services provided, AP, NP, or PAs working with a specialty department, the patient may not have a primary care within the practice, just have had multiple visits with an APP, resulting in assignment to the practice."

Mm-hmm. So, I'll answer part of this, and then I'll turn it over to our Acumen colleagues to answer, I think, with a few of their thoughts. So, one is how do we know two things about attribution -- "A," what the relationship is between the clinician or practice and patient and, "B," is there a number of visits you'd need to say, "Hey, this patient really identifies this clinic as," I think in your example, "their primary care clinic," for instance? Patient-relationship categories help us to get a little bit towards that in terms of understanding what the relationship is between the clinician and the patient. Another thing that will be helpful that we want to receive more feedback on is for the different cost measures that we want to develop, how many visits makes sense? What should the window of time here be? These are decisions we haven't made yet, but these are those sort of -- To go back to somebody's earlier question about trying to err towards simplicity, we do want to make this as simple as possible, but these decisions are also really important, thinking about exactly how many visits makes sense to be rolled into an episode, thinking about the relationship between the clinician and the patient. This, we believe, is what we really want to get right through asking clinicians what they think, and patients, for that matter, through our Technical Expert Panels. So, I'll pause there and see if our Acumen colleagues have anything more they want to add.

Hi. Thanks, Ted. This is Jay Bhattacharya from Acumen. So, the key thing to think about here, from the way that we're thinking about episode structure, is to design the episodes around the attributed clinician. The distinction I want to make is between deciding about who the episode should be attributed to ex post, after all the services have been provided. That's one way to do it. The other way to do it, and this is the way that we're actually doing it, is we're thinking about asking the question about what services should be included in the episode from the point of view of the attributed clinician first. So, the idea is you consider very carefully the role of the attributed clinician in deciding what service to include rather than looking ex post and saying, "Oh, well, these services were provided. Who is most responsible?" So, this question about plurality rule in the second approach won't come up because you've designed the episode around the attributed clinician as opposed to vice versa, where you say -- or as opposed to the former, where you say, "Who's most responsible?" The clinical committees are

going to play a very, very important role in helping us think through these issues, and we are still very, very open to a lot of input on this. We believe it's a very, very important topic for how the effects that this program will have on care.

Great. Another comment that came through -- "Add a measure of ability to link discrete services to condition or procedure, i.e. create solid episode definitions."

Mm-hmm. This is Ted Long from CMS. Yes. Thank you for your comment. That's definitely what we hope to do, and it's important to emphasize that. Thank you.

The next comment -- "The patient is the person in the best position to reduce cost for many chronic conditions, but we don't incentivize them. Is it possible to develop a model similar to many employer health plans where the patient is incentivized for achieving positive results -- maybe a reduction in Part B premiums?"

Mm-hmm. This is Ted Long from CMS. So, just to restate it again, we very much want the patient voice to be front and center in our processes here, because you're right -- the patient is the one experiencing care and that really is the expert of their own care. And we want to continue to receive patient input through things like our Technical Expert Panels, which we are very much looking forward to. To specifically answer your question, I think it's a little bit outside of the scope of our current work in the Merit-Based Incentive Payment System. Different ways to consider adjusting cost for patients is a very interesting idea, and I know this actually is an area of active research that's going on now and might be something applicable in other CMS programs. In our specific context here, I think it might be a little bit outside of the scope of the clinician cost measurement that we're doing, though, but I appreciate the comment.

Okay, great. Next comment -- "Need to develop valid episodes for chronic conditions as well as acute events."

Mm-hmm. Yeah. I think this comment is getting back to the recognition that there are at least three different types of episodes. There's procedural, acute inpatient medical, and chronic. And, moving forward, we look forward to receiving a lot more feedback on what chronic episodes could and should look like. It is very much our intent to better understand this and to work with you all to better understand this, and we're not there yet, so we appreciate the emphasis on continuing to think about this, and we hope to learn as we go with you.

Great. Next comment -- "CMS has been promising for years that they will start taking into account socioeconomic factors for risk adjustment. When will that actually become part of the algorithm? Thank you."

This gets back to the earlier question around adjustment for social risk factors as a consideration, and, like I said earlier, I appreciate the comment, and the emphasis on it will -- This will be something that we want to discuss in one of three contexts or all of three contexts -- our Technical Expert Panel moving forward, our clinical committee work moving forward, and further through public comments. This is the second comment about that, so I appreciate it, and we're taking note.

Okay. Next comment -- "Because the cost component of MIPS is frozen --" [Cellphone rings] I'm sorry. Sorry about that. "Because the resource-use cost component of MIPS is frozen at zero for 2017, I could see a situation in which multiple providers are held responsible for the total cost of services for the same patient's episode in which they were all involved. The caveat to this higher level of responsibility would be for CMS to provide one provider with cost data on the other providers that were involved in the care of their patient. That way, in following years, all providers know who the high-quality and low-cost clinicians are and can make patient referrals in a way that benefits all parties the most."

I appreciate that comment. I think part of this is around what the different roles of multiple clinicians are and how those roles can be captured in cost measurement. And that actually directly pertains to how we're thinking about constructing these episodes, so I appreciate the comment.

Okay, great. Another comment -- "Regarding cost attribution to episode group, I think a key question is not just, 'Is this related or attributable to a particular episode,' but also, 'Is this cost understandable and actionable such that its inclusion in the cost measure could result in improved value?'"

Mm-hmm. So, your comment here gets at the issue of how we think about what criteria we would want to use in making the decisions about which costs or claims to include in episode-based cost measures, and having actionability as a criteria, I'm taking away, is something that you would favor, and I appreciate that comment.

Great. I have two more here. "The VM and QRUR reports were not available in a helpful timeframe. The cost measure for MIPS needs to be available for performance review during the same year as it is being measured."

Mm-hmm. So, this comment I very much appreciate, as well, so this, just to restate it in terms of how we're noting it here -- it's very important to have feedback in as timely a manner as possible to give clinicians information that they could use to make an actionable change in their clinical practice. I am definitely taking note of that.

Great. And then a final comment -- "I believe that possible unintended consequences should be thought through prior to implementation. This should be monitored to make sure that patient safety and access is thought through."

Thank you. I can say we very much agree with that comment, and we're noting that, as well.

Okay. Stephanie, anything on the phone?

We have a question or a comment from Dale Schumacher.

Yes. Thank you. Appreciate all of the discussion about chronic conditions, and someone mentioned the dual-eligible. As I remember, the Acumen group were gonna have claims data for home health and SNF and IRFs and maybe long-term care. How about the Medicaid claims data? We certainly have a lot of emphasis on home-care LTSS through Medicaid. Are we gonna be able to include Medicaid claims data in some of our episode development?

This is Ted Long from CMS. I think you referenced Acumen in your question, so I'll defer this to them.

Thanks for the question. Currently, the plan is to use just Medicare claims data and take the perspective of Medicare allowed amounts in the computation of these metrics.

So there will be some chronic conditions where there could well be deficits associated with different Medicaid programs state to state, so there might be a need for an adjustment in that regard, since the Medicaid programs vary so much from one state to another.

That's a good comment, and that's something we certainly will consider in the development going forward.

Okay. Thank you. Really tough effort. [Chuckles] Lot of heavy lifting there.

Thank you.

Thank you, Dr. Long. I think we're almost about out of time, so if we don't have any others on the phone, I think we can just remind everyone to please submit their feedback to the e-mail address on the current screen, and thanks to everyone who joined today. I don't know if there's any final comments you wanted to make, Dr. Long.

Yeah, no. I very much wanted to say one more time thank you, everybody, for taking the time out of your busy schedules to join us today, and we look forward to being in touch.

Thank you.

Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.