

NATIONAL QUALITY FORUM

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EPISODE GROUPER EVALUATION CRITERIA  
EXPERT PANEL

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WEDNESDAY  
FEBRUARY 5, 2014

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The Expert Panel met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Kristine Anderson and Joseph Cacchione, Co-Chairs, presiding.

PRESENT:

KRISTINE MARTIN ANDERSON, MBA, Panel Co-Chair

JOSEPH CACCHIONE, MD, Panel Co-Chair

STEPHEN BANDEIAN, MD, JD, John Hopkins

University Bloomberg School of Public Health

DAVID BODYCOMBE, MSc, ScD, Johns Hopkins

University Bloomberg School of Public Health

FRANCOIS DE BRANTES, MS, MBA, Health Care

Incentives Improvement Institute\*

NANCY GARRETT, PhD, Hennepin County Medical

Center

JENNIFER HOBART, MBA, MSc, Blue Shield of

California

DAVID HOPKINS, PhD, Pacific Business Group on

Health

JIM JONES, MBA, AmeriHealth Caritas

MARJORIE KING, MD, American Association of

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JAMES NAESSENS, ScD, MPH, Mayo Clinic  
DAVID REDFEARN, PhD  
TAMARA SIMON, MD, MSPH, Seattle Children's  
Hospital  
CHRIS TOMPKINS, PhD, Brandeis University

NQF STAFF:

TAROON AMIN, Senior Director, Performance  
Measurement  
HELEN BURSTIN, MD, MPH, Senior Vice President,  
Performance Measurement  
NEAL COMSTOCK, JD, Vice President, Member  
Relations  
ANN HAMMERSMITH, JD General Counsel  
ANN PHILLIPS, Project Analyst  
ASHLIE WILBON, RN, MPH, Managing Director,  
Performance Measurement  
EVAN WILLIAMSON, MPH, MS, Project Manager,  
Performance Measurement

\* present by teleconference

A-G-E-N-D-A

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1 P-R-O-C-E-E-D-I-N-G-S

2 8:33 a.m.

3 MR. WILLIAMSON: Good morning and welcome to  
4 the expert panel meeting. We will now  
5 begin. We will start with Neal Comstock who  
6 will give us an update on the annual  
7 conference.

8 MR. COMSTOCK: Well, good morning  
9 and welcome to NQF. Thank you for coming  
10 here and joining us in person as well as on  
11 the phone.

12 I wanted to just introduce myself  
13 and tell you a little bit about our annual  
14 conference next week which I very much hope  
15 you can join us for.

16 We will have a terrific  
17 conference to focus specifically on the type  
18 of information, information about healthcare  
19 quality that can be useful to actual  
20 patients and consumers, and also of course  
21 to providers and other healthcare  
22 professionals.

1                   There's a great wealth of  
2 information that's made available as a  
3 result of measures approved by NQF and as a  
4 result of many other sources, some reporting  
5 by professionals and institutions as well.

6                   And there's a very wide array of  
7 sources that actual patients when they need  
8 to make healthcare decisions go to to get  
9 this information.

10                   There is a wide variety of  
11 information that is better -- some which is  
12 better than others and that is more  
13 accessible than others. And we want to have  
14 basically a day and a half conversation with  
15 everyone in the quality enterprise about how  
16 we can collectively make that information  
17 more useful to actual patients and  
18 consumers.

19                   And so that's what we're going to  
20 do. We will start off with of course  
21 remarks from our CEO Chris Cassel. This  
22 will be her first annual conference as CEO

1 of the organization.

2 We'll have a series of  
3 discussions on variations of this topic.  
4 But among those who will be speaking are  
5 James Guest, the president of the Consumers  
6 Union. And of course Marilyn Tavenner, the  
7 CMS Administrator.

8 And on Friday afternoon to close  
9 out our conference we'll have remarks from  
10 Senator Tom Daschle, the former Senate  
11 Majority leader and from Mike Leavitt, the  
12 former Governor of Utah and HHS Secretary.

13 We'll have an engaging and  
14 interesting and I believe you'll find  
15 informative conference. I very much hope  
16 that you can join us for it.

17 It's at the Marriott Wardman Park  
18 Hotel next Thursday and Friday. And you can  
19 find more information about it at our  
20 website. But please also don't hesitate to  
21 ask me any questions or follow up with me  
22 afterwards.

1                   Again, my name's Neal Comstock.  
2                   I'm fairly new to NQF here as vice president  
3                   for member relations. Welcome to NQF.  
4                   Welcome to our meeting. Thank you for your  
5                   time and for your work here today. We very  
6                   much hope we will see you next week. Thank  
7                   you.

8                   MR. WILLIAMSON: Great, thank you  
9                   very much, Neal.

10                  At this point we'll go over some  
11                  of the logistics for the meeting. And my  
12                  name's Evan Williamson. I am the project  
13                  manager for this project. We want to go  
14                  over and make sure everybody knows the lay  
15                  of the land here, what we'll be doing the  
16                  next 2 days, where everything is and how we  
17                  can functionally operate through this  
18                  meeting.

19                  So if you want to leave the room  
20                  here, head out past the elevators and take a  
21                  right. We have restrooms. We'll be taking  
22                  three main breaks today, 10:15, 12:45 for

1 lunch and then again at 3:15 after the  
2 breakout session.

3 We do have wi-fi here. The  
4 network is NQF Guests. The login is "guest"  
5 lowercase and the password is "nqfguest."

6 We want to make sure everybody  
7 mutes their cell phone during the meeting.  
8 We don't want to have any unwelcome  
9 interruptions.

10 We will be using again  
11 microphones. Please be sure when you are  
12 speaking that you speak directly into the  
13 microphones. You see that these  
14 microphones, red means that it's on. We can  
15 only have three microphones on at once so if  
16 you are not speaking and you have finished  
17 speaking please be sure to press the speak  
18 button again to turn it off.

19 And you just need to press -- to  
20 turn it on. Don't press and hold. We've  
21 had issues with that. So these microphones  
22 pick up everything for the court reporter.



1 We want to make his job as easy as possible.

2 We have provided a discussion  
3 guide along with an agenda. The discussion  
4 guide will be the main document we'll be  
5 using for this meeting. We have printed out  
6 a copy for you. It's also available on the  
7 SharePoint site. We'll be making realtime  
8 changes to it as we go through. You see  
9 it's displayed on our two auxiliary monitors  
10 on the side. So we'll be going through that  
11 as well. Again, that contains all of the  
12 key questions for today's meeting that we'll  
13 be hoping to answer as we go through. And  
14 that's our main document.

15 I'll introduce the rest of the  
16 project staff now. Or I'll let them  
17 introduce themselves. I'll start with  
18 Ashlie.

19 MS. WILBON: Good morning,  
20 everyone. I think I got a chance to greet  
21 everyone individually this morning so I just  
22 want to thank everyone for coming.

1 I am one of the managing  
2 directors in the performance measurement  
3 department and I've been working on most of  
4 our cost and resource use work over the last  
5 couple of years. So I'm really excited  
6 about this work and I'm excited about the  
7 group that we've gathered today. So I'm  
8 looking forward to a good meeting. Thanks.

9 MR. WILLIAMSON: And Taroon?

10 MR. AMIN: Good morning,  
11 everyone. I'm very excited to get started  
12 on this work.

13 My name's Taroon Amin. I'm a  
14 senior director here at NQF supporting our  
15 cost of care efforts both on the performance  
16 measurement side and on the Measure  
17 Applications Partnership side of NQF.

18 In terms of disclosures I just  
19 wanted to note that I maintain an academic  
20 affiliation with Brandeis University and was  
21 part of version 1 of the Medicare Episode  
22 Grouper Development Team. But I have since

1 not been part of that team for almost 3  
2 years now.

3 MR. WILLIAMSON: Thank you,  
4 Taroon. We also have Ann Phillips.

5 MS. PHILLIPS: I'm Ann Phillips.  
6 I'm a project analyst here at NQF.

7 MR. WILLIAMSON: Additionally  
8 next to me we have Helen Burstin.

9 DR. BURSTIN: Good morning,  
10 everybody. I'm Helen Burstin, the senior  
11 vice president for performance measurement  
12 here at the National Quality Forum.

13 I'm delighted to see so many  
14 familiar faces and we're also -- and some  
15 new ones. I'm really thrilled to get to  
16 consider this really very important new line  
17 of inquiry for us.

18 MR. WILLIAMSON: We also have Ann  
19 Hammersmith, our general counsel. She'll be  
20 talking to you all in a minute.

21 At this point I want to go over  
22 the time-line. We went over this in

1 orientation just to remind everybody of what  
2 we are doing today and then we will be doing  
3 in the future.

4 So again, we've gone through our  
5 orientation. We've had our information  
6 review. We'll be doing our in-person  
7 meeting today and tomorrow.

8 We do have two post meeting calls  
9 scheduled on March 12 and March 19. We will  
10 have a draft report posted on March 24 for  
11 public review and comment. We'll be meeting  
12 again on May 14 to review those comments by  
13 phone.

14 Then we have a CSAC review and  
15 approval through June. Hope to get  
16 endorsement by the board at the end of June.  
17 And then our final report will be complete  
18 by the 1st of July.

19 So again, this is a quick trip  
20 through this. We appreciate all your effort  
21 on this. We know it's going to be a lot of  
22 work here going forward. We'll hope to make

1 it as easy as possible.

2 At this time I'll turn it over to  
3 Ashlie to go over the project scope.

4 MS. WILBON: So I'll just talk a  
5 little bit -- some of these slides you may  
6 remember from orientation, but since we're  
7 reconvened here in person we just want to  
8 make sure that everyone is on the same page  
9 as we start the day.

10 So, our work today is primarily  
11 going to be focused around understanding  
12 exactly what we mean when we say episode  
13 grouper. So how do we define that, how do  
14 we differentiate that between other types of  
15 measurement systems.

16 And in doing that we're going to  
17 take a lot of time kind of defining what  
18 those key elements of a grouper would be.  
19 What are some of the key principles when  
20 you're defining those and evaluating them.  
21 And then what criteria might we use to  
22 evaluate them.

1                   And then the last part of the day  
2 tomorrow will be used to kind of think  
3 through some of the implications that we  
4 need to think through before we begin to  
5 actually endorse grouper. So that will be a  
6 key discussion we'll have tomorrow.

7                   In terms of the scope of this  
8 project I just want to reiterate that we are  
9 going to be focusing on principles and  
10 considerations. We're not going to be  
11 actually evaluating groupers today. That's  
12 not the purpose and the charge of this  
13 group.

14                   We're going to really try to stay  
15 away from talking specifically about the  
16 merits of specific tools or products, and  
17 that the criteria that we would develop  
18 potentially could be applied to any grouper.

19                   This criteria will not be  
20 developed to evaluate a specific grouper or  
21 tool that we may be familiar with. So just  
22 want to make sure that everyone understands

1 this is kind of, just like our measurement  
2 evaluation criteria for resource use  
3 measures and quality measures, the criteria  
4 are broad such that any type of measure  
5 could be -- or the criteria could be applied  
6 to evaluate any type of measure within those  
7 domains. So, just want to make sure that we  
8 reiterate that as we go forward.

9 MR. AMIN: Yes, and I'll just  
10 sort of emphasize I think one point that  
11 Ashlie is bringing up here. We can't stress  
12 how critical this is.

13 We recognize that when we're  
14 talking about principles and considerations  
15 many of you in the room have spent a  
16 considerable number of hours and days and  
17 years working on either developing groupers  
18 or using groupers in various different  
19 applications.

20 So the thought of making  
21 considerations or principles that are  
22 divorced of your own product seems a bit

1 challenging.

2           So one of the critical things  
3 that we're going to ask you to do in a  
4 minute is to make sure that at least  
5 everyone -- I mean, it may be challenging,  
6 but we're going to ask you to do that  
7 anyway.

8           And at least we can try to  
9 understand various different people who have  
10 worked with different products. Maybe we  
11 can generalize some different principles and  
12 considerations across different products.

13           But it is extremely important  
14 that all members of the panel disclose to  
15 each other if they have any experience using  
16 any of these groupers in any application.

17           That way we have any potential  
18 considerations or your own personal interest  
19 in terms of how you developed groupers out  
20 on the table so we can all have a pretty  
21 open conversation about how these principles  
22 may transcend an individual product but



1 could be applied across different grouper  
2 types. So again, I just want to reiterate  
3 that.

4 It's extremely important for the  
5 success of this project and the credibility  
6 of the outcomes of this group that we make  
7 sure that we're at that level of making sure  
8 that this is across different products. So,  
9 I think that's all I needed to say.

10 MS. WILBON: And pardon me if you  
11 were going to say this, but just to kind of  
12 piggyback on Taroon's statement.

13 Considering that all of you guys come from  
14 various backgrounds and we've actually  
15 convened you because of the expertise that  
16 you have.

17 And you are actually sitting on  
18 this committee as individuals because of  
19 your expertise that you bring as an  
20 individual professional and so forth. And  
21 so you're not representing your organization  
22 or affiliations that you have with

1 particular products and so forth.

2 So that said, I'll hand it over  
3 to Ann to carry us through the disclosures  
4 process. Thank you.

5 MS. HAMMERSMITH: Thanks, Ashlie  
6 and Taroon, both of whom did a very good job  
7 of summarizing key considerations when doing  
8 disclosures of interest.

9 As Ashlie mentioned you sit as  
10 individuals so you're not representing an  
11 organization that nominated you or that you  
12 work for or that you're somehow associated  
13 with.

14 And as Taroon pointed out you're  
15 not looking at measures today, you're not  
16 looking at individual groupers. You're  
17 looking at developing criteria.

18 And because of that as Ashlie and  
19 Taroon noted most, if not all of you are  
20 going to have involvement with groupers.  
21 You've worked on them, you've consulted on  
22 them, and so on.

1                   So what we want to do today is we  
2                   want to go around the table, tell us who  
3                   you're with and have you disclose any  
4                   involvement you've had with groupers.

5                   On the slide you will see the  
6                   specific disclosures that we are looking  
7                   for, involvement in the development of an  
8                   episode grouper system, a personal financial  
9                   arrangement or affiliation with a specific  
10                  product or service based on a product. That  
11                  may be stock ownership. It may be that you  
12                  consulted with a company on a grouper.

13                  Investment in a specific product  
14                  by your organization. And employment by or  
15                  other affiliations with organizations,  
16                  companies, or other entities that own,  
17                  develop, or use episode groupers.

18                  We are not looking for you to  
19                  summarize your résumé. We're looking for  
20                  you to make specific disclosures regarding  
21                  the work of the committee today.

22                  So, with that I'm going to start

1 with the co-chairs. We can go around the  
2 table. To the extent people are on the  
3 phone I will call on them.

4 MS. MARTIN ANDERSON: Thank you,  
5 Ann. I'm Kristine Martin Anderson. I'm  
6 currently employed by Booz Allen Hamilton.

7 I've had two interactions with  
8 grouper development, one in the late  
9 nineties where CareScience, my former  
10 employer, developed a grouper that  
11 ultimately was not taken to market because  
12 we weren't satisfied with its overall  
13 reliability of performance.

14 And then now I work for Booz  
15 Allen and Booz Allen is a subcontractor to  
16 Brandeis University and their CMS contract  
17 on the open source grouper.

18 DR. CACCHIONE: I'm Joe  
19 Cacchione. I'm with the Cleveland Clinic.

20 I'm on the scientific advisory  
21 board for United Healthcare which has an  
22 ownership of Optum Insights. And we have

1 customized some grouper tools for local use  
2 only with Optum. Otherwise I have no other  
3 affiliations that are material.

4 MR. HOPKINS: I'm David Hopkins  
5 from Pacific Business Group on Health. And  
6 I don't have anything to disclose that fits  
7 any of those bullets. But I do have some  
8 experience with groupers, so a couple of  
9 things.

10 Back in the early two thousands  
11 we got an AHRQ grant and worked with Doug  
12 Cave as he was actually developing his  
13 grouper system. And we were looking at the  
14 variation in costs among physician groups  
15 with Blue Shield of California.

16 More recently I was chair of the  
17 technical efficiency committee for IHA's  
18 pay-for-performance program and we did some  
19 work with -- what was the name at the time?  
20 It was Medstat, or Thomson Reuters, or  
21 something, one of those. At any rate the  
22 owner of MEGS. So I got some familiarity

1 with MEGS but never had any involvement of  
2 that type.

3 MR. BODYCOMBE: Hi, I'm Dave  
4 Bodycombe. I'm with Johns Hopkins Bloomberg  
5 School of Public Health. I direct research  
6 and development for the ACG System. It's a  
7 commercially available case mix adjustment  
8 predictive modeling tool. We do not have an  
9 episode grouper component to that so I don't  
10 think any of these particular conflicts  
11 would apply.

12 DR. LEVINE: HI, I'm Mark Levine.  
13 I'm a physician employed by Centers for  
14 Medicare and Medicaid Services and I'm the  
15 clinical lead for the development of the  
16 Medicare episode grouper.

17 DR. BANDEIAN: I'm Steve  
18 Bandeian. I'm an internist at AHRQ. I  
19 developed at AHRQ an analytic system that  
20 includes groupers as -- episode groupers as  
21 a component. And I have participated in the  
22 CMS project.

1 MR. TOMPKINS: HI, I'm Chris  
2 Tompkins. I'm on the faculty at Brandeis  
3 University. I'm the project director for  
4 the CMS support contract to develop the  
5 public source grouper.

6 MR. JONES: I'm Jim Jones. I'm  
7 vice president at AmeriHealth Caritas. It's  
8 an IBC-owned Medicaid plan.

9 I don't have any specific  
10 disclosures that fit the descriptions there.  
11 But like everyone else I've used various  
12 tools for network tiering and performance  
13 contracting, MedStat, BPS, tools like that.

14 MS. HOBART: I'm Jennifer Hobart  
15 at Blue Shield of California. I'm also on  
16 the technical committee of IHA California  
17 PFP, the technical committee of CHPI which  
18 is a California collaborative that among  
19 other things is working towards an all-  
20 claims database, and worked with PBGH and  
21 other entities.

22 I think in terms of particulars

1 Blue Shield has had a grouper in the past.  
2 They had Optum ETGs which we suspended for  
3 awhile but now we're re-initiating, putting  
4 in a grouper, and the various collaboratives  
5 use groupers.

6 MR. MCLEAN: Hi, I'm Jelani  
7 McLean. I'm the head of cost analytics for  
8 BCBSA Blue Distinction Center Program, so  
9 developing the entire methodology from  
10 administrative claims all the way to  
11 evaluating the facilities.

12 And in that component obviously  
13 would be some sort of grouper. So I've had  
14 experience with a lot of customer groupers  
15 when they come for transplants, so forth and  
16 so on.

17 MS. SIMON: I'm Tamara Simon.  
18 I'm a pediatric hospitalist at Seattle  
19 Children's.

20 I've been involved in -- I  
21 haven't been involved in the development of  
22 an episode grouper system, but I have been



1 developing through the Centers for  
2 Excellence for Children with Medical  
3 Complexity a pediatric medical complexity  
4 algorithm that is through funding from AHRQ  
5 and CMS.

6 It's essentially designed to be a  
7 publicly available algorithm to identify  
8 children with medical complexity. Our  
9 center has done comparisons with the 3M CRG  
10 system.

11 MR. REDFEARN: I'm David  
12 Redfearn. On Monday of this week I retired  
13 from WellPoint after 31 years with the  
14 company.

15 While I was at WellPoint --  
16 WellPoint licenses the Optum ETG product and  
17 the Truven MEG product. I've had fairly  
18 extensive experience with both of them.

19 I've also spent some time looking  
20 at the Optum procedure episode grouper. And  
21 most recently I've been trying to take a  
22 look at the 3M patient-focused episodes

1 model.

2 So I've had wide experience, in  
3 fact, hands on experience with trying to run  
4 these suckers which is sometimes a  
5 challenge. But no conflicts at all.

6 MS. GARRETT: Good morning, I'm  
7 Nancy Garrett. I'm the chief analytics  
8 officer for Hennepin County Medical Center  
9 which is a safety net care provider in  
10 Minneapolis.

11 And I don't have any conflicts to  
12 disclose of that nature. I have worked with  
13 various episode groupers from a payer  
14 perspective in past positions in my career.

15 And at NQF I'm involved in a  
16 couple of other committees, the cost and  
17 resource use as well as the risk adjustment  
18 and socioeconomic status group.

19 DR. MIRKIN: Hello, I'm Dave  
20 Mirkin. I'm the chief medical officer for  
21 Milliman MedInsight analytic platform.

22 And as far as I know I have

1 nothing to disclose, but I do need to  
2 disclose that Milliman on the consulting  
3 side works with a number of organizations.  
4 And I wouldn't know if they actually  
5 contributed to development of an episode  
6 grouper.

7 MR. NAESSENS: Good morning. I'm  
8 Jim Naessens, a health services researcher  
9 at Mayo Clinic.

10 I've been involved with  
11 evaluating groupers including MEG and ETGs  
12 and PROMETHEUS, but haven't been involved  
13 with any development and as far as I know  
14 Mayo Clinic has not been involved in  
15 developing an episode grouper.

16 MR. MACURDY: Hi, I'm Tom  
17 Macurdy. I'm a professor of economics at  
18 Stanford University but I also serve as the  
19 senior research associate at Acumen LLC.

20 Acumen has held the evaluation  
21 contract for evaluating episode groupers for  
22 CMS since 2008. And we've had extensive

1 experience with ETG grouper, the MEG grouper  
2 and the 3M grouper.

3 Acumen also is a payment support  
4 contractor for the hospital payment system  
5 with Medicare and in that role we have  
6 developed groupers for pay-for-performance  
7 sort of schemes.

8 DR. KING: Hello, I'm Marjorie  
9 King. I'm a clinical cardiologist working  
10 at an acute rehab hospital in the  
11 metropolitan New York area, Helen Hayes  
12 Hospital affiliated with Columbia  
13 University.

14 For disclosures I was involved in  
15 the Brandeis PCPI et cetera initial product  
16 that was developed for CMS and am now in the  
17 clinical work group of the CMS episode  
18 grouper project.

19 MS. HAMMERSMITH: Okay, thank  
20 you. I'm going to call on some people who  
21 may be on the phone so that they can do  
22 their disclosures. Is Francois de Brantes

1 on the phone?

2 MR. DE BRANTES: Yes, I am. Hi,  
3 Ann. Can you hear me?

4 MS. HAMMERSMITH: Yes.

5 MR. DE BRANTES: All right. So  
6 I'm Francois de Brantes. I'm the executive  
7 director of the Healthcare Incentives  
8 Improvement Institute. And I led the  
9 development of the PROMETHEUS payment model  
10 which created as a part of that payment  
11 model a grouper tool called the Evidence-  
12 informed Case Rate Analytics.

13 I then worked with Brandeis on  
14 the development of a prototype for what we  
15 refer to as version 1 of the Medicare  
16 episode grouper. And HCI3 is also a  
17 subcontractor on the development of the  
18 current versions of the Medicare episode  
19 grouper.

20 In addition to that HCI3 has a  
21 relationship with the SAS Institute in which  
22 the SAS Institute has developed a new

1 episode system that's based on our ECR  
2 analytics called the SAS episode analytics.

3 MS. HAMMERSMITH: Okay, thank  
4 you. Is Dan Dunn on the phone? Is Jim  
5 Loiselles on the phone?

6 MR. LOISELLE: Yes, good morning,  
7 everyone. Jim Loiselles from McKesson  
8 Corporation.

9 Going down the bullets no direct  
10 involvement with developing episodic  
11 groupers. But at my work through McKesson  
12 we have in various business units we have  
13 deployed and/or implemented as OEM partners  
14 ETGs and PEGs from Optum, MEGs from Truven,  
15 PROMETHEUS tools in our payer solutions as  
16 well as I've evaluated internally for  
17 McKesson the 3M grouper as well.

18 MS. HAMMERSMITH: Okay, thank  
19 you. Thanks, everyone, for those  
20 disclosures. I just want to give you a few  
21 additional reminders.

22 The most important one is that we

1 expect you to participate in the committee's  
2 work in an open way. We expect you to  
3 listen to each other, keep an open mind.

4 We realize that you all have  
5 ideas and opinions which is part of the  
6 reason you're on the committee, but this is  
7 a group process.

8 If you are ever in a committee  
9 meeting doing work with the committee and  
10 you believe that a fellow member is biased,  
11 is unable to participate in an open and fair  
12 manner you should bring that to our  
13 attention immediately.

14 If you want to bring it up openly  
15 in the meeting you are entirely welcome to  
16 do that. You can go to your co-chairs who  
17 should then go to NQF staff, or you should  
18 go to NQF staff directly.

19 What we don't want is any  
20 committee member sitting thinking that there  
21 is bias or something improper is going on  
22 and not speaking up.

1                   So, in that spirit do you have  
2                   any questions of each other, or of me, or  
3                   anything you'd like to discuss based on the  
4                   disclosures this morning?

5                   Okay, thank you.

6                   MR. WILLIAMSON: Thanks a lot,  
7                   Ann. And we're running exactly on time.  
8                   Let's see how long that lasts.

9                   Now we'll move into setting the  
10                  stage. We have Ashlie Wilbon and Taroon  
11                  Amin.

12                 First, we'll just quickly go over  
13                 the agenda of the meeting. We just went  
14                 over the welcome, the project purpose and  
15                 the time-line. We just did the disclosures  
16                 of interest. We will now set the stage.

17                 After that we will review key  
18                 definitions. We will then review the  
19                 existing NQF resource use measure evaluation  
20                 criteria.

21                 After that we will define the key  
22                 modules for episode groupers followed by a



1 public and member comment period.

2 After that we'll have lunch. We  
3 then have breakout sessions where we will  
4 use those defined modules to really talk  
5 about how we construct and evaluate an  
6 episode grouper.

7 We'll then convene back as a full  
8 group where we'll review the work of the  
9 breakout groups, going over the principles  
10 for constructing and evaluating. After that  
11 we will adjourn.

12 We do have a dinner planned  
13 tonight that is optional but we will get a  
14 final headcount at lunch. It's located just  
15 a block away from the hotel so we hope that  
16 most of you will be able to join us.

17 MR. AMIN: Evan, before you move  
18 on if we can just go back to the slide right  
19 before lunch.

20 I just wanted to point out to the  
21 committee one of the critical things that  
22 we're going to be doing today is there's a

1 degree of flexibility in the agenda here in  
2 terms of how we define the key modules.

3 NQF staff has sort of developed a  
4 straw person for the committee to react to  
5 in terms of what the key modules are for  
6 episode groupers. And we can discuss that  
7 at further length.

8 In general terms the clinical  
9 logic, construction logic and adjustments  
10 for comparability.

11 Our goal is to ensure that those  
12 are appropriate modules and the components  
13 within those modules are appropriate. So,  
14 once we have that structure in place we'll  
15 use the breakouts to then do deep dives in  
16 each of those modules.

17 So, by no means is this setup set  
18 in stone. The purpose of the morning  
19 session is to go through those modules and  
20 ensure that we're all comfortable with that  
21 construction or at least can live with that  
22 construction and then do a deep dive later

1 on in the day.

2 So there is a high degree of  
3 variability here but we wanted to at least  
4 start with a structure and ensure that we  
5 had something to start with and then we can  
6 make some adjustments as we move forward.

7 So you may have noticed that as  
8 you reviewed your discussion guide that  
9 there's a lot -- much of the structure is  
10 already set up for you to react to. But you  
11 shouldn't feel constrained by that structure  
12 as it's set up.

13 MR. WILLIAMSON: Thank you very  
14 much, Taroon.

15 MR. DE BRANTES: Evan, this is  
16 Francois. Just a question on the breakout  
17 sessions. How is that going to work for us  
18 on the phone?

19 MR. WILLIAMSON: Yes, we will  
20 have a dial-in available. We have a speaker  
21 sub-conference that we'll pull the groups  
22 into. We have one group set for this main

1 conference room and so we'll make sure that  
2 you guys are able to participate via phone.

3 MR. DE BRANTES: Okay, thank you.

4 DR. BANDEIAN: This is Steve  
5 Bandeian. I'm sorry to raise this but I'm a  
6 little -- I mean, while I understand that  
7 there are modules I'm -- and I've read  
8 through the document so I kind of know  
9 what's there I sort of think that actually  
10 higher-level discussion prior to  
11 consideration of modules is, you know, may  
12 be worth considering.

13 And while it may well be true  
14 that almost any grouper would have these  
15 modules that somehow seems a bit more  
16 detailed than sort of the very high-level  
17 concepts of what is required for the grouper  
18 to be acceptable.

19 And so to me I appreciate all the  
20 work that's been done here, but it does seem  
21 to me that some higher-level concepts may be  
22 worth considering first.

1                   MR. AMIN: So, let me propose  
2 this in terms of how we were thinking about  
3 it. And if the committee feels strongly  
4 about that we can have some fuller  
5 discussion.

6                   So, the goal of this isn't -- of  
7 my statement wasn't to jump right into the  
8 conversation around those modules.

9                   The agenda is set up to first  
10 have some overarching considerations of how  
11 we're thinking about this space. And then  
12 that would certainly be the opportunity to  
13 have general higher-level conversation.

14                   And more importantly, there is a  
15 section right afterward which is to define  
16 the critical components of what a grouper  
17 entails. And in that period we can also  
18 talk about general constructs that seem  
19 appropriate for the group that may need to  
20 be discussed in broader detail, or from a  
21 broader context. See if that's sufficient  
22 to the group and the chairs.

1                   MR. REDFEARN: First, a  
2                   procedural. Should we use a little rule of  
3                   turning our signs sideways if we want to  
4                   talk so that the chair can recognize us?

5                   DR. CACCHIONE: Yes, I think that  
6                   would be a good idea.

7                   MR. REDFEARN: But, my comment  
8                   was that I think we're going to start  
9                   talking about definitions. And I already  
10                  have comments about the definitions. I  
11                  don't think the definition is broad enough  
12                  to encompass all the variety that's out  
13                  there. So I suspect we're going to get into  
14                  some of these issues before we drill down  
15                  just inevitably, just based on what we're  
16                  seeing.

17                  MS. WILBON: So, this is one of  
18                  our template slides that I'm sure most of  
19                  you have seen if not on the orientation a  
20                  few weeks ago. Just to kind of give a  
21                  little bit of context on NQF and the work  
22                  we've been doing and how we conduct our work

1 in terms of using multi-stakeholder groups  
2 to build consensus around different  
3 measurement, quality measurement and cost  
4 measurement topic areas.

5 And for this particular process  
6 we have named you guys an expert panel.  
7 Generally the expertise for our steering  
8 committees tend to be more multi-stakeholder  
9 and representative of our eight membership  
10 councils which include consumers, providers,  
11 health professionals and so forth.

12 Because the task of this group is  
13 much more specific and technical we have  
14 convened a group that as you can hear from  
15 the introductions around the table that  
16 there are multiple stakeholders represented,  
17 but that the people we've actually asked to  
18 participate on the committee have that very  
19 specific technical expertise.

20 But I did want to add that  
21 because we are a membership organization and  
22 we do represent a multi-stakeholder group

1 that the work of this group will be shared  
2 with our multi-stakeholder group.

3 And we would like to work with  
4 you guys in terms of the report that we put  
5 out to make sure that it is a product that  
6 can be shared with the multi-stakeholder  
7 group and that is understandable and  
8 digestible for a broader audience than just  
9 a very technical group.

10 Although we understand obviously  
11 that you guys, we're asking you to do a very  
12 technical task and the context of this  
13 meeting will be very technical. So I just  
14 wanted to kind of bring that context in as  
15 we embark on this journey.

16 MR. AMIN: Just quickly, sorry.  
17 I will also note that the work of this  
18 committee clearly impacts both our  
19 endorsement process. And we will have a  
20 discussion as well about potential  
21 implications to the Measure Applications  
22 Partnership and potential considerations for



1 applications of measures that might be  
2 coming out of episode groupers. And that  
3 will be part of our day two path forward  
4 discussion.

5 MS. WILBON: Thanks. So, a lot  
6 of these things we've talked about before.  
7 And some of these things will be covered in  
8 upcoming slides, and particularly the "why  
9 now?" so I'll kind of skip over that.

10 But historically the purpose of  
11 NQF endorsement has been to adopt standards  
12 that can be used to be compared, to make  
13 national comparisons around different  
14 quality measurement topics. Particularly in  
15 the last few years we've moved into the cost  
16 measurement space.

17 So generally endorsed measures  
18 are deemed to be kind of national standards  
19 for measuring these topics. So that theme  
20 is going to kind of carry through as we get  
21 into the criteria for episode groupers as we  
22 kind of think about whether or not that

1 concept of having a national standard or  
2 particularly having one particular method  
3 for measuring episodes in a particular way  
4 is applicable in terms of the endorsement  
5 context that we have used in the past. So  
6 we'll kind of refer back to that as we go.

7           And that also kind of encompasses  
8 the balancing the flexibility in some of the  
9 grouper methods in that many of the tools  
10 have user options that allow users to choose  
11 different methods depending on what the  
12 intended use of their analysis is. So we'll  
13 talk a little bit about that as well as we  
14 go forward.

15           Clearly there is a cost  
16 imperative that there is a need for more  
17 tools and measures to measure costs in the  
18 healthcare system. And a lot of policy  
19 implications some of which are listed here  
20 in terms of legislation around physician  
21 feedback programs, value-based payment  
22 modifier and so forth. I won't read them

1 all off.

2 MR. AMIN: Yes. And clearly this  
3 discussion broadly has implications for both  
4 commercial and public applications.

5 So that, again, we want to keep  
6 this conversation broad. It obviously has a  
7 lot of implications for various programs.

8 Chris, do you have a question?

9 MR. TOMPKINS: Yes, it's more of  
10 a state-setting question I guess as we sort  
11 of feel our place here.

12 When I think of NQF I think  
13 sometimes in terms of your mission is to  
14 uphold I'll just call them minimum  
15 standards. You probably don't call them  
16 minimum standards, but standards of  
17 acceptability.

18 And it's possible that many  
19 measures that are purporting to do the same  
20 thing or similar things can be acceptable in  
21 their own way.

22 We say we're going to do this,

1 we're going to say we're going to do it that  
2 way. And then somebody else comes along,  
3 does a measure development activity. We say  
4 we're going to do something similar but  
5 we're going to choose a different pathway.

6 In general are you trying to look  
7 for standards that are minimum which could  
8 accommodate a lot of flexibility discretion  
9 among the building of episode systems in  
10 such a way that NQF could see that several  
11 of them meet those standards because they  
12 say what they're going to do and they do  
13 what they're going to say.

14 Or, part two is sometimes I think  
15 of NQF as this best in class kind of thing.  
16 In other words, discriminating criteria that  
17 say yes, two of them are reasonably good but  
18 we are going to choose the winner.

19 So anyway, you can comment or not  
20 comment on that. Are we attempting the  
21 latter?

22 MS. WILBON: I will just say real

1 quickly and I'll just have Kristine add on.  
2 I think we're still trying to figure some of  
3 that out. And I think some of your  
4 questions may be -- the discussion on day  
5 two will help us flesh some of that out.  
6 But I'll --

7 MS. MARTIN ANDERSON: I think  
8 we're not -- definitely not at the point of  
9 trying to do a best in class here in this  
10 particular area.

11 But one thing I would offer is  
12 that there's a lot to be learned from past  
13 efforts to look at and proper ways to  
14 approach sort of methodologies. And I think  
15 the most recent one in my mind for NQF was  
16 around risk adjustment. Where in the end of  
17 the day it really turned out that it's not  
18 so much exactly how you do it, it's that how  
19 do you know if when it's done it's good.

20 So I think from that perspective  
21 I always think about us looking from the  
22 endpoint backward.

1                   And it may be that there are many  
2 different methods that can produce a good  
3 result and this committee needs to talk  
4 about that.

5                   But the question is what's a good  
6 result. And in context of how it's being  
7 used, or intended to be used.

8                   So I think if we keep ourselves  
9 at that level it will be easier to try to  
10 figure out what kind of criteria should  
11 there be that you could then say this is a  
12 good episode grouper without getting into  
13 this is how you create an episode, you know,  
14 being so prescriptive about the how.

15                   DR. BURSTIN: Yes, that was great  
16 actually, Kristine.

17                   I think the only thing I'd add to  
18 Chris' question is I think this may not be  
19 the same space as the measure space we have  
20 lived in traditionally of individual measure  
21 by measure.

22                   And I think we're open to

1 whatever emerges out of this, what is the  
2 right approach.

3 We do hear a lot from the field  
4 of people wanting to at least have some  
5 confidence that if they're using different  
6 systems the results are somehow comparable.

7 I think that's going to be  
8 something -- from an end user perspective  
9 people will want to feel comfortable that  
10 the end results of the use will not  
11 disadvantage one group or another. But  
12 again, I think that's to be told as you go  
13 through your process.

14 So I think you should assume this  
15 is a very open-ended assignment and we're  
16 really in a space we've not been in before.  
17 So we really look to your guidance.

18 MS. WILBON: This is a very busy  
19 slide, but I will just highlight a few  
20 things.

21 The purple boxes are highlighting  
22 some of the other work that we have going on

1 in the cost measurement space. We've  
2 definitely grown in terms of the type of  
3 work we've been taking on in this space over  
4 the last few years.

5 And those purple boxes are  
6 superimposed upon another kind of framework  
7 in the blue and the green boxes that kind of  
8 show how we think about kind of cost  
9 measurement in the context of efficiency and  
10 value.

11 And that cost measurement really  
12 along with quality is how you come up with  
13 your efficiency signal. And that the  
14 efficiency signal potentially with the cost  
15 and quality in combination with stakeholder  
16 preference is how you get your value, how  
17 you better understand value.

18 So, the purple boxes within the  
19 different blue boxes is kind of explaining  
20 the different parts of work and which parts  
21 of the model they're addressing.

22 So, in the value box, the big



1 value box you can see we're doing a project  
2 around measuring affordability for  
3 consumers.

4 That's a piece of work that is  
5 sponsored by the Robert Wood Johnson  
6 Foundation and it's really focused on kind  
7 of understanding what types of measures and  
8 measurement concepts are important to  
9 consumers in understanding affordability and  
10 how they can make decisions about purchasing  
11 and engaging with the healthcare system.

12 There's another effort just under  
13 that in the linking cost and quality project  
14 also sponsored by Robert Wood Johnson  
15 Foundation in which we're producing a white  
16 paper that will discuss some of the  
17 methodological challenges around combining  
18 costs and quality signals to get an  
19 efficiency signal, what that looks like, the  
20 different approaches that there may be to  
21 get to an efficiency signal. And we're  
22 convening an expert panel to discuss those

1 issues as well.

2 And then the episode grouper work  
3 we have in the resource use space as well as  
4 a parallel effort we have with the standing  
5 committee for cost and resource use  
6 measurement in which they are using the  
7 consensus development process to evaluate  
8 cost and resource use measures.

9 So, our current effort, we're  
10 reviewing three cardiovascular measures for  
11 cost and resource use and that is ongoing.

12 We also have an ongoing effort  
13 through our Measure Applications Partnership  
14 in which there is a subset of one of the MAP  
15 committees that has been developed to  
16 address, to discuss affordability and  
17 develop an affordability family of measures,  
18 and kind of think about some of the high-  
19 leverage opportunities there are to identify  
20 measures and measure costs at the system  
21 level.

22 So, that's kind of some of the

1 work we're discussing. You can kind of see  
2 how it's somewhat connected in the context  
3 of what we're doing here today.

4 MR. AMIN: I'll just reiterate on  
5 that, our conceptual framework that we've  
6 been working with at NQF is that in order to  
7 really understand efficiency you need to  
8 look at costs in relationship to quality.

9 And really what differentiates  
10 value is taking into account preferences of  
11 various different stakeholders. So our goal  
12 is to try to move toward measures and  
13 measurement of efficiency which really  
14 includes both signals, to be able to really  
15 understand the efficiency of providers and  
16 the health system broadly.

17 So again, this work fits in the  
18 context of broader work that some members of  
19 the committee are very familiar with as  
20 being part of the Cost and Resource Use  
21 Standing Committee that is essentially  
22 overseeing the body of this work.

1                   So, the current landscape for  
2 groupers. Again, we have -- many of you in  
3 the room are obviously very familiar with  
4 them. But for those of you that are not  
5 episode groupers have, you know, this is an  
6 established space in some ways and new in  
7 some ways.

8                   There's been established players  
9 in the episode grouper market from many  
10 established people including Optum Insight,  
11 former or still part of I think United  
12 Healthcare, and various different other  
13 products that are in the market for the  
14 commercial population that have been used  
15 for commercial, potentially profiling, for  
16 provider profiling and potentially for pay-  
17 for-performance applications.

18                   There has been increasingly new  
19 work that has been in play for an episode  
20 grouper for the Medicare population which  
21 Tom and Chris obviously are very familiar  
22 with and others in the room as well clearly.

1                   And so there's various different  
2 tools. And a lot of what we heard is that  
3 it clearly varies by region. There is not  
4 one national standard.

5                   And there is a concern -- and  
6 there are various concerns about episode  
7 groupers that we've heard from our  
8 stakeholders. And we will explore these  
9 challenges during the course of these two  
10 days.

11                   The first which is not an  
12 insignificant challenge is the complexity of  
13 the groupers makes it very difficult to do  
14 an evaluation of them and to understand what  
15 the cost implication on the other end when  
16 you're being profiled, what you're actually  
17 being profiled for.

18                   The transparency of these  
19 groupers varies. Understanding how decision  
20 logic or how individual claims are being  
21 assigned to various different episodes, how  
22 various episodes relate to one another.

1 There is a varying degree of transparency in  
2 the market.

3 Part of what this initiative is  
4 intending to do is to create increased  
5 transparency or expectations for increased  
6 transparency for products that are in the  
7 market both for consumers and purchasers,  
8 clearly, and also for providers who are  
9 being profiled using these products going  
10 forward.

11 There's obviously a lot of  
12 challenges for providers who are being  
13 profiled using multiple different grouper  
14 systems and are being given different  
15 information, different results. And  
16 different methodologies causes a lot of  
17 challenges in terms of being able to  
18 understand how to improve.

19 We also recognize and we're  
20 obviously not walking into this blindly that  
21 this effort has clear market implications  
22 where the efforts of many different

1 commercial products that are in the market.

2 And also there are various  
3 different proprietary components of these  
4 groupers that should not be underestimated.

5 Again, the goal of NQF's effort  
6 in this space is to move toward national  
7 standards of how to measure cost and  
8 resource use using episode groupers as one  
9 potential approach, and to keep transparency  
10 at the forefront of that effort.

11 And so NQF's role in the  
12 evaluation of groupers is very new. We are  
13 in, in a lot of ways, uncharted territory  
14 for NQF. And so we will be asking a number  
15 of series of path-forward questions around  
16 can episode groupers be evaluated in  
17 isolation of their -- can they be evaluated  
18 just in terms of their output, meaning the  
19 episode grouper measures as in the way that  
20 they're slated to be used for the Physician  
21 Feedback Reporting Program and potentially  
22 other value-based purchasing applications.

1                   Or can they be looked at in -- or  
2                   should they be looked at in totality,  
3                   meaning the episode grouper, all of its  
4                   components and its output.

5                   So, this is a very new space for  
6                   NQF. Again, we're looking for some  
7                   guidance. And the guidance here will be  
8                   translated to other governing bodies of NQF  
9                   that will evaluate the recommendations of  
10                  this expert panel. And those will mainly be  
11                  our Consensus Standards Approval Committee  
12                  and the board who will both be looking at  
13                  the recommendations of this committee in  
14                  terms of what NQF's future role will be in  
15                  the actual evaluation of groupers going  
16                  forward.

17                  That seemed to have initiated a  
18                  lot of comments so I'll turn it to the  
19                  chairs to manage that.

20                  DR. CACCHIONE: Steven, you had a  
21                  question or a comment?

22                  DR. BANDEIAN: On the previous



1 slide where you have the different boxes and  
2 the different colors the point that I'd make  
3 is that if one is talking about sort of cost  
4 of care or efficiency one might want to  
5 think about going back and looking at the  
6 existing types of things that you've been  
7 looking at and approving.

8           Because all cost and efficiency  
9 measures are really part of a more  
10 comprehensive picture of care. So one could  
11 look at, you know, an emergency room visit,  
12 what the cost of that is. But if you didn't  
13 consider what happened to the patient after  
14 they leave the emergency room you may not  
15 have a very good understanding of what the  
16 implications were of that care in the  
17 emergency room.

18           So what I'm trying to say is I  
19 suspect that this episode discussion may  
20 well ultimately move to looking at the whole  
21 range of cost measures because there is a  
22 lot of interconnectedness between the

1 different ways of looking at costs.

2 And so it may be that there will  
3 be implications of this episode work that  
4 feed back to how you've been thinking about  
5 cost of care measures in other contexts.

6 Even for the consumer, by the  
7 way. Because when the consumer has a knee  
8 problem and is thinking about going to Dr.  
9 Jones or Dr. Smith ultimately what's  
10 important is what the total cost to the  
11 consumer will be, likely, from beginning to  
12 end which is almost an episode type of  
13 concept.

14 So, all I'm trying to say is if  
15 one sort of goes up to an abstract level and  
16 thinks about how do we measure efficiency  
17 broadly, cost and quality, I think you'll  
18 find that all of these areas have a lot of  
19 interconnectedness. And it may be  
20 worthwhile to try to puzzle that out. At  
21 some point in the longer term.

22 DR. CACCHIONE: The episodes tend

1 to be somewhat arbitrary in terms of their  
2 time constraints or the constraints that are  
3 put on them by how we do that.

4 Mark, you were next I think.

5 DR. LEVINE: Yes, just the  
6 observation that on the following slide when  
7 you talk about the current uses of groupers,  
8 that really is just a population and  
9 geographic look at uses.

10 But I wonder whether or not we  
11 would be wise to consider the use case for  
12 groupers in general.

13 What are the use cases that we  
14 have? And what are their purposes? A  
15 grouper that is good at one use case might  
16 not be applicable in another use case.

17 And I suspect that we're going to  
18 need to evolve different standards and  
19 different approaches for looking at  
20 different use cases of groupers. So I  
21 welcome discussion about use case.

22 MS. MARTIN ANDERSON: Yes, that

1 is on the agenda.

2 MR. TOMPKINS: I think I just had  
3 a quick clarifying question. Under  
4 "Challenges" the first two bullets are  
5 complexity and transparency. So if you  
6 understand that complexity is a challenge  
7 then you move on to the next bullet,  
8 transparency.

9 Does that mean that the methods  
10 that are used in the grouper are disclosed?  
11 Or does it mean that, for example, that they  
12 are proprietary and undisclosed? In other  
13 words, are these two separate bullets?

14 You can have a complex system  
15 that is fully disclosed in which maybe some  
16 people understand it and some people don't,  
17 versus you could have a system of any  
18 complexity that isn't disclosed and it  
19 becomes literally kind of a black box.

20 MS. MARTIN ANDERSON: One of the  
21 elements that's come up often in NQF review  
22 of measures is could somebody repeat the

1 results on their own. So there's a level of  
2 typically that would be required.

3 Now, if they could handle the  
4 complexity is a whole nother issue. Could  
5 they do it, right? But is it transparent  
6 enough that someone could recreate the  
7 results for themselves.

8 And assuming they have the  
9 capability with the complexity which  
10 oftentimes people do not, and/or the access  
11 to the data that would allow them to do it  
12 which oftentimes they do not. So I think  
13 they're two very separate things, but  
14 important.

15 MR. HOPKINS: So, just to extend  
16 that issue a little bit more.

17 So, episode groupers are by  
18 nature very complex. They are difficult to  
19 understand. By busy physicians, certainly  
20 by lay consumers.

21 So often when I have heard people  
22 raise issues around transparency what

1 they're really saying is, you know, I don't  
2 have time to look at it, it's too  
3 complicated. It's really about complexity.

4 I haven't met an episode grouper  
5 yet that one can't delve down into the  
6 deepest part of it and look at codes if you  
7 want to do that.

8 So, I haven't seen that  
9 transparency is an issue. But maybe I'm  
10 missing something.

11 MR. LOISELLE: This is Jim  
12 Loiselle. May I interject?

13 Yes, I think the distinction, and  
14 I think the previous commenter made that  
15 point, is that the greater variation comes  
16 in how you apply the episode, whether it's  
17 for a payment purpose, an initiative  
18 purpose, or an analytical purpose, or an  
19 efficiency purpose. The outcomes are very  
20 variable even on the same grouped  
21 information.

22 So I think that looking at the

1 use case question about how you use this  
2 information is really a much wider and  
3 broader discussion than actually the  
4 evaluation or the creation of the episodes  
5 themselves.

6 MS. MARTIN ANDERSON: Thank you.

7 DR. LEVINE: I was just going to  
8 suggest that perhaps the issue is really not  
9 complexity or transparency but  
10 understandability, that it must be committed  
11 to the user in a way that they understand  
12 what's going on and can therefore interpret  
13 the results.

14 MS. MARTIN ANDERSON: Let's have  
15 this conversation -- that's a great point  
16 and let's have that conversation when we  
17 talk about the applicability of the NQF  
18 endorsement criteria because I think that  
19 comes up, that usability element comes up  
20 very clearly, as do some of these issues  
21 around transparency.

22 DR. BANDEIAN: Just briefly. So,

1 why are complexity and transparency  
2 important? That also then relates to the  
3 use case.

4 But part of the use case is also  
5 what do we want people to do with this. And  
6 so if we want doctors to trust and feel  
7 comfortable to be able to use the  
8 information to improve the care that they're  
9 providing that I think has -- if one says  
10 that, that statement has a whole series of  
11 logical consequences that I think are --  
12 what I would argue would be the principal  
13 things that this committee should define as  
14 criteria.

15 What needs to be in a grouper so  
16 that the medical community looks at this and  
17 says we trust it, we're comfortable with it,  
18 we think it's fair, but even more than that  
19 it's providing us information that we can  
20 use to do a better job.

21 And if we can then say what is  
22 logically required so that physicians across



1 the country feel that this is something that  
2 they can trust and use to transform the care  
3 that they provide, those logical  
4 requirements I think would go a long way to  
5 what you want to specify.

6 MR. DE BRANTES: Evan, this is  
7 Francois. Unfortunately I don't have a  
8 table tent that I can raise so I don't know  
9 if I'm -- so I'm raising my hand, but if I'm  
10 not in order --

11 MR. WILLIAMSON: That's fine.  
12 Whenever you want to talk just go ahead and  
13 speak up.

14 MR. DE BRANTES: All right, thank  
15 you. So, my concern about these comments is  
16 that it seems to me that we're veering from  
17 a task which to me seems to be pretty clear,  
18 and that is establishing some criteria that  
19 others can use, i.e., other committees in  
20 NQF ultimately will use to evaluate a  
21 grouper as opposed to establishing criteria  
22 that prejudge groupers.

1                   And I think this is an important  
2                   and dangerous line that we shouldn't cross.

3                   So in other words, criteria to  
4                   evaluate a measure should include things  
5                   such as, and it's on the list, reliability  
6                   and validity testing and so on and so forth.

7                   Then the burden is on the  
8                   developer of the grouper to demonstrate that  
9                   they have and they can meet those criteria  
10                  of validity and usability and so on and so  
11                  forth.

12                  Some of these issues such as  
13                  transparency and understandability by  
14                  physician, I mean that's fine. But you  
15                  know, to a large extent it's irrelevant.

16                  And I'll tell you why it's  
17                  irrelevant from my perspective which is if  
18                  someone wants to develop a grouper that they  
19                  feel is valid and that a committee might  
20                  feel is valid but is completely not  
21                  understandable by the field, it will  
22                  essentially fail.

1                   Now, then it's NQF's decision as  
2                   to whether or not it wants to spend time  
3                   reviewing those types of submissions. But  
4                   I'm not sure that we should stand in  
5                   prejudgment of the submission of potential  
6                   developers of groupers.

7                   MS. MARTIN ANDERSON: Thank you,  
8                   Francois. And I think we are going to get  
9                   deep into this conversation when we talk  
10                  about what the endorsement criteria should  
11                  be. And so thanks for offering that and to  
12                  Steve, and to Mark, and to David, and I  
13                  think we'll be getting deep into that.

14                  I think we want to dive into now  
15                  the definitions of a grouper because I think  
16                  we have plenty of debate to have around that  
17                  too. That's where we'll attack the use case  
18                  issue, for what purpose are you developing  
19                  the grouper.

20                  So, Taroon?

21                  MR. AMIN: Yes, I think actually  
22                  Evan is going to lead that section. Evan,

1 take it away.

2 MR. WILLIAMSON: Great. At this  
3 point we'll be starting with the key  
4 definitions of episode groupers to make sure  
5 that we are all speaking the same language  
6 and have a general agreement on the  
7 definition.

8 So these are a straw man. These  
9 are provided for talking points. So we will  
10 pull them up here. We have these five  
11 discussions. The full discussions are  
12 listed in the discussion guide on page 3.  
13 So, we are asking key questions about these  
14 definitions.

15 So the first question we want to  
16 go through is describing the purpose and  
17 function of an episode grouper. And so we  
18 have two definitions here laid out that will  
19 help us get to that and where we have a  
20 definition of an episode and then definition  
21 of an episode grouper.

22 So, as far as the episode we have

1 an episode of care is defined as a series of  
2 temporally contiguous healthcare services  
3 related to the treatment of a given spell of  
4 illness or that is provided in response to a  
5 specific request by the patient or other  
6 relevant entity.

7 Do we have comments on the  
8 episode definition?

9 DR. CACCHIONE: One thing that I  
10 would say here is that the episode is not  
11 just related to the treatment but also to  
12 the condition itself.

13 I mean, I think that  
14 comorbidities that confound an illness are  
15 very important in terms of the providers.  
16 So it's not just related to the treatment  
17 arm. David?

18 MR. REDFEARN: There is sort of  
19 an implication here that an episode is sort  
20 of a clinically homogenous set of  
21 complaints. It's sort of driven off of the  
22 diagnosis. And a patient that has multiple

1 diseases is going to have multiple episodes.

2 First, there are groupers that  
3 are driven by procedures. For example, the  
4 Optum PEG Procedure Episode Grouper. So  
5 what triggers the episode is a procedure  
6 being performed.

7 And that may be fairly homogenous  
8 with regard to the underlying condition but  
9 not necessarily. You can do the same  
10 procedure for multiple underlying  
11 conditions. So you have to expand it a  
12 little bit to take into consideration when  
13 procedures drive the groupers because  
14 they're out there, they're being used.

15 The other is something I ran into  
16 in terms of looking at the new 3M patient-  
17 focused episode model in which there is only  
18 one episode active at a time for a member.

19 So what happens when you have a  
20 member that has multiple comorbidities?  
21 They're all in the same episode. They're  
22 all lumped together.

1                   And 3M argues that that avoids  
2                   the difficulty of parsing the utilization  
3                   out by disease when a patient has multiple  
4                   diseases. And we all know there's lots of  
5                   work that's been done to show, for example,  
6                   ETGs and MEGs carve things up differently  
7                   when you do that. So basically we're just  
8                   going to avoid it, we think that's too hard  
9                   to do, and lump it together.

10                   So it's not necessarily driven by  
11                   diagnosis and it's not separate by  
12                   underlying diagnosis codes. So I think we  
13                   need to expand the definition a little bit.

14                   MS. SIMON: As the pediatrician  
15                   in the room I just want to point out that I  
16                   agree with your statements. And with  
17                   children, particularly with children we have  
18                   acute episodes of illness for the vast  
19                   majority of healthy children that are out  
20                   there.

21                   And then we have these incredibly  
22                   complex children who are born with chronic

1 conditions and continue to have chronic  
2 conditions. So when I read about episode of  
3 care I really struggled with acute versus  
4 chronic conditions, and really understanding  
5 how long an episode of care might last for a  
6 chronically ill child.

7 MR. JONES: That's the exact  
8 point I was going to make, building on what  
9 David said. In that one challenge that I've  
10 always found and quite frankly the reason  
11 that we stopped using some of these tools  
12 was how do you really put bookends around  
13 something that has no clean period.

14 So, I almost would argue that it  
15 should not be considered an episode.

16 MS. GARRETT: I was going to talk  
17 about chronic conditions as well. And they  
18 just don't fit very well here and I don't  
19 think we can leave them out. So I'm not  
20 sure what the answer is, but I don't feel  
21 that the treatment of a given spell of  
22 illness is broad enough for what we're doing



1 here.

2 MR. MACURDY: I guess I think the  
3 definition is broad enough. Because in the  
4 cases of multiple comorbidities which come  
5 up a lot in Medicare you can, I mean the  
6 illness is kind of the comorbidities  
7 themselves and the combination.

8 I understand that you get a lot  
9 of combinations of illness as a consequence  
10 but that's actually the way a lot of the  
11 risk adjustment models work. And then the  
12 issue becomes, well how do you have not too  
13 many kind of conditions or episode kind of  
14 constructions. But I think the definition  
15 is broad enough.

16 And the issue on chronic care,  
17 that's true it's not a well-defined period.  
18 But this doesn't necessarily have a  
19 definition of a well-defined period. It can  
20 be over an extended period of time. You  
21 have an illness and there's a particular  
22 kind of sequence of care you're going to

1 have. So, I don't think you have to modify  
2 the definition accordingly.

3 DR. CACCHIONE: I think there's  
4 some -- or there's anchoring in all of our  
5 heads when we think about episodes around  
6 time constraint.

7 And you know, I think that to  
8 somebody's point earlier we may have to  
9 think about this thing more broadly and  
10 think about things differently. Because we  
11 all have this preconceived notion about an  
12 episode being anchored in time. And I think  
13 that that might not be the case when we walk  
14 out of this room.

15 MS. MARTIN ANDERSON: One thing  
16 to ask is do you all -- I'm hearing various  
17 levels of support for even including the  
18 words "of care" right? So, an episode of  
19 care. And is it just treatment, or is it  
20 also natural progression of disease, or a  
21 period of time that a disease exists.

22 Because this and the next

1 definition both are anchored in how the care  
2 is provided which I think is the signal we  
3 see through the data. But are you all in  
4 support that we're looking at episodes of  
5 care? Or episodes of illness? What is the  
6 feel of the group there? Dave?

7 DR. LEVINE: I think it goes back  
8 again to use case in the sense that if  
9 you're looking at an episode of care for  
10 hypertension or diabetes your use case may  
11 require looking at it over 20, 30, 40 years  
12 in order to -- if what you're looking at,  
13 what your endpoint is trying to get to is  
14 how does care influence the outcomes of the  
15 disease.

16 So, it needs to be very flexible  
17 I think at this level of definition of what  
18 is an episode. And then as you get into a  
19 particular use case each use case may be  
20 defining what it means by an episode in a  
21 much more flexible way.

22 So I think we're going to need to

1 wind up eventually looking at a whole set of  
2 criteria for different use cases. But in  
3 the overall way I think the definition as  
4 presented is appropriate.

5 MR. BODYCOMBE: When I looked at  
6 this I thought what happens between  
7 episodes. And you know, there are episodes  
8 of management, there are episodes of  
9 prevention.

10 And in fact, I would argue that  
11 an episode of care is in a sense a  
12 performance measure of a poor job at  
13 management or prevention. It's a failure.

14 So you could actually use it as  
15 an outcome measure. You shouldn't be having  
16 an episode of care if you have a well-  
17 managed patient.

18 DR. BANDEIAN: Episode of care, I  
19 read this definition and I was kind of okay  
20 with it.

21 But to have a complete picture of  
22 the consequences of the care that is

1 provided for a particular condition one may  
2 need to look at other conditions so to  
3 speak.

4 So, for example, a person has a  
5 hip fracture and it's treated and the  
6 patient is discharged. And a few weeks  
7 later the person develops a pulmonary  
8 embolism or deep venous thrombosis.

9 Well, that's sort of itself an  
10 episode, you know, the treatment of the deep  
11 venous thrombosis or the pulmonary embolism.

12 But if it were the case that that  
13 was caused in effect by the care or lack  
14 thereof during the hip fracture care somehow  
15 one needs to take those two things into  
16 account.

17 Because if one only looks at the  
18 care or the surgery and not some of the  
19 consequences of the care or the surgery that  
20 may create new condition episodes one may be  
21 having an incomplete picture.

22 So, I'm okay with the concept of

1 episode of care more or less with how it's  
2 defined and also including treatment  
3 episodes, surgical episodes, et cetera.

4 But that's not necessarily the  
5 unit of analysis on which one makes  
6 judgments as to whether what was being  
7 provided is the most efficient or the best  
8 possible. One needs to look at the  
9 interconnectedness of these things.

10 DR. CACCHIONE: Do you think that  
11 when you use the term related to the  
12 treatment -- so, a pulmonary embolism that  
13 occurs after a hip replacement is thought to  
14 be causal and related because of some --  
15 whether it be some comorbidity.

16 So, is it covered in the  
17 definition by saying health services related  
18 to the treatment of a given -- does that  
19 suffice for the definition?

20 DR. BANDEIAN: It may well be  
21 that one can do something of that sort to  
22 tweak it. Yes, it may well be.

1                   But I guess what I'm trying to  
2                   say is there are, you know, a clinical  
3                   entity may give rise to complications which  
4                   are also clinical entities. And to have a  
5                   complete picture one may need to make  
6                   connections between episodes.

7                   So one might say what are the  
8                   costs of the condition plus the cost of  
9                   complications which are fairly attributed to  
10                  the base episode.

11                  MS. MARTIN ANDERSON: We're going  
12                  to take these -- did you have another  
13                  question? These questions that are here, or  
14                  these comments that are here.

15                  But then I think I'm being  
16                  persuaded to Mark's argument that we better  
17                  talk about purposes and function. Because I  
18                  think it's going to be hard to agree on a  
19                  definition if we don't understand the  
20                  breadth of purposes and functions in this  
21                  room. So let me just --

22                  MR. DE BRANTES: This is

1 Francois. I just, you know, sometimes it's  
2 good to go back to the origin of the  
3 concepts because the concept of an episode  
4 of medical care was developed -- was at  
5 least written about in March 1967 by Dr.  
6 Jerry Solon.

7           And his definition of an episode  
8 of medical care is as follows. An episode  
9 of medical care is a block of one or more  
10 medical services received by an individual  
11 during a period of relatively continuous  
12 contact with one or more providers of  
13 service in relation to a particular medical  
14 problem or situation.

15           And since then pretty much  
16 everyone has built groupers around that  
17 definition.

18           Now, the relationship of one  
19 episode to another episode, and how someone  
20 might construct it, and link a complication  
21 to a core episode and so on and so forth,  
22 those are design definitions for those who



1 will submit the episode groupers. And at  
2 some point they'll have to justify why they  
3 made those decisions.

4 Here we're talking about a base  
5 definition of what is an episode. And I  
6 would submit that we go back and use Jerry  
7 Solon's.

8 MS. MARTIN ANDERSON: Thank you,  
9 Francois, that's a good suggestion. That  
10 sounds like a good definition. Jelani?

11 MR. MCLEAN: I'm okay with the  
12 concept of episode of care, but I do go back  
13 to Mark's point about the use case. And you  
14 know, and to Jim's point about constraints  
15 around time.

16 When you work with groupers a lot  
17 you find out that either the time frame for  
18 the standard software is too long or it's  
19 too short.

20 I would argue that the key thing  
21 that's just really missing here is an  
22 episode is either designed to -- or an

1 episode is either an objective to get to a  
2 certain point of care, so a certain state  
3 for the patient, or a certain time of care  
4 based on some time constraint. But it's not  
5 really just time. It could be the  
6 alternative of I'm trying to achieve a  
7 certain state for a given patient. I think  
8 that's the one pressing thing that's missing  
9 in the definition.

10 MR. REDFEARN: Maybe I'm getting  
11 down -- I have a tendency to get down to a  
12 practical level real quickly. And I don't  
13 mean to disrupt things.

14 Going back to the acute versus  
15 chronic things, when you're actually using  
16 these things you have to deal with chronic  
17 episodes.

18 And I think what we need to ask  
19 the groupers is that they produce data with  
20 enough flexibility so that based on your use  
21 case you can do what you need to do with  
22 them based on your practical considerations

1 and what you're trying to do.

2 Typically at WellPoint we run 2  
3 years of data with 3 months of run-out.  
4 That's our production. But we're running it  
5 on 35 million members.

6 Now, we would like to go out to 3  
7 years but there are technical constraints in  
8 doing that.

9 And then from a practical point  
10 of view, and we deal with chronic -- what  
11 the grouper defines, the ETG grouper defines  
12 as a chronic episode, we chop them up,  
13 analyze them. That's generally the default  
14 way we do it.

15 But there is flexibility in the  
16 grouper that you could say I want to look at  
17 2 years at a time. Or maybe if we could run  
18 3 years of data we want to look at 3 years  
19 of data or something. So you have to have  
20 that flexibility and it's based I think on  
21 the use case.

22 DR. KING: And I was just going

1 to comment on hospice care, end of life  
2 care. I'm just concerned that this  
3 definition we have here is a little bit too  
4 narrow.

5 I really like that historical  
6 definition a lot better. I think it covers  
7 a lot more.

8 MS. MARTIN ANDERSON: Let's jump  
9 into the -- thank you, that was all great  
10 input. And one thing I've learned is that  
11 the NQF staff is really good at taking that  
12 input and then giving us something else to  
13 react to.

14 So we're not going to try to  
15 write the definition here, although  
16 Francois, I would invite you to send in the  
17 one that you offered on the telephone to the  
18 NQF staff so they can also take a look at  
19 that and bring that back to us.

20 MR. DE BRANTES: On its way.

21 MS. MARTIN ANDERSON: Let's jump  
22 into this first question on the purpose and

1 function of an episode grouper. For those  
2 on the phone we're looking at slide 20.  
3 Mark?

4 DR. LEVINE: You do it in the  
5 singular. Is there a purpose and a  
6 function.

7 MS. MARTIN ANDERSON: Purposes  
8 and functions, yes.

9 DR. LEVINE: I guess the real  
10 question is how many purposes and how many  
11 functions.

12 MS. MARTIN ANDERSON: Let's  
13 figure out what this group at least thinks  
14 the range is.

15 MR. REDFEARN: I have one at  
16 least to add. One of the things that I have  
17 done and we had done for some of the ACO and  
18 patient-centered medical home pilots that  
19 we've been working on, we have used episode  
20 of care models in which you assign a  
21 physician to the episode to link patients to  
22 the physicians.

1                   Rather than using the Dartmouth  
2 method of just sort of counting PCP direct  
3 interventions, we actually put them all  
4 around and said well, what episodes are  
5 being managed for that patient, what  
6 physicians are managing those episodes, and  
7 then linking the patient back to a physician  
8 so that you can assign the patient to the  
9 physician and the ACO. So that's one thing  
10 that's not mentioned here.

11                   We didn't get very far with the  
12 methodology. Everybody's kind of gone back  
13 to the Dartmouth methodology because that's  
14 the default, but I think that's a very  
15 interesting and possibly productive use of  
16 the groupers.

17                   DR. CACCHIONE: Attribution. So  
18 you say you didn't get very far using it as  
19 an attribution tool?

20                   MR. REDFEARN: Well, we actually  
21 did it in California and got about a year  
22 into it until the company decided that no,

1 we're going to go with the default  
2 methodology of Dartmouth.

3           Interestingly the medical groups  
4 we were dealing with in California which was  
5 Healthcare Partners and Monarch, very, very  
6 large medical group, so large that they're  
7 almost like insurance companies, didn't have  
8 a problem with the methodology.

9           In fact, they kind of liked it  
10 because they thought it did a better job of  
11 actually identifying what physicians are  
12 actually managing the care for the patients.  
13 Because they didn't want to have people mis-  
14 assigned, thrown into the group that they  
15 have to figure out how to deal with. They  
16 wanted to know who was actually seeing their  
17 physicians already in the medical group. So  
18 they were very happy with it.

19           But our network folks kind of  
20 said well, that's not the way the industry  
21 is going so we're going to default back to  
22 the Dartmouth methodology of just looking at

1 the PCPs which I had a lot of problem with.  
2 I didn't really like that methodology. I  
3 think it was over-simplistic.

4 So it's these operational things  
5 that happen that kind of go in a different  
6 direction. But I think the method worked  
7 fine.

8 DR. BANDEIAN: Episode is  
9 something that we're sort of focusing in on  
10 as sort of the starting point.

11 I think actually episodes are a  
12 means to an end. They are not an end of  
13 themselves.

14 What I mean by that is the  
15 purpose of all of this is to try to  
16 accurately understand the efficiency of  
17 care.

18 So, for example, if one just uses  
19 a hospital admission as a unit of analysis  
20 and does not take into account what happens  
21 after the hospital discharge one might have  
22 a misleading impression as to the efficiency



1 of the care. I mean, if the patient is  
2 rehospitalized 3 days later or what have  
3 you.

4 So, the reason why episodes are a  
5 useful approach is because care is often  
6 provided over a period of time. And to have  
7 a complete picture of the care one has to  
8 look over a period of time and link things  
9 together.

10 So, to me the -- I mean, maybe  
11 not the very top-level principle, but the  
12 second to the top level would be to have a  
13 valid basis for comparing resource use. And  
14 that's what we're trying to accomplish.

15 It's not necessarily -- and  
16 episodes are a means to that end. But the  
17 goal I should imagine is not to have a  
18 perfect episode grouper, but rather to have  
19 a valid measurement of resource use and  
20 episodes are a means to that end I would  
21 submit.

22 MR. LOISELLE: And this is Jim

1 Loiselle. Just to add to that.

2 From all of these definitions I  
3 think the important concept that needs to be  
4 built in is the concept of variation, is  
5 whether it's warranted or unwarranted.  
6 That's really what you're using these for at  
7 some level. That term "variation" needs to  
8 be built into these definitions.

9 DR. LEVINE: While variation and  
10 efficiency of care are important attributes  
11 and outcomes of groupers that doesn't  
12 address what is the purpose.

13 The purpose of the grouper, you  
14 know, there are basically two things. One  
15 is judging providers and helping to score  
16 their efficiency and use it for tiering, or  
17 for value-based purchasing, or for  
18 improvement purposes, or whatever have you.

19 Another is these are also applied  
20 for populations of patients for purposes of  
21 bundling and payment and other things.

22 And perhaps in David's use case

1 where you have different people in the same  
2 company some of whom thought it was good and  
3 others who didn't, maybe they were looking  
4 at it from different purposes. Looking at  
5 perhaps even the same attributes of  
6 variation efficiency, you know, capture, et  
7 cetera.

8 So I wonder whether or not we  
9 wouldn't be wise just to continue the  
10 discussion about what are the use cases.  
11 What are people using groupers for? What is  
12 their intent? What are people hoping to get  
13 from the output of groupers?

14 MR. DE BRANTES: This is  
15 Francois. To Mark's point, in addition to  
16 broadly speaking network management, network  
17 design which includes efficiency  
18 measurement, and tiering, and so on and so  
19 forth, and payment there's a third use that  
20 I can think of which is calculating the  
21 price of an episode for public transparency  
22 purposes. And that's a function that's

1 being increasingly done in states around the  
2 country in response to the lack of  
3 transparency on price information.

4 DR. CACCHIONE: We have used it  
5 for standardization of care as well, and for  
6 quality purposes. Using -- understanding  
7 what's in an episode and understanding that  
8 variability to the point earlier,  
9 understanding that variability to help  
10 reduce that variability and used to  
11 prescribe care paths and things like that.  
12 So, I think there is a quality purpose to  
13 these as well.

14 DR. BANDEIAN: Following up on  
15 Mark's comment and also I think what I heard  
16 Francois say.

17 I think the two basic use cases  
18 are measurement on the one hand of  
19 efficiency or at least the cost of the care  
20 of a particular set of clinical problems,  
21 and the other use case would be a bundle  
22 payment. Maybe there's a third or fourth,

1 but to me those are the two principal use  
2 cases that I'm aware of. One is a  
3 measurement purpose and the other is a pre-  
4 payment purpose or definition of a payment.

5 MS. MARTIN ANDERSON: I think  
6 we've heard four use cases so far, at least  
7 articulated. And we can see if there are  
8 more to add to the list.

9 One, the most frequently cited so  
10 far is a measurement of resource use, or  
11 comparison of clinicians around resource  
12 use, or something that's around that to that  
13 effect.

14 There's been an example of not  
15 just resource use but quality, right? Is  
16 this series of treatments effective in the  
17 quality of care which, Joe, is I think what  
18 you were getting at.

19 We've also heard that payment,  
20 right, a mechanism to bundle payment.

21 And then I think a fourth one  
22 that is always important to keep in mind is

1 that it's being also used operationally  
2 within in this example health plans to try  
3 to tackle other operational challenges like  
4 attribution.

5 And I'm sure there are perhaps if  
6 we had a broader stakeholder group there  
7 would be other examples of operational uses  
8 where it's a convenient way to solve a  
9 problem that's related to -- and it's not a  
10 problem that can be solved with looking at a  
11 single incident or a single form of care.  
12 David?

13 MR. HOPKINS: I think you missed  
14 Francois' suggestion which is actually a  
15 very good one.

16 More and more we're talking about  
17 price transparency these days. And very  
18 seldom do I hear people notice that what  
19 really matters to the consumer who's got  
20 skin in the game now is what's it going to  
21 cost me to go through in fact an episode of  
22 care.

1                   Rather, we talk about oh, the  
2                   hospital is going to cost you this, and the  
3                   pathologist will charge that. That's not  
4                   the answer the consumer is looking for.  
5                   It's got to be built around episode.

6                   MS. MARTIN ANDERSON: Right, the  
7                   consumer-driven one.

8                   MR. MACURDY: A classification  
9                   that commonly gets used is whether an  
10                  episode is patient-centric or provider-  
11                  centric which I actually think is a good  
12                  categorization to use to kind of organize  
13                  these uses.

14                  MS. MARTIN ANDERSON: And Tom,  
15                  does that map to specific use cases as well?  
16                  I mean, I can map them in my head, but are  
17                  there other use cases that we're missing in  
18                  either the patient-centric or the, those of  
19                  you that are providers, a provider-centric  
20                  view of what's valuable in getting an  
21                  episode?

22                  MR. MACURDY: I think between the

1     notion of a patient-centric and provider-  
2     centric almost everything goes under those  
3     classifications because in any case you're  
4     doing it from the perspective of providers  
5     in terms of the care they're providing. And  
6     you can do cost, you know, resource use,  
7     quality, et cetera.

8                     And then the other one is from  
9     the patient perspective which would hit  
10    David's point on cost transparency. But  
11    it's kind of then reorganized from the  
12    patient's perspective irrespective of what  
13    provider they're getting, what is the kind  
14    of sequence of care, cost of care, quality  
15    of care, et cetera. So I think almost  
16    everything can be categorized under those  
17    two categories.

18                    I mean, everything you mentioned  
19    are uses but there was large overlap in what  
20    you discussed.

21                    DR. LEVINE: I just wanted to add  
22    a nuance to the efficiency use because I



1 think there's two things that -- there's two  
2 different use cases.

3 One is actual use of resources in  
4 which case you did want some kind of  
5 standardized pricing methodology for that so  
6 you could compare physicians or health  
7 systems equitably.

8 And the other one is use of  
9 different priced services. So, if you have  
10 -- I think that's how United uses the ETGs  
11 to tier their Premier Network. They looked  
12 at use of more expensive specialists I think  
13 in the episodes. So I think there's those  
14 two nuances.

15 MR. LOISELLE: When you say  
16 population or person you're really talking  
17 disease management or something less broad  
18 than that?

19 DR. CACCHIONE: Are you  
20 addressing that to the last speaker?

21 MR. LOISELLE: The one before  
22 that. I didn't get a chance to interject.

1 When you talk about population management or  
2 person, the person as opposed to the  
3 provider, the physician. Is it really the  
4 disease management application, or is it a  
5 cost management application? Where at the  
6 person level does this become relevant?

7 MR. MACURDY: Actually, I guess  
8 I'm still not very clear on your question.  
9 So, you're saying --

10 MR. LOISELLE: The application of  
11 the use case. Is the use case evaluating  
12 the cost or the disease management which is  
13 above and beyond the cost. Obviously it's  
14 an outcome question. How far do you take  
15 this in evaluating the performance at a  
16 person level?

17 MR. MACURDY: Well, I mean all of  
18 the above. There are instances where if you  
19 take a look at, say, the quality measures or  
20 kind of how they're evolving one is a  
21 measure of cost. Another one is a measure  
22 of re-hospitalization, you know, various

1 kinds of healthcare sequences.

2 So, I mean I think they're pretty  
3 broad in terms of the way they're done. And  
4 I didn't mean to restrict it to either cost  
5 or just purely efficiency. It's just kind  
6 of outcomes.

7 And outcomes I kind of view as  
8 all those combined. I mean is just a way of  
9 aggregating across a variety of outcomes.  
10 But if you --

11 MR. LOISELLE: Yes, exactly.  
12 Cost is just one --

13 MR. MACURDY: Yes, sure, but  
14 that's all I meant.

15 MR. LOISELLE: Okay, just a  
16 clarification.

17 MR. MACURDY: Yes, the notion is,  
18 you know, rehospitalization from a  
19 provider's perspective -- I mean, a patient  
20 can have a rehospitalization and from one  
21 provider's perspective it may be the case  
22 that they aren't very accountable for it,

1 another provider is. But from the patient's  
2 perspective they had one, so.

3 So when I meant provider-centric,  
4 I mean that -- it's a different perspective  
5 for each set of providers.

6 MR. MCLEAN: I was going back to  
7 David's point about the patient and the  
8 value. One of the ways we use, or we're  
9 looking at using groupers is understanding  
10 for us it's members but patients to  
11 understand the value they're going to get.

12 And then I would argue it's not  
13 just cost. We're looking at the cost and  
14 the balance between cost and quality.  
15 Because what good is buying a service if you  
16 don't get your outcome that you desire.

17 So, trying to figure out  
18 groupers, how to use a grouper to look in  
19 that holistic view of what is the most  
20 effective in that sense outcome for a  
21 patient. And also evaluating providers by  
22 doing that and saying this provider is good

1 at providing the holistic view of care for  
2 best value for a patient.

3 So yes, I just -- my key point is  
4 just I would argue that value is not just.  
5 Efficiency is not just cost. It is some  
6 sort of relationship between cost and the  
7 outcome or the end result.

8 MS. HOBART: I think in terms of  
9 the use cases there's really two dimensions  
10 which weave together a bunch of the things  
11 we've been talking about.

12 So one is what are you trying to  
13 find out or accomplish, like efficiency  
14 versus quality. And the second is  
15 pragmatically, be it WellPoint or whoever,  
16 how are you going to operationalize that and  
17 do it. And that's where you tend to get  
18 into sort of pragmatically being driven in  
19 terms of the time period that you can look  
20 at.

21 So to me naturally the episode of  
22 care, it's a fuzzy line when it starts or

1 stops. So you can go from a day to a DRG to  
2 the events around the procedure to in the  
3 end, you know, life is an event or an  
4 episode. And you're getting into population  
5 health, and they're all really episodes. So  
6 to me you're just going to have to kind of  
7 make a somewhat arbitrary decision about how  
8 you're defining the episode for a particular  
9 use case. It's not going to naturally  
10 define itself.

11 MS. MARTIN ANDERSON: Thank you.  
12 I'll give the last two words here and then  
13 we want to try to move onto the third  
14 question.

15 DR. LEVINE: I see us coming to  
16 sort of a categorization in a way all based  
17 upon a series of P's. I think there are two  
18 basic categories: payment and performance.

19 And within each of those there  
20 are a series of P's too. For payment  
21 purposes it's a population approach and it  
22 needs to be a patient-centered mechanism in

1 order to evolve the episodes.

2           Whereas for performance it needs  
3 a provider-centric approach. If you're  
4 really looking at how well does a provider  
5 perform you need a whole different approach  
6 to the construction of episodes than you  
7 would have otherwise. So, is the series of  
8 five P's properly arranged?

9           MR. BODYCOMBE: I wonder if,  
10 since we've talked about quality, we've  
11 talked about cost, if there's not you might  
12 consider a bundle of quality measures and  
13 cost measures that might be associated with  
14 an episode, and would those be considered  
15 something that NQF, for instance, might wish  
16 to approve on their own.

17           And that way you kind of mix and  
18 match different episode groupers. Well, I  
19 like the way this grouper handles this  
20 particular episode, but for this other kind  
21 of episode I prefer the other kind. You  
22 know, I hate to complicate your work but

1 that could happen.

2 MS. MARTIN ANDERSON: I think  
3 we're going to get to the how do you go  
4 about getting to endorsement from all this.  
5 So let's hold that thought.

6 I think we want to move on now to  
7 the third question on how an episode grouper  
8 differs from a case mix or risk adjuster.

9 I don't know that we need to  
10 focus too much on that last after the comma  
11 "or other measurement systems." I think the  
12 real question here is how is an episode  
13 grouper different from the other types of  
14 constructs that are currently evaluated.

15 MR. JONES: I think the biggest  
16 difference is -- I just view them in two  
17 broad categories, a member or total cost of  
18 care based versus provider-centric,  
19 episodic. So, tools like CRGs, ACGs,  
20 population-based. You know, your total cost  
21 of care, your illness burden, your risk  
22 score. Whereas the episodic is completely



1 different in that there's a trigger event,  
2 there's the clean period, there's all that  
3 focus on how that particular disease or  
4 episode of care was actually managed as  
5 opposed to the total burden of the member.  
6 Does that make sense?

7 MR. TOMPKINS: Part of my -- I'm  
8 just pointing out that there are actually  
9 two different words here. It might be  
10 equivocating or semantics.

11 In the first part of the question  
12 it's an episode grouper. And then the  
13 sentence ends with "systems." Because there  
14 is such a thing as an episode system. And  
15 an episode system I would argue properly  
16 configured or fully configured would include  
17 a case mix adjuster and maybe some other  
18 features to it. But, all right, I'll come  
19 back to that.

20 The grouper itself is a portion  
21 of the function of the entire episode system  
22 where you're trying to make logical

1 decisions about which disparate data  
2 elements ought to be, quote unquote,  
3 "grouped" to become clinically meaningful or  
4 otherwise actionable.

5           And then the episode system takes  
6 advantage of that, or uses that as a basic  
7 engine, but then does some other things too.  
8 For example, in that clinical context what  
9 is average performance or, quote unquote,  
10 what is "expected." And as soon as you  
11 start to say well, what's average  
12 performance or what's expected, controlling  
13 for what? That's the case mix adjuster.

14           So I think a fully episode system  
15 would incorporate the risk adjustment into  
16 it because you want, in my book, all  
17 analytical comparisons should be actual to  
18 expected.

19           MS. MARTIN ANDERSON: In that  
20 construct that you just laid out, right, you  
21 have a grouper which is a sequence of how  
22 we're putting together care. And we'll get

1       into -- or disease over time.

2                       And then you have, I presume,  
3       measures that you create around a grouper  
4       that are then risk-adjusted. Is there such  
5       a thing as an episode that's risk-adjusted,  
6       or is it really just the metrics that are,  
7       you know, built on top of the grouper that  
8       actually get risk-adjusted or in whatever  
9       way?

10                      DR. CACCHIONE: I think there is  
11       risk adjusting to an episode. I mean, I  
12       think that was your question.

13                      MS. MARTIN ANDERSON: Is there a  
14       risk adjustment applied actually to the  
15       episode, or is it to the elements of the  
16       care that you're evaluating within the  
17       episode? So, for instance, cost, or  
18       quality, or any other type of outcome.

19                      MR. REDFEARN: When I saw the  
20       section on risk adjustment I did kind of a  
21       double take.

22                      Because my working assumption is

1 that an episode of care model should produce  
2 a clinically homogenous group of patients.  
3 So the fundamental episode methodology  
4 should have built into it some sort of thing  
5 that you could call risk adjustment, or some  
6 adjustment. So it should produce a  
7 clinically homogenous group.

8 But the odd thing is from a  
9 practical point of view that's not the way a  
10 lot of the groupers work.

11 For example, ETGs now for some  
12 episodes will have a layer on top of it and  
13 will generate up to four levels of risk that  
14 is layered on top of the grouper.

15 The MEGs which is sort of  
16 designed from a disease progression, that's  
17 the basic underlying model, they will still  
18 tell a lot of people using the models well,  
19 go license the DxCG risk model and put  
20 patient risk on top of the MEGs that you  
21 already have.

22 So, from a logical point of view

1 I think all episode modules should produce  
2 clinically homogenous groups of patients.  
3 From a practical point of view typically you  
4 have another process that's layered on top  
5 of it because the underlying model I guess  
6 doesn't produce a homogenous enough group.  
7 So, they sort of say well, we didn't quite  
8 get there so here, use this too. So it's  
9 kind of an odd dichotomy.

10 But from a theoretical point of  
11 view they should -- the groupers themselves  
12 should produce a homogenous group of  
13 patients I think.

14 MS. MARTIN ANDERSON: Do others  
15 agree with that?

16 DR. BANDEIAN: I understand  
17 exactly what you're saying. There are lots  
18 of ways to skin a cat. And I'm not  
19 necessarily sure that one necessarily wants  
20 to get into the, at least at this initial  
21 stage of the discussion, whether it's okay  
22 to do kind of risk adjustment after you've

1 constructed your episodes. I personally  
2 think it is and we could have a longer  
3 discussion about that.

4 I'm sorry, I kind of want to go  
5 back to a very high level. To me, in terms  
6 of, for example, how is it different from  
7 DRGs it's again the episodic nature of  
8 things.

9 But why do we care about episodic  
10 nature? The only reason why we're doing  
11 this I think in terms of the measurement.  
12 And I think the pre-bundled payment is a  
13 completely different kettle of fish and I  
14 would actually advocate perhaps we don't  
15 talk about that and focus on measurement  
16 because we already have a huge set of things  
17 to talk about.

18 So, basically from a measurement  
19 perspective the systems however they're  
20 constructed are intended to lead to a  
21 result, a conclusion that says Dr. ABC or  
22 Healthcare System XYZ is providing care of

1 some acceptable standard at a lower cost  
2 than other people are. So that's a good  
3 thing. So we want to reward them somehow.

4 So the question really is is that  
5 a true statement. Or if we have a whole  
6 bunch of methodologists sitting around the  
7 table and we poke holes in the methodology  
8 and say it didn't take into account this,  
9 this, this and this, and basically you can't  
10 draw any conclusions from the methodology,  
11 do you have confidence that when the system  
12 says episode cost is 1.3 times benchmark  
13 that that's a reasonable statement to make?

14 So I think that largely it's a  
15 question of what do you need to do to have  
16 validity so that when you look at the output  
17 you have confidence that it's -- that's  
18 true, that you can actually hang your hat on  
19 it, that it is therefore reasonable for  
20 Medicare to give a bump up in payment under  
21 the value modifier, that it's reasonable for  
22 a health plan to kick out a doctor because

1 they have a high episode score. So, that's  
2 sort of one use case. It's a measurement  
3 use case.

4 Now, there's a different use case  
5 which is still measurement which is now  
6 we're a group practice, or an ACO, or what  
7 have you. How can we improve what we're  
8 doing and what can we do within our ACO or  
9 whatever to get a better high-level  
10 aggregate score.

11 So, to me the principal use case  
12 that we should be focusing on here are  
13 measurement. And there are two types of  
14 measurement. The sort of external to the  
15 providers saying you're doing a good job or  
16 bad job, and then within the provider  
17 community what can we do to get a better  
18 score.

19 And in both cases what's -- a  
20 critical issue is are the conclusions  
21 correct. Or if we had a whole bunch of  
22 methodologists sitting around and throwing



1 rocks at the methodology and looking at  
2 statistical outputs it would be obvious of  
3 course you can't draw a conclusion on this.

4 DR. CACCHIONE: In terms of  
5 specified level of quality --

6 DR. BANDEIAN: Yes. And the only  
7 reason why I phrase it that way is because  
8 we still have got a long ways to go on the  
9 quality space. And so kind of short-term we  
10 have to a little bit fudge on the quality.

11 Because obviously if XYZ --

12 DR. CACCHIONE: I know what you  
13 mean.

14 DR. BANDEIAN: -- it's pretty  
15 complicated. And maybe we should try to  
16 take that on.

17 But obviously if XYZ Healthcare  
18 System or ACO or practice is lower-cost and  
19 also very low quality then that's not a very  
20 good situation either.

21 But these things are being used  
22 to draw conclusions to reward under a value

1       modifier, or alternatively within an ACO or  
2       an organized delivery system of some sort as  
3       a guide to what they can do to improve their  
4       performance.

5                   MS. MARTIN ANDERSON: I want to  
6       give just one more piece of clarity here  
7       which is that while we're talking about uses  
8       because it's important to understand the  
9       context of all these high-stake uses as  
10      we're coming up with the criteria, NQF has  
11      not historically endorsed specific measures  
12      or whatever for a specific use.

13                   So I think what we need to keep  
14      in mind, not saying that would never happen,  
15      but I think what we need to keep in mind is  
16      these uses are context for the rest of our  
17      work on what are some of the criteria.

18                   And it would be the measure  
19      developer would state what their intended  
20      use is and under what context they've  
21      developed such a thing.

22                   The criteria need to support the

1 evaluation by the committee of whether or  
2 not it's acceptable in terms of whatever  
3 criteria we get through next.

4 And then users will do what users  
5 do with things after they're endorsed and  
6 out there. And so I don't think we need to  
7 -- I'm saying that because I don't think we  
8 need to restrict that we're only going to  
9 think about one kind of use.

10 I think it's important for us to  
11 understand there are broad and high-stake  
12 uses, and keep that in mind in the context  
13 of our work. Rather than thinking that we  
14 need to come up with criteria for one type  
15 of use or another type of use at this stage.  
16 So I think it's a good idea to keep it broad  
17 and that gives us context.

18 So we have I think a couple of  
19 more tents up.

20 MR. JONES: I just wanted to echo  
21 a couple of things that I heard and  
22 underscore a point that Dave made earlier in

1 that when you're using these tools to,  
2 quote, "gauge efficiency" if there's not  
3 that flexibility to level for your  
4 differences which are oftentimes very large  
5 in how you're contracting with providers,  
6 you know, you really need to have that  
7 flexibility in there where you're solving  
8 that price equation and you're teasing out  
9 differences due to mix and volume.

10 I don't know if we want to add  
11 that to criteria anywhere, if anybody agrees  
12 or disagrees with that.

13 DR. CACCHIONE: Are you getting  
14 at this idea that you assume a standardized  
15 cost model?

16 MR. JONES: Yes.

17 DR. CACCHIONE: So that we don't  
18 get corrupted by contractual relationships  
19 between whoever the purchaser is and the  
20 provider.

21 MR. JONES: Yes, I think that's  
22 key. And that was a cause of a lot of

1 challenges that we had.

2 DR. CACCHIONE: Okay. Jelani?  
3 Jelani, move a little closer to the mike  
4 because you sort of drop off.

5 MR. MCLEAN: Sorry, I just don't  
6 talk that loud. I'll make sure I stay  
7 closer.

8 One of the things I think we're  
9 missing, we're overlooking is groupers don't  
10 -- historically groupers don't evaluate  
11 providers. The analytics you put around it  
12 evaluates the provider. So therefore while  
13 I agree with case mixing which is more  
14 around the provider and the mix the provider  
15 actually has and the -- and the risk  
16 adjustment portion I'll get to in a second.

17 But I don't think you can case  
18 mix from a provider standpoint within the  
19 grouper because the grouper is focused on  
20 the patient, the population that they're  
21 using in it.

22 And so you would essentially if

1 you're using claims have to match the claims  
2 to the provider. And then it's a whole  
3 nother algorithm that you're going to apply  
4 to it. There would be another requirement  
5 and criteria you would have to put in your  
6 evaluation of the grouper and its  
7 effectiveness, and how good it really is.

8           And I don't think it's something  
9 you want to go down that path, having the  
10 experience with trying to match claims to  
11 providers is a challenge in itself.

12           To the risk adjustment portion,  
13 risk adjustment from my experience is all  
14 about the data and the population that  
15 you're trying to evaluate.

16           Trying to do that within a  
17 grouper while I agree is useful, I agree  
18 with Steve it's probably more practical to  
19 do that after or before you've put the data  
20 within the group inside the grouper because  
21 of the fact that it's all about the data  
22 that you're having.

1                   The population, for example,  
2                   transplants. Everyone is risky. But there  
3                   is a large variation of risk within the  
4                   population receiving the transplant. But  
5                   how do you do that as opposed to evaluating  
6                   a cardiac care facility, or cardiac  
7                   population? It's totally different. So  
8                   therefore I would argue that that may be a  
9                   bit of a challenge and a bit extreme with  
10                  trying to evaluate a grouper.

11                  DR. CACCHIONE: One last comment  
12                  before the break because we're over the  
13                  break. So Tom, if you could give us a  
14                  zinger for the last comment before the  
15                  break.

16                  MR. MACURDY: I don't know if I  
17                  want to do that. I just wanted to note I  
18                  don't think there's a sharp distinction  
19                  between the risk adjustment case mix  
20                  adjuster and the grouper. I think the best  
21                  way to do it is to illustrate it.

22                  I kind of see a continuum between

1 a bundler and a grouper. If the services  
2 you're looking at are provided by one  
3 provider you call it a bundle, and if it's  
4 across providers you call it a grouper.

5 And to illustrate the difference  
6 here is -- I mean, DRGs are a good example,  
7 either MS DRGs or APC DRGs, et cetera.

8 There the risk adjustment is partly involved  
9 in the bundling because you essentially are  
10 moving the DRG around depending upon the  
11 risk characteristics of the patient.

12 Another way to really get at this  
13 issue is if you take a 3M bundler or grouper  
14 versus, say, an ETG MEG grouper the main  
15 distinction between those two is that the 3M  
16 combines its risk adjustment with the  
17 grouping. So it'll take all expenses after  
18 a certain period of time irrespective of  
19 what the circumstances are and try to fix it  
20 all with the risk adjustment.

21 Whereas the ETG grouper and the  
22 MEG grouper try to select a particular set



1 of those services in those categories and  
2 then do the risk adjustment separately.

3 One other point I wanted to make  
4 is it is true that it would be nice to have  
5 groupers have homogenous patients. And you  
6 get one patient per item. And that's the  
7 challenge.

8 I mean, the difficulty is if you  
9 take the MEG grouper you can get up to 1,800  
10 categories, and if you take the ETG you get  
11 about the same order and you get hardly any  
12 individuals per group and then you can't do  
13 any benchmarking. So that's always the  
14 challenge. You're always going to have a  
15 heterogenous set of patients. You're going  
16 to have to be able to do some kind of  
17 adjustments.

18 DR. CACCHIONE: For those of us  
19 who treat patients we know that it's a --  
20 who we treat is heterogenous.

21 (Laughter)

22 MR. MACURDY: That's the reason.

1 It's because -- yes, you can get them  
2 homogenous, it's just then you get really  
3 small cells and you can't do very much. So  
4 everybody is their own special case.

5 MS. MARTIN ANDERSON: Thank you.  
6 I think we're going to take our break. Just  
7 to give you a closing comment to think about  
8 during the break is that keep in mind that  
9 our objective here isn't to push the science  
10 in a certain direction, it's to acknowledge  
11 the state of the science and come up with  
12 some criteria that can live within where we  
13 are.

14 So I think it's important that we  
15 -- as we continue through the criteria we  
16 keep that in mind. We're not trying to  
17 create criteria to box developers in. We're  
18 really trying to figure out how given the  
19 state of this business could we assist NQF  
20 in evaluating how to do endorsement for  
21 where we are today. And it might look  
22 different in the future. So, let's take our

1 break.

2 (Whereupon, the foregoing matter  
3 went off the record at 10:24 a.m. and went  
4 back on the record at 10:44 a.m.)

5 DR. CACCHIONE: Ashlie, do you  
6 want to go ahead and get started with the  
7 criteria?

8 MS. WILBON: Sure. There's a few  
9 people missing. We'll go ahead and get  
10 started without them.

11 So this next portion of the  
12 discussion is designed to give you guys an  
13 overview of our existing criteria that we  
14 use to evaluate kind of standalone cost and  
15 resource use measures in our consensus  
16 development process.

17 And this section is really  
18 focused around kind of giving you some broad  
19 protocols for how our criteria is applied  
20 and then walking through each of the four or  
21 five criteria.

22 And then we'll have a discussion

1 about which of those criteria we think could  
2 be applied to episode groupers and if there  
3 are criteria that are missing or ones that  
4 don't apply, do apply we'll have that  
5 discussion. So I'll just kind of go through  
6 all the criteria and then we'll open it up  
7 for discussion if that's okay.

8           So, there are essentially four  
9 kind of core criteria that we use to  
10 evaluate resource use measures: importance  
11 to measure and report, scientific  
12 acceptability of measure properties,  
13 feasibility and usability and use.

14           There is a fifth criteria that  
15 we'll talk about that is applied only when  
16 we have identified when there are measures  
17 that have similar specifications and we have  
18 identified them as similar or competing.  
19 And we'll talk a little bit about that as  
20 well.

21           So, some of the key principles  
22 that guide the application of the criteria.

1 So, within the four kind of major criteria  
2 that we described there's two must-pass  
3 criteria. And the criteria are applied in a  
4 hierarchical manner so they're in a specific  
5 order.

6 And the measures have to meet the  
7 importance to measure and report criteria in  
8 order to move onto the next criteria which  
9 would be scientific acceptability of measure  
10 properties. And once they pass that  
11 criteria they move onto the other two.

12 If they don't pass these two  
13 criteria the measure doesn't -- the  
14 remaining criteria aren't applied and the  
15 measure cannot be recommended for  
16 endorsement.

17 Within each of the four overall  
18 criteria there's a series of subcriteria  
19 which really are used to provide the  
20 additional detail. So, how do you know if  
21 the scientific acceptability -- if the  
22 measure is scientifically acceptable. How

1 do you know if the measure is important.  
2 And so there's a series of subcriteria  
3 within each of those major criteria that  
4 we'll discuss in some detail.

5 Also, the criteria that were kind  
6 of originated or out of the quality  
7 measurement side were really designed to  
8 parallel best practice for measurement  
9 development.

10 So, some of the way that we  
11 structured this discussion with this group  
12 is to kind of think about some of the key  
13 principles that should be applied when  
14 developing episode groupers and identifying  
15 which criteria might be applied to kind of  
16 parallel those key principles or  
17 considerations so that there's some  
18 alignment of those ideas.

19 And generally the application of  
20 the criteria require both evidence and  
21 expert judgment. So, not everything is  
22 black and white. There's usually a matter

1 of degree in judging whether or not a  
2 criteria has been met.

3 And generally all the criteria  
4 are rated as we go through, walk these  
5 through with our committees we ask them to  
6 rate the overall criteria and some of the  
7 subcriteria on a scale of high, moderate and  
8 low and insufficient, and then at the end  
9 make an overall recommendation depending on  
10 the criteria that have been met throughout  
11 the evaluation process.

12 So, actually we'll just pause  
13 here for one second. Some of the questions  
14 that we'll be asking you guys to address,  
15 and we'll come back to these after we kind  
16 of walk through each of the four criteria,  
17 is whether or not these criteria can be  
18 applied to episode groupers. Of the major  
19 criteria that apply how might the  
20 subcriteria also apply to groupers.

21 And then trying to find out  
22 whether or not there are other major or

1 subcriteria that should be considered that  
2 aren't listed here that we haven't captured  
3 already in some of our existing framework  
4 for thinking about other types of measures.

5 So, the first criteria, and I'm  
6 on page 5 of the discussion guide. What we  
7 have on the slides is kind of a summary of  
8 what's in the discussion guide. So if you  
9 want some additional detail you can kind of  
10 read along as I go.

11 So, the importance to measure and  
12 report criteria is used to determine if the  
13 measure focus or the topic is important in  
14 making significant contributions towards  
15 understanding healthcare costs for a  
16 specific high-impact aspect of healthcare.

17 So, for example, is it important  
18 to measure the cost of hip and knee  
19 replacements in an over-65 population. So  
20 it's really the topic itself and whether or  
21 not it's important to measure in the context  
22 that the developer is suggesting.



1                   And then to determine whether or  
2 not there's variation or demonstrated high-  
3 impact aspect of healthcare or overall poor  
4 performance.

5                   So, in the submissions we really  
6 are asking the developers is this an area of  
7 healthcare that we know there's a lot of  
8 variation already that this measure is going  
9 to help illuminate or help us better  
10 understand that variation or poor  
11 performance in that area? So we're really  
12 just trying to understand the need for  
13 measuring this topic with this particular  
14 measure for this population, et cetera.

15                   So the subcriteria are really  
16 focused on having the developers identify  
17 which major national health goal or priority  
18 that this measure would help to address,  
19 that there is a demonstrated resource use or  
20 cost problem and an opportunity for  
21 improvement.

22                   And we're also asking them to

1 explain the intent of the measure and the  
2 types of costs and ensure that the types of  
3 costs they're capturing are actually  
4 consistent with the intent of the measure  
5 and that those costs are important to  
6 measure for that particular topic area.

7           So, for scientific acceptability  
8 this criteria is focused on determining the  
9 extent to which the measure is reliable and  
10 valid, and produces consistent and credible  
11 results about the cost of resources used to  
12 deliver care.

13           Again, the two main components of  
14 this criterion are reliability and validity.  
15 And within the reliability criteria there's  
16 two additional kind of micro-criteria if you  
17 will that look at the preciseness of the  
18 specifications and whether or not they can  
19 be used to reproduce or facilitate  
20 consistent implementation of the measure.

21           And then that there are testing  
22 results submitted that demonstrate the

1 results are repeatable. So that's generally  
2 some statistical analysis of the measure  
3 results or the data elements.

4 MR. AMIN: So, I just wanted to  
5 reiterate here that when we're talking about  
6 the preciseness of the specifications that  
7 will be the specifications in what we're  
8 describing will be the module discussion  
9 that will -- which will be the next agenda  
10 item.

11 So that would consist of the  
12 clinical logic, construction logic and  
13 adjustments for comparability broadly at  
14 this point unless we decide that there are  
15 other specifications that we would need to  
16 evaluate as part of an episode grouper.

17 MS. WILBON: So, the next major  
18 subcriteria within scientific acceptability  
19 focused on the validity of the measure.

20 And there's several bullets here.  
21 I guess I'll go ahead and read through them  
22 just to make sure we're all on the same

1 page.

2 That the measure specifications  
3 are consistent with the measure intent. So  
4 are they actually measuring what they said  
5 that they are intending to measure with the  
6 measure results.

7 That the validity testing  
8 demonstrates that the measure data elements  
9 are correct and the measure score accurately  
10 reflects the cost of care.

11 That exclusions are supported  
12 with clinical evidence or a rationale or  
13 analysis of those exclusions. That the  
14 exclusions are transparent. That the  
15 evidence that exclusions are applied due to  
16 patient preference are also disclosed.

17 That an evidence-based risk  
18 adjustment strategy if it is applied that  
19 it's based on patient clinical factors that  
20 influence the measured outcome.

21 That there's adequate  
22 discrimination and calibration of the risk

1 model or rationale to support why they have  
2 not chosen to use a risk adjustment method.

3 That the scoring and analysis of  
4 the measure produces statistically  
5 significant and practically and clinically  
6 meaningful differences in performance.

7 If they have chosen to use  
8 multiple data sources we ask them to  
9 demonstrate through their analysis that the  
10 results are comparable between those two  
11 data sources.

12 Generally we don't run into this  
13 issue as much with the cost measures because  
14 they tend to all be specified using admin  
15 claims data so that tends to be a moot  
16 point. But it is part of the kind of  
17 framework for the criteria.

18 MR. AMIN: Ashlie, let me just  
19 point out though while it's not necessarily  
20 from a data source perspective, there are --  
21 the bar here is that if there are multiple  
22 methods meaning other multiple risk

1 adjustment methodologies or multiple costing  
2 approaches there that only one is specified  
3 so that it can actually produce comparable  
4 results for an individual provider.

5 If they're using one particular  
6 measure we can't have the same measure  
7 having both a standardized pricing approach  
8 and an actual prices paid approach because  
9 those two obviously wouldn't be comparable  
10 even though they're using the same NQF  
11 measure number.

12 So it does come up in other ways  
13 in terms of episode groupers that we should  
14 consider because we are looking for precise  
15 specifications and not really looking for  
16 potentially additional variation or  
17 flexibility that are typically designed in  
18 these types of products.

19 MS. WILBON: Thanks, Taroon,  
20 that's a really important point.

21 The last kind of micro-criteria  
22 if you will within the validity subcriteria

1 are around disparities. And that if there  
2 are disparities in care that have been  
3 identified for this particular topic area or  
4 measure focus that the measure actually  
5 allows for the identification of those  
6 disparities through some mechanism,  
7 stratification or what have you.

8 MR. AMIN: So just one other  
9 point of clarification that I want to just  
10 make here is that when we're talking about  
11 reliability and validity testing we offer  
12 the opportunity to do that at the data  
13 element level or the performance measure  
14 score level.

15 But when we talk about validity  
16 testing here we're really -- it could be at  
17 any one of those levels. And when we're  
18 looking at testing that also includes  
19 testing of the risk adjustment model.

20 So, those are two different  
21 components that we would be looking at. And  
22 again, that would potentially translate

1 potentially translate to how we're looking  
2 at testing of episode groupers. And so  
3 we'll explore that in more detail later on  
4 in the discussion.

5 MS. WILBON: Thanks. The third  
6 criteria is around feasibility. And the  
7 goal of this criteria has been to assess the  
8 extent to which the required data elements  
9 are readily available and can be captured  
10 without undue burden and implemented for  
11 performance measurement.

12 So, the subcriteria for this  
13 major criterion focus around whether or not  
14 the required data elements are routinely  
15 generated through the delivery of care, that  
16 the data elements are available in  
17 electronic sources and that a data  
18 collection strategy can be implemented  
19 without undue burden.

20 And this criterion has also in  
21 our resource use work tends to include an  
22 assessment of any cost or financial burden



1 to implement the measure. So any measures  
2 that require some type of purchase of risk  
3 adjustment software or licensing or anything  
4 to be able to run the measure, that that is  
5 taken into consideration in terms of the  
6 evaluation process as well.

7 The fourth criterion is around  
8 usability and use. And the goal of this  
9 criterion is to assess the extent to which  
10 potential audiences which encompass kind of  
11 our stakeholder and membership councils, so  
12 the consumers, purchasers, providers,  
13 policymakers and others are using or could  
14 use the performance results for both  
15 accountability and performance improvement.

16 And the subcriteria are focused  
17 around the developer explaining or  
18 demonstrating how the measure is currently  
19 used, or how they expect the measure will be  
20 used. So how they plan for it to be used.  
21 And a public reporting or accountability  
22 application.

1                   That the measure -- if it's  
2                   already in use we're asking them to show  
3                   data that demonstrates that there is some  
4                   type of improvement or, you know,  
5                   understanding of cost and resource  
6                   performance over time. And that any  
7                   benefits of the measure outweigh any  
8                   unintended consequences. So, asking them to  
9                   think about if there are any unintended  
10                  consequences of the measure that they've  
11                  thought those through and that weighing  
12                  those between the positives and the  
13                  negatives of the measure, that the benefits  
14                  outweigh those unintended consequences.

15                   And then the last one which  
16                   seemed to come up already in some discussion  
17                   is around whether or not the measure can be  
18                   deconstructed to facilitate transparency and  
19                   understanding. So, based on provider or  
20                   clinician receiving a measure score, can he  
21                   or she go back into the measure and figure  
22                   out exactly what that score represents and

1 what they're actually being measured on.

2 MR. AMIN: So Ashlie, before you  
3 move on on this criteria I just want to  
4 reiterate something that Kristine said and I  
5 think will translate to multiple different  
6 components over the next two days.

7 So, NQF's current criteria  
8 requires essentially reliability and  
9 validity for the measure to be used for both  
10 accountability and performance improvement  
11 applications. It does not draw distinctions  
12 between accountability applications, meaning  
13 between public reporting or payment  
14 applications.

15 And so the idea here is that the  
16 criteria should apply broadly for all  
17 applications.

18 Now, we've had a lengthy  
19 discussion around use and we will have  
20 additional conversations around use as we go  
21 through each of the modules. So if there is  
22 a belief that depending on which

1 accountability application the grouper  
2 potentially is intending to be used for that  
3 if the criteria do need to be different that  
4 needs to be really clearly laid out.

5 Because as current standard at  
6 NQF there is no -- you use the same criteria  
7 and think about it broadly for  
8 accountability applications and performance  
9 improvement. So, I just wanted to kind of  
10 reiterate that.

11 And especially also this last  
12 subcriteria around transparency and  
13 understanding was also another key  
14 subcriteria as we were looking at measures  
15 that were a result of episode groupers in  
16 our first evaluation of cost and resource  
17 use measures. So again, that would be  
18 another logical subcriteria that might  
19 require more exploration as we move forward.

20 MS. WILBON: So, the last  
21 criteria. Again, and this is one --  
22 criterion. And this is one that again we

1 generally only apply if the four previous  
2 criteria have been met and if the measure or  
3 measures that are under review have been  
4 identified as being related or competing  
5 with other measures under review or  
6 currently in the portfolio of endorsed  
7 measures.

8           And for resource use measures the  
9 way that we've kind of conceptualized this,  
10 taking into consideration that there are  
11 different components to cost measures that  
12 we may want to consider in this analysis of  
13 related and competing, that we take into  
14 consideration whether or not it's been a  
15 per-episode or per capita measure, whether  
16 or not they're applying the same types of  
17 costing methodology, so actual prices paid  
18 versus standardized prices, the types of  
19 costs that are being measured, and the  
20 actual population that's being addressed  
21 within the measure.

22           So is it an all-population

1 measure, total cost. Is it focused around a  
2 specific disease condition like diabetes or  
3 cardiovascular disease.

4 And a measure that we would call  
5 competing would actually share all of these  
6 same characteristics. And we have generally  
7 done some analysis with the committee to  
8 determine whether or not both measures are  
9 needed, or is there some justification for  
10 having both measures endorsed at the same  
11 time considering they are similar in many  
12 aspects.

13 We can have some discussion. I  
14 think this issue has come up already I think  
15 with Chris' question in the beginning about  
16 whether or not we would want to potentially  
17 endorse multiple groupers, or is there a  
18 best in class if you will.

19 So with that we can kind of go  
20 back to the questions that we're asking the  
21 group to consider and have the co-chairs  
22 take it away.

1 MS. MARTIN ANDERSON: So I think  
2 the thing that I'm struggling with in  
3 reading through these criteria is that the  
4 episode grouping is really, it's unit of  
5 analysis. It's a building block for  
6 measures.

7 And so it's a way of taking  
8 different kinds of healthcare services and  
9 putting them together into often clinically  
10 meaningful groups.

11 But from that then you use that  
12 to build measures. You might have a  
13 disease-specific measure of provider  
14 efficiency, or you might have a cost  
15 measure, or a resource use measure.

16 So, this is all geared toward  
17 individual measures and that's why I think  
18 we're going to have to really change the  
19 language in order to make it work for  
20 evaluating what is really a building block  
21 towards measurement.

22 MR. TOMPKINS: I have comment

1 that's similar to that, namely that in a  
2 sense an episode grouper is like a sausage  
3 maker, or it's actually maybe a sausage  
4 maker in reverse, right, because it takes  
5 the scrambled and unscrambles.

6 And I could deliver you an  
7 episode grouper and say, you know, if you  
8 run this properly it will produce 600  
9 different measures for you.

10 And then you could convene panels  
11 around -- 600 panels if you want around each  
12 measure and probably apply many of these  
13 criteria to each one at a time. Is this  
14 important? Is it important to measure  
15 resource use for transplantation? Is it  
16 important to measure resource use for Band-  
17 aid placement? Some will be yes, some will  
18 be no. So the importance question is, you  
19 know, magnitude and so forth, or variation  
20 issues.

21 And then reliability the same  
22 way. Have I measured the transplantation



1 costs reliably so that you can repeat them,  
2 and that they have fairly narrow confidence  
3 intervals, for example. Again, that  
4 applies.

5 Feasibility as well seems duck  
6 soup here, especially with Ashlie's side  
7 comment that these often just rely on  
8 administrative data.

9 I think when the trip-up comes in  
10 is in the validity and the usability.  
11 Because if you were going to -- in my mental  
12 thought experiment there of giving you a  
13 grouper and saying you can evaluate 600  
14 measures, the validity question comes in.  
15 Because sometimes the groupers in that  
16 sorting-out process, in that parsing-out  
17 process are using presumably consistent  
18 logic for doing so.

19 And therefore there's an  
20 efficiency to you examining the logic by  
21 which that is done which would cross the 600  
22 measures to a large degree as opposed to

1 each one at a time.

2 But my short comment is that most  
3 of these criteria apply because you're  
4 looking at the end use, the measures  
5 themselves, the reliability, the importance  
6 and even the validity. But it's nice to  
7 have an engine or a grouper that  
8 systematically gives you logic that you can  
9 review in advance which gives you a head  
10 start on the 600 measures that you would  
11 otherwise be evaluating.

12 MS. MARTIN ANDERSON: Since the  
13 first two comments took us here I just want  
14 to make sure we have just a little bit of  
15 discussion around this topic of is there  
16 value in evaluating a grouper as well as the  
17 outputs from a grouper that might be around  
18 measures themselves. Or do you just focus  
19 on the measures and by default you're  
20 looking at the grouper.

21 I see this as the reverse of the  
22 bundling -- I mean, the composite

1 discussion, where originally all measures  
2 needed to be endorsed and then a composite  
3 could be endorsed.

4 And at first it was all the  
5 measures inside the composite had to be also  
6 endorsed.

7 So the question is if you have a  
8 measure that's an episode-based measure does  
9 the grouper itself also have to be endorsed  
10 in order for the measure to be endorsed. So  
11 there's a relationship here.

12 So I just want to hear your  
13 thoughts on this concept of the grouper and  
14 also of measures, and how it might impact  
15 how we do our work this afternoon.

16 MR. LOISELLE: This is Jim  
17 Loisel. I struggle with the context. I  
18 never thought of a grouper in the context of  
19 a measure. Obviously it populates outputs  
20 and the outputs are variable. So I think  
21 the focus should be on the grouper itself.

22 Because you can create measures

1 that are valuable that are not otherwise  
2 outputs of the grouper. It's whatever  
3 analytical process, or payment, or clinical  
4 process you add on top of it where measures  
5 become specific. That's my struggle with  
6 thinking of a grouper as a measure-based.

7 MS. MARTIN ANDERSON: Well no,  
8 I'm not saying that, it's just that there  
9 are current measures that are approved that  
10 are actually episode-based.

11 MR. LOISELLE: Yes.

12 MS. MARTIN ANDERSON: Right?  
13 Where you say, you know, there's total cost  
14 of care over an episode. So the question is  
15 do you agree that NQF should also look at  
16 the grouper itself as something to be  
17 endorsed, or are we looking at the outputs  
18 that are used in specific ways for  
19 endorsement.

20 MR. LOISELLE: That's I think a  
21 whole topic of discussion and an afternoon  
22 in and of itself, just going on the total

1 cost element. Cost is variable, and trying  
2 to differentiate performance from a payment  
3 perspective, or a clinical utilization, or  
4 care management perspective, what cost you  
5 use might be a different thing. It all  
6 depends what you want to use the grouper  
7 for.

8           Because we evaluate and look at  
9 cost. A tertiary hospital is less expensive  
10 than a primary inner city hospital attached  
11 with a medical school. So trying to use  
12 cost variations as a topic, that's not  
13 really an output of the grouper, that's the  
14 intelligence that you apply afterwards. The  
15 groupers themselves just might create that  
16 number but there's too much variation in  
17 even the term I think in just saying total  
18 cost.

19           MS. MARTIN ANDERSON: Even 30-day  
20 mortality, that is an episode that has been  
21 defined just for the purposes of calling  
22 mortality at 30 days. So let's continue.

1 MR. REDFEARN: My work has mostly  
2 been focused on using episodes of care as a  
3 foundation for provider cost efficiency  
4 profiling.

5 And there's a certain amount of  
6 variability when you do that across time.  
7 When you repeat the measures of the  
8 physicians. Physicians can change. They  
9 can move around a little bit about how  
10 efficient they look.

11 And I was curious about whether -  
12 - ETGs has been our default tool. I was  
13 curious about if you pull ETGs out, plug  
14 something else in and run the rest of the  
15 analysis in exactly the same way to see what  
16 kind of results you get. And I've done  
17 that. I did it using MEGs. I plugged MEGs  
18 in.

19 And the interesting outcome for  
20 my work is that essentially the results are  
21 very similar. I'm exaggerating but it's  
22 almost like I don't care how the groupers

1 carve things up. They carve them up into  
2 groups that make some sense and I use them  
3 for my analysis.

4 Now, it doesn't mean that they're  
5 exactly the same. Things move around.  
6 Doctors move around. But they don't move  
7 around much more than they move around  
8 across time when I use the ETGs. So, my  
9 argument there is it's the measure, it's not  
10 the grouper that you would want to really  
11 focus on.

12 I really am struggling with the  
13 idea of how you can evaluate a grouper. How  
14 could you look at ETGs and MEGs and say  
15 clinically I think one is better than the  
16 other. It makes more sense. It's all very  
17 specific to how you're using them and  
18 whether you can justify them.

19 Because I know there's a lot of  
20 really smart people that develop those two  
21 models and they did it -- they ended up  
22 doing it differently. And how can you say

1 that one is better than the other. It's  
2 just how you end up using it.

3 DR. CACCHIONE: I think it's the  
4 output that we're really looking here for.  
5 I mean, I think that to go that far up the  
6 chain, I mean I think people -- there are a  
7 lot of different groupers that are out there  
8 that work.

9 But we've had the same  
10 experience. We've evaluated two different  
11 grouper tools and have come up with very,  
12 very similar outcomes with as best we can  
13 tell different methodologies. So you can  
14 arrive at the same thing that is valid and  
15 has valid outputs. I don't know that we  
16 need to go that far up the chain to evaluate  
17 the individual tool. Jim?

18 MR. JONES: I agree and I do  
19 think they produce similar results. But in  
20 terms of looking at a grouper I think that  
21 we should consider having certain criteria  
22 that they must certify that they've done



1 properly.

2 An example of that is that when  
3 they're normalizing your data, when they're  
4 using their reference data sets that they  
5 should not be allowed to market to a  
6 Medicaid plan and allow that Medicaid plan,  
7 for example, to run the grouper based on a  
8 commercial reference set, for example.

9 Those things I think should be disclosed.

10 Because I have run into that problem before  
11 and I was quite shocked.

12 DR. CACCHIONE: But that's not a  
13 problem of the tool itself, that's the input  
14 that was used to --

15 MR. JONES: It's not the tool,  
16 it's just -- exactly.

17 DR. CACCHIONE: -- into the tool.  
18 So I think that is -- so I'm not sure it's  
19 the grouper itself, but it's the inputs in,  
20 the data inputs. Tom?

21 MR. JONES: More like rules of  
22 the road for groupers.

1                   MR. MACURDY:  So I guess I want  
2                   to indicate that I disagree with this.  And  
3                   the reason why is I've looked at a lot of  
4                   grouper output.  They don't give the same  
5                   answers.

6                   And the difficulty is if you're  
7                   using -- I'll use the specific example of  
8                   using this for payment purposes.  There is  
9                   going to be the provider, say the physician  
10                  who's going to ask why did I get stuck with  
11                  that claim and you're going to have to have  
12                  an answer to that question.

13                  And the challenge is with a lot  
14                  of the groupers, especially if you take a  
15                  Medicare population where they're very  
16                  complex kinds of cases.  There's a lot of  
17                  comorbidities, there's a lot of competition  
18                  for where the claim could be assigned.  And  
19                  if you have a rule the claim goes to one and  
20                  only one spot there's a back-end kind of  
21                  logic that's kind of going on there which is  
22                  somewhat of a black box.

1           Which I've spent a lot of time on  
2           groupers and you can't understand. The  
3           people who develop the grouper don't really  
4           understand how those rules get applied and  
5           why the claim went where it did.

6           So if you have a provider who got  
7           stuck with a \$10,000 home health claim and  
8           you can't explain to them why they got that  
9           claim it may be an okay measure but it's  
10          going to be a real challenge.

11          Because at some point the grouper  
12          has to be actionable on the part of the  
13          provider so they can make that correction.  
14          If there's something in the back that nobody  
15          really understands why it got assigned,  
16          well, you've got your measure and that's  
17          fine.

18          Depends on the level you're  
19          looking at. If you're at a really high  
20          level maybe it doesn't matter. But I can  
21          tell you when you get down to the individual  
22          level and you're actually docking somebody's

1 pay based on this you're going to have to  
2 have a pretty clean explanation as to why.

3 MR. DE BRANTES: This is  
4 Francois. I'm going to build exactly on  
5 Tom's comments because whether you're using  
6 it for pure payment purposes, or whether  
7 you're using it for analytic performance  
8 evaluation purposes you have to -- the  
9 physicians are going to look at not just  
10 which claims were assigned but whether or  
11 not the condition or the episode that was  
12 triggered was in their estimation a valid  
13 episode.

14 So in other words, based on the  
15 criteria that the episode grouper is using  
16 to determine whether or not a patient has  
17 essential hypertension, or hypolipidemia or  
18 ischemic heart disease, or some other  
19 conditions, or had one procedure versus  
20 another procedure, is that even a valid  
21 determination.

22 So in other words, does that

1 actually match the clinical evidence of that  
2 patient based on the physician's medical  
3 records.

4 And if it doesn't, I mean if  
5 there's no matching whatsoever then it's a  
6 completely invalid output.

7 So, I think we're caught in a  
8 dilemma because -- and in full disclosure I  
9 had this conversation with NQF way over a  
10 year ago when they started this process of  
11 establishing criteria for measuring  
12 efficiency.

13 And at one point we were looking  
14 at whether or not we would bother applying  
15 for into that process. And the answer at  
16 the end was no because the language used to  
17 determine these criterion have nothing to do  
18 with a grouper.

19 And so I think it's the language  
20 that has been developed and the evaluation  
21 criterion used by NQF traditionally are for  
22 measures.

1                   And here we're not talking about  
2                   a measure. We're talking about a grouper  
3                   which is a process to assemble claims into  
4                   logical units of inference, or as logical as  
5                   they can be. And then used for various  
6                   purposes as Mark and Steve and others have  
7                   mentioned.

8                   And so if you're going to  
9                   evaluate the logic of that grouper to  
10                  determine whether or not it does have any  
11                  resemblance to the medical reality of the  
12                  patient it requires a different way of  
13                  looking and evaluating and establishing  
14                  criteria than I think NQF has done in the  
15                  past.

16                  So, if you ignore the grouper  
17                  itself then you're asking people to submit  
18                  for potentially 300 measures or 500  
19                  measures. Or maybe they decide oh, I'm just  
20                  going to file for diabetes but how does that  
21                  even make any sense.

22                  So I think we're -- and again,

1 this is like an 18-month now, or 24-month  
2 discussion. And we need to resolve this  
3 today. Because otherwise I don't even know  
4 why we're on this call.

5 DR. CACCHIONE: Tom, I'm going to  
6 come back to you. I want to ask a question,  
7 then we'll go to Dave.

8 What do you consider the source  
9 or the benchmark -- what do you consider the  
10 source of truth when you compare grouper  
11 tools to grouper tools?

12 And what do you consider, as you  
13 have done the analytics on this what do you  
14 consider the source of truth and what are  
15 you establishing as the benchmark?

16 MR. MACURDY: I said you got  
17 different results. I don't know the source  
18 of truth.

19 I mean, ultimately what -- I  
20 mean, I don't think I'm the best person to  
21 judge on that sort of thing. Ultimately  
22 what you need are the clinicians you're

1       trying to provide information to and  
2       incentivize to provide better care as to  
3       whether it's something that's understandable  
4       to them and actionable and moves them in the  
5       direction that whoever happens to be paying  
6       them or supervising them wants them to go.

7                   DR. CACCHIONE:  The problem is  
8       that most of the providers are in an  
9       information void.  Being on the front line  
10      they're in an information void.

11                   MR. MACURDY:  But that's part of  
12      the goal of the grouper is to give them  
13      better information.  And that is doable,  
14      it's just right now the way the -- you know,  
15      it's difficult.

16                   DR. CACCHIONE:  Most of them  
17      can't spell "episode" right now or  
18      understand it.

19                   (Laughter)

20                   MR. MACURDY:  Well, if it's not  
21      understandable to them you haven't been  
22      successful on doing it.  It's going to be



1 very difficult to make a payment modifier  
2 based on that.

3 DR. CACCHIONE: David.

4 DR. MIRKIN: I may be getting  
5 ahead of the discussion but Tom was talking  
6 about attribution which is a very important  
7 issue obviously.

8 But I'm just wondering given all  
9 these experts around here is an attribution  
10 rule, even a rule set, essential to the  
11 definition of a -- essential part of an  
12 episode grouper? Or is there so many ways  
13 to slice and dice attribution is that an  
14 entirely different topic?

15 MR. MACURDY: I don't think it's  
16 a different topic. I mean, attribution,  
17 first of all it can be sliced and diced  
18 different ways.

19 The easiest way to see that is if  
20 you take -- just take concretely, say, a  
21 hospital admission. Well, depending on  
22 which kind of provider group you're

1 evaluating, be it the physician, be it the  
2 hospitalist, be it the anesthesiologist,  
3 what's relevant for them in terms of grouper  
4 may be different.

5           If it's provider-centric  
6 attribution is really fundamental. If it's  
7 patient-centric it's not so fundamental  
8 because patient-centric is the patient is  
9 looking and they may not care which  
10 providers are giving them services, how that  
11 sequence is put together.

12           But from a provider perspective I  
13 think it's absolutely essential. But it's  
14 also multiple ways. Is is -- completely.  
15 For one set of providers it's one, for  
16 another set of providers it's another. So  
17 there's no uniqueness there.

18           MS. GARRETT: So, I'm just  
19 building on what Francois said. I really  
20 agree that we're talking about evaluating  
21 building blocks, not a measure. And so I  
22 think we're going to have to really change

1 the criteria.

2 And so it would just be helpful  
3 to understand a little more of the context  
4 of why the group is convened. Is it because  
5 CMS is going to be required to bring their  
6 publicly available measure through the NQF  
7 endorsement process? Is that the reason?  
8 And if so we have to figure out how to do  
9 that, how to get ready for that. Or is that  
10 still in question.

11 And then are the commercial  
12 grouper companies going to -- is Optum going  
13 to bring ETGs forward for NQF endorsement.  
14 I mean, what's their rationale for doing  
15 that and would they even do it. So I have  
16 some questions about what are we doing here  
17 and why.

18 MS. MARTIN ANDERSON: And this  
19 issue has been around for awhile. Because  
20 the day that measures that were based on  
21 episodes start coming in for endorsement  
22 you're already dealing with, well, what do

1 you do with the grouper and how do you  
2 evaluate the underlying grouper. So I think  
3 it's been around for awhile.

4 I think what we'll do because as  
5 this panel was empaneled for, we're going to  
6 go forward saying you actually can. For the  
7 rest of this afternoon we're going to go  
8 forward and say you actually can evaluate a  
9 grouper. And we're going to try to figure  
10 out how you do that. Even if it means  
11 changing this criteria.

12 And just keep in mind a couple of  
13 things. One is how useful is it if when you  
14 define it everything passes. So everybody  
15 who has a grouper brings it in, they're all  
16 endorsed, we're in the same spot. You're  
17 still then looking at the measures.

18 And that's okay, that can be an  
19 outcome, but at least there's a vetting  
20 process.

21 And doing that while also not  
22 trying to shape the science through what

1 we're doing. So I think we have a needle to  
2 thread that I think will be hard. But I  
3 think we should now just jump to saying  
4 okay, we don't have to start with the NQF's  
5 measure process. It was a place to look at,  
6 to think about.

7 I think we've heard already that  
8 there is at least some interest in the  
9 components that might not look the same but  
10 be similar around the scientific  
11 acceptability on reliability and validity.  
12 And then I think there's been a focus on  
13 validity but both apply.

14 And then there also has been a  
15 number of comments on the feasibility  
16 elements and usability.

17 So, let's try to figure out  
18 should we eliminate any of those categories.  
19 Should we just say, hey you know what, I  
20 can't get my head around importance, I can't  
21 get my head around whatever.

22 And then say what else would we

1 add. If we're going to do breakout groups  
2 we have to decide what we're breaking out to  
3 talk about. So, let's start with at least  
4 what are these high-level categories that we  
5 think are important if you're actually going  
6 to endorse a grouper. Steve?

7 DR. BANDEIAN: Hi. I obviously  
8 missed most of the discussion. My daughter  
9 is on their way to the emergency room right  
10 now with paroxysmal atrial tachycardia but I  
11 can't do anything about it so I might as  
12 well come back to the conversation.

13 (Laughter)

14 DR. BANDEIAN: I think she's  
15 fine. The doctor said she was laughing and  
16 taking pictures of herself with the cell  
17 phone at the student health. And her mom is  
18 in South Africa. My wife, her mom, is in  
19 South Africa.

20 (Laughter)

21 DR. BANDEIAN: Anyway, so I  
22 obviously missed most of this.

1           The importance issue -- let me  
2           just -- that to me seems to me to be kind of  
3           an issue of use of NQF resources. Like, if  
4           an illness affects a -- well, as long as  
5           there are enough people to do statistics on  
6           the illness and if somebody can do a useful  
7           set of measures that are helpful to that  
8           illness even if it's pretty rare in the  
9           scheme of things I wouldn't know that that  
10          means that it shouldn't be done.

11                 So I don't quite understand the  
12           purpose of importance other than  
13           prioritization of NQF resources. Is that  
14           really what the purpose of importance was?

15                 MS. MARTIN ANDERSON: When we're  
16           looking at individual measures it's really  
17           is this important to measure. Does it have  
18           value in being endorsed and worth the  
19           resources.

20                 I think the question is how does  
21           that apply to one grouper system versus  
22           another. Can you look at one and say is

1 this one important, is that one important.  
2 Or are they already fundamentally so similar  
3 in their --

4 DR. BANDEIAN: Yes. I guess,  
5 again, I missed almost all the discussion.  
6 To me it does seem as though one should look  
7 at the system to see how well the system  
8 works.

9 There needs to be some checking  
10 to make sure that the logic for individual  
11 conditions is okay as well. That may be a  
12 different level of scrutiny. But I could  
13 easily imagine that in a comprehensive  
14 system that addresses all conditions there  
15 would be some conditions that wouldn't make  
16 it onto anyone's top 100 list. Even there  
17 though.

18 So you might think about some  
19 alternative sort of lesser resource-  
20 intensive way of being able to pass judgment  
21 on -- you know, there's like probably, I  
22 don't know, depending upon how you slice and



1 dice there could easily be one to two  
2 thousand conditions in the entire universe.

3 MS. MARTIN ANDERSON: So let me  
4 ask another parallel question here to help  
5 get us focused again.

6 Is it possible or is it desirable  
7 to endorse a grouper, or are you talking  
8 about endorsing the episode construction for  
9 some subset? So, is it -- do you evaluate  
10 whether or not a grouper for AMI, or a  
11 grouper for diabetes, are you evaluating  
12 them all separately or could NQF steering  
13 committees actually evaluate the whole  
14 grouper itself? Can you create a list of  
15 sample conditions or something that would  
16 allow you to evaluate the entire grouper all  
17 at once?

18 MR. DE BRANTES: This is  
19 Francois. Just a couple of points.

20 So, on the importance you can  
21 boil it down to potentially how much of  
22 total spend does the grouper cover.

1                   Because if, you know, you could  
2                   theoretically have someone go in and submit  
3                   for endorsement a grouper that only covers  
4                   two conditions, or one specific set of  
5                   procedures. That would be a very small  
6                   percentage of total spend and specify  
7                   Medicaid, Medicare, commercial.

8                   Versus a grouper to Steve's point  
9                   which is an entire system that covers  
10                  everything in which case obviously it has a  
11                  lot of importance because it's going to  
12                  cover 80 percent, 90 percent of total cost  
13                  of care.

14                  So, all the rest of the questions  
15                  become meaningless because if you're  
16                  covering 80 percent of care of course you're  
17                  covering -- it's important. Then you've got  
18                  lots of variation and so on and so forth.

19                  So that might be a way to cut to  
20                  the chase at least from a -- is it  
21                  important? Yes, if it covers a lot of -- a  
22                  significant percentage of total cost of care

1 it's important.

2 And then to your other question  
3 about should NQF waste its time evaluating a  
4 grouper for one condition or two conditions.  
5 I mean, that's NQF's decision.

6 MS. MARTIN ANDERSON: Okay.  
7 Mark.

8 DR. LEVINE: I again think that  
9 we should bifurcate in the sense that if one  
10 is looking at a grouper whose intent is to  
11 inform upon payment, spending, financial,  
12 population performance then, for instance,  
13 looking at importance you'd look at  
14 percentage of spend and what it is that  
15 you're -- are you coming up with valid  
16 measures that reflect your intent.

17 But if the intent of the grouper  
18 is to inform upon practice and performance  
19 then you might be able to look at importance  
20 might be the amount of a physician's  
21 practice that you're actually able to  
22 address, et cetera. So again, separate

1 criteria for separate use cases would seem  
2 to be in order.

3 MS. SIMON: I would be concerned  
4 about framing it in the context -- or  
5 importance in the context of total spend  
6 because children will lose out. And I think  
7 that's pretty important to incorporate total  
8 population. If you're going to improve  
9 overall health.

10 MR. REDFEARN: Just a slightly  
11 different take on that.

12 In the conversation I've had with  
13 the 3M folks before they went into this  
14 full-blown PFE the argument that they were  
15 making is that the real episodes are  
16 basically hospital-based episodes. It's an  
17 admission plus things that surround that  
18 admission and discharge.

19 And the explanation for that is  
20 that's where the money is. That's where the  
21 expensive care occurs and that's what you  
22 should be focusing on.

1                   So it doesn't have to account for  
2                   80 or 90 percent of the total experience to  
3                   be important I think in that context.

4                   MR. MACURDY: I wanted to address  
5                   the earlier question about whether you have  
6                   to evaluate the whole grouper or particular  
7                   components of the grouper. It depends on  
8                   the grouper.

9                   And the best example there is if  
10                  you were to look at groupers like ETG, less  
11                  so MEG.

12                  The difficulty there is when you  
13                  look at the particular outcome for one  
14                  measure there is this competition that's  
15                  taking place on the back end about where a  
16                  claim goes. So there you almost have to  
17                  understand what overall the grouper is doing  
18                  to be able to figure out why it did the  
19                  assignment it did.

20                  Another -- and 3M was a good  
21                  example. If you take 3M, you could take  
22                  each individual one and they're modular so

1 they're pretty well self-contained and you  
2 wouldn't really need to understand what was  
3 happening with the other episodes to be able  
4 to do that. So I think it really depends on  
5 the grouper constructed.

6 DR. MIRKIN: I would like to  
7 agree with Mark that it really depends on  
8 the use case and maybe expand that a little  
9 bit that the use case would include  
10 population.

11 So, for pediatrics the use case  
12 would be if we're going to evaluate the  
13 quality of care in the pediatric population  
14 that's one use case. And I think Francois  
15 would agree with that in terms of we might  
16 want to measure total cost of care for that  
17 population in that setting. And I also  
18 agree that they're also different.

19 And then finally, I know it's not  
20 directly related to this, but again in my  
21 role as a software basically marketer or  
22 seller for MedInsight one of the things that

1 happens is we produce so much information to  
2 our clients is that they basically want to  
3 winnow it down.

4           So I do think that there needs to  
5 be some way of maybe prioritizing the actual  
6 -- what's most important for a particular  
7 use case. Which is different than  
8 evaluating it for endorsement. I think  
9 that's -- it sort of fits in that same  
10 bucket.

11           MR. BODYCOMBE: I think I would  
12 have to put myself along the lines of  
13 Kristine's argument about I think there is  
14 some sense in looking at that.

15           Episodes are kind of a commodity.  
16 And they exist in a context. And when  
17 you're evaluating a performance measure I  
18 think you need to think about is it  
19 important to look at this measure in the  
20 context of an episode, or would it be just  
21 as valid outside of that episode.

22           And as I think I was indicating

1 before, yes, it really depends on the  
2 specific instance. You know, like every  
3 episode grouper is different. They define  
4 episodes somewhat differently.

5 It gets back to that use case.  
6 When you get down at the micro level maybe  
7 one's better than another, but that all gets  
8 lost when you look at a global evaluation of  
9 it.

10 MR. HOPKINS: So, Kristine,  
11 you've asked the right and the very  
12 difficult question. Can we mention  
13 endorsing a grouper?

14 I don't know the answer to that.  
15 It's difficult to see how one would go about  
16 that.

17 If one did I think you'd reach  
18 the conclusion that most of the groupers  
19 that are widely used meet these criteria.

20 And I sure can't imagine anybody  
21 trying to answer which is the best in class.  
22 Some are probably better at doing some



1 things and some at others.

2 By the way, the ones that I'm  
3 familiar with have all been put together  
4 with very solid clinical expert panels.  
5 There were a bunch of clinicians that  
6 advised these folks on how to do the  
7 grouping and all of that.

8 And yet they come out somewhat  
9 differently. So, it's hard to imagine that  
10 one could endorse groupers.

11 On the other hand, you have to  
12 consider the implications of not endorsing a  
13 grouper. Which is what we saw in one of the  
14 recent Cost and Resource Use Steering  
15 Committees where they were grappling with a  
16 specific use and very specific to a  
17 condition as I remember or procedure.

18 And are we going to have expert  
19 advisory committees for NQF go through this  
20 exercise every time? Of deconstructing the  
21 episode that's under consideration and  
22 rehashing the same issues.

1                   And by the way, while I have the  
2 floor I just want to note that a couple of  
3 times we've sort of passed through some  
4 mention of actual versus standardized  
5 pricing. I hope we can come back and have a  
6 discussion of that as a property of actually  
7 a grouper but also the use of groupers.

8                   Because I don't want to see what  
9 went on in that steering committee again  
10 which is the whole discussion about what's  
11 right, is actual versus standard,  
12 standardized. And no, you shouldn't use  
13 actual pricing because of X, Y and Z. Let's  
14 see if we can at least resolve that one  
15 here.

16                   MS. MARTIN ANDERSON: I think two  
17 reasons we passed by it. And we'll see if  
18 either one of them changes. Because I did  
19 hear it.

20                   One is it's getting into a  
21 detail. We have to figure out how it's  
22 going to fit in the framework. So is that

1 going to be something that gets into the  
2 scientific acceptability? Or is it  
3 something where the science differs and you  
4 just want transparency? I think we're just  
5 going to have to deal with that. There's  
6 lots of issues like that. Should a claim go  
7 in one episode versus many.

8           Those are kinds of examples of  
9 things that are the detail of constructing a  
10 grouper and using a grouper. And we just  
11 have to decide if they have any place in how  
12 you evaluate groupers given that our  
13 objective is not to tell someone what they  
14 have to do to get to a grouper.

15           I know the couple of times that  
16 we've kind of gone down that route I think  
17 we've regretted that from a point of view  
18 outside of episodes.

19           DR. BANDEIAN: I'm still having  
20 trouble with -- and I'm sorry, maybe the  
21 discussion has moved on. But I'm still  
22 having trouble with the issue of importance.

1                   And to me there are, you know,  
2                   this is a great big country. There are all  
3                   sorts of healthcare programs, and there are  
4                   all sorts of users who may have different  
5                   priorities than national, you know, the  
6                   Medicare program, what have you.

7                   So, to me the only issue with  
8                   importance is is it worthwhile NQF spending  
9                   its time on the subject given that you have  
10                  a limited amount of time.

11                  So it's kind of like the Supreme  
12                  Court deciding not to issue certiorari to  
13                  consider an appeal.

14                  And so I could see that you might  
15                  say well, you know, it may well be  
16                  worthwhile but we can't look at it.

17                  Now, having said that, to me on  
18                  the other point which is I think you do need  
19                  to make sure that the methodology in the  
20                  grouper system as a whole is sound. And so  
21                  I think the system does need to be  
22                  evaluated.

1                   And then it would seem to me at  
2                   least for those conditions which are quote  
3                   unquote "very important" then one would need  
4                   to make sure that the logic for, for  
5                   example, coronary disease or heart failure  
6                   was sound and that you would look at some  
7                   outputs from the system relative to coronary  
8                   disease or heart failure and convince  
9                   yourself that when this grouper is saying  
10                  that somebody has a high cost for heart  
11                  failure or coronary disease that that is a  
12                  valid conclusion and that the user can act  
13                  upon that conclusion.

14                  With regard again to these -- and  
15                  Tom is exactly right that there is  
16                  competition for the assignment in the  
17                  background. And so that's again part of the  
18                  reason why you need to look at the system as  
19                  a whole. But it also might be for these  
20                  things that are, quote, "less important"  
21                  maybe there would be a less resource-  
22                  intensive way of at least saying if they've

1 done XYZ in developing their logic for these  
2 500 lesser conditions then it's probably  
3 good enough and we'll sort of provisionally  
4 or kind of give it a 50 percent endorsement  
5 as opposed to the intense review of the  
6 critical -- I'm being a little, you know, I  
7 don't know the right language here.

8           But I'm saying for the things  
9 that are really, really, really important,  
10 dollars or lives, I think you need to  
11 actually be convinced that the system is  
12 functioning properly.

13           For the other stuff, well, it may  
14 be very important to the patients who have  
15 those conditions, et cetera, et cetera. But  
16 given that you have limited resources you  
17 may need to come up with a sort of less  
18 resource-intensive way of saying in general  
19 it looks okay and maybe eventually we'll be  
20 able to get around to looking at the  
21 specific details.

22           MS. MARTIN ANDERSON: So, we are

1 a little over time. Thank you, Steve.

2 We're going to start talking a  
3 bit now about the key modules. I just want  
4 to ask you guys is it something you really  
5 feel like you need to get out now? Because  
6 we have a whole -- we'll be in deep on this  
7 for the rest of the day. Okay.

8 Marjorie? You haven't said much  
9 so go ahead.

10 DR. KING: I just wanted to get  
11 in the point that as a clinician and as  
12 someone who has submitted a measure for  
13 endorsement, it's been endorsed and re-  
14 endorsed, et cetera, I understand where  
15 you're coming from with this.

16 But you may want to think about  
17 that the importance and the scientific  
18 applicability are not the pass-go steps for  
19 this particular project.

20 That the pass-go steps really are  
21 is it understandable, is it valid, is it  
22 reliable. And they may want to go up to the

1 top.

2 Because this importance thing is  
3 one paragraph and you're done for this.

4 MS. MARTIN ANDERSON: So yes,  
5 we've got that. I think for now we'll leave  
6 it in because there was some debate about  
7 it, but does not mean it will be -- in any  
8 way what's done for measures just be adapted  
9 here. So, Taroon?

10 MR. AMIN: Okay, great, Kristine.  
11 So, again, so for context where we're going  
12 now is that we wanted to introduce the  
13 criteria, what we've been using.

14 It doesn't -- you know, that it's  
15 a starting point and we'll continue to have  
16 this discussion as we talk through each of  
17 the modules both today and tomorrow. So  
18 we'll come back to this to make sure that  
19 we're all in alignment.

20 And so what we're really talking  
21 about now is that when we're talking about  
22 the scientific acceptability of the grouper



1 and the grouper measures that come out of  
2 the grouper we wanted to start with a straw  
3 person of the key elements of the grouper.

4 And these are by no means  
5 intended to be sequential, first and  
6 importantly, nor is it intended to be a  
7 steady state meaning that these are all  
8 adjustable.

9 So the questions that we want you  
10 to consider as we go through this section  
11 are do these modules reflect the major  
12 elements of episode groupers. Let's just  
13 call it episode groupers, not construction  
14 but episode groupers.

15 And again, we want to have the  
16 most diverse perspective around that, around  
17 every type of episode grouper that's out  
18 there, ETG, MEGs, the PROMETHEUS product,  
19 the Medicare grouper.

20 So do these modules reflect the  
21 major elements? Are there elements missing?

22 And secondly, we want to look at

1 the components within the modules and we  
2 want to make sure that that association is  
3 appropriate, or at least that we can live  
4 with the classification system that we've  
5 developed.

6           Again, for context what we want  
7 to be able to do after this is take whatever  
8 key modules we come out with. You know,  
9 let's assume that we're starting with  
10 construction, clinical and adjustments for  
11 comparability, and that we'll break out into  
12 groups and each group will be responsible  
13 for each one of these modules.

14           They will be evaluating the best  
15 practices -- sorry, that's not the right  
16 term -- the key principles that one should  
17 keep in mind for each of the modules and the  
18 components.

19           Also, think about what use cases  
20 may do to the specification. If there is  
21 some guidance related to how the use might  
22 change the construction of the module.

1                   And the relevant criteria for  
2 each of the modules. So those are the key  
3 things that we'll be looking at this  
4 afternoon.

5                   So, what I want to present to you  
6 now is just this straw person for your  
7 reaction. And the key takeaway before we  
8 break for public comment and lunch and where  
9 we want to get to is ensuring that we're in  
10 general agreement around the construction of  
11 these modules and the components within the  
12 modules.

13                   So let's get started with  
14 construction logic. Although it probably  
15 would have been easier to start with  
16 clinical logic now that I think about it.  
17 Go ahead.

18                   DR. BANDEIAN: Why -- I'm just  
19 again curious why do we want to do this?  
20 Why do we want to identify the modules?

21                   MR. AMIN: So, the way that we're  
22 -- the reason why I wanted to set it up this

1 way is because we still think that -- so,  
2 the purpose of NQF endorsement, let's just  
3 take it all the way back, is that we want to  
4 have some standardized specifications for  
5 national comparison.

6 And so if you're using this  
7 episode grouper we want -- the straw person  
8 we're working from here is that these  
9 modules represent the specification of an  
10 episode grouper system. That is where we're  
11 starting.

12 Now, if that -- if others  
13 disagree with this setup, that this is not  
14 really the specification of what an episode  
15 grouper contains we can have that  
16 discussion. But maybe if I can just start  
17 with where we -- start here and then we can  
18 disagree if this is not an appropriate  
19 approach.

20 DR. BANDEIAN: I'm sorry to press  
21 the point but I'll --

22 MR. AMIN: Go ahead, please.

1 DR. BANDEIAN: -- one more time.  
2 So, for example, missing data. Why is that  
3 there? Well, presumably it's there because  
4 it somehow relates to perhaps validity, or  
5 maybe to feasibility or some such.

6 So, and why are complementary  
7 services here? Complementary services I  
8 think, if I understand what that means and I  
9 think I do understand what it means would be  
10 like anesthesia. And so here a person gets  
11 surgery. Now, how are we going to put the  
12 anesthesia with the surgical episode  
13 perhaps. Maybe that's what's intended or  
14 not.

15 MR. AMIN: Perhaps, yes.

16 DR. BANDEIAN: Again though that  
17 strikes me as a validity issue. Because if  
18 the anesthesiologist puts on his claims or  
19 her claims -- my mom is an anesthesiologist  
20 -- you know, COPD because that's what he or  
21 she is most concerned about as a risk factor  
22 for the patient, but the patient is actually

1       undergoing cardiac surgery it should  
2       probably go into the cardiac surgery episode  
3       as opposed to the COPD episode.

4                   But that again is sort of an  
5       issue of validity of the construct.

6                   So it seems to me that these are  
7       all things that are in grouper systems as a  
8       means to an end.

9                   And I think there really are two  
10      ends. And number one is validity and number  
11      two is actionability of the outputs.

12                   And so to me I would first try to  
13      flesh out those concepts. Because maybe  
14      there are different ways of accomplishing  
15      the goals of validity and actionability, and  
16      not necessarily these specific components.

17                   MS. WILBON: Right. So let me  
18      just try to give you a little context on  
19      kind of where our starting point framework  
20      is for doing kind of evaluation of measure  
21      work.

22                   Generally the way we've

1 structured our evaluation of measures on the  
2 resource use side, we're starting with  
3 quality and then kind of moving into  
4 resource use, is identifying what  
5 information do we need from the developer in  
6 order to (a) understand how the measure  
7 works.

8                   Which these components  
9 essentially represent if a developer was to  
10 submit a grouper to us, for example, we  
11 would want to know how they've handled these  
12 different things, and explain and describe  
13 their rationale for why they decided to do  
14 it that way to make sure that it aligns with  
15 the intent, that it aligns with the intended  
16 use that is transparent.

17                   So without having this type of  
18 information that you can't evaluate it  
19 without kind of understanding how these  
20 different components work.

21                   And similarly on our quality side  
22 we essentially asked for the developer to

1 submit specifications on the measure. And  
2 the criteria are applied in context of what  
3 has been submitted by the developer.

4 So we may find that these  
5 different components, that the validity  
6 criteria, whatever we decide those are, need  
7 to be applied to these different elements in  
8 order to determine whether or not the  
9 approach that's been specified is valid.

10 So, these are really kind of to  
11 help us understand (a) what types of  
12 information we would need to understand how  
13 the construction of the grouper has been  
14 proposed in order to give an evaluator an  
15 idea of what we're looking at. So that's  
16 kind of the context that we're coming from.

17 And the criteria piece will come  
18 as we kind of identify what those are and we  
19 figure out how we would actually determine  
20 whether or not it's appropriate.

21 DR. BANDEIAN: Okay. I'll just  
22 try one more. See to me, I heard what you



1 said, but to me what I would suggest is an  
2 alternative. But I understand you're pretty  
3 far down this road.

4 Is first to have a discussion of  
5 what the threats to validity are. Identify  
6 the threats to validity. And so, and then -  
7 - as opposed to saying let's have this  
8 component, identify what is going to put  
9 validity at risk. And have a bulleted list  
10 of these things. And then you would ask the  
11 developer what are you doing.

12 So rather than calling it a  
13 module I would say to the developer what are  
14 you doing to deal with complementary  
15 services. Not necessarily a module, but  
16 just the question -- or maybe I'm now  
17 getting tied into semantics.

18 DR. CACCHIONE: There's a little  
19 semantics here. I think that -- David, did  
20 you have a comment?

21 MR. REDFEARN: I just -- we're  
22 going to split up in groups and I guess

1 mechanically I'm concerned about that  
2 process.

3 I think we have a very wide  
4 spread of opinion here and I am concerned  
5 about chopping us into pieces so that we are  
6 not exposed to that wide range of  
7 experience. That's just mechanically an  
8 issue that I'm a little concerned about.

9 Especially since we're chopping  
10 it into pieces that the group has widely  
11 divergent opinions on whether that's the  
12 right way to do it.

13 MR. AMIN: So, I mean again, we  
14 have a tall order in the next two days. So,  
15 part of this is to achieve a little bit of  
16 efficiency.

17 However, this discussion right  
18 now and the discussion at the end of the  
19 breakouts is to bring some of these pieces  
20 together and to make sure that we have that  
21 diversity of opinion across the various  
22 different groups.

1                   We're open to making some changes  
2 here, but we're also trying to make sure  
3 that we're --

4                   DR. CACCHIONE: I think we ought  
5 to just keep with the program the way it is.  
6 I think we'll have a rich discussion  
7 afterward. Because I think there will be  
8 some efficiencies gained by being in  
9 breakout groups.

10                   And so as much as, David, I hear  
11 you and respect that, I think that there is  
12 some efficiency in breaking out and then  
13 reassembling to do a debrief.

14                   MS. MARTIN ANDERSON: I think one  
15 other thing we want to remind everyone is  
16 we're just, we're testing this. So this is  
17 one bite at an apple that we have to eat  
18 over a couple of months.

19                   So, it may not work. We may find  
20 that this isn't the right set of issues to  
21 discuss that the NQF staff has laid out for  
22 us.

1           But I think some of the right  
2 issues are at least in here. And then we  
3 can add others that we need to put together.

4           I do think there is a lot of  
5 diversity of experience in the room. And so  
6 we'll -- I guess the one risk that we run is  
7 that we'll get back together and we'll have  
8 to rehash each section.

9           But I think in that sense if  
10 that's the reality that is going to have to  
11 be the reality. We have to hear all  
12 viewpoints and see how we can advance.

13           I actually don't know how we're  
14 assigned, so. Are we choosing ourselves or  
15 are we assigned?

16           MR. DE BRANTES: Can I make a  
17 couple of comments? This is Francois. Can  
18 I just make a couple of comments?

19           MS. MARTIN ANDERSON: Yes, go  
20 ahead.

21           MR. DE BRANTES: Okay. So, on  
22 the construction logic I felt that there

1 were a few issues that were blended together  
2 that might best be kept separate.

3 So, if you -- because as you look  
4 at both -- you almost have to look at  
5 construction logic module and the clinical  
6 logic module and the components that you  
7 would put in there together.

8 So, the clinical logic has as I  
9 read it mostly issues around the rules to  
10 trigger episodes and close them and so on  
11 and so forth.

12 But then in the construction  
13 logic you also put clinical hierarchies. So  
14 the methods used to define the hierarchy of  
15 codes and condition groups.

16 And it seems to me that that's an  
17 inherent part of the clinical logic.  
18 Because if you're going to figure out how to  
19 trigger an episode and you're blending in  
20 some kind of clinical hierarchy in your  
21 definition of codes that's going to impact  
22 inherently how the grouper works to trigger

1 an episode. So I thought that was kind of  
2 putting something there that belonged in the  
3 other one.

4 And the construction logic to an  
5 extent as I read through this seems to be  
6 dealing mostly with what decisions are made  
7 to assign services to different episodes  
8 which is a very complex and important issue  
9 to discuss.

10 I'm not sure I would blend that  
11 with the attribution. Because the  
12 attribution here as I read it is really  
13 about attributing how claims are assigned to  
14 responsible entities.

15 Usually claims are not assigned  
16 to responsible entities because the claims  
17 emanate from an entity. It's the episode  
18 that ends up by being assigned to an entity.

19 So (a) let's be clear about what  
20 you're actually asking here.

21 And second, if it is about the  
22 assignment of episodes to providers that's a

1 completely separate issue from the  
2 construction logic and the clinical logic.

3 And we had a little bit of  
4 discussion earlier today. It deserves a  
5 separate conversation. And blending it in  
6 with the construction logic is going to --  
7 not going to be particularly helpful.

8 MR. AMIN: So, if it's okay with  
9 the chairs maybe I can just walk through  
10 these three modules really quickly, just  
11 talk about what's in them, and then we can  
12 open it up to see.

13 That is exactly the type of  
14 feedback we're looking for, Francois. And  
15 we can decide what to do with attribution.  
16 We can maybe have a separate group to  
17 discuss it, or we can figure that out.

18 But let me just make sure that  
19 we're all on the same page. I don't want to  
20 assume anything here.

21 So, the construction logic  
22 essentially is the methods of assigning

1 claims beyond that which is associated with  
2 the clinical logic.

3 So you can think about the  
4 clinical logic as essentially the individual  
5 episode, and then the construction logic is  
6 essentially how you're dealing with episodes  
7 and how they relate to one another. So,  
8 hierarchies, concurrence of clinical events,  
9 things of that nature.

10 There is some components here  
11 that may not be directly related to that  
12 topic around missing data, how missing data  
13 is handled in the system.

14 And then essentially what are the  
15 resource use service categories that are  
16 built into the episode grouper, meaning --  
17 resource use service category would include  
18 sort of durable medical equipment, or  
19 pharmacy claims, things of that nature.

20 What are the categories that these services  
21 are assigned to.

22 And attribution would be



1 essentially -- I think the intent of this  
2 was to describe what Francois is describing  
3 which is how the episode essentially is  
4 attributed to an entity.

5           The clinical logic on the next  
6 slide is essentially the definition of how  
7 the individual episode is constructed,  
8 meaning the trigger and end mechanisms and  
9 potentially interactions of comorbidities  
10 and how that is handled in the system.

11           And then finally, adjustments for  
12 comparability includes inclusion and  
13 exclusion criteria broadly, meaning the  
14 claim line or other data quality exclusions,  
15 high-dollar claims, Winsorization, any other  
16 approach that's included there outside of  
17 the trigger and end mechanisms.

18           Your risk adjustment methodology,  
19 your stratification approach, if any, the  
20 costing method which David was referring to  
21 before around actual versus standardized  
22 pricing approaches, and then the scoring

1 methodology of how you come up with the --  
2 whether you're using an O/E ratio, observed  
3 to expected and how one could interpret  
4 that.

5 DR. CACCHIONE: There seems to be  
6 a lot of overlap in these. I mean, these  
7 are sort of arbitrary, the buckets.

8 MR. AMIN: Absolutely.

9 DR. CACCHIONE: Because I look at  
10 clinical severity levels versus  
11 stratification versus risk adjustment. And  
12 I think that some of the uncomfortable -- I  
13 just have sort of -- because it just doesn't  
14 -- it's not clean.

15 MR. AMIN: Okay.

16 DR. CACCHIONE: And I'm not sure  
17 that I have a solution for you. Just it  
18 doesn't feel quite right looking at these  
19 because there is a lot of overlap.

20 David, you have some comments?

21 DR. MIRKIN: I was just going to  
22 say what you just said pretty much.

1 (Laughter)

2 DR. MIRKIN: Other than maybe --  
3 one thing that helped me was to get rid of  
4 the modules and get rid of the titles for  
5 the modules and just say there's a bunch of  
6 topics that in order to get through them  
7 they're going to have to divide the group up  
8 to attack those topics.

9 And maybe as we discuss  
10 individual topics we may say this is a total  
11 overlap. Or maybe, I don't know if you want  
12 to spend the time going through some of that  
13 now? Because I do agree there's a lot of  
14 overlap.

15 And when you actually look at  
16 those individuals who are actually building  
17 episode groupers these are all part of one,  
18 you know, one thought process. There's one  
19 logical process that they go through. So,  
20 anyway.

21 MS. MARTIN ANDERSON: We'll take  
22 proposals. We've got a half hour to figure

1 out what we're going to do after lunch. So  
2 if there are alternate proposals let's get  
3 them out.

4 DR. CACCHIONE: So, do we want to  
5 hold to this sort of breakdown of the three  
6 modules? Or do we want to think about  
7 things differently and break it down  
8 differently? Mark?

9 DR. LEVINE: There's an interface  
10 between the grouper and the user of the  
11 grouper that is murky in my mind.

12 For instance, one talks about  
13 attribution. That will depend upon what the  
14 user is intending to do with the underlying  
15 technology that is able to group claims in  
16 an appropriate way.

17 And so if we're really going to  
18 be looking at what are the criteria for a  
19 grouper we also need to discuss when does  
20 the responsibility of the grouping and we  
21 pass it over to the user to be able to pick  
22 up at this point in time and apply it to a

1 given use case.

2 And that's within the context of  
3 these broad use cases of a patient-centric  
4 approach versus a provider-centric approach  
5 which I think is a useful bifurcation.

6 DR. CACCHIONE: Is that a  
7 bifurcation that we ought to think about in  
8 terms of the breakouts? Thinking about the  
9 use of these as a patient. And I think,  
10 Tom, you were the first one to -- but  
11 breaking it on that -- that's the breakout?  
12 Is it around patient-centric versus  
13 provider-centric?

14 And then addressing all of these  
15 issues. David?

16 MR. HOPKINS: Sort of addressing  
17 the same issue. I think there's some logic  
18 to having the breakouts. It matters less to  
19 me what the labeling is of construction  
20 versus clinical logic than that the bullets  
21 underneath are meaningful. So we can have  
22 discussions of those.

1                   But I've heard suggestions that  
2                   there's two big bullets here that really  
3                   ought to be discussed by all of us. So one  
4                   is attribution and the other is what I guess  
5                   is referred to as costing method. Those are  
6                   big topics and I don't think they should be  
7                   limited to breakouts.

8                   MR. MACURDY: I just wanted to  
9                   note that I mean, obviously, I have no  
10                  objections to discussing how to rearrange  
11                  these. But I assume that when we're all  
12                  done it's not going to be super satisfactory  
13                  to everyone already.

14                  And the fact that there's overlap  
15                  here I would have thought people would be  
16                  happy with because everybody wanted to have  
17                  one meeting to start with. The fact that  
18                  there's overlap is kind of fine.

19                  I mean, no matter what -- if I  
20                  did mine, people would object. You do  
21                  yours, it seems like it's fine.

22                  I think maybe underneath if

1 there's maybe following up with David, if  
2 you want to have like attribution across  
3 many maybe we can do that, something of that  
4 nature so that we can get more discussion  
5 and have the breakouts and then people can  
6 share their ideas when they get back.

7 But I would have thought trying  
8 to reorganize them is going to be a lot of  
9 time for something about where we're going  
10 to be.

11 DR. CACCHIONE: To staff, I mean,  
12 other than the fact that these -- you had to  
13 draw lines somewhere. That's great. I  
14 mean, is there going to be enough -- with  
15 all the overlap you guys will feel  
16 comfortable with synthesizing this into some  
17 sort of logical rule around these different  
18 modules?

19 MR. AMIN: So, these, just for  
20 context these modules are reflected in terms  
21 of the specifications that we get for cost  
22 and resource use measures already.

1                   And we recognize that there is  
2                   some overlap, again, specifically around how  
3                   we handle the severity levels and the  
4                   comorbidity interactions. I think that's  
5                   what's causing a lot of -- and the clinical  
6                   hierarchies which is what's causing some  
7                   concern.

8                   But part of what we're trying to  
9                   get from this is which of these components  
10                  can we sort of eliminate or combine. And so  
11                  if we could just, you know, if we go through  
12                  the discussion it will become very natural  
13                  to us which ones to take away.

14                  So in summary, I feel pretty  
15                  comfortable that we could probably get that  
16                  information from the work groups.

17                  MS. WILBON: I think from a  
18                  broader perspective it would be useful to  
19                  know whether or not there are things that  
20                  are glaringly missing.

21                  If it's an issue that there's  
22                  overlap like Taroon I'm less concerned about



1 that, as opposed to making sure that we  
2 captured everything that potentially we  
3 might want to evaluate if we were to look at  
4 a grouper or individual episodes within a  
5 grouper.

6 So, if we could kind of maybe,  
7 like David suggested kind of take a step  
8 back, try not to look at the labels that  
9 we've given these different buckets and kind  
10 of look within the buckets and determine  
11 whether or not there's anything here that is  
12 -- or anything that's missing.

13 Again, I think the overlap is  
14 something that we can address as we kind of  
15 synthesize the information and hear your  
16 discussion. It'll give us an idea of how we  
17 might actually frame the criteria.

18 Because the criteria have to be  
19 based on something. It has to be based on  
20 either the components that we're asking for  
21 within the grouper, or things that we think  
22 represent what a grouper is.

1                   So, I think I'm still struggling  
2                   in understanding, you know, getting some  
3                   consensus from the group on where you are  
4                   with what we think actually consists of the  
5                   grouper. So, I don't know if that helps  
6                   anyone.

7                   MR. MCLEAN: So, one, I start off  
8                   by saying I'm okay with doing it this way if  
9                   you want to do it that way.

10                  I think where I'm struggling  
11                  though, where I think most people is  
12                  struggling is when I step back for a program  
13                  for BDC and select a grouper that I want to  
14                  use for this evaluation I don't look at it  
15                  this way.

16                  I look at it in a holistic form  
17                  of what I want and what my use case is, what  
18                  my purpose is. If I'm looking at it from a  
19                  provider evaluation, or I'm looking at it  
20                  from a patient-centric evaluation.

21                  And then I look at for each  
22                  component in a holistic form. I don't look

1 at it in parsing it out.

2 And so it would be easier for  
3 this group to take a step back and say well,  
4 this is your user case. Now, what  
5 components need to go from your perspective  
6 into that grouper?

7 So if we want to make a change  
8 that would be my suggestion. But otherwise  
9 I would just do it the way it's set up.

10 MS. HOBART: I had a comment and  
11 a question. My comment was basically the  
12 same, that I think if you're a health plan  
13 or something else you're applying the whole  
14 package.

15 So you want it to have certain  
16 characteristics, that it's easy to explain,  
17 it's consistent over time and other things,  
18 that it's going to be holistic, not so much  
19 individual components as how they come  
20 together. So at some point I think we need  
21 to put that openly.

22 My question is when we're talking

1 about the provider-centric versus patient-  
2 centric whether that's the organizing  
3 principle of the logic as to whether it's  
4 tagged to the person versus the provider, or  
5 it's the use case as to who's taking the  
6 results and using it. I just wasn't clear.

7 DR. CACCHIONE: So I guess one of  
8 the questions -- and I'm going to answer a  
9 question with a question and get consensus  
10 from the group.

11 Do you think that within each of  
12 these modules that we should -- is it  
13 important to think about a construct that  
14 would divide this into a patient-centric and  
15 a provider-centric within each of the  
16 modules? And to see if within each of these  
17 modules there is a separation about these  
18 issues?

19 Or is there just enough of an  
20 overlap that it shouldn't be -- that we  
21 should just sort of go generically and look  
22 at these modules?

1                   Because in the absence we are  
2 talking here, in the absence of any concrete  
3 proposal we're going to stick with what  
4 staff has put together for our discussion  
5 purposes simply because we'll sit here all  
6 day and try to figure out how to break it  
7 up.

8                   So, I would just say we'll stick  
9 with what staff proposed. And I just offer  
10 that up as a potential way to sort of take  
11 it a different route within each of those  
12 modules.

13                   MR. MCLEAN: You guys put it  
14 together. I think at the end of the day,  
15 like someone said earlier no one's going to  
16 be satisfied with either way. Let's just go  
17 with the way you guys kind of have set it  
18 up. I think we'll get it done either way.

19                   MR. NAESSENS: It's always good  
20 to think about examples, and I think those  
21 two examples of the patient perspective or a  
22 provider perspective would help us think of

1 more of the issues that will come out in  
2 each one.

3 DR. CACCHIONE: Whoever the leads  
4 are of the staff maybe they can at least  
5 direct a discussion in that way.

6 MR. HOPKINS: Can someone help me  
7 understand better what that's -- provider  
8 perspective versus patient perspective? I'm  
9 not sure.

10 MS. MARTIN ANDERSON: I think  
11 what we just want to do is say would you  
12 evaluate a grouper differently in whatever  
13 you're discussing if you were taking a  
14 perspective of a provider use case, and  
15 there were some examples of those, or of a  
16 patient-centered use case, and there were  
17 some examples of those.

18 Because I think we're getting at  
19 the question of does the actual evaluation  
20 need to be divided according to the use.  
21 And I think we can only take that up at a  
22 detailed level. And so we're saying

1 consider that in each of your subgroups,  
2 whether or not you would be stating what's  
3 important to evaluate differently had you  
4 had one or the other use case in mind. And  
5 that way we can bring that back into the  
6 dialogue.

7 MR. HOPKINS: So what's the  
8 patient-focused use case? I'm just not --

9 MS. MARTIN ANDERSON: Well, I'll  
10 give you the -- I take all these notes. Or  
11 actually, Mark said payment versus  
12 performance. You use those. And Tom used  
13 patient-focused episodes versus provider-  
14 focused episodes.

15 So, whereas under performance a  
16 provider-centric view of looking at, say,  
17 resource use and whatever outcome based on a  
18 provider. Or under payment where it might  
19 be more focused on, you know, you're paying  
20 at a patient level so it's more patient-  
21 centered, or population-centered groups of  
22 patients. So that was part of your -- Mark,

1 that was your summary of a proposal?

2 DR. LEVINE: Yes. Let's look at  
3 it in terms of patients with diabetes. A  
4 patient-centric approach would be looking at  
5 diabetes over a period of time and it would  
6 consider nephropathy and retinopathy and all  
7 of the different kinds of complications.  
8 All of those can apply to a patient.

9 Whereas a provider, a particular  
10 physician might be a nephrologist, or he  
11 might be an ophthalmologist, or something  
12 like that who would be looking at only one  
13 part of that whole continuum.

14 So a patient-centric is looking  
15 at a continuum of care whereas a provider-  
16 centric is looking at it within the  
17 provider's context.

18 MS. HOBART: So I think this goes  
19 back to my question. I think we've actually  
20 thrown two different concepts out there.

21 Because I think one of the use  
22 cases was around transparency to the member



1 or patient in terms of what their overall  
2 cost liability would be. Which that's why  
3 I'm saying that's saying it's just from the  
4 perspective that you're the user and that's  
5 different than a provider wanting to know  
6 his or her efficiency.

7 But then to say if your cut for a  
8 provider by a population clinical cut versus  
9 maybe their practice cut it's a different  
10 thing.

11 So that's why I was asking are we  
12 talking about the logic of the attribution,  
13 or are we talking about who's using the  
14 information? And if we get some more into  
15 the member liability question. And I think  
16 they're two different things.

17 DR. CACCHIONE: So we're going to  
18 take -- I think that we've sort of come to a  
19 closure on this. At least we have a roadmap  
20 for the breakouts.

21 And I don't know, are there more  
22 that you feel like you need to cover?

1       Because we're sort of -- I think we've at  
2       least come to a consensus as much as the  
3       group is going to come to consensus on how  
4       we're going to discuss this, how we're going  
5       to break out the discussions.

6                   Is there more you need to cover  
7       from the staff perspective?

8                   MS. WILBON: I think --

9                   DR. CACCHIONE: Because we'd like  
10      to spend -- we'd like to spend some time on  
11      this cost issue and this attribution issue  
12      which are sort of in a lot of people's -- in  
13      the forefront of a lot of people's thoughts.

14                  MS. WILBON: I would say let's  
15      move on. I think we're still a little bit  
16      unsure where the group is going and how -- I  
17      think we're just going to --

18                  MS. MARTIN ANDERSON: We're going  
19      to go with your design.

20                  MS. WILBON: Okay. Okay.

21                  MS. MARTIN ANDERSON: And see  
22      where it takes us. We are organic.

1                   Was there something you needed to  
2                   add? I didn't want to cut you off.

3                   MR. NAESSENS: No, I was just  
4                   going to give another example from our  
5                   practice. It's more or less separating off  
6                   the referral patients from the community or  
7                   population-based. It's a very different  
8                   focus and a very different thinking about  
9                   the groups.

10                  MS. MARTIN ANDERSON: Thank you.  
11                  Okay. So you want to go to attribution or  
12                  pricing?

13                  DR. CACCHIONE: David, do you  
14                  want to start us off on cost issue? Because  
15                  this was something that --

16                  MR. HOPKINS: So, I'm stretching  
17                  this memory for this discussion that took  
18                  place at a steering committee. And it was a  
19                  lot of these -- you folks were there. And  
20                  so, I wasn't actually but I read all this.

21                  What I think I recall was this  
22                  resistance to a measure using actual pricing

1 because actual pricing reflects local market  
2 conditions. And therefore we could not  
3 compare performance, you know, across the  
4 country.

5 And I found that to be a really  
6 interesting and somewhat strange argument  
7 because for those of us who work in the  
8 purchaser and payer domain we care a lot  
9 about these market factors that do influence  
10 pricing.

11 And the fact that episode  
12 groupers can reveal some of the variation in  
13 pricing is part of what makes them important  
14 to us.

15 So we had a very strong reaction  
16 to a group that seemed to kind of get dug in  
17 on that particular issue.

18 So maybe we could discuss it  
19 here. Maybe I would hope that we could be  
20 more open to the idea that actual pricing  
21 does have its place in episode groupers and  
22 their applications and certain use cases.

1 MS. MARTIN ANDERSON: So, just a  
2 proposal for where this might belong. How  
3 you think about, whether you're looking at  
4 standardized pricing or actual pricing or  
5 cost to whom, whatever, probably doesn't  
6 affect much how somebody would form the  
7 group through the construction logic or the  
8 clinical logic.

9 But it does come into play when  
10 there is this question of risk adjustment  
11 and just adjustments of output that you can  
12 -- around specific types of measures that  
13 are dollar-oriented.

14 So, maybe the best place to put  
15 it for now is in that group that's going to  
16 handle talking about adjustments that are  
17 made.

18 I know it's very specific to a  
19 certain kind of measure in a way. I mean, I  
20 don't know whether or not you could evaluate  
21 -- I could imagine the person who creates  
22 the groupers may or may not have a

1 preconceived notion of exactly how that gets  
2 done. You know, many of them give it to you  
3 both ways and then users choose which way  
4 they want to use it.

5           So in evaluating the grouper I  
6 think we have to decide -- I want to hear  
7 from this group -- is this really an element  
8 of evaluating the grouping methodology, or  
9 is it really an element of evaluating the  
10 user of the measure.

11           MR. HOPKINS: But if we punt on  
12 that here then I just foresee -- I'm trying  
13 to be really practical. I foresee that  
14 every time a grouper or a measure, specific  
15 measure that uses one of these groupers  
16 comes up on the table at future steering  
17 committees the same discussion is going to  
18 go on. And depending on the makeup of the  
19 committee you'll come out one way or  
20 another.

21           I just feel like we ought to  
22 weigh in on it. It doesn't feel to me,

1 Kristine, quite like an adjustment issue.

2 It feels like kind of a standalone issue.

3 MR. JONES: I think we need to  
4 discuss that at detail. Because I think the  
5 criteria should be how flexible the grouper  
6 is to accommodate those adjustments.

7 In that you want to see what your  
8 actual network looks like, for example, if  
9 you're going to tier it and develop select  
10 networks and higher copays and all that.

11 But if you're trying to actually  
12 see which providers are more efficient, you  
13 want to flatten and just make sure you're  
14 solving for mix and volume changes.

15 So I haven't seen too many good,  
16 acceptable responses from the big players in  
17 their ability to do that. So I think if  
18 they can disclose how they plan to do it, or  
19 how they do do it and how easy it is for us  
20 to adjust I think that's a key, key  
21 criteria.

22 Because if you can't take the

1 output of this outside of your building an  
2 actual, you know, and face out to the docs  
3 in a credible way there's really no value.

4 MR. DE BRANTES: Well, this is  
5 Francois. Again, I think it depends on the  
6 use. Because if you're going to use a  
7 grouper for payment purposes you're not  
8 adjusting for price. I mean, that defeats  
9 the entire purpose of using a grouper for  
10 bundle payments.

11 MS. HOBART: I was going to say  
12 basically the same thing. I think it's a  
13 question of functionality, not a black or  
14 white is it standard cost or whatever.

15 I mean, there are different  
16 situations where you're going to want to  
17 look at the utilization pattern, you're  
18 locked into some crazy contract. It's not  
19 going to make sense to look at the cost or  
20 whatever. So, for me I would want the  
21 functionality to look at both utilization  
22 and the cost as a dependent variable. And



1 it's not a higher-level conversation, it's  
2 just functionality.

3 MR. MACURDY: I just want to go  
4 back to Kristine's point. I mean, most of  
5 the use of the groupers that I've seen you  
6 can either use real prices or use  
7 standardized prices. And obviously I  
8 totally agree with you that depending on how  
9 you're using it if a hospital costs twice as  
10 much in one area versus another that  
11 actually matters. Because if you're trying  
12 to get lower costs then that's what you do.

13 On the other hand if you're  
14 trying to do quality measures you might use  
15 standardized price.

16 But I think it's -- and I'm going  
17 to use the term "side issue." And I don't  
18 mean that it isn't important, but from a  
19 grouping perspective once it's grouped you  
20 can use either real prices or standardized  
21 prices.

22 And if somebody kind of says,

1 well, the only way we'll report the measure  
2 is in standardized prices because well,  
3 okay, that I agree with you I don't  
4 understand. It depends on the purpose.

5 But as far as the challenges you  
6 have with regard to the grouper it can go  
7 either direction. I mean, you can even use  
8 another price mechanism as well if you need  
9 to and that's sometimes done.

10 It depends on its context. But I  
11 think it's an easy sort of thing at the end  
12 just to say use these prices, or use those  
13 prices, or use yet a third price level.

14 DR. CACCHIONE: So Mark?

15 DR. LEVINE: I think this goes  
16 back to a point we were discussing earlier,  
17 when does the grouper's responsibility end  
18 and the user's responsibility take over.  
19 And we're going to need to have some  
20 discussion about that.

21 This is one area in which we  
22 might want to have a defined handover point.

1 And there may be others that we should  
2 discuss.

3 DR. CACCHIONE: Do we want to  
4 talk about attribution now? I think about  
5 the groupers and attribution. Those were  
6 two big themes that we wanted to have.

7 MR. MACURDY: Well, I think  
8 attribution is easy too because in some  
9 cases groupers don't do attribution. And  
10 they explicitly don't do attribution. They  
11 leave it up to the user to do attribution.

12 And if you're talking the  
13 mainline groupers like ETG, or MEG, or 3M  
14 don't do attribution. So that has to be a  
15 feature that's added on.

16 I mean, if you want to basically  
17 say they have to have attribution as well  
18 you're not going to get very far in this  
19 regard.

20 But I mean, it depends on its  
21 purpose. I mean, if it's for provider  
22 payment there's going to have to be some

1 attribution role, but that can be kind of  
2 done separately.

3 DR. CACCHIONE: So it's almost  
4 like a cost issue. David?

5 MR. REDFEARN: I think  
6 attribution is sort of an add-on. But if  
7 you want to look at it another way, I mean  
8 the ETGs, for example, the current version  
9 of ETGs generate what's called an  
10 attribution file. And they give you data to  
11 let you get yourself in trouble. The user  
12 can get into trouble.

13 There's a whole host of pieces of  
14 data that you can make choices in terms of  
15 cost, who the first provider was, who the  
16 last provider was. There's a whole host of  
17 kinds of information.

18 So, one thing I would look at a  
19 grouper if I am doing provider profiling I  
20 would say does the grouper provide  
21 information for me that helps me make these  
22 kind of decisions on the back end. But

1 that's not a core -- it's not the grouper,  
2 that's just what information it provides  
3 that you can use.

4 Because MEGs makes by default I  
5 think, just says the most expensive one.  
6 And the PFE doesn't do it at all. So,  
7 that's just the dimension.

8 MR. MACURDY: I just want to note  
9 both ETG and MEG explicitly say that they'll  
10 provide you information but it's up to the  
11 user to do attribution. They don't do  
12 attribution.

13 DR. LEVINE: There's a  
14 responsibility I think of the grouper to  
15 align the technology and the approach to  
16 attribution that enables appropriate  
17 attribution.

18 In other words, if the intent of  
19 the grouper is to inform upon provider  
20 performance and they're using a patient-  
21 centric method of evolving the grouper  
22 they're going to have trouble in coming up

1 with an appropriate attribution algorithm.

2 So, one of the things that we  
3 might want to consider for a grouper is that  
4 they are explicit in terms of what the  
5 attribution opportunities are as a result of  
6 their grouping technology.

7 DR. BANDEIAN: We've actually  
8 spent a little bit of time on this topic,  
9 the so-called off-ramp discussion that we've  
10 had.

11 And again, if one steps back and  
12 says well, why are we talking about  
13 episodes. And ultimately the purpose of  
14 that I think is to assess the efficiency of  
15 the care being delivered and the further  
16 discussion about care being provided over a  
17 period of time.

18 The problem with the sort of  
19 conventional standard whole episode concept  
20 is you're attributing the entire enchilada  
21 to one or more or a team of physicians who  
22 may or may not have had really an

1 opportunity to influence what happened  
2 during certain aspects of the care.

3           So, if you think, for example,  
4 about say hip fracture and there is the  
5 acute care of that and then there might be  
6 the rehabilitation portion of the care.

7           The folks who are involved in the  
8 rehabilitation may not necessarily have had  
9 much opportunity to influence the acute care  
10 side of things.

11           So again, depending upon what one  
12 wants to do, how one wants to implement it  
13 one might attribute the entire episode to  
14 one or more physicians, or one might split  
15 the episode into pieces that reflect what  
16 different roles and responsibilities people  
17 had at different times.

18           So again, it turns out that this  
19 actually, it can be potentially quite  
20 complicated. But certainly the traditional  
21 way of implementing this which I guess to  
22 use Tom's language would be the sort of

1 patient-centric I suppose whole episode  
2 approach is to try to attribute the entire  
3 episode to somehow a small number of  
4 physicians or some such.

5 An alternative implementation  
6 tries to figure out what parts of the  
7 episode different people were responsible  
8 for and/or had control over, and then  
9 attribute that to those people.

10 And there are pros and cons of  
11 both approaches and I suspect there could be  
12 lots of discussion. But it is itself a  
13 fairly complicated topic.

14 MR. MCLEAN: I'd add to Steve's  
15 point about it being very, very complicated.

16 Provider attribution, and I think  
17 I said it earlier, I actually believe it  
18 should be a separate discussion from  
19 episodes. I don't think -- just like I  
20 mentioned about risk adjustment.

21 Simply for the fact that the  
22 purpose of a grouper is to figure out how to



1 take these claims or this data and group it  
2 into some meaningful information.

3 Now, how you want to use that, do  
4 you want to attribute it to five different  
5 providers with one main provider and then  
6 some other ancillary services and those  
7 providers? Or do you want to just do a  
8 population-based analysis? That's more  
9 about the user and the use case.

10 Do you want to risk-adjust or do  
11 you want standardized cost, the actual cost?  
12 All those things are about the use case and  
13 what you are trying to attempt to do with  
14 this grouper.

15 The more complex you make things  
16 with the grouper with the attribution and  
17 the adjustments you're relying heavily on  
18 the reliability of data. And anyone who's  
19 ever tried to match claims data knows it's  
20 very, very complicated.

21 Because a lot of times it's not  
22 there. And what groupers typically do when

1 data is not there is they drop the episode.  
2 Which is also problematic because the  
3 reliability and validity discussion we had,  
4 you don't have the samples now.

5 So, the more complex -- although  
6 it sounds great at a very high level I think  
7 when you get down to thinking about it these  
8 discussions I think should take place, and  
9 they're very important, but outside of  
10 evaluating an episode.

11 MS. MARTIN ANDERSON: So I think  
12 at least what I've heard so far is that  
13 these are both issues of user preference,  
14 not just they are related to a grouper.

15 And I've also heard a perspective  
16 that says maybe at a minimum we need some  
17 transparency on what the grouper allows.  
18 And maybe others feel like there ought to be  
19 standards for what a grouper needs to be  
20 able to allow to occur.

21 But regardless we can pick those  
22 up in breakouts as needed if there is a

1 specific point of view someone wants to put  
2 forward in terms of how you would consider  
3 these issues if you're doing endorsement, or  
4 whether you would just leave them outside.

5 So I think it's good that we took  
6 this time to hear the perspectives on these  
7 two topics. If there are other topics like  
8 that I'm sure we'll be taking some time to  
9 hear perspectives too.

10 The good news is we actually  
11 don't have to solve everything right here,  
12 we just have to keep inching forward in our  
13 work.

14 So, I know that you had a member  
15 comment scheduled for now before lunch?

16 MR. WILLIAMSON: Yes. Any public  
17 comments in the room?

18 OPERATOR: At this time if you  
19 would like to ask a question or have any  
20 comments please press \*1 on your telephone  
21 keypad. We'll pause for just a moment to  
22 compile the Q&A roster.

1 MR. WILLIAMSON: Operator, we  
2 have one comment in the room.

3 MS. RUBIN: Hi. First, thank you  
4 for the opportunity to comment. Today's  
5 discussion was very insightful and helpful.

6 From a physician's perspective  
7 evaluation of episode groupers need to  
8 include all components within the episode  
9 for physicians to have actual information to  
10 know how they are evaluated and to improve  
11 upon their care.

12 Also, the construct of an episode  
13 may be different based on what you are  
14 evaluating and what is included in the  
15 episode.

16 And that's all I have to say. My  
17 comments are just reflective of the  
18 discussion that occurred today. Thank you.

19 OPERATOR: There are no public  
20 comments or questions over the phone line.

21 MR. WILLIAMSON: Thank you very  
22 much. At this point we will break for

1 lunch. And so lunch will be served in the  
2 other half of the room over here. We will  
3 be convening again at 1:15 for breakout  
4 sessions.

5                   Actually, we could -- we'll say  
6 1:10 and we'll give you some instructions.  
7 We'll be taking you to other rooms for the  
8 breakout session. But we'll reconvene at  
9 1:10.

10                   (Whereupon, the foregoing matter  
11 went off the record at 12:29 p.m. and went  
12 back on the record at 1:18 p.m.)

13                   MR. WILLIAMSON: So, as we break  
14 into our module groups, again construction  
15 logic, clinical logic and adjustments for  
16 comparability we're going to really discuss  
17 the principles for constructing an episode  
18 grouper. And we might get into criteria for  
19 evaluation. We'll see if there's enough  
20 time on that. But we really want to dive  
21 into the principles right now.

22                   So, in that regard we're going to

1 examine the key questions that we've  
2 outlined. We're going to further define the  
3 module and key elements, and really identify  
4 the principles and considerations.

5 So we've broken the group up into  
6 three groups here. We have construction  
7 logic will be in this main meeting room,  
8 clinical logic will be in the other half of  
9 the room and adjustments for comparability  
10 will be downstairs with me in the 8th floor  
11 conference room.

12 Taroon Amin will be facilitating  
13 group A, Ashlie will be facilitating group B  
14 and again I have group C.

15 So at this point we're going to -  
16 - or Ashlie, do you have any other? Okay.  
17 So at this point for people on the phone  
18 we're going to be going into a speaker  
19 subconference in this room. So Operator, if  
20 you could please pull in Jim Loiselle and  
21 Francois de Brantes. They'll be staying in  
22 the main meeting room here on the line.

1                   And for the rest of you on the  
2 phone, I'm sorry, you won't be able to  
3 listen in for the group discussion. But we  
4 will be reconvening again at 3:15 on the  
5 line to recap the breakout session.

6                   So Operator, are you able to do  
7 that?

8                   OPERATOR: Okay, one moment.  
9 Okay, you did say Jim and Tim's line,  
10 correct?

11                  MR. WILLIAMSON: Jim and  
12 Francois, yes.

13                  OPERATOR: Jim and Francois.  
14 Okay, one moment. Okay, I've pulled all  
15 three of your lines into the subconference.

16                  MR. WILLIAMSON: Thank you. Jim  
17 and Francois, are you on the line?

18                  MR. LOISELLE: Yes, I'm here.  
19 This is Jim.

20                  MR. DE BRANTES: Yes.

21                  MR. WILLIAMSON: All right.

22                  Excellent, okay. So we're all set here in

1 the main room.

2 And so again, if group B wants to  
3 meet in the room next door and group C wants  
4 to meet me by the front desk here in the  
5 conference center I'll take you downstairs  
6 and we can go ahead and get started.

7 MS. WILBON: I would suggest if  
8 you're not taking your laptop to bring your  
9 paper copies of the discussion guide because  
10 we'll be referring to several questions in  
11 there as the group goes along.

12 (Whereupon, the foregoing matter  
13 went off the record at 1:21 p.m. and went  
14 back on the record at 3:35 p.m.)

15 MR. WILLIAMSON: At this point  
16 we're going to go over the breakout  
17 sessions. We're going to do kind of a  
18 report-out and overarching discussion of  
19 each breakout session.

20 We'll start with the clinical  
21 logic module, or clinical logic group. We  
22 may move away from the module moniker for



1 this.

2 But I think, again, a lot of  
3 great discussion over the last 2 hours so we  
4 want to make sure we share that with the  
5 whole group, get input, feedback. And so  
6 we'll go ahead and kick it off here.

7 MS. WILBON: We have two  
8 spokespersons. Marjorie and Jennifer are  
9 going to kind of partner up and present kind  
10 of what the group came up with.

11 We have a document on Word -- we  
12 weren't able to get it into slides -- kind  
13 of summarizing what we came up with.

14 And we also have our notes on the  
15 notepad paper in the back of the room. I  
16 don't know if it's legible but if you were  
17 trying to figure out where we were going you  
18 can kind of see where we ended up. So thank  
19 you, Jennifer and Marjorie.

20 MS. HOBART: So, I'm tag-teaming  
21 this with Marjorie so I'll start.

22 So our group really came up with

1 three categories of criteria. So the first  
2 criteria was just around basic what I'd call  
3 software functionality which was just  
4 considered the minimum to even be considered  
5 for the episode grouper.

6 So, you had to have something  
7 that would be relatively easy to implement,  
8 there's clear documentation, it's reliable  
9 just in terms of if you do the same thing  
10 twice you're going to get the same answer.  
11 If it's hosted at a vendor site that there's  
12 a clear security protocol for PHI  
13 information. There's a plan for user  
14 support and maintenance.

15 So, those are just examples, but  
16 just very standard expectations if you have  
17 some sort of software product. And then  
18 after that you can start talking about the  
19 content.

20 So then we got into what was the  
21 actual clinical logic that was put onto that  
22 software and Marjorie's going to talk about

1 that.

2 DR. KING: And that's what we  
3 spent most of our time talking about. We  
4 looked at the subgroups under clinical logic  
5 section, the second page in the back, and  
6 talked about well, should we have specific  
7 criteria within each? Should we require the  
8 measure -- it's not really a measure, but  
9 the grouper submitters to describe how  
10 they're addressing each of those criteria,  
11 the evidence to support it, the triggers,  
12 end mechanisms, the clinical severity and  
13 the comorbidities.

14 And we basically ended up with we  
15 really want them to give us a coherent  
16 description of why they are using this  
17 clinical logic, the evidence to support the  
18 clinical logic, how they are going to deal  
19 with triggers and end mechanisms, how  
20 they're going to deal with some sort of --  
21 risk adjustment may not be the right term,  
22 but how they're going to separate the

1 different types of patients with different  
2 levels of clinical severity into different  
3 buckets to compare across providers, how  
4 they're going to deal with clinical  
5 characteristics that occur during the  
6 episode that are part of the underlying  
7 pathophysiology as opposed to a patient  
8 safety issue that arises related to, or an  
9 occurrence that arises due to an actual  
10 complication of what happened. And we had  
11 some discussion around that.

12                   And decided that rather than  
13 being proscriptive about what they want them  
14 to do, we would want the submitters to  
15 provide a narrative so that the reviewers  
16 could understand their logic.

17                   We talked about basic principles.  
18 And one of the principles that we -- and it  
19 really ended up with at the end was that  
20 whatever the clinical logic is that's used  
21 the system should have been tested for  
22 reliability, perhaps with a set of claims

1 data related to various diseases that then  
2 the episode grouper can be run using that  
3 set to look at the results, similar to what  
4 Medicare did when they did their bid for an  
5 episode grouper.

6 We also talked about other --  
7 that we felt that the clinical logic should  
8 undergo some sort of face validity testing,  
9 perhaps using panels of expert clinicians.

10 I'm trying to remember what else.  
11 Did I miss anything else within the testing?  
12 The reliability and validity testing.

13 We basically felt that rather  
14 than say here's what you should do for your  
15 clinical logic, show us, help us understand  
16 the logic behind your clinical logic and  
17 show us that it's valid and reliable.  
18 That's sort of where we ended up.

19 We also felt that the clinical  
20 logic should be patient-centric clinical  
21 logic, but that it should be understandable  
22 and usable by providers and by patients.

1 So, it's always patient-first logic about  
2 how you think about these clinical things.

3 And we listed the things that we  
4 had talked about before. We re-discussed  
5 attribution but we just -- they reminded me  
6 that we'd already put that to rest.

7 And from the rest of the group --  
8 I was the only one that had three cups of  
9 coffee so that's why I got elected to speak.  
10 Did I miss anything?

11 MS. HOBART: The third category  
12 we talked about was handling of the data  
13 that fed into the model.

14 So, currently that's probably  
15 largely claims-based but that might evolve  
16 over time into more clinically rich  
17 information.

18 But whatever the source was that  
19 there should be criteria around having clear  
20 documentation about the specifications,  
21 about how the model is expecting to see the  
22 data.

1                   There should be some sort of data  
2                   profiling capability that would identify  
3                   when the data that the model is receiving is  
4                   not in the format or content of what's  
5                   expected. So people could make sure there  
6                   wasn't a mismatch of the actual model and  
7                   the data that was going into it.

8                   And in general that there would  
9                   be those types of feedback processes to make  
10                  sure that you were using the model correctly  
11                  in terms of the data that you were  
12                  submitting.

13                  DR. KING: And we also, we  
14                  forgot, we also talked about the fact that  
15                  the data should be able to be used for  
16                  performance improvement by providers.

17                  MS. HOBART: Yes, so there was a  
18                  usability component too I think with the  
19                  clinical logic. Not only -- there needed to  
20                  be a high-level story that people could  
21                  understand the derivation of the clinical  
22                  logic and what the framework was.

1                   And then there needed to be a  
2                   drill-down capability that you could see the  
3                   services that were bundled into the episodes  
4                   that would give you a path for action.

5                   So, was there anything else from  
6                   the rest of the group?

7                   MS. WILBON: Other group members,  
8                   feel free to chime in if there's something  
9                   that you're -- you're doing a great job.  
10                  But if there's something.

11                  So, I'll just kind of summarize  
12                  some things that I think were really good  
13                  that the group came out with in terms of  
14                  principles around some of these topics.

15                  Marjorie mentioned there should  
16                  be the ability to drill down for clinical  
17                  improvement.

18                  We talked a lot about kind of the  
19                  use of clinical severity levels and how the  
20                  specificity of the episode in terms of the  
21                  type of I guess the broadness or the  
22                  specificity of the episode may be indicative



1 of how severity levels are used.

2           So, I think Chris' example if I  
3 can use that about heart failure patients,  
4 if there may be different levels of severity  
5 of heart failure patients, that if your  
6 episode is just heart failure that you may  
7 want to use some type of severity levels to  
8 kind of further differentiate and further  
9 specify the type of heart failure patient  
10 that is being measured.

11           Also, some discussion about the  
12 sensitivity of triggers and that there are  
13 different types of trigger codes and flags,  
14 including -- some of them may be clinical.  
15 They could be site-specific in terms of  
16 whether it's outpatient or inpatient.

17           They could be potentially  
18 clinical data, or claims data-based, or  
19 procedure-based, or what have you.

20           And, let's see. That there needs  
21 to be some kind of recognition that you  
22 don't want your episodes to be so sensitive,

1 opening to everything so that you're  
2 creating kind of these false episodes that  
3 don't really have any meaning, but that  
4 there's -- the episodes that are being open  
5 are still clinically relevant to the  
6 population of the data that is being put  
7 into the grouper.

8 DR. CACCHIONE: We also thought  
9 there would be some consistency on the  
10 triggers.

11 But on the end mechanism, or the  
12 end events, that that might be variable  
13 depending on the end user who might choose  
14 or it may be the contractor, somehow that  
15 those would have some variability.

16 Whereas the triggers would be  
17 very consistent. There would be a  
18 transparency and a consistency to the  
19 triggers in terms of both how they're used  
20 and then the risk profile that might be --  
21 the prospective risk profile for these  
22 triggers.

1 DR. BANDEIAN: Can I ask a couple  
2 of questions? Now that I've stopped looking  
3 at the EKG.

4 I think I just heard you say  
5 something to the effect of defining things  
6 to try to prevent false positive episodes  
7 from opening falsely when the condition was  
8 not really there.

9 I understand that that's an  
10 issue. There are multiple ways of  
11 addressing that question. And so I'm not --  
12 I mean, I think that the issue is not so  
13 much how the episode is defined, but rather  
14 what protection is being taken against the  
15 possibility of false episodes being opened.

16 And I don't think that that  
17 concern is necessarily one that should  
18 govern the identification of the condition  
19 episode. Because again, as I say, there are  
20 countermeasures so to speak that -- so  
21 that's sort of point number one.

22 MS. WILBON: I think the group

1 generally agree with that. It was just a  
2 recognition that that's an important  
3 consideration. Yes, we're on the same page.

4 DR. BANDEIAN: Okay. Point  
5 number two, and maybe I -- because I've been  
6 multitasking and being bad looking at my  
7 phone, did you talk about sort of how one  
8 would think about how one would define a  
9 condition? What is a condition? And is  
10 that up there?

11 DR. KING: We didn't talk about  
12 it because -- we talked about it but we  
13 weren't explicit about it. I mean,  
14 basically -- again, I'm on the cardiac work  
15 group for the CMS one so I just figured that  
16 they all worked that way.

17 DR. BANDEIAN: Okay. Because --

18 DR. KING: We did talk a little  
19 bit about surgical ones versus medical ones  
20 versus do you get it out of claims data. We  
21 talked about registries, would that be an  
22 appropriate way to get --

1 DR. BANDEIAN: No, I mean like  
2 what are the basic units of analysis.

3 DR. KING: No, I don't think so.

4 DR. BANDEIAN: So, because this  
5 then actually relates to, I don't know, not  
6 necessarily drill-down but sort of  
7 actionability, usability, as well as perhaps  
8 to validity as well.

9 Let me give you an example. This  
10 is probably the one. I'm trying to  
11 remember.

12 So, just as an analogy if you  
13 look at some of the DRG labels. I shouldn't  
14 be throwing rocks at them, but if you look  
15 at some of the DRG labels it's a little  
16 unclear exactly what is clinically in that  
17 DRG category.

18 And actually, in terms of episode  
19 groupers of when I was in the commercial  
20 health insurance world and we were using  
21 groupers I remember one occasion where we  
22 showed some grouper results to one of our

1 specialty committees and the doctors on the  
2 committee said well, that's interesting.  
3 Now tell me exactly what that condition  
4 category is.

5                   And so for things to be  
6 clinically meaningful, actionable, et  
7 cetera, it would seem that it would be at  
8 least helpful, not necessarily something  
9 that you would require for the Good  
10 Housekeeping stamp of approval, but it might  
11 be at least helpful that it would be  
12 reasonably clear from reading the condition  
13 category label to clinicians exactly what it  
14 is that is within that unit of analysis.

15                   DR. KING: We didn't talk about  
16 it at that level, but we did talk about it  
17 in the context of face validity, perhaps  
18 that you would show, and Chris may have to  
19 help me out, but that you show clinicians  
20 the result of your episode grouper.

21                   You show them the clinical  
22 characteristics of that person who had that

1 claims data -- not the clinical. You show  
2 them the claims data from that one  
3 individual person with that episode grouper  
4 to a clinician and they say yes, that makes  
5 sense, or no, that doesn't make sense as  
6 sort of a face validity level.

7 But Chris, do you understand his  
8 question and can you help me out here? You  
9 were in our group.

10 MR. TOMPKINS: Well, he probably  
11 understands his question too and can restate  
12 it if we need to.

13 I think what he's saying -- let  
14 me make a stylized comment here which is  
15 that being a non-clinician but observing a  
16 lot of clinicians over the last few years  
17 there is an art to determining when do you  
18 say that there are distinguishing  
19 characteristics of a condition that make it  
20 different from some other condition, and  
21 furthermore, there are distinguishing  
22 characteristics within a condition that need

1 to be identified and kept track of whenever  
2 you're trying to purportedly make constructs  
3 that are useful for comparison.

4 And part of the clinical logic of  
5 an episode grouper is to have an inventory  
6 of definitions as to what constitutes those  
7 conditions. And presumably somebody can  
8 articulate how that came about. I mean,  
9 that's a nice aspiration.

10 But even more concretely and more  
11 immediately the episode grouper should have  
12 in fact an objective definition of what that  
13 condition is which consists of what we call  
14 trigger codes which are individual diagnosis  
15 codes, et cetera.

16 So that anybody who is viewing  
17 supposedly the outcomes related to heart  
18 failure can actually trace it all the way  
19 back to say what set of diagnostic codes  
20 would have qualified to call this person a  
21 heart failure case in the first place.

22 DR. KING: Which is why we left



1 the first part very open-ended, so that  
2 people could explain that. As opposed to  
3 being proscriptive and say you've got to  
4 have specific definitions here. But you  
5 have to explain sort of how you got there.

6 As a clinician I understand that  
7 there's an infinity of heart failure  
8 patients. It's a continuum within many,  
9 many, many little subsets within there.

10 DR. BANDEIAN: I don't know if  
11 this is helpful or not, but let me -- I  
12 could give an example or two.

13 My sort of favorite example would  
14 be talking about an ankle fracture. It's  
15 fairly simple.

16 So, should that be a condition  
17 episode? Should it be fracture of the lower  
18 extremity as a condition episode?

19 And then even further let's talk  
20 about ankle fractures. And there's a  
21 difference between a simple lateral  
22 malleolus fracture versus a trimalleolar

1 fracture.

2 And there would be very, very  
3 different resource use implications as well  
4 as very different implications in terms of  
5 complications.

6 So it's not just -- it's  
7 partially a clinical  
8 meaningfulness/understandability/usability  
9 concept, but it also goes to the underlying  
10 issue of whether the entity that is being  
11 looked at actually is homogenous in terms of  
12 the expected resource use and the expected  
13 rate of complications.

14 DR. CACCHIONE: We had a lot of  
15 discussion around this about when do you --  
16 because there is, you know, your example is  
17 a good one.

18 We talked a lot about a  
19 pneumonia, an outpatient pneumonia versus an  
20 inpatient pneumonia. And then a pneumonia  
21 with a parapneumonic effusion.

22 And so we talked about should

1 risk-adjusting or severity judgments, or do  
2 we specify populations based on severity  
3 prospectively, or does everybody go in as a  
4 uniform population with a fractured ankle?  
5 And is that taken care of on the back end  
6 through risk-adjusting and through whatever  
7 data you're collecting through the bundle?

8 We deferred to Chris on this a  
9 little bit because he has more experience,  
10 but we really did arrive at the fact that we  
11 thought that there is some sort of  
12 prospective risk profiling, risk  
13 stratification, something.

14 And that using that risk  
15 stratification as best we can up front to  
16 identify what bundle, is it 1, 1A, 1B, or 1C  
17 around this ankle fracture is something that  
18 we believe -- we thought was one of the  
19 clinical constructs that needed to be in  
20 place in a bundle.

21 And that needed to be sort of  
22 transparent to who is -- by the bundle-maker

1 or whatever the author to say this is how we  
2 use this construct.

3 MS. MARTIN ANDERSON: One thing  
4 that I'm getting a little bit mixed up in  
5 this conversation on is it seems to be a  
6 mixture of some software features which I  
7 think, you know, we can have opinions on,  
8 but I'm not really sure whether or not it's  
9 evaluable for NQF.

10 Some principles around some  
11 things that you need to know, have submitted  
12 about an episode and how the clinical logic  
13 is done so that you can make it -- evaluate.

14 And then also some preferences  
15 maybe on how the actual episode grouping  
16 happens. And I think it's this third  
17 category that makes me the most nervous.  
18 Because I don't know that we can superimpose  
19 how someone in the -- should do an episode.

20 But I do think this issue of this  
21 is an area where you want some transparency  
22 in the application process. And if we could

1 translate that into this should be  
2 explicitly noted in terms of how are you  
3 handling --

4 DR. CACCHIONE: -- done  
5 prospectively, retrospectively, but it needs  
6 to be transparent.

7 MS. MARTIN ANDERSON: But it  
8 needs to be transparent. And we can  
9 articulate you need to be -- this is a  
10 question you need to be able to answer about  
11 your grouper and justify and test.

12 DR. CACCHIONE: David, do you  
13 have a comment?

14 MR. REDFEARN: I'm interested in  
15 the idea of prospective risk. Because most  
16 of the risk adjustment with groupers that  
17 I'm familiar with you calculate the risk on  
18 the same time period that you do your  
19 grouping. So they're happening at the same  
20 time.

21 Now, I do know the PFE model will  
22 allow you to go back a year before you

1 actually start your grouping process to  
2 calculate the CRG risk score that you want  
3 to apply. Is that what you're talking  
4 about?

5 MR. DE BRANTES: This is  
6 Francois. I can interject here. We create  
7 prospective budgets in our grouping system,  
8 so that's a pure prospective adjustment of  
9 the patient's historical cost. But you're  
10 actually doing a prospective budget, so  
11 you're severity-adjusting and estimating  
12 what the future cost is going to be. Which  
13 by the way is essential for payment  
14 purposes.

15 MR. TOMPKINS: If I may, I may  
16 get this wrong but I think I understood your  
17 question.

18 I think Joe used the word  
19 "prospectively" but in a different sense.  
20 We did talk about the fact that we want to  
21 make sure that there's clinical homogeneity.  
22 And that can be done he said front end, back

1 end. And I think he was using front end and  
2 he said prospectively with regard to the  
3 taxonomy of the episode definitions  
4 themselves.

5 In other words, you can -- to use  
6 Steve's example you could have four  
7 different episodes that define four  
8 different types of ankle fractures, and if  
9 you did it that way then you need less risk  
10 adjustment at the back end because  
11 prospectively in the taxonomy you have  
12 already absorbed, or you've already  
13 accounted for by stratification a lot of the  
14 severity.

15 Now, Francois' comment also ties  
16 back to maybe something you said too. But  
17 it is -- and was part of our conversation  
18 too, namely when you are defining the risks  
19 that you want to control for when you're  
20 making useful comparisons across providers,  
21 to what extent do you want to limit yourself  
22 to information that is, quote,

1 "prospectively known" that is before the  
2 episode begun or before the period of  
3 accountability begin.

4 And Francois was saying that in  
5 many instances people prefer to define the  
6 risk, quote, "prospectively" so that the  
7 consequences of clinicians actions and  
8 inactions and so forth are part of the end  
9 result and are not adjusted for in mid --

10 MR. DE BRANTES: Adjusted for,  
11 right.

12 And again, I mean I think to the  
13 comments earlier I'm not sure we should be  
14 deciding which approach is best or worst  
15 more than encouraging the developers to be  
16 clear about what approach they've taken and  
17 then delineate its shortcomings if there are  
18 any.

19 DR. CACCHIONE: I'm not sure  
20 where you left off.

21 DR. KING: As far as I'm  
22 concerned I'm done.



1 (Laughter)

2 DR. KING: He summarized it.  
3 Basically it's explain yourself and convince  
4 us that this works and that it's valid and  
5 reliable and all that.

6 Did we miss anything? I sense  
7 everybody running out of steam. Did we miss  
8 anything from your perspective?

9 MS. SIMON: We didn't elaborate a  
10 lot about this in the group, but there was a  
11 little bit of a distinction made between  
12 diagnosis and procedures. Procedure is a  
13 very clear trigger event for lack of a  
14 better term.

15 But I think part of our  
16 discussion around this example of pneumonia  
17 and really stratifying out the outpatient  
18 pneumonia from the inpatient pneumonia from  
19 the pneumonia with parapneumotic effusion  
20 was trying to come up with a comparable  
21 trigger for a diagnosis code for lack of a  
22 better construct. Does that make sense?

1 DR. CACCHIONE: The only thing I  
2 would add would be the use case and I think  
3 you hit it a little bit. We did try to  
4 break it down versus -- the provider-centric  
5 versus the patient-centric.

6 So we talked about the uses of  
7 the clinical logic using a more provider-  
8 centric use for this with regards to public  
9 reporting, payment, comparisons, whether  
10 health plans or networks would be using that  
11 and performance improvement. We did brush  
12 over the attribution.

13 And then on the patient-centric  
14 side it's really about the patients having  
15 the ability to compare cost and out-of-  
16 pocket cost as well as provider quality.

17 And so we do think that the uses  
18 of these tools will have a little different  
19 implications as we start to look at if  
20 they're being designed more in a provider-  
21 centric or a patient-centric way.

22 But there is some convergence of

1 all these things, especially as you start to  
2 look, the cost item, the quality item. But  
3 they do -- and they do converge, but there  
4 are some subtle differences.

5 MR. HOPKINS: That's sort of  
6 interesting, that last point. I'm trying to  
7 think of the role of NQF in monitoring or  
8 arbitrating how insurers present cost  
9 information to their members. Is that  
10 something that NQF would be involved in?

11 MS. WILBON: Can you repeat that  
12 question? I missed the last few words of  
13 your sentence, sorry.

14 MR. HOPKINS: I think Joe was  
15 suggesting that one obvious use of episode  
16 groupers is, and we talked about this  
17 earlier, enabling patients to see or health  
18 plan members, let's say, to understand what  
19 costs they're facing when somebody has  
20 recommended a procedure or treatment regimen  
21 to them.

22 And maybe they have some choices

1 of providers, and maybe those choices in  
2 part are related to cost.

3 So my question was would NQF ever  
4 be wanting or needing to interpose itself in  
5 that process of determining whether the  
6 health plan is providing that information in  
7 an appropriate way to its members. I can't  
8 see that. But that's really what that use  
9 case was if I understood it.

10 DR. KING: I don't think so. I  
11 think that was just a codicil.

12 Unless the insurer was going to  
13 say the average Doctor X cost \$10,000 to  
14 replace your knee or whatever, and they have  
15 a deductible. That would be the only way --  
16 they're not going to. I couldn't see --

17 I mean, it's really about making  
18 sure that the measure is valid, reliable,  
19 that the grouper is a good grouper that can  
20 really give a good estimate of cost that's  
21 not going to encourage -- that's going to  
22 discourage fly-by-night companies from

1 developing them and selling them to  
2 insurance companies. That's kind of my  
3 thought.

4 DR. CACCHIONE: Maybe I was  
5 misunderstood or I probably misspoke. I  
6 don't see it being that granular, at that  
7 level.

8 But I do think that the use of a  
9 grouper tool if it is patient-centric should  
10 have the ability for -- if it's done in a  
11 way that is transparent and is useful can  
12 aggregate costs around an episode so a  
13 patient can understand what a total episode  
14 of cost is.

15 Now, whether it translates into  
16 the NQF needs to be the entity that sort of  
17 discloses that. But at least around the  
18 idea around an episode -- or a payment model  
19 like the episode payment model that it at  
20 least allows the consumer for comparison  
21 purposes to understand that there is an  
22 episode cost that far exceeds the event that

1 occurred, but there is some episode cost.

2 So I guess I don't know that -- I  
3 guess I don't know -- I would defer to the  
4 NQF folks to say. I mean, I don't think NQF  
5 wants to insert itself there, but I do think  
6 that there is a role for NQF to establish  
7 the principles of how an episode tool would  
8 work to -- and how it should be constructed  
9 to allow an apples to apples comparison.

10 Mark?

11 DR. LEVINE: Yes, I think it  
12 would be pretty difficult and dangerous for  
13 NQF to get into endorsing the uses of  
14 groupers. That's up to whoever is using the  
15 grouper to be able to do that.

16 I think our role is to look at  
17 are the groupers being constructed in a way  
18 that enables them to be used in a reliable  
19 manner.

20 MR. AMIN: Just quickly on the  
21 NQF note. So, the challenge that we have  
22 here is that in typical performance measures

1 we endorse measures for quality improvement  
2 and performance accountability applications  
3 broadly. We don't distinguish between  
4 accountability applications.

5 I think one of the issues that we  
6 need to explore further, and I know that our  
7 subgroup had a lot of discussion around  
8 this, is that there still is this  
9 overarching fact of the use of the episode  
10 grouper may in very clear ways influence the  
11 design of the grouper itself.

12 And so bringing in the use case  
13 obviously has to be front and center, but I  
14 will say that it's not NQF's goal of this  
15 effort to impose itself in particular  
16 applications, particularly in commercial  
17 applications which I'm not even sure that we  
18 quite have the leverage to do anyway.

19 But it's more to say let's  
20 understand the use case in a more detailed  
21 way, especially if it has implications for  
22 the actual design of the grouper itself.

1                   MR. TOMPKINS: I'm not sure if we  
2 want to belabor this or play it out.  
3 Because if I understood the question it  
4 could be framed something like this. Is NQF  
5 indifferent to the use of a grouper -- one  
6 grouper versus another.

7                   Let's say one grouper studiously  
8 collects likely complication costs  
9 associated with an elective procedure and  
10 the other grouper doesn't.

11                   The health plan might prefer to  
12 use the grouper that does not if it turns  
13 out that it's the cheaper providers who have  
14 the higher complication rates.

15                   So that if they're trying to give  
16 information to the members about which ones  
17 to choose that they're very selective about  
18 the costs that they're revealing as part of  
19 that bundle then it might lead more people  
20 to use the cheaper one, whereas there's been  
21 a research base showing that consumers are  
22 very sensitive to avoiding providers who



1 have a high share of costs that are related  
2 to complications.

3 DR. MIRKIN: I can't speak for  
4 NQF, but I think as far as -- and certainly  
5 there's no -- there's nothing that requires  
6 insurers or anybody else who aggregates data  
7 to use NQF-endorsed measures.

8 But in fact I think NQF-endorsed  
9 measures have become sort of the standard  
10 for health insurance or anybody who's going  
11 to report on those kinds of areas.

12 So I see no reason why NQF can't  
13 more or less endorse principles for a  
14 construction of an episode grouper which I  
15 think is what we discussed in our clinical  
16 group. Not saying this is the only way to  
17 do it, but if your grouping methodology  
18 follows these principles and this is  
19 something that we think is appropriate for -  
20 - it can be endorsed. So I guess that would  
21 be up to NQF. You can't force anybody to  
22 use it.

1           The other thing, as far as use  
2 case I don't think we were discussing, and  
3 the rest of the group correct me. I don't  
4 think we were discussing use cases as  
5 something that would be required for NQF  
6 endorsement, but it was a way of packaging  
7 the various criteria.

8           If you have -- this is your  
9 intended use case, and I guess if a  
10 developer said we want to use it for all  
11 these things then they would be -- the whole  
12 set of criteria would be applied against  
13 that. I think that's how we were looking at  
14 use cases, correct?

15           MS. MARTIN ANDERSON: Just to  
16 make sure I'm getting this right, you're  
17 articulating a desire to make sure that the  
18 use case disclosed. And then I think you  
19 all took it a step further and said and  
20 maybe NQF could have a set of principles  
21 that would be important to support that kind  
22 of a use case. Right? But not a required.

1 So it's how to walk that line of not telling  
2 them exactly how they have to group it.

3 DR. MIRKIN: To Mark's point, I  
4 don't think the group ever was suggesting  
5 that NQF would say here are appropriate use  
6 cases. But more or less you disclose what  
7 use case if you are going to limit yourself  
8 to a particular use case and then here are  
9 the criteria that NQF would say are  
10 appropriate to use to evaluate your grouper  
11 for that particular use, be it reimbursement  
12 or different kinds of things.

13 DR. BANDEIAN: This is a  
14 different topic from what just has been  
15 talked about so I can either stop or  
16 continue on. I mean, it's within the  
17 clinical domain.

18 MS. MARTIN ANDERSON: Mark, is  
19 yours related to this topic or a new topic?  
20 And Jennifer?

21 MS. HOBART: I'll just quickly  
22 close on this. I mean, I think it would

1 just -- the health plans would benefit from  
2 having what expertise there is to help  
3 guide. Because there is a lot of both  
4 market and political pressure for these  
5 transparency things. And it's complicated  
6 to figure out so we would like, at least  
7 some health plans would like to leverage the  
8 expertise without saying it's a mandate on  
9 either side if one needs to be done.

10 And also, to have some  
11 consistency of engagement with the provider  
12 community so on both sides we aren't going  
13 crazy with 50 different approaches.

14 DR. BANDEIAN: I see that there  
15 is some mention of complications there. And  
16 again, maybe I missed the further  
17 discussion. And we talked a little bit  
18 about that in our group.

19 But complications can add a lot  
20 to the cost of a condition episode. And so  
21 I would think that one would want to know  
22 what the mechanism is for determining

1       whether a complication should be assigned to  
2       a condition.

3                   And in cases where -- I mean, and  
4       what's the logic and what is the mechanism,  
5       if any, of resolving some ambiguities as to  
6       what actually caused the complication and  
7       what do you do if it seemed like two  
8       conditions might have caused the  
9       complication.

10                   And I'm not sure if you'd  
11       necessarily want to quite go down this road,  
12       but it does seem almost in my mind that  
13       addressing complication costs is a  
14       requirement in the sense that the  
15       comparisons of cost can be extremely  
16       misleading if complications are not  
17       considered.

18                   But this is also a complicated a  
19       topic and it's hard to get it right. So I  
20       don't know whether you address that, or any  
21       folks --

22                   DR. CACCHIONE: We did talk a lot

1 about complications versus comorbidities  
2 versus expected complications. And we  
3 thought there was a real continuum there.  
4 And we understood that there was a -- yes,  
5 there was quite a bit of variability in  
6 terms of the cost as it relates to those  
7 things.

8           And we had a fair amount of  
9 discussion. I don't know that we concluded  
10 anything, we just really spent a fair amount  
11 of time talking about that there were  
12 comorbidities, there were expected  
13 complications and then complications that  
14 were a defect in care.

15           And that there was definitely a  
16 gradation in terms of the expense of care or  
17 the cost of that care. And there are  
18 implications. I mean, I think that  
19 everybody understands that there are  
20 implications that you would be paid for  
21 comorbidities but you might not be paid for  
22 unexpected complications. But we never got

1 that far down the road on that.

2 DR. BANDEIAN: If I might just  
3 elaborate just for a second if that would be  
4 helpful.

5 So, comorbidity I think has an  
6 impact on the expected cost of a condition.  
7 So, if a person has a hip fracture but also  
8 happens to be morbidly obese they're  
9 probably going to have a little difficulty  
10 with rehabilitation and the rehabilitation  
11 would take a little bit longer. So that to  
12 me is kind of a risk adjustment issue.

13 Now, complications also have some  
14 risk adjustment implications, although I  
15 think as Chris Tompkins just indicated you  
16 might not necessarily want to risk-adjust  
17 for the complication because that would be  
18 kind of giving the folks a little bit of a  
19 pass on the fact that the complication  
20 occurred.

21 So, actually really what I'm  
22 focusing in on is a concern that if we do

1 not have a mechanism for taking into account  
2 complications, you know, a post-operative  
3 wound infection, et cetera, it might appear  
4 as though episode A is less expensive for  
5 the same condition than episode B. But  
6 actually if you factored in the  
7 complications it was twice as expensive.

8           And so in terms of again the  
9 validity concept of when we compare two  
10 episodes, putting aside the issue of  
11 comorbidity for the moment, and one is more  
12 costly than the other is that actually a  
13 true statement that makes sense.

14           And I would submit that if we do  
15 not have at least some mechanism of taking  
16 into account the complications that are  
17 directly related to that condition episode  
18 we might be making a very misleading  
19 judgment.

20           So, if one --

21           DR. CACCHIONE: So that's part of  
22 the clinical construct. The complications



1 need to be somewhere, and that -- we needed  
2 to have those complications that are  
3 failures and those complications that I  
4 guess are less about a failure, more about  
5 something that is a known complication.

6 But yes, we did account for that  
7 in the discussion and we think that needs to  
8 be part of it.

9 I think we ought to stop with  
10 this. We only have 45 minutes left and we  
11 have two other topics to go and we're sort  
12 of beating this. And so let's go onto the -  
13 - did I miss that?

14 MS. WILBON: If the group feels  
15 like we're done with this and there's not  
16 anything else to add then we can move onto  
17 the next topic.

18 DR. CACCHIONE: I wasn't aware  
19 that --

20 MS. WILBON: No, that's fine. I  
21 mean, I think we were thinking there might  
22 be more discussion, but I know people are

1 kind of petering out.

2 DR. CACCHIONE: Well, if there  
3 are more discussion points or there are  
4 other questions. I think, David.

5 MR. HOPKINS: I don't understand  
6 what episode grouper would not incorporate  
7 complications? I can't imagine that. So,  
8 it sounds more like an academic issue than a  
9 real one.

10 MS. MARTIN ANDERSON: I think one  
11 thing I'm trying to catch up on is this  
12 concept of what really is a principle. You  
13 know, what is a principle statement.

14 And if a principle statement for  
15 an episode grouper was something like the  
16 episode grouper must be able to account for  
17 complications. You know, I don't really  
18 know what --

19 MR. DE BRANTES: You can't say  
20 that. I'm sorry. This is Francois. You  
21 can't say that without then having to define  
22 very, very, very clearly your concept, i.e.,

1 NQF's concept of a complication.

2 MS. MARTIN ANDERSON: Yes, I  
3 wasn't actually trying --

4 MR. DE BRANTES: And so is the  
5 complication a natural progression of the  
6 disease which is how some people define a  
7 complication? Is it an error? If it is,  
8 what type and how do you bind it.

9 MS. MARTIN ANDERSON: Yes, I  
10 think that what I just heard them say is  
11 that they're saying the complication can be  
12 all of those. And I was just trying to  
13 paraphrase and give an example of is that  
14 what we mean when we say we want to have  
15 principles. And if it's just so obvious --

16 MR. DE BRANTES: The principle  
17 should be you explain what you're doing.

18 MS. MARTIN ANDERSON: But you  
19 have to tell them under what dimensions do  
20 you still need explanation.

21 So there's a couple of different  
22 things. One is some principles. The other

1 is what information do you have to submit.  
2 If this just falls under the category of the  
3 kinds of things you should have to submit  
4 and explain in your application that's what  
5 I'm trying to get at.

6 When we said there are some  
7 principles that came out of this clinical  
8 logic workgroup what are those principles as  
9 compared to -- and do we have clarity on  
10 that? If we do then we can follow up later.  
11 Versus what are those things that just need  
12 to be submitted.

13 DR. KING: Yes, the principle is  
14 you need to explain. Not that you need to  
15 define your condition, your complications,  
16 but you need to explain it, you need to  
17 address it.

18 And another principle is that you  
19 need to pass testing criteria or validity  
20 criteria for your measure. And we kept  
21 going back to the test cases, or what did we  
22 call them, sample cases or something.

1                   So, if really what an episode  
2 grouper is is about defining cost of care  
3 then you should be able to have the person  
4 who had the hip fracture, got the anemia,  
5 got the myocardial infarction. And you  
6 should still come up with the same cost of  
7 care regardless of whether you call that  
8 myocardial infarction a complication or part  
9 of the disease of that poor old person who  
10 happened to have silent coronary disease,  
11 got anemia and had the heart attack.

12                   But, so if you go to the testing  
13 part of it, the validity, the reliability  
14 testing part of it with the test cases then  
15 who cares how you explain your clinical  
16 logic and what you call a complication  
17 versus what you call just a natural  
18 progression of disease.

19                   Did I explain that sort of?  
20 That's basically what we cardiologists kind  
21 of came up with.

22                   MS. MARTIN ANDERSON: Were you

1 saying that the test -- are you articulating  
2 what needs to be tested, or a particular  
3 methodology for how to do the testing? Or  
4 were you saying both?

5 DR. KING: We landed on test  
6 cases, but there may be a better methodology  
7 for doing it.

8 DR. CACCHIONE: I think we said  
9 it was iterative, you know, that it was  
10 going to be continually refined. But I  
11 don't think that we got -- answered your  
12 question specifically.

13 MS. MARTIN ANDERSON: Okay. So  
14 we still maybe have some work to do to say  
15 what information would have to be collected  
16 as part of an application for endorsement,  
17 what are anything that you would tease out  
18 as principles that are just information  
19 you're going to share, or you know, require  
20 to be shared. And then if you have any  
21 requirements.

22 It would be relatively unusual to

1 specify exactly how something needed to be  
2 tested, but I do think we have to wrestle to  
3 the ground how do you determine validity if  
4 -- on the clinical logic.

5 MR. AMIN: Our construction logic  
6 group touched upon some of these very same  
7 topics. So maybe what would be helpful is  
8 to walk through a little bit of where we  
9 were. Because this is not by any means  
10 complete but I think it raised some of the  
11 same concerns that you're raising right now.

12 And I think some of us walked  
13 away wondering whether we really have --  
14 whether we're suggesting testing approaches,  
15 or we're actually looking at criteria.

16 So, this may be helpful or it  
17 just may add some more complexity to what we  
18 needed to do tomorrow. But I'd rather at  
19 least put it on the table and then maybe we  
20 can address it together tomorrow.

21 So, I got nominated as the  
22 spokesperson.

1 (Laughter)

2 MR. AMIN: Although Tom was a  
3 quick second so he's going to help out.

4 So, what we talked about were --  
5 I mean, I have some overarching statements  
6 that the group had. And I think our group  
7 was probably the most -- well maybe, I don't  
8 know, I don't want to speak for everybody  
9 but had some of the more innovative  
10 approaches here that really suggest that NQF  
11 rethink its typical endorsement process and  
12 how it relates to episode groupers.

13 And suggesting that potentially  
14 our consensus development process of  
15 convening panels may potentially not be the  
16 best approach for what we're trying to  
17 achieve here.

18 So again, I want to just tag this  
19 because I know we can't have a full  
20 discussion of this today but I think we need  
21 to give this some thoughtful consideration  
22 tomorrow.



1                   But overarching, you know, what I  
2 really tried to push the group to work with  
3 in the framework and ultimately we push back  
4 was that we wanted to first discuss what  
5 were the components that we would want  
6 submitted, how would one evaluate those  
7 components and how would those components  
8 potentially vary depending on the use.

9                   And we talked about -- our charge  
10 was to look at issues of concurrence of  
11 clinical events, complementary services,  
12 hierarchies, missing data, things of that  
13 nature.

14                   And ultimately what the group  
15 came back with was the two really important  
16 things that we would want submitted is an  
17 understanding of how conditions --  
18 identifying conditions of an episode,  
19 essentially the trigger and end mechanisms  
20 of the episodes within the grouper, and then  
21 the methods by which the claims are assigned  
22 to an episode, and all of the steps that

1 would be required to have services assigned  
2 to an episode.

3 That would include how these  
4 tiebreakers are managed, statistical  
5 inferences, and all of that should be  
6 transparent.

7 A concern that David raised which  
8 was a valid one was around whether even this  
9 would be feasible in an environment where we  
10 would be evaluating hundreds potentially,  
11 depending on the grouper, of individual  
12 episodes.

13 And so that was -- those were the  
14 components that we could at least agree on.  
15 We discussed a number of others but those  
16 were the only ones that we could agree were  
17 components that should be submitted for  
18 evaluation. Those are quite different than  
19 what our charge was so that was by design in  
20 some ways.

21 The second component that we were  
22 looking at was how one would -- what we

1 would use to evaluate this. And essentially  
2 we came back to essentially I think what  
3 your clinical logic group came up with which  
4 is essentially validity testing was the  
5 dominant testing approach that we would want  
6 to look at and essentially was the dominant  
7 criteria.

8           And one potential approach,  
9 again, this is not the criteria, but one  
10 potential approach that one could use for  
11 validity testing would be to develop --  
12 using a validated data set to use a set of  
13 scenarios and follow where the claims were  
14 assigned, understand the service assignment  
15 episodes and then put the episode grouper in  
16 a potentially more complex environment to  
17 understand how the groupings changed.

18           So again, we talked about the two  
19 elements that we would want submitted. And  
20 then the dominant approach to actually doing  
21 the testing was validity testing.

22           And then on the next slide I

1 think we discussed at a high level -- Evan,  
2 if you can move me to the next slide --  
3 maybe Tom, you can give us a better example  
4 of what a complex environment is for moving  
5 the episode grouper to a complex  
6 environment.

7 MS. MARTIN ANDERSON: So put the  
8 claims in a complex environment. What's  
9 that mean?

10 MR. MACURDY: The sort of thing I  
11 had in mind was to first start out with,  
12 just to be very concrete, suppose you start  
13 with 25 claims so that the group would be  
14 able to get a handhold on how various claims  
15 got assigned in that sort of world.

16 And then take that and maybe put  
17 it in an environment where there's 250  
18 claims and see how things get reassigned.  
19 Because you find very often that they do get  
20 reassigned and the question is why.

21 They can be assigned to a  
22 different episode type because they're now

1 classified as a complication, or that sort  
2 of thing.

3 But the biggest challenge I've  
4 always had with these sorts of things is to  
5 be able to -- I think it's better to start  
6 somewhat simple so you get a grasp of what's  
7 going on and then build the more  
8 complicated.

9 So once again, it would be a case  
10 of something that's manageable and then  
11 putting it in a more complex environment and  
12 then see what happens. And then be able to  
13 address why it did what it did.

14 MR. AMIN: So, a few other  
15 components that we discussed. Let me just  
16 lay this out for the group.

17 Steve really recommended that we  
18 lay out essentially what we mean by validity  
19 in this environment. And there were at  
20 least two that the group agreed upon which  
21 is that the person actually had the  
22 condition, and then the services assigned to

1 the condition are correctly assigned.

2 And then there are other examples  
3 in terms of identifying or determining high-  
4 or low-risk conditions as a potential,  
5 another area for defining validity.

6 One key takeaway for me as we  
7 were discussing this, and I think this has a  
8 lot of implications to how we think about  
9 the criteria validity is that there may be  
10 no -- the group felt very strongly that  
11 there may be no right or wrong output. But  
12 the intent of the grouper needs to be clear.

13 Which in itself is a little bit  
14 challenging to think about in terms of  
15 validity, at least the way I conceptualize  
16 validity which is that there is some truth,  
17 or some right that you're trying to move  
18 toward. So, that was an interesting  
19 characterization of where the group landed  
20 and I think has some very clear implications  
21 for how we think about criteria.

22 And oh, so we explored the

1 question about use. Again, I think adding  
2 to the complexity here was this overarching  
3 issue around use, and that the groupers may  
4 vary based on use and may require  
5 flexibility in defining parameters.

6 And so one of the challenges here  
7 is that if you're actually looking at  
8 validity and the grouper in a lot of ways  
9 has flexibility or the parameters are  
10 changing what exactly is it that you're  
11 looking at.

12 And the group felt pretty  
13 strongly that the developer should specify  
14 the use of the grouper in the evaluation and  
15 the parameters and at least the range of  
16 those parameters so that we can get a sense  
17 of what exactly it is that we're evaluating  
18 and that's being tested.

19 So, maybe I'll turn that back to  
20 you in terms of kind of how that resonates  
21 with where the clinical logic group was.  
22 But I think it still raises some more macro

1 questions around what exactly is it that  
2 we're expecting to be submitted. What is  
3 the criteria and what are rising to the  
4 level of principles. And I think those are  
5 sort of consistent.

6 MS. MARTIN ANDERSON: Just a  
7 couple of quick questions, clarifications.  
8 What do you mean by the word "parameters" in  
9 this context?

10 MR. MACURDY: Pretty well every  
11 grouper -- a concrete example would be you  
12 can often vary the criteria for what starts,  
13 you know, what's an open period that starts  
14 or ends an episode. But pretty well the  
15 groupers had various kind of parameters you  
16 can set.

17 MS. MARTIN ANDERSON: Okay.

18 MR. MACURDY: And for the most  
19 part the way that's been generally handled  
20 is to have the -- whoever's submitting the  
21 grouper to give their recommended parameters  
22 to begin with and then you can see how they



1 vary.

2 MS. MARTIN ANDERSON: The user-  
3 controlled options that are in the  
4 beginning.

5 MR. MACURDY: There's usually  
6 quite a few.

7 MS. MARTIN ANDERSON: Yes, okay.  
8 We talked about that too.

9 So, if you go back to the  
10 previous page I think the one thing that it  
11 sounds like you're highlighting but strikes  
12 me as the second bullet said validity is  
13 services assigned to the condition are  
14 correctly assigned but there is no correct.

15 So, what do we do about that? I  
16 mean, you know, so in a sense the bar is can  
17 you explain it credibly but not necessarily  
18 does it work correctly because we can't  
19 define correct, right? That's what I'm  
20 hearing. I'm just repeating. I'm not --

21 MR. DE BRANTES: Well, this is  
22 Francois. So, I'm not sure you can't define

1 some level of correctness.

2 So, to Tom's point, if you have a  
3 preset claims database that has very  
4 specific profiles of patients.

5 You know, for example, that they  
6 have certain conditions. You know that  
7 they've had certain procedures done. You  
8 might know that some of those procedures  
9 ended up by having complications such as  
10 infections, et cetera. So, you know all of  
11 that ahead of time. That's your base claims  
12 data set that you transmit to the developer  
13 for testing through their grouper.

14 If what comes out is markedly  
15 different from the picture painted of these  
16 patients a prior then something is wrong.  
17 There's an inconsistency that they should at  
18 least be able to explain.

19 So there is something right about  
20 does the patient have -- is there sufficient  
21 evidence in the data set that a patient has  
22 pneumonia, or is there sufficient evidence

1 that the patient has diabetes. And if the  
2 answer in that claims data set would lead  
3 anyone to say yes, but the grouper comes out  
4 with no, then there's a discrepancy that  
5 needs to be explained.

6 Similarly, if there are certain  
7 services that are very clearly misassigned  
8 because -- and Steve's example was an X-ray  
9 for an ankle fracture that ends up by being  
10 dumped into an episode for pneumonia.  
11 Obviously that's wrong, that's just  
12 basically wrong.

13 So, there is some -- there are  
14 right answers in some circumstances, but  
15 then there's a fair amount of gray area.

16 An example of a gray area is if a  
17 lab test was done for a patient who has two  
18 conditions should the lab test be assigned  
19 to both conditions or just one. That's a  
20 subjective design that at some point someone  
21 needs to justify the reason for that single  
22 assignment, or for a double assignment.

1                   So, the areas we think that are  
2                   fairly clear-cut, something is just clearly  
3                   badly assigned, an episode that should have  
4                   been triggered is not triggered. And then  
5                   there's the rest of it which is you're not  
6                   going to be able to stand up to any kind of  
7                   gold standard because it's a function of the  
8                   subjective decisions made by the developers  
9                   as they designed their grouper.

10                   MS. MARTIN ANDERSON: Okay, thank  
11                   you. So, I just suggested to Taroon I think  
12                   maybe we should avoid the word "correct"  
13                   right? Something services assigned to the  
14                   condition -- or logically assigned. Just  
15                   acknowledging that there can be more than  
16                   one correct that's a design -- that you  
17                   could at least logically explain. Steve.

18                   DR. BANDEIAN: The exact word,  
19                   adjective, et cetera, should be.

20                   I think, first of all, I think  
21                   Francois summarized the discussion extremely  
22                   well.

1                   Just as another example, just to  
2                   kind of make the point. Suppose that we  
3                   have a glycated hemoglobin has a lab test  
4                   and suppose that it is assigned in the  
5                   grouper to the patient's hypertension  
6                   episode but the patient actually also has a  
7                   diabetes episode. So, it would be really a  
8                   little hard to imagine why a glycated  
9                   hemoglobin would be used for hypertension  
10                  but it would be pretty easy to understand  
11                  why it would be used for diabetes.

12                  So those are the sorts of things  
13                  which looking at output one could have  
14                  clinicians look at and make a judgment of  
15                  whether the error rate there, whether it  
16                  would cause an error or not. Whether things  
17                  are sort of looking basically okay.

18                  And it's actually pretty easy.  
19                  You just would take all of your hypertension  
20                  episodes and see exactly what services are  
21                  being associated with it.

22                  If there's a lot of stuff that

1 doesn't really make sense related to  
2 hypertension then you might at least  
3 question it.

4 MR. MACURDY: Just to emphasize  
5 the point further. Francois' point is  
6 there's a real challenge comparing across  
7 groupers because they do different  
8 classifications in what you call an episode.  
9 And one's not right and the other one's not  
10 wrong, they just have a different  
11 organization scheme.

12 And even within the same grouper  
13 you can -- by making the case kind of more  
14 complex with more claims something can get  
15 reassigned and you look at it and it's  
16 reasonable in terms of the way it were  
17 assigned. Something that was an episode by  
18 itself becomes a complication to another  
19 episode.

20 So, even within the same grouper  
21 it can be quite plausible in terms of what  
22 the assignment is. And that's what's meant,

1 that there's not really a right or wrong  
2 answer.

3 MS. GARRETT: I just wanted to  
4 elaborate a little bit on what Taroon was  
5 saying about that we feel that the typical  
6 process might not really work for this.

7 So we talked about the fact that  
8 really episode groupers are software,  
9 they're software products. And so there's  
10 not a numerator and denominator that's set  
11 in time that you can evaluate and then that  
12 stays the same for 3 years until the next  
13 endorsement process.

14 And it's complex software.  
15 There's lots and lots of elements.

16 So, one of the criteria we  
17 suggested is that there be an iterative  
18 process for improvement of that tool. And  
19 for the next version to be released and that  
20 there's clinical input into that process.  
21 And that the developer can demonstrate that  
22 that's part of the tool that they're

1 bringing forth to be endorsed. So we're not  
2 freezing it in time. So, that's something  
3 that I think is a little bit different.

4 And we also talked about the  
5 complexity of this. And having an expert  
6 panel spend a day and a half on this we  
7 might not get what we really need in terms  
8 of understanding how that grouper works and  
9 if it's going to work well enough.

10 So, we sort of threw out NCQA has  
11 a process for certifying vendors that do  
12 HEDIS rates. So certifying that they  
13 actually know how to take in claims data,  
14 apply the right algorithms and produce HEDIS  
15 rates. Maybe it's something more analogous  
16 to that than a typical endorsement process.  
17 So that's another thing we talked about.

18 And then one other unrelated  
19 point is we also talked a bit about how  
20 we've been really assuming all day that  
21 we're talking about administrative claims  
22 data.



1                   But I hope that we can be a  
2                   little more generic in the language that as  
3                   EHR data becomes more readily available that  
4                   that can potentially be a source for episode  
5                   grouping. Because there's lots of potential  
6                   use for that within providers and a lot of  
7                   clinical richness that isn't found in claims  
8                   data there. So, another point that we  
9                   talked about.

10                   MS. MARTIN ANDERSON: Just a  
11                   quick question on this testing methodology.  
12                   I want to go back to that for a second.

13                   So, is it a reasonable assumption  
14                   that if you came up with a set of data and  
15                   you had them run through it that if had you  
16                   chosen different data you would have made  
17                   the same endorsement decision? What's the  
18                   risk of teaching to the test and/or what's  
19                   the extensibility of that kind of testing?  
20                   You've probably done it so tell us.

21                   (Laughter)

22                   MR. MACURDY: Well, I wasn't

1 suggesting that you have the people who  
2 developed the grouper to do the scenarios.

3 And one of the challenges you'll  
4 find in the grouping is that you can change  
5 -- you can actually change the order of  
6 claims and it changes grouping. Now, it's  
7 fairly slight, it happens, but it affects  
8 the hierarchies.

9 So there is some arbitrariness  
10 that occurs there that you just kind of  
11 can't handle. And all the groupers have  
12 that sort of problem. So I mean, I meant  
13 you literally can just resort the claims and  
14 you get a slightly different kind of  
15 reorganization of the grouping.

16 Certainly if you add more claims,  
17 even in episodes that are not related to the  
18 one you're after you can get a new grouping.  
19 So there's a lot of sensitivities. And to  
20 try to go through every one of those  
21 scenarios is a real challenge.

22 What we were trying to do is

1 figure out -- was to give whoever's doing  
2 the evaluation a chance to be able to get a  
3 grasp of what's going on and say does this  
4 look like first round reasonable. And I  
5 think that's about all they're going to be  
6 able to do at that point. Because it is a  
7 real challenge.

8 MS. MARTIN ANDERSON: Okay.

9 DR. BANDEIAN: I'm not sure that  
10 there was consensus on this although there  
11 may have been, I'm not sure. And Tom or  
12 others can say whether there was or not.

13 But in addition to the sort of  
14 vignette or scenario scenario where there  
15 are sort of by definition a relatively  
16 limited set of scenarios one could also run  
17 through the system a few million people and  
18 look at aggregated results.

19 So one could look at aggregated  
20 results, for example, for diabetes, or for  
21 pneumonia, or what have you. And look at  
22 results that seem reasonable, things that

1 look reasonable, things that don't look  
2 reasonable.

3 Now, again I'm not entirely sure  
4 that there was or wasn't consensus about  
5 this. You know, you could look at how long  
6 the pneumonia episode was lasting. If you  
7 saw a lot of pneumonia episodes that were  
8 lasting 180 days it might raise an eyebrow.

9 And you could also -- picking up  
10 on what we were just talking about a few  
11 minutes ago you could look at all of the  
12 types of specific services that were being  
13 assigned to the episode. So, if one saw a  
14 lot of cardiac stress test being assigned to  
15 diabetes it might again raise a little  
16 concern, especially if the person already  
17 had a coronary episode.

18 MS. MARTIN ANDERSON: The model I  
19 think that you all are proposing for  
20 consideration is a model that looks a lot  
21 like software certification programs. So,  
22 whether it's how Meaningful Use is done,

1 it's how all these various software  
2 certification type programs where it's  
3 independent testing that is -- usually  
4 induces cost on the developer. The NQF  
5 wouldn't necessarily be doing all that.

6 But I get the model now so thank  
7 you for explaining it.

8 MR. HOPKINS: If you did that  
9 then you obviate all the discussion  
10 repeating itself over and over and over  
11 again in steering committees when a measure  
12 comes that's based on an episode grouper.

13 MS. MARTIN ANDERSON: Maybe.

14 (Laughter)

15 MS. MARTIN ANDERSON: I know we  
16 have to get to public comment. So we have  
17 like a minute before public comment. So  
18 Tom, you want a last word?

19 MR. MACURDY: Yes. I just want  
20 to note that it's not as straightforward as  
21 just doing software certification because  
22 there's a lot of judgment calls that are

1 involved.

2 But I think the main thing is,  
3 and it gets back to Taroon's earlier point,  
4 that the usual kind of process is going to  
5 be somewhat of a challenge. And you are  
6 going to want some analysis done here.  
7 Exactly, a process. Exactly.

8 MS. MARTIN ANDERSON: Okay. So  
9 now Evan, are you doing public comment?

10 MR. WILLIAMSON: We will now have  
11 public and member comment. Do we have any  
12 comments in the room? Okay. Operator,  
13 could you please open the lines for public  
14 and member comment?

15 OPERATOR: Okay. To ask a  
16 question please press \* and then the number  
17 1. At this time there are no questions or  
18 comments.

19 MR. WILLIAMSON: All right, well  
20 I think that wraps up our agenda for today.  
21 We want to thank you guys for your  
22 attention. We know that was a long day and

1 I think we got a lot of work done that will  
2 help tomorrow as we start to really move  
3 towards some recommendations and what we're  
4 going to put in the report and move towards.  
5 Kind of herding all these cats that we kind  
6 of have running around right now.

7 But we'll be convening again at  
8 P.J. Clark's. Our reservation is at 6 but  
9 feel free to head over at any point. And  
10 thanks again and we'll see you tomorrow  
11 morning bright and early again.

12 (Whereupon, the foregoing matter  
13 went off the record at 4:43 p.m.)

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