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Summary of Findings on Episode Costs for Medical Groups Eligible to Receive 2011 Supplemental QRURs
Call Transcript
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[Slide 1] **Craig Caplan**: This is Craig Caplan from CMS. This is a follow-up presentation to the "How to Read Your 2011 Supplemental QRURs" presentation that we did last week. In this discussion, we're going to go through the summary of findings on episode costs for the 54 groups that were eligible to receive the 2011 Supplemental QRURs. Acumen did some pooling of the 54 groups, and we're going to present the results of their analyses. We also want to allow enough time for feedback, so we'll get your feedback at the end. We'll try to go through the slides at a reasonable clip. If you have your report handy, that would be useful to have in front of you.

[Slide 2] The purpose of this presentation is to provide summary-level information for the 54 groups that received 2011 Supplemental QRURs. I'll be doing that part, and then Dr. Sheila Roman will be summarizing and providing results on attribution and identification of suggested lead EP, providing reliability and validity information, and discussing how the information can be used by the groups, and then discussing next steps.

[Slide 3] The next slide is just a review of the 12 episode types that we have gone through that are covered in the 2011 Supplemental QRURs. There are five major episode types: pneumonia, AMI, CAD, PCI, and CABG. Pneumonia, AMI, and CAD each have subtypes.

[Slide 4] For this analysis when Acumen pooled the 54 groups that were eligible to receive the 2011 Supplemental QRURs, they are also compared to the national sample. This is the same 547,000 beneficiaries that we discussed last week that are fee-for-service beneficiaries with a claim that included one of the diagnoses or procedures that would have triggered one of the 12 episode types. I want to note that all costs that are presented are payment-standardized, and they are also risk-adjusted unless otherwise noted. I also want to note that beneficiaries had to be in the sample for both 2010 and 2011 to be included in this analysis.

[Slide 5] The point of this next slide is to provide the risk-adjusted costs for the group population, that is comprised of the pooled 54 GPRO groups, as well as the national sample. This is a lot like the information that is in Exhibit 2 of your report. This shows the mean cost and also the 80th percentile. The 80th percentile in this slide is a little different than the 80th percentile in your reports. The 80th percentile is the exact figure at the 80th cost percentile, whereas the data in your reports on Exhibit 2 are the average of the 80th percentile and above. The point of Exhibit 2 is so you can compare with the national average. You can see that if we looked across the pooled sample of the 54 GPRO groups, compare that to the national sample, you can see that in some cases the average is above, and in some cases the average is below the national mean. You also can see that the lowest-cost episode was pneumonia without inpatient, which was about $1,700 across the 54 groups. The highest-cost was AMI with CABG, which was $58,264 across all 54 groups. Again, it may be helpful to have your report in front of you.

[Slide 6] The next five slides, we're going to go through the distributions related to the previous slide, slide 5. Slides 6 through 10 go through the major episode types, and each bar represents each of the 54 groups that were eligible to receive the 2011 Supplemental QRURs. You can see that for all pneumonia, the average for each group ranged from about $4,000 to about $18,000, with the national mean of $9,115. You can also see that the mean differed depending on whether the pneumonia episode included an inpatient stay or excluded an inpatient stay. Those without an inpatient stay range in cost from a low of $1,000 to a high of $3,000 across the 54 groups. Those pneumonia episodes with an inpatient stay in the episode range from about $7,000 low to $23,000 high.

[Slide 7] The next slide is looking at the AMI distribution. Once again, the national mean is about $22,000, and the costs range from about $15,000 to about $37,000. You can see that in the box at the bottom, the cost ranges differ depending on the episode subtype. The lowest was AMI without PCI or CABG, which ranged from about $10,000 to $24,000. The highest was for AMI with CABG, which ranged from $37,000 to $120,000. In-between was AMI with PCI, which ranged from about $14,000 to $35,000.

[Slide 8] The next slide looks at CAD episodes, the distribution across the 54 groups. The national mean was about $37,000. The costs range from about $3,000 low to just under $6,000 for a high. You can see also that the mean cost varied across the two episode subtypes. Those without an AMI in the episode had a lower cost, ranging from $2,700 to $4,900 across the 54 groups, and those with an AMI ranged from about $12,000 to $25,000.

[Slide 9] This shows a couple more of these distributions. This shows PCI without AMI – the distribution across the 54 groups. The national mean was about $15,000. The range was about $13,000 to just over $18,000.

[Slide 10] The next slide shows CABG without AMI. The national mean is about $42,700, with the costs ranging from a low of about $30,000 to a high of about $62,000 across the 54 groups.

[Slide 11] The next slide summarizes this information. If you look back at the previous 5 slides, you can see that for 4 of the 5 major episode types, about half of the groups had a mean episode cost that was above the national episode mean and about half were below. The one exception was CAD, for which only about 20% of groups had a mean episode cost below the national mean. Once again, this was meant to provide a high-level overview of the information from the pooled sample of the 54 groups that Acumen did. This is again Exhibit 2 information.

[Slide 12] The next slide, slide 12, shows the summary of the performance of the 54 groups. This is like the information you'll find on Exhibit 1 of your supplemental reports. Acumen once again looked across the 54 groups and saw how many had costs that were statistically significantly higher than the national mean or lower than the national mean. And remember in the reports in Exhibit 1, if it was significantly higher than the national mean, it had an asterisk followed by the word "High" in parenthesis next to the average episode cost for that episode type. Also, if it was lower than the national mean, you would see an asterisk and the word "Low" in parenthesis. Looking across all 54 groups, Acumen found that for higher than national mean, the highest were for all pneumonia at 28%, pneumonia without inpatient at 26%, and CAD was the highest at 46%, and CAD without AMI was 39%. This is consistent with the finding that 20% of the groups had average CAD costs below the national mean. You can see the lower than national

mean, 28% of the pneumonia episodes were statistically significantly below the national average, and 33% of pneumonia with inpatient stays were below the national average, and 22% of AMI with CABG were below the national mean. Those are the three ones with the most that were below the national mean.

[Slide 13] The next three slides, we're going to go through the service category compositions for the pneumonia episodes for the 54 groups. This is like the information that is found in Exhibit 3 of your reports. Once again, this is pooled across the 54 groups that were eligible to receive the reports. Acumen also, after pooling the data, looked at the median episode and they looked at the high-cost episode. Here, high-cost is the 90th percentile. So they looked at what were the cost drivers for each episode type. In Exhibit 3 of your reports, these numbers would add up to 100%, but here, not all columns were included, just due to space considerations. You look at all pneumonia, it's all over the map for the median and the high-cost, which leads to looking at pneumonia without IP and pneumonia with an inpatient stay in it. Looking at pneumonia without the inpatient stay, you see that the main drivers of the cost – again, this is the share of the total cost of the episode – so 22% of the median episode of pneumonia without IP across the 54 groups was for E&M services, whereas the 90th percentile, the high-cost, 30% was made up of E&M. You can see that other high-cost categories at both the median and high-cost episodes were the outpatient hospitalization and home health. You can see that for pneumonia with inpatient the main drivers were the inpatient stay. You can see that the high-cost episodes had a higher share of rehab – rehab was a bigger contributor to the total costs.

[Slide 14] Moving on to the next slide, you notice that inpatient stays are separated into index and other inpatient stays. This was an additional analysis that Acumen did – they divided it up for the acute and procedural-based episodes. On slide 14, this shows the service category composition for AMI, and we also put in PCI and CABG because the story is very similar. You can see that the middle column, for both the median and high-cost episodes, that the trigger inpatient stay drives a lot of the cost. You can see that some other interesting findings, if you look at AMI without PCI or CAG – that's the second set of numbers – the median cost, 57% is for the trigger inpatient stay compared to the high-cost episodes which have a share of 41%. You can see that SNF made up a higher share of costs for high-cost episodes than the median episodes – 25% versus 16%. You can see that AMI with PCI, AMI with CABG, a lot was due to the trigger inpatient stay. For PCI without AMI – the second to last – you can see that the inpatient stay made up a good chunk, but compare the median episode to the high-cost episode across all the episodes of the 54 groups, and 39% of the costs for PCI without AMI at the median and 19% at the high-cost. CABG without AMI was largely driven by the index trigger IP stay.

[Slide 15] Slide 15 is the last of these slides. You can see that CAD doesn't separate all inpatient stays into the two categories, as the previous two slides did. This is because CAD episodes are chronic, and they don't have to have a trigger inpatient stay. Overall CAD, you can see that there's a big difference between the share of the cost for inpatient stay and outpatient stays at the high-cost and at the median episodes. For CAD without AMI, the costs were mainly driven by all IP stays and OP stays. For CAD with AMI, costs at the median and for high-cost episodes were mainly driven by all IP stays.

[Slide 16] I'm not going to go through the summary slide as I'm eager to hand this off to Dr. Sheila Roman for the remainder of the presentation. She's going to start with attribution, then we're eager to get to your questions at the end. Thank you.

[Slide 17] **Sheila Roman**: Good afternoon. We're now on slide 17, and we're looking at a summary of medical practice group attribution rules. Episodes are attributed to medical practice groups for the Supplemental QRURs based on one or more of the following three criteria: the performance of specific procedures, in this case the group billing for the surgery was assumed to be responsible for the episode of care; the plurality or shared majority (35%) of physician fee schedule costs billed during the episode; or the plurality or shared majority of E&M visits during the episode. I want to point out before we look at the table below that based on the 35%, episodes may be attributed to more than one group. Basically, pneumonia and AMI were handled as acute episodes and handled similarly by physician fee schedule costs and E&M visits. CAD was handled based on outpatient E&M visits alone. The CAD episode attribution was restricted to outpatient E&M visits to avoid attributing the episode to an inpatient hospital provider who may have cared for the patient only during an acute exacerbation of the underlying chronic condition, such as an AMI in this setting of the CAD patient.

[Slide 18] This shows the percent of episodes attributed to more than one medical group practice varied by episode type; 85% of all episodes are attributed to exactly one group.

[Slide 19] This slide shows a summary of suggested lead identification rules. Once an episode was attributed to one or more medical group practices, a single individual within each attributed group was then identified as the suggested lead EP using one or more of the three methods that I just described for attribution. The method of identifying an individual EP varied by episode type. As we can see in the chart, for pneumonia, it was E&M visits; for AMI, it was attending on trigger inpatient hospital claim; for CAD, outpatient E&M visits; for PCI, EP performing surgery; for CABG, EP performing surgery.

[Slide 20] This shows the suggested lead EP specialties identified with at least 5% of episodes. Only EPs with what were classified as clinically appropriate specialties were identified as suggested lead EPs. For example, while a general practitioner was considered the lead EP for a pneumonia episode, he or she was not considered a lead for a PCI without AMI episode. The question of nurse practitioners (NPs) had come up on the last call, and nurse practitioners were allowed to be assigned pneumonia, AMI, and CAD episodes. For pneumonia with inpatient, AMI, and CAD, they were assigned less than 5% of the time. You can see that, because NPs are on this chart only for pneumonia without an inpatient admission and the percent of episodes assigned for that was 9%.

[Slide 21] If we look at a summary of group attribution and identification of suggested lead EP on Slide 21, as I stated, most (85%) of the episodes are attributed only to one group. The suggested lead EP identification methodology was for informational purposes only, and the methodology assigned most episodes to only a few specialties and specialties which made clinical sense within each group. EPs with internal medicine and family practice specialties were primarily identified for pneumonia episodes. Cardiologists, surgeons, and internal medicine specialists were mainly identified for AMI episodes. Cardiologists and internal medicine specialists were primarily identified for CAD episodes. Cardiologists were identified for PCI without AMI episodes. Thoracic and cardiac surgeons were identified for CABG without AMI episodes.

[Slide 22] We're now on Slide 22, and this shows you our reliability testing. I just want to remind me, and perhaps you, that reliability is a measure of precision and therefore evaluates the extent to which the performance of one group can be confidently distinguished from another based on the episode attribution and grouping methodologies. A higher ratio means that relatively more variation in episode costs is due

to differences in performance across groups. As you can see, looking at the data on the table, the reliability testing was moderate to high for the episode types.

[Slide 23] As I said, most episodes have a high or moderate reliability, indicating that the episode grouping and attribution methodologies did consistently distinguish performance between groups. All CAD and CAD without AMI had the highest reliability scores (0.89 and 0.9, respectively). The episode types that had a more moderate reliability score, AMI without PCI or CABG, AMI with CABG, PCI without AMI, and CABG without AMI, also have a lower number of episodes per group, which can affect the reliability score.

[Slide 24] Now to Slide 24, validity testing. Just to remind me, validity measures the accuracy of the episode costs and the attribution methods by comparing results to separate supported measures of provider efficiency. Measuring the validity of episodes is difficult for episodes because there are few existing validated episode constructs. What we did to test validity for the five major episode types: we compared them to the group per capita cost measures that were drawn from the 2011 Group QRURs, which you've previously received.

[Slide 25] If we look at the validity testing, the table presents the Pearson correlation between the per capita measures and the episodes. The per capita cost measures are more closely correlated with the acute and chronic conditions of pneumonia, AMI, and CAD than with the procedural episodes PCI and CABG.

[Slide 26] If we just review the validity summary, higher total per capita costs within groups are moderately associated with higher pneumonia, AMI, and CAD costs. Higher CAD per capita costs within groups are moderately associated with higher pneumonia, AMI, and CAD costs. Both per capita measures were weakly correlated with CABG without AMI and PCI without AMI costs. These procedural episode types may be less closely related to total costs for a patient because they represent a very specific and clearly defined by time course of care, unlike the other episodes.

[Slide 27] We received several comments over the week about how the 2011 Supplemental QRURs can be used, and I'll go through this slide and the next slide is my last slide and then we'll go through a few questions and discuss some other thoughts that we had. Essentially, based on the group data which we have shown you, and I think it's important to keep in mind that these are group level reports, these data can be used to support you in efforts to improve the efficiency of medical care provided to the Medicare Fee-For-Service patients that you treat. That was a prime goal. The reports allow you to examine group specific information on volume, actual episode costs, relative episode costs, and episode subtype composition. They allow you to obtain information on the utilization of specific service types and the cost of those services and, finally, to compare a group's episode costs with the national mean to help improvement efforts by identifying possible factors that could contribute to higher or lower than national mean costs.

[Slide 28] Finally, just to review next steps, I just want to remind you that these 2011 Supplemental QRURs were supplied for informational purposes. There was a comment on the last call, and I just want to clarify again, that at this point, this information is not currently to be incorporated into the calculation for the value modifier for 2015. CMS looks forward to continuing to receive feedback about these reports from you, and we look for comments about the types and adequacy of information included in the reports, the understandability of the reports, the actionability of the reports, and the summary information

provided about the reports. As mentioned during the July 23 call, the CMS episode grouper will continue to evolve over the next three years, and there will be other opportunities to provide clinical feedback in the future. A couple things that we know we're working on: the number of episodes will be expanded and the clinical logic and risk adjustment methodology will be refined. I just want to remind you that comments can be provided through the QRUR Episodes web portal discussion board for the 2011 groups or by emailing QRUREpisodes@acumenllc.com. Comments you provide through either mechanism can only be seen by your medical group practice, Acumen, and CMS. One last reminder: when sending comments and questions, do not post or email any personal identifiers or any confidential information as stipulated by government regulation.

That's the end of our presentation and we have received a number of questions from several groups since last week. Craig and I are going to go through just a few of them, because we want to leave most of the time that we have left together today for an interactive time on the phone. We're going to address just a few questions and then talk a little bit more about how the groups use the data and act on the information.

One of the questions we received is, "When is the cutoff for feedback on the QRUR supplements?" We would appreciate feedback no later than Monday, September 16. Obviously, the earlier the better. We would like to receive feedback no later than this date so that it is possible for us to consider your feedback during development of the next iteration of reports.

Another question we received is whether the software to create the episodes will be eventually available, when will this information be public, and what is defined as public. The plan is to make the episode grouper publicly available in the near future on a website operated under CMS's Innovation Center contract. This issue is currently under discussion and more detail should be coming shortly.

"Currently the measurement profiles are at the group level, will this expand to the individual physician level within a group and when?" At this time, there is no plan to expand the episode analyses to the individual physician level. Once again, I want to emphasize that these are group level reports.

This is really a question for brainstorming both, I think, among us and you and the groups and CMS. "How do the groups use the data and act on the information?" Slide 27 listed some possible uses for the group level data. The data were intended to support medical groups in efforts to improve the efficiency of medical care provided to the beneficiaries they treat. Some other thoughts that we've had that I'll share with you are that groups can look to see what care and again, you as groups, have the benefit of having the clinical data to actually look in the chart or even discuss with the identified lead EP, what care is driving the costs of the high or the low cost beneficiaries. I think that there's probably information at both ends of those spectrums. I think it's important to look at those beneficiaries and to look for some systematic care that is going on during those episodes and the care of these patients that can be driving costs. For the high cost beneficiaries, you can review the charts and see whether the care was appropriately delivered or whether there were gaps in care or redundancies in care that could have driven up the costs. I think that this should also be done for those that are out of range with others and for low costs, likewise looking to see why the low cost beneficiaries are low and looking to see whether there might be best practices that occur consistently for low cost beneficiaries. This information, ideally, would be linked to quality of care for the episode. Clearly we welcome feedback on the actionability of the information included in the 2011 QRUR Supplements and other potential areas of improvement of the reports. Craig, do you want to answer some of the other questions?

Craig Caplan: There are some other questions that we received, as Sheila mentioned, we want to open this up to other comments, and if there's no time at the end, we'll email the responses to the questions that we weren't able to cover today.

The question is, "What is the relationship between risk adjustment and the complexity of the patient when adjusting upward or downward for risk adjustment?" The answer is that, as we discussed last week, more complex patients have their episode costs adjusted downwards. So, if the group's average risk adjusted costs are higher than its non-risk adjusted costs, its patient population is said to be less complex than average, and conversely if the group's average risk-adjusted costs, its patient population is more complex than average.

The next question was, "Why were specific choices made in the development of the grouper? For example, why did the reports benchmark the top 20 percent?" The development of the clinical logic and the episode construction logic of the CMS Grouper is under contract, as Sheila mentioned, that's administered by the CMS Innovation Center. There was some flexibility in how we presented the data from the CMS Grouper in the 2011 Supplemental QRURs. The choice of examining the top 20 percent - I won't really refer to that as a benchmark. The choice of examining the top 20 percent of episodes in Exhibit 2 was selected because we thought it would be a helpful test-point for a group to be able to get a sense of its highest cost episodes. Additional or alternative test-points could have been chosen, but we tried to balance the goal of presenting enough usable information at a high level in Exhibits 1, 2, and 3, but ensuring also that the initial supplemental reports are a manageable length for clarity, not an overwhelming length. We welcome feedback on this and what information would be most useful for the groups.

Another couple questions - one is a quick question: "What is the time period for a CAD episode? Is it a rolling twelve months or does the episode end and start again after a set amount of time since this is a chronic condition?" The answer is that it is a rolling twelve months. It ends 365 days after discharge from the trigger inpatient hospital stay or after the first trigger E&M visit. The episode is extended 365 days with each occurrence of the trigger diagnosis code. For the 2011 Supplemental QRURs, Acumen selected CAD episodes that had a quarter that ended in 2011.

And finally, "How is CMS/Acumen preparing the modeling analysis for transition to ICD-10?" The initial version of the CMS Episode Grouper is undergoing multiple changes to create the next versions of the grouper and starting in the program year 2014 data, future QRURs will present episode data that will be using a version of the grouper that will use ICD-10 codes instead of ICD-9 codes. So, that will occur. We'll open it up to further questions from the group.

Camille: Hi, Craig. This is Camille from Acumen. We had a question through the webinar chat box that I'd like to bring up right now so that you can address it. This is a question about the role of the episode grouper beyond 2015: "Can you explain how episodes will be incorporated into the value based modifier in 2016 and beyond?"

Sheila: Michael Wroblewski is going to answer that question.

Michael: Thanks, Sheila. It's a great question. As you all know we put out our proposed rule for the modifier that will apply in 2016, and we have not proposed to have episode costs in the modifier that

would be applied in 2016. So we don't have any proposals right now. That's the short answer. We do ask for suggestions and comments on how we should, or whether we should, include episode based costs into the value modifier cost composite, and if so how to do it. So we would welcome your thoughts, and you guys are in a great position to give us those because you've seen kind of what they look like, at least an early prototype of it, to see what would make sense to determine who would be high cost and who would be low cost in terms of making that determination given our current framework for the value based modifier.

Sheila: Any other questions?

Unidentified: I have a question. Actually, I missed the previous webinar, so you might have addressed it before, but if I look at Exhibit 4, it breaks up costs that are claims billed by our group practice versus by other group practices, or outside our group practice. Are many of those costs outside our group practice due to hospital billing?

Craig: Acumen, do you want to cover that?

Camille: Sure, this is Camille from Acumen. Yes, that's correct. A lot of times, you might see higher than you would expect costs outside of your group. That's because Exhibit 4B includes facility costs. So that'll include costs for hospitals as well.

Unidentified: Okay, so that's the ambulance, that's the hospital, that's the post-acute care, etcetera?

Camille: Yes, that's correct.

Tammy: Hi, this is Tammy from OHSU. I just want to ask a piggy-back off of that. We have our medical group practice where we bill our professional services, but we're associated with a hospital for our provider based. So in Exhibit 4 when it lists out the other facilities, can I assume that since the hospital bills under a different TIN that it's falling under the other facilities bucket?

Camille: Yes, that's correct. Groups were identified using TIN numbers, so facilities that bill under a separate TIN will be in the claims billed by other groups or facilities.

Unidentified: So that would be a suggestion for future reports: to be able to associate affiliated hospitalizations with your own medical group where possible.

Craig: That's a great suggestion.

Jason Shropshire: Hi this is Jason Shropshire from UNC. I've done a quick and dirty analysis from the data that was presented, and only about 10% of the total costs associated with all the different groups are part of our physician group. So is there any plan in the future to sort of make a hybrid perhaps of visits and costs? I have an example. For instance, there was a patient who was grouped to pneumonia without inpatient hospitalization. He had a tertiary diagnosis of pneumonia. However, he came here for skilled nursing and rehab as part of our PM&R department. He was associated with us and literally only about10% of his overall costs were caused by our E&M services. So it kind of begs the question: how are we supposed to use this data when most of the costs are attributed elsewhere where we can't control?

Camille: Hi, this is Camille from Acumen. I'll clarify that the attribution methods both to groups and suggested lead EP don't exclusively use visits. Some of them use costs and some use procedures. In some cases, so for pneumonia, which was your example, episodes were attributed to groups that had at least 35% of E&M visits or at least 35% of costs. We are hoping by using both visits and costs can help identify groups who can affect the care.

Daniella: This is Daniella from Acumen. If you have examples like that where you are looking at your attribution, and you are investigating and finding something such as a pneumonia episode attributed to you for PMR that you don't think accurately reflects who should be attributed the episode, if you could let us know, that is one way we can review those cases and improve those attribution rules going forward. That is the type of thing we would really like to hear from you.

Jason Shropshire: Ok thank you. I will just reiterate I feel like there should be some sort of mix, meaning that we shouldn't be attributed just because we happen to have the most E&M visits, 90% of the costs were incurred elsewhere. It sounds like from the earlier slide that if we have 35% of the physician fee schedule E&M visits, we would be attributed to that patient. As well as the entity that is occurring all of this cost. It seems like it would be attributed to one group that is doing a majority of the visits and the cost.

Daniella: Well so attribution is something that we are definitely interested in investigating in the future. Ideally, we would want to select the medical group that is most responsible, they may not necessarily be the one that has billed the most for example, but is the managing physician or the managing group that the majority of the episode costs could be attributed to help promote management and care coordination. I think that if you find examples in your list of episodes that don't suggest that flavor, that something was attributed and maybe the group was not the main group that would have been coordinating events for the episodes, we would encourage you to contact us and we would like to hear about it.

Jason Shropshire: Ok.

Jesse: This is Jesse from Oregon Health and Science University. We noticed on our side to our group were costs that we never billed, such as ambulance services and chemo and Part B drugs, so how would those be attributed to us?

Daniella: Well the attribution occurred for all of those episode costs in blocks, so the costs for the episode were aggregated together and that was based on the Grouper rules that again Craig has said earlier outsourced by CMS to Brandeis, and then once those are all put together the attribution attributes the entirely of those costs to the medical group. They are not split up, and I know there are worksheets in there and it may be confusing that the worksheets that you have will break costs down, but in terms of attribution they go for the entire episode in blocks. That is the issue that there may be costs incurred by other entries, other TINs other groups and actually that again that is one of the things that we are hoping to get feedback from you about. In other words, if you see that there is large cost items in there that you don't think should be included in the episode for grouping because it is actually the step that you are identifying. If ambulance should not be attributed to that episode which is then attributed to you, we would like to get that feedback as well.

Jesse: So let me just understand that in a given episode that we see an ambulance cost it was attributed to us because we were mainly managing that patient's care and they were ending up having an ambulance service and because of their diagnosis we were then given the responsibility for. Is that the right way to think about it?

Daniella: That is correct. What is happening is that the grouper software is using definitions of what gets grouped, the cost of which services get grouped into that type of episode, and then you are attributed the entirety of the costs of that episode, and I think what you are describing there, and you can comment on it when I am finished, is your thinking that maybe the ambulance costs wouldn't be responsible to attributed to your group, or responsible to consider was under the control of your physicians managing care for that condition and that patient and therefore what we would have to go do is go back and review that and make a decision and give that feedback to the panels reviewing that are these and say should ambulance costs be excluded? And I think that this whole process is the mechanism in getting that feedback from you so we can do that.

Jesse: Ok. Ok. And not to belabor the attribution and how this is attributed to a particular group because it sounds like there is vetting that definitely needs to happen, but in the examples that we have at Oregon Health and Science University is that some of these patients have never been to our group at all until that episode of care. And I think and I hear that the purpose of this is to figure out what kind of quality of care lead up to the patient's episode, and if the patient has never presented at our organization before and I would think the attribution of that patient would go to their primary care or wherever they started. So again not to belabor the attribution issue because it sounds like we've got a lot to vet out. That is one of the things that we noticed.

Daniella: Well, this is Daniella from Acumen. I think I can, I appreciate that comment, and I think there are some things and some good things in that comment that we are trying to move toward where we haven't flushed out as many of what we would call chronic care episodes so what we have provided for you is mostly these acute care episodes, so someone could be coming to your group and be getting assigned to your group after getting an acute pneumonia for example. That is actually not the best example but let's just go with pneumonia and say that there may be an underlying chronic condition that wasn't managed that well, so for example COPD, and I'm kind of making this up as I go along, and so the chronic care episode for COPD for example that would then be attributed to an underlying primary care doctor would include that acute pneumonia that you are looking at. Our goal is to match the types of services and costs that are coming subsequent to that episode to the type of care that would be provided by the physician group. For example for the acute pneumonia that you may not or your group may not been primarily responsible for the primary care, the chronic disease management of that patient previous to the pneumonia but we would say that we would like to include in that acute pneumonia the type of episodes and the grouping of costs only related to that acute event, not the post chronic type care management costs that wouldn't necessarily be attributed to the providers that are caring for that acute event. We would understand that should be a relatively time limited and type of service limited event where we would still aim to get the right types of services grouped to just the acute pneumonia and if there were things that you thought would be more appropriate for the longer term primary care that shouldn't necessarily be and are in that acute pneumonia episode we would like to get that feedback. We would consider removing those and in the final version of this there would again be that separate episode that would be looking at whatever the chronic or primary care type conditions that a better management

of would lead to a prevention of that pneumonia for example. Does that make sense? That was kind of a long-winded answer, I apologize.

Jesse: Yup.

Mary Wheatley: This is Mary Wheatley from the AAMC. Just as we are running toward the end of the hour, people go through and start looking at their own clinical databases and seeing how and finding things that look a little unusual, should they be providing the episode ID and a summary? How should they provide this feedback to you? What is the best way to do that? I know that there is the portal you said and the email address.

Camille: Sure.

Mary Wheatley: Just episode ID and other information? What information would you be looking for and what kind of format?

Camille: Sure. This is Camille from Acumen. You are welcome to use either the email address supplied or you can use – the web portal through which you downloaded the reports has an "ask a question" discussion board function on the left navigation panel. We will need the episode ID from you and obviously what the reason is that this episode that you have particular interest in – what issue you have identified or what question you have about it. Please do not post beneficiary healthcare numbers, just the episode ID please.

Michael: Hey Mary, it's Michael. I do want to reiterate what Camille just said. Please do not put a HIC number in an email. Ok? Thank you.

Mary Wheatley: No, that is fine, but the episode ID should be sufficient for anyone who is looking at, that should be the ID that people should be looking at.

Camille: Yup. That is correct.

Michael: That should be ok.

Mary Wheatley: Ok.

Craig: Well it is the bottom of the hour, do people have further questions? Again you can feel free to submit your questions and we will respond to the ones that we have received by email that we didn't get a chance to go through today. Does anyone else have future questions now?

Unidentified: I'll ask one. My understanding would be that most CABG patients and most PCI patients without an AMI have CAD. Are you counting them in both places?

Sheila: Yes. Presentation in an AMI or PCI procedure or a CABG would also open up a CAD episode.

Unidentified: It might be interesting to look at the CAD patients without PCIs, without CABG to kind of compare how things are going. I have access to both, some academic center data and some community hospital data and that is the big differences in CAD appear to be.

Sheila: Thank you for that suggestion.

Craig: Are there other questions? If not we will wrap up and again we encourage you to please submit feedback and questions on the last bullet again gives the address.

Sheila: And particular things that are in your report that do not make sense to you, or look like your responsibility, or your patient.

Craig: We thank you very much for your time and these really thoughtful questions, and we look forward to receiving more feedback.

Sheila: Thank you very much, and have a good evening.