

NATIONAL QUALITY FORUM

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EPISODE GROUPER EVALUATION CRITERIA  
EXPERT PANEL

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THURSDAY  
FEBRUARY 6, 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 9:00 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\*

DAN DUNN, PhD, Optum

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 Cardiovascular and Pulmonary Rehabilitation

MARK LEVINE, MD, Centers for Medicare &  
Medicaid Services  
JIM LOISELLE, McKesson Corporation\*  
THOMAS MACURDY, PhD, Stanford University  
JELANI McLEAN, PhD, MPA, Health  
Intelligence Company, LLC  
DAVE MIRKIN, MD, Milliman MedInsight  
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  
KAREN PACE, PhD, MSN, Senior Director,  
Performance Measurement  
ANN PHILLIPS, Project Analyst  
ASHLIE WILBON, RN, MPH, Managing  
Director, Performance Measurement  
EVAN WILLIAMSON, MPH, MS, Project  
Manager, Performance Measurement

\* present by teleconference

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

9:06 a.m.

THE OPERATOR: Welcome to the Medicare Episode Grouper Expert Panel meeting.

Please note today's call is being recorded.

Please stand by.

MR. WILLIAMSON: Good morning and welcome to day two of the Episode Grouper Evaluation Criteria meeting.

We want to welcome you all to the second day. We had a very productive first day and we got a lot of issues out on the table that we're going to continue to discuss today.

We have a new member in the room joining us, Dan Dunn. He just stepped out. Okay.

We went through a disclosure process yesterday that we want Dan to go through as soon as he is finished chewing. But we will have him introduce himself, and

1 then, we have four bullet points up here on  
2 the slide that I will remind you of.

3 We need to disclose any  
4 involvement in the development of an episode  
5 grouper system, personal financial  
6 arrangements or affiliations with a specific  
7 product or service based on a product,  
8 investment in specific products by  
9 organization, and employment by or other  
10 affiliations with organizations, companies, or  
11 other entities that own, develop, or use  
12 episode groupers.

13 So, Dan, we'll have you take it  
14 away. Just press the Speak button here.

15 MEMBER DUNN: Okay. Good morning.

16 Dan Dunn, Optum, Senior Vice  
17 President, Business Solutions. And I have  
18 been involved and continue to be involved in  
19 the development of Optum's episode treatment  
20 groups and procedure episodes grouper. I  
21 actually have equity in United Health Group,  
22 which owns Optum.

1 MR. WILLIAMSON: Great. Thank you  
2 very much.

3 At this time, I will turn it over  
4 to our Co-Chairs, who will help us kick off  
5 the meeting.

6 CO-CHAIR MARTIN ANDERSON: Great.

7 Well, everyone looks a little  
8 refreshed now, right? That was a really great  
9 day yesterday. I think it was really tiring  
10 for all of us by the end, but we got a lot out  
11 on the table and I think a lot of things to  
12 work with for the next iteration for staff.

13 Just a couple of reminders for  
14 today, partly for Dan, who wasn't here  
15 yesterday. So, it is just to give you kind of  
16 our guidance for how we're interacting.

17 And then, also, just a reminder  
18 for everyone else. We are all here as  
19 individuals. So, it is important that, even  
20 if we have strong, passionate views about a  
21 particular solution or approach we're taking  
22 on a product, we are really here to get



1 diversity of opinion and have people share  
2 their expertise, and not really to win an  
3 argument over what is the best way to build an  
4 episode. We're not really working together to  
5 define the best episode grouper. We're  
6 working together to try to figure out how  
7 would you evaluate an episode grouper and how  
8 would you know a good one when you saw one.  
9 So, thanks for that.

10           The other observation is that we  
11 have diversity of expertise. And as often  
12 happens in committees, just keep in mind that  
13 some people will naturally speak more than  
14 others, but we will be looking, as Co-Chairs,  
15 for people when they put their tabletop up.  
16 When they want to make a comment and they  
17 haven't really said as much, we'll make sure  
18 to call on them first, so we hear from  
19 everybody. So, I just want those of you who  
20 have more to say to know that we are not  
21 passing over you. We're just trying to make  
22 sure that we hear from everyone.

1                   So, with that, did you have any  
2 other comments?

3                   CO-CHAIR CACCHIONE: No. I think  
4 we had a nice dinner last night and there was  
5 some conversation about the output of the  
6 Committee and were we successful.

7                   I think that we are charged with  
8 something that is in a very short period of  
9 time what I think is a very difficult task.  
10 That being said, I don't think that when we  
11 walk out the door today, that the task is  
12 nearly done, nor did I think the staff or  
13 Christine and I thought we would be done at  
14 all.

15                   They see this as more of a  
16 brainstorming and really directing and  
17 starting to hone-down thoughts on where we are  
18 going to go with this. I think there is still  
19 going to be a fair amount of work to do, and  
20 staff is going to have to winnow this down,  
21 take our thoughts, come up with a product.  
22 And then, we will have to react to that

1 product. I think that is where a lot of sort  
2 of some of the heady work.

3 But this has been very  
4 enlightening. I consider it a more of a  
5 brainstorming and really trying to get a lot  
6 of ideas out there. And then, we will  
7 continue to refine this process over the next  
8 six months.

9 I think Steve asked me yesterday  
10 how did we think we did. I don't think we  
11 were surprised by the product that we ended up  
12 with yesterday. And I don't want to set  
13 people's expectations that we're going to  
14 finish this today, just because this is our  
15 face-to-face.

16 MR. AMIN: So, if I can offer a  
17 few reflections from yesterday as well, and  
18 then, I'll turn it back over to Evan to walk  
19 through a little bit of how we are going to  
20 structure the agenda for the rest of the day.

21 So, ultimately, our objective and  
22 the charge of the group is to identify what

1 information developers of episode groupers  
2 would submit to NQF, how NQF would evaluate  
3 said grouper, and then, potentially, other  
4 considerations in terms of use cases and  
5 things of that nature that we might want to  
6 consider.

7 I think what was clearly  
8 challenging in the conversation that we had  
9 yesterday was that we spend across the  
10 continuum in terms of different options for  
11 different components. We had a lot of debate  
12 around different options for different  
13 components. But, again, I think the most  
14 important thing that we want to identify is  
15 what are the elements that would need to be  
16 submitted to us.

17 I think once we go through where  
18 this Adjustments for Comparability Group went,  
19 we are going to ask that we really follow that  
20 structure again and come to some sense of  
21 consensus around what are the most clear  
22 components that we would need to have

1 submitted. And then, what are some basic  
2 criteria that we could use for evaluation?

3 And I know that framework has been  
4 challenging to some in the room. You know,  
5 moving directly to criteria at times, and  
6 then, really spending a lot of time around  
7 potentially user options or things that are  
8 not necessarily even within the grouper's  
9 control, for lack of a better term.

10 So, hopefully, it sounds like many  
11 of those people who had some concerns, we have  
12 had some conversations at the end of the  
13 meeting and over dinner last night that I  
14 think we are in a better place today. But,  
15 really, that is where we need to get to by the  
16 end of the day today.

17 So, if there are any questions  
18 about that, we can talk about that, but I will  
19 turn it over to Evan to talk about what the  
20 agenda for this morning will be and, then, a  
21 very important session this afternoon.

22 MR. WILLIAMSON: Thanks a lot,

1 Taroon.

2 So, as I'm showing you here on  
3 this screen -- let me screen-share it for  
4 everybody who is not in the room.

5 We are going to be removing one of  
6 the agenda items we had on the original agenda  
7 for today, which is the finalized principles  
8 and proposed criteria. Again, as we had  
9 mentioned earlier, we are still in the  
10 brainstorming process and we don't want to  
11 really get into the finalization of anything  
12 at this point.

13 So, rather than have that, we are  
14 going to continue our review of the principles  
15 and proposed criteria, starting with the  
16 adjustments for comparability group that did  
17 not present yesterday. So, we will start with  
18 that.

19 And then, we are going to revisit  
20 the construction of clinical logic and try to  
21 find, first of all, some of the similarities.  
22 I think some of the groups came up with a lot

1 of the same principles regarding reliability,  
2 validity, some of the things that each group  
3 discussed in relation to their module, and  
4 then, try to find some areas where we have  
5 some disagreement or differences of opinion in  
6 those sections.

7 We will have lunch around noon.

8 And then, we have two hours devoted for the  
9 afternoon for the implications of episode  
10 grouper endorsement. So, we really want to  
11 dive into that section, get a lot of ideas on  
12 the table for what it will actually mean when  
13 NQF or if NQF evaluates groupers, and what  
14 that really means in the whole landscape.

15 We hope to wrap up by 2:30 and get  
16 everybody on their way today.

17 So, that is kind of how the agenda  
18 is going to lay out today.

19 So, with that, we will go ahead  
20 and start right away into the review of  
21 principles and proposed criteria. We will go  
22 to the risk adjustment or the adjustments for

1 comparability section and pull up those  
2 slides.

3 We designated Jelani as our  
4 spokesperson. He happened to leave the room  
5 for a time. And so, with nobody else  
6 volunteering, he was volunteered.

7 (Laughter.)

8 So, go ahead and take it away.

9 MEMBER McLEAN: That's funny.

10 So, I am definitely going to need  
11 some help. I was just talking to David this  
12 morning, and we were talking about how some of  
13 the things slipped our mind from overnight  
14 about what we talked about.

15 (Laughter.)

16 So, feel free to jump in.

17 One of the things that we  
18 definitely -- well, our topic at a very high  
19 level, as you know, is about risk adjustment,  
20 case-mix adjustment, what data is input, and  
21 what do we get from that.

22 One of the top things that we



1 discussed was inclusions and exclusions and  
2 transparency specifically with that. You  
3 know, what type of data are you feeding into  
4 or required to define your cohort, so to  
5 speak. And then, once we do that, you know,  
6 transparency in what the results are from your  
7 test case, a lot of things that you guys  
8 talked about in other sessions, about having  
9 a test trial and test reporting, we honed-in  
10 on as well.

11 And then, we moved on to, I  
12 believe we moved on to that section of a topic  
13 of reliability and face validity. And some of  
14 the things you talked about, about is it  
15 accurate from an external standpoint, does it  
16 represent what the original intent for the  
17 grouper was, what the original intent was.

18 And then, man, I've got a couple  
19 of things.

20 MR. WILLIAMSON: You can go back  
21 to the risk adjustment. So, we did the  
22 inclusion/exclusion.

1 MEMBER McLEAN: Inclusion --

2 MR. WILLIAMSON: Yes.

3 MEMBER McLEAN: And then, we went  
4 through the risk adjustment portion.

5 MR. WILLIAMSON: Yes.

6 MEMBER McLEAN: Do we want to talk  
7 about the risk adjustment portion?

8 MR. WILLIAMSON: Yes, sort of  
9 that. Yes. This was all kind of stream of  
10 consciousness yesterday. We were just getting  
11 all of our ideas. So, you can see we bruised  
12 a lot of paper here on the wall, and we tried  
13 to capture as much of that as we can on these  
14 slides. So, we will try to talk through it.

15 MEMBER REDFEARN: One addition  
16 about the inclusion and exclusion that we  
17 talked a little bit about is the sensitivity  
18 of the model and about what happens to the  
19 results when things are included or excluded.  
20 So, that model sensitivity to this kind of  
21 variability we thought was important.

22 MR. WILLIAMSON: I think the data

1 fallout was something that we talked a lot  
2 about, about range of potential fallout.

3 MEMBER McLEAN: Yes, the data  
4 fallout was definitely where I was going with  
5 the transparency. You know, we talked about  
6 maybe even having some test funnel report that  
7 shows from the beginning at each point the  
8 breakdown of data that potentially they lose  
9 in the test file.

10 Because one of the big concerns  
11 with groupers is, from the end-user, you  
12 always say, "Well, that's not the data I put  
13 in. Where is my data now?" So, therefore, we  
14 talked about the transparency and that  
15 potential loss of data because of the various  
16 reasons with the groupers.

17 Then, we did, you're right, we did  
18 move to risk adjustment. We had a debate  
19 about should it even be included into a  
20 grouper or should it be excluded. Should it  
21 be their risk adjustment after the grouper is  
22 complete?

1                   And there are various reasons for  
2 both sides, from both perspectives. I think  
3 we included -- and I can't remember  
4 specifically the wording around it, but there  
5 were two different types of risk adjustment we  
6 talked about. It was actually more of Mark's  
7 wording around the population type of risk  
8 adjustment, and then -- what did it say? --  
9 the patient risk adjustment, the patient-type  
10 risk adjustment.

11                   The population risk adjustment  
12 could take place, we felt, within the grouper,  
13 and that was fine. But when we get more  
14 specific around the patient, there are certain  
15 attributes that a grouper in the claims can't  
16 account for that you may have to do outside of  
17 the grouper, looking at the result.

18                   And then, from there, we went  
19 through --

20                   MR. WILLIAMSON: Stratification.

21                   MEMBER McLEAN: We went to where?

22                   MR. WILLIAMSON: Stratification.

1                   MEMBER McLEAN: Stratification,  
2                   yes. I can't see it.

3                   MR. WILLIAMSON: It's around the  
4                   corner, but it should be up on the slide here.

5                   MEMBER McLEAN: I don't want to  
6                   move away from the microphone because no one  
7                   can hear me then.

8                   Stratification. So, we talked  
9                   about stratification of the population. And  
10                  one of the things we talked about specifically  
11                  with that was, ideally, a grouper would  
12                  stratify itself by just your inclusion  
13                  criteria.

14                  For example, if you look at  
15                  certain groupers, they say you have to have  
16                  certain diagnoses and procedure code  
17                  combinations within that. But there is  
18                  concern, does that stratification suffice for  
19                  the output or the end-users' desire? And I  
20                  think the conclusion that we came to is that  
21                  is more of an end-user responsibility than it  
22                  is the grouper's responsibility. The

1 grouper's responsibility is to specify, and  
2 going, again, back to transparency, specify  
3 what those requirements are. So that the user  
4 in the beginning knows what's going on and  
5 what they actually have to feed the grouper.  
6 So, I think that is where we stood with  
7 stratification.

8 We were actually all over the  
9 place. We finished kind of early with our  
10 original topics, and we moved to some of you  
11 all's topics.

12 So, then, we moved to -- what is  
13 this, Evan?

14 MR. WILLIAMSON: We talked about  
15 scoring, just that the developer would have to  
16 describe that they provide an output that  
17 enables scoring to occur. They provide the  
18 file for the end-user to create a score.

19 But we are discussing, is this  
20 part of a grouper system as opposed to the  
21 grouper itself? Yes, it was really drawing a  
22 line about where that handoff is between the

1 grouper and, then, the use of the grouper by  
2 the end-user.

3 MEMBER REDFEARN: Can you go back  
4 one slide?

5 MR. WILLIAMSON: Sure.

6 MEMBER REDFEARN: I would like to  
7 comment about the conditions and sub-  
8 conditions one, too, which I think is  
9 interesting. I mean, this is an example of  
10 why you might want to stratify your output.

11 So, the requirement is that the  
12 grouper would support the end-user's ability  
13 to do that, not necessarily that it is built  
14 into it. Because we talked about a few  
15 examples of which there is sort of a built-in  
16 heterogeneity of the condition, but the  
17 groupers typically put them into one category.  
18 And if you are looking at that particular  
19 condition specifically, you might want to  
20 drill down and split that episode apart into  
21 different types of members, so it can make  
22 more sense and it is most logical.

1                   MEMBER McLEAN:  So, I think I  
2                   remember what we were talking about here,  
3                   Evan.  We were talking about to what you said,  
4                   the grouper just allowing the ability to do  
5                   different types of use cases with the output.  
6                   So, not necessarily that the grouper would  
7                   provide a score.  The grouper will provide  
8                   some output, but it is not that we are  
9                   measuring it on its scoring ability.  We are  
10                  measuring it on does it provide the capability  
11                  for the end-user to do certain things they are  
12                  expecting the typical user would want to use  
13                  and desire from a grouper standpoint.

14                  And I think those base criteria  
15                  have to be set.  We don't, obviously, know the  
16                  answer to that now, but we said the grouper  
17                  would need to be able to report and provide  
18                  information that it can and it is capable of  
19                  doing those things.  So, I think that is where  
20                  we were going here.

21                  MR. DE BRANTES:  Hi.  This is  
22                  Francois.



1                   Can you guys clarify on that? I  
2                   mean, why would that be a requirement?

3                   MEMBER McLEAN: Well, Francois,  
4                   why would it be a requirement that a grouper  
5                   be able to put the user in a position of  
6                   flexibility?

7                   MR. DE BRANTES: Well, why would  
8                   it be a requirement for a grouper to provide  
9                   certain outputs?

10                  MEMBER McLEAN: Go ahead.

11                  MEMBER LEVINE: I believe our  
12                  discussion led to the fact that the grouper  
13                  needs to express what it is capable of  
14                  accomplishing. So that the end-user knows  
15                  upfront what the capabilities are in using the  
16                  output of the grouper.

17                  MR. DE BRANTES: Yes, that makes  
18                  perfect sense, Mark. But I thought you guys  
19                  were going more in a direction of saying the  
20                  grouper has to have certain types of outputs.

21                  MEMBER McLEAN: Oh, no, no. I  
22                  apologize for not being clear on that. It is

1 more about, once the grouper expresses what  
2 its capabilities are, then it is very clear to  
3 the end-user what the output would be to allow  
4 those capabilities.

5 MR. DE BRANTES: Good. Thank you.

6 CO-CHAIR MARTIN ANDERSON: This is  
7 Kristine. I just wanted to jump in, too,  
8 because we started to talk about this a little  
9 bit yesterday. I think we will have to tease  
10 it apart a little bit more today in our bigger  
11 session. We started it in our bigger session  
12 yesterday, which is trying to get more clarity  
13 of when we're talking about preferences for  
14 functionality, right, we're trying really not  
15 to be prescriptive about what a product should  
16 do.

17 But there are people in the room  
18 who have preferences for functionality, and  
19 they state them, right? So, what some of the  
20 sorting will need to be, was that really just  
21 a statement of preference for functionality?  
22 Is it something that we need to know in order

1 to be able to evaluate the grouper, right?  
2 And in some cases those overlap. Or is it  
3 something that is really just an option that  
4 is not related at all to this evaluation  
5 process.

6 So, we will have to sort through  
7 that, and that is part of what we are going to  
8 be doing today. We are saying, does it affect  
9 criteria? Is it information that needs to be  
10 submitted for endorsement? Or is this really  
11 just a statement of preference? I think we  
12 are going to get them all out on the table  
13 and, then, we will have to sort through all  
14 that.

15 MEMBER McLEAN: This goes back to  
16 the reliability and validity at every  
17 discussion, I think, at every topic that  
18 everyone had. You know, I think everyone is  
19 on the exact same page, that it has to be able  
20 to express its reliability and face validity  
21 for external validity to the end-user and the  
22 actual attempt and goal of the episode

1 grouper. So, I don't know if I need to  
2 elaborate much more on this. We had a pretty  
3 extensive discussion about this yesterday.

4 MR. WILLIAMSON: Well, I think  
5 there was one thing that we just wanted to  
6 highlight. As far as disclosure of  
7 limitations, that is when we talked about  
8 there was the example of cancer, cancer  
9 episodes, where if it doesn't have staging  
10 information, it is not going to produce -- the  
11 result won't be as reliable or be as valid  
12 there. And so, something where you are able  
13 to disclose the known limitations of the  
14 grouper was something we talked a lot about.

15 MEMBER McLEAN: Oh, yes.

16 MEMBER BANDEIAN: Are you  
17 expanding further on the validity or is this  
18 the time to talk about validity?

19 MEMBER McLEAN: Go ahead, yes.

20 MEMBER BANDEIAN: Okay. so, one  
21 way to think about this is sort of what I --  
22 and I may have the words wrong. So, please

1       excuse me. Sort of construct validity, when  
2       an episode is constructed and we say that it  
3       is a case of pneumonia, is it really a case of  
4       pneumonia. And, No. 2, that we include in  
5       that episode all of the care that is related  
6       in some manner to the pneumonia.

7                    But another type of validity might  
8       be -- and again, I'm not necessarily going to  
9       have the right language -- but might be when  
10      comparisons are made across providers and the  
11      score of Dr. Smith is 1.3 times expected and  
12      Dr. Jones is .9 times expected, and therefore,  
13      Dr. Smith seems to be more costly than Dr.  
14      Jones, is that a valid conclusion?

15                   And so, that I would sort of say  
16      is kind of an analytical validity point. So,  
17      I am assuming that one would really need to  
18      have tests and further definitions for both  
19      types of validity.

20                   MEMBER McLEAN: I will go back to  
21      your point about the construct. I will start  
22      with that, the construct validity.

1           I would presume in the example you  
2 gave around pneumonia, if pneumonia was for  
3 some reason the creation of some sort of  
4 episode, usually, with groupers, what triggers  
5 the event, the trigger event, will define what  
6 procedure and diagnosis combination.

7           Now I think that is where you go  
8 with the transparency around the inclusions  
9 and exclusions. And to some degree, you're  
10 right, you have to assess it. There is some  
11 validity around that. Is that a truly a case  
12 of what we're saying? But, for a test report,  
13 I don't know if that is something that you  
14 would put in a test report, so to speak, just  
15 from my perspective in looking at it.

16           But I do see where you're going as  
17 far as trying to ensure that the diagnosis  
18 that we are seeing and the type of condition  
19 we are seeing is true, but can you put some  
20 sort of statistical value around that? I'm  
21 not sure.

22           MEMBER JONES: Yes, we talked a

1 good deal about that. To your second point,  
2 that is a large concern, in that when you are  
3 facing out and you are saying Dr. Smith is  
4 better than Dr. Jones based on this  
5 calculation, we were talking about things that  
6 could have an impact on the power of that  
7 comparison. In other words, what is the  
8 likelihood that those differences are due to  
9 chance or, more importantly, what is the  
10 likelihood and can it be disclosed and  
11 quantified of the impact of not having a drug  
12 file included in the grouper, for example, or  
13 any other data that may have fallen out during  
14 the load process?

15 You know, we didn't solve this  
16 problem, but we talked a lot about how it  
17 would be very valuable to have some sort of  
18 guidance around that. In other words, how do  
19 we assess the impact of fallout beyond a  
20 certain acceptable level?

21 MEMBER REDFEARN: First, I would  
22 say that you're talking about something that

1 is sort of post-grouper. You're using grouper  
2 information to make an inference about the  
3 efficiency of a physician or physicians.

4 When you are looking at that ratio  
5 and you want to get a sense about whether that  
6 ratio is accurate or not, there are strategies  
7 that you can use. And it would be nice if the  
8 vendor talked about that. I don't think it is  
9 absolutely necessary, but you can use  
10 statistical techniques to determine confidence  
11 intervals or something like that.

12 You could also repeat the  
13 measurement across time and say, well, if you  
14 add three months of data to your analysis and  
15 you look at the same two physicians, do the  
16 relative positions stay the same across time?  
17 So, there are techniques you can do that, but  
18 I think that is post-grouper. That is what I  
19 would call using groupers as a foundation for  
20 cost efficiency.

21 MEMBER BANDEIAN: Well, yes and  
22 no. I mean, I understand what you're saying



1 about post-grouper, except that I would, then,  
2 say, well, why are we even talking about doing  
3 risk adjustment in this? Because risk  
4 adjustment is really the purpose. Risk  
5 adjustment, I think, is to try to help to  
6 ensure the comparability of episodes. And,  
7 yes, there are other techniques like stop-loss  
8 and exclusions that can be used to help to  
9 make one more confident about Dr. Smith versus  
10 Dr. Jones.

11 But, for example, I will just use  
12 my sort of simpleminded example. Suppose that  
13 we were talking about hip fracture, and the  
14 patient happens to also be morbidly obese. It  
15 is almost certainly the case that more  
16 rehabilitation would be required because of  
17 that coexisting condition.

18 And so, to my mind, I think that  
19 that is one of the sorts of things that risk  
20 adjustment might potentially address. And so,  
21 while I understand that there are a lot of  
22 other post-grouper calculations that kind of

1 go into this, it does seem as though -- I  
2 mean, let's just suppose that there were no  
3 adjustments for coexisting conditions.

4 MEMBER KING: Steve, I just want  
5 to cut in here for a second because, from the  
6 perspective of the group, we're not arguing  
7 about a grouper should and shouldn't do around  
8 risk adjustment at all. We didn't really have  
9 that conversation.

10 The conversation was, what kind of  
11 information should need to be submitted in a  
12 form? And as it related to any type of  
13 adjustment, the conversation was, if the  
14 grouper itself has a way of stratifying the  
15 risk, patient risk, through the grouping  
16 mechanism itself, that that needed to be  
17 disclosed, right?

18 And we recognize that the measure  
19 level, you know, when you are looking at  
20 output from groupers, there are often more  
21 risk adjustment as you are doing these post-  
22 processing services. And we said that's not

1 really what -- what we really wanted to make  
2 sure that the grouper disclosed was how it was  
3 handling the topic of risk, whether it was  
4 doing it by stratifying episodes and making  
5 some episodes marked as more higher-risk  
6 groups of patients than other episode or  
7 whether it produced some type of a case-mix  
8 number that was associated with the episode  
9 that would allow someone to do something else.

10 But what we really were trying to  
11 get at was we thought this was an important  
12 area of disclosure of what the episode grouper  
13 does for the purposes of reviewing for  
14 endorsement.

15 MEMBER McLEAN: Yes, I would add  
16 to that, one of the things that we tried to  
17 stay focused on is we are not telling the  
18 groupers what it can and can't do, like you  
19 said. But, in bringing it all together, if  
20 you're going to say that you can do this --  
21 this goes back to the transparency in the very  
22 beginning -- what does your grouper do? And

1 then, saying, well, if this is what your  
2 grouper does, then give us a report of the  
3 reliability of that, the validity of that.

4 So, if you are going to do a risk  
5 adjustment, you don't have to explain your  
6 methodology. Give us a test report that you  
7 have tested the reliability and the validity  
8 of your risk adjustment methodology with some  
9 sort of data, so that we can present it to us  
10 and we can say, "Yes, this is good" or "No,  
11 this does not meet the criteria."

12 The same thing for your inclusions  
13 and exclusions and the funneling that we  
14 talked about. All those things, if you are  
15 going to say these things that you're going to  
16 do within your grouper, then provide a report,  
17 that is really what we are saying. We are not  
18 assessing what you can and cannot do within  
19 the grouper.

20 Because I agree with you, there  
21 are groupers that do risk adjustment, and  
22 that's perfectly fine. That meets some end-

1 users, maybe as yourself, it meets their  
2 business need. But there are also users that  
3 would not choose that grouper. They would use  
4 one that doesn't do a risk adjustment, prefer  
5 that, and do like what David is saying he  
6 would do, do an additional risk adjustment  
7 post-grouper, because they feel like that is  
8 more applicable for their business need. Does  
9 that make sense?

10 MEMBER BANDEIAN: This is a  
11 difficult topic, No. 1. And, No. 2, I'm still  
12 kind of reorienting my thinking to thinking  
13 about how NQF thinks about things, which I  
14 have never done before. So, I understand that  
15 NQF has a special mission and a special  
16 approach to things.

17 Maybe let me just try this on.  
18 Maybe this is what you are saying. So, let me  
19 try some words that may be helpful, at least  
20 for me.

21 Perhaps you might ask the vendor  
22 to explain their thinking about how one makes

1     sure that episodes are comparable, so that  
2     valid conclusions could be drawn from them,  
3     and just have them describe their  
4     methodologies and approaches to address that.

5                   MEMBER HOPKINS:  It is really a  
6     wide-open question.

7                   MEMBER BANDEIAN:  Well, I am  
8     trying to figure out what the difference is  
9     between -- I mean, in other words, to me, I  
10    would actually ideally like to see some  
11    fairly-rigorous statistical testing of a large  
12    number of condition episodes.  So that in a  
13    standard prototype implementation, recognizing  
14    that, yes, the end-user can do all different  
15    sorts of things, but in a standard use case  
16    implementation I would like to see statistical  
17    results and have a real solid understanding of  
18    whether -- let me put it to you this way:

19                   At the end of the day, the doctors  
20    of America will be a little distressed if they  
21    are being scored and, then, the methodologists  
22    of the world come around and say, "Well,

1 actually, there are all these problems in the  
2 report that is telling you that you're high  
3 cost."

4 So, again, I'm backing up and  
5 saying, I don't know where the NQF  
6 responsibility begins and ends. Actually, I  
7 guess, well, I'm here, so I'm trying to help.

8 But it does seem to me that at the  
9 end of the day the doctors of America are  
10 going to be really upset if they feel that the  
11 system is not actually giving valid  
12 information.

13 CO-CHAIR MARTIN ANDERSON: I think  
14 this is a matter of semantics. I think the  
15 one thing we all agree on is that there ought  
16 to be disclosure around how this topic. Some  
17 people phrase it as that the episodes are  
18 comparable. Others will say, how are you  
19 handling risk and, if you are, disclose it.

20 The one thing I will say about  
21 NQF's processes, what I have learned over the  
22 years doing this is that you can't possibly

1 anticipate really well what is going to come  
2 in the future in terms of what someone might  
3 submit as an episode grouper in this case for  
4 endorsement, right?

5           So, it is possible that someone  
6 could define, for a purpose of some new  
7 payment methodology, that the episodes that  
8 they are looking at are heterogeneous in some  
9 level, right, and there are some analytics  
10 that happen after the fact, right?

11           We just want to keep the language  
12 so that we're not boxing-in the methodology.  
13 So, however that is done, let the staff work  
14 on that. But I think the point is the same,  
15 which is, whatever it is you're doing, either  
16 to make the episodes homogeneous or whether  
17 you're to account for risk in an episode, we  
18 think that is an important element of an  
19 episode design and we should find a way to  
20 have that in the criteria as it relates to  
21 validity and, also, to testing. Is that fair?

22           MR. DE BRANTES: Yes, and if I



1 could make just -- this is Francois -- two  
2 comments?

3 So, the first one is, if you look  
4 at quality measures that have been endorsed by  
5 the NQF and other measures that have been  
6 endorsed, they are measures, period. So,  
7 you've got a numerator and you've got a  
8 denominator, and groups have agreed on the  
9 composition of the numerator and denominator.  
10 And so, each one of these measures outputs a  
11 number, most of the time a percentage or a  
12 value.

13 Groups on the outside, whether  
14 they are health plans, provider organizations,  
15 medical specialty societies, others in the  
16 industry, have used those endorsed measures  
17 and brought them together in baskets for  
18 various scoring purposes. Those scoring  
19 purposes have never been reviewed by the NQF,  
20 nor is it the job of the NQF to review those  
21 scoring mechanisms.

22 So, that is very analogous to

1 you've got a grouper that is designed to  
2 create a number because you've got claims that  
3 are assigned to a specific unit of accounting,  
4 which is an episode. And therefore, it  
5 creates a number.

6 What happens after that with that  
7 number, how it is used, how it is assembled  
8 with other numbers to create a scoring  
9 mechanism is not within the purview of the  
10 NQF.

11 And I would submit that the second  
12 point I want to make is that, if the NQF  
13 becomes highly prescriptive in what it asks  
14 developers to submit for these grouper  
15 endorsements, no one will submit anything.

16 MEMBER LOISELLE: Okay. This is  
17 Jim Loiselle.

18 I want to add to that, if we were  
19 to go that route, then, again, as a vendor  
20 that embeds ETG and others in our solutions,  
21 would that require a vendor, then, to also  
22 reach out to NQF? It is just a much broader

1 potential process than just looking at the  
2 grouper itself. What happens to the  
3 downstream analytics, results, measures,  
4 calculations, that is for the individual user  
5 to decide what you do with the group detail,  
6 once it has been completed.

7 MR. AMIN: So, I just want to  
8 clarify. This is Taroon from NQF.

9 The goal of this exercise is not  
10 to get into the reporting components or how  
11 scoring would potentially be used in various  
12 different health-plan-type or for CMS scoring  
13 purposes.

14 The one question I do have for  
15 this group, in particular, is it sounded like  
16 there was a combination -- you described  
17 scoring in some ways as how the observed-to-  
18 expected value is calculated. To me, that  
19 sounds like the result of the grouper number,  
20 as was described by this, which would  
21 potentially have some ramifications that would  
22 include risk adjustment or some things like

1 that.

2 Is that what you are referring to  
3 or not? No? No. Okay.

4 MEMBER McLEAN: Yes, I would just  
5 take note, I guess. I am really interested in  
6 -- I just want to make sure you understand  
7 what we are trying to say, as far as our goal  
8 is not to tell a grouper what they can do. I  
9 think that would be very complicated to do.  
10 I don't think you want to even get into that  
11 business.

12 And with providers, working with  
13 the designation program that measures  
14 providers, I definitely understand where  
15 you're coming from, Steve. However, the  
16 groupers we use, it is not their  
17 responsibility to make that explanation and  
18 that evaluation. It is our methodology. It  
19 is our responsibility to make that explanation  
20 and communicate to them how they were  
21 equitably measured and evaluated against each  
22 other in their case mix.

1                   But we don't come back to the  
2 grouper and say, "Hey, the grouper did it,"  
3 because it's not the grouper's responsibility.  
4 It is our responsibility. It was the  
5 grouper's responsibility to disclose to us  
6 what it could go and what that number actually  
7 meant that they gave us.

8                   From that standpoint, it was our  
9 responsibility to take that number and our  
10 interpretation of that meaning behind that  
11 number and do a risk adjustment and a case-mix  
12 adjustment for our evaluation of a provider.

13                  A lot of groupers, they are not  
14 doing it at a provider level. They are giving  
15 you a population. They take the dataset for  
16 the entire population, and here is your  
17 result. So, they are not trying to compare  
18 providers in that sense.

19                  MEMBER HOPKINS: While we are in  
20 the reliability and validity topic, the  
21 concept of testing has come up a number of  
22 times, and I'm troubled by this, at least the

1 way we have been thinking about it. This  
2 sounds like we think that it is fairly  
3 straightforward to, quote/unquote, "test" an  
4 episode grouper.

5 And the other thought on my mind  
6 is, you know, these groupers have been tested  
7 widely in the market. That is different from  
8 most of the measures that come to NQF, some of  
9 which have never really been used before they  
10 are endorsed.

11 So, I'm just sort of wondering,  
12 you know, what weight can we attach, if any,  
13 to market testing? To me, it is very  
14 significant. It has met the test of countless  
15 health plans, providers, purchasers, you name  
16 it, the customers of the folks who use these  
17 tools. And the tools have been adjusted and  
18 tweaked to sort of meet the objections that  
19 have been raised over time. I just don't  
20 understand how NQF is going to test these  
21 episodes.

22 CO-CHAIR MARTIN ANDERSON: Yes, so

1 our group had this discussion about the market  
2 and acknowledged widely that for existing  
3 groupers, just like any existing product that  
4 is out there actually used in the marketplace,  
5 or at least purchased and, then, variable use  
6 by the purchasers, there is a feedback loop  
7 and there is a refinement that occurs that  
8 meets the market demand.

9           And we also acknowledged in our  
10 group that oftentimes it is the market who  
11 slows down the advancement, right, that tells  
12 the developer, "Don't fix it because you're  
13 going to mess me up for all the things I've  
14 implemented with it. So, I don't want you  
15 upgrading every time."

16           Now it is different from code  
17 sets, which they often want the groupers to be  
18 accurate. But, for functionality, risk  
19 adjustment, ICD-10, fill in the blank, they  
20 don't always want it updated. But that is a  
21 market dynamic that takes care of itself.

22           At some level, you would ask the

1 question, if that's the case, they're deeply  
2 embedded, what is the value of a commercial  
3 grouper even seeking endorsement, right,  
4 because what does it get? That is something  
5 that we started to talk about and stopped.

6 But, then, we also said, analogous  
7 to the measure situation, there will be new  
8 groupers that have never been used in the  
9 market, right, just like we are having with  
10 measures. And what kind of testing would be  
11 adequate testing for endorsement in that  
12 circumstance? Exactly analogous to measures,  
13 where we struggle with this topic. I know NQF  
14 struggles with that topic, too, and the  
15 Steering Committees struggle with it.

16 So, I do think there is value to  
17 market testing, but I don't think NQF has ever  
18 wrestled to the ground how do you intersect  
19 usability and use with the testing  
20 requirement.

21 MEMBER HOPKINS: But, if I hear  
22 you right, there would be weight attached to



1 market tests, right?

2 CO-CHAIR MARTIN ANDERSON: I think  
3 we have acknowledged that. I don't know  
4 whether we are to the point of saying "Wait"  
5 to anything, but we acknowledged this is an  
6 issue.

7 DR. BURSTIN: Let's build on that.  
8 Kristine is absolutely right. This is an  
9 issue we have talked about for a long time,  
10 David. And I am glad Karen Pace is here, our  
11 methodologist, if she wants to add anything.

12 But, you know, there is a lot of  
13 testing in a perfect laboratory and, then,  
14 there is testing in the real world. And  
15 measures, particularly when they come up for  
16 maintenance, we do request that we have  
17 information about how this is playing in the  
18 real world.

19 So, I think, increasingly, we  
20 would love to have measures come to us that  
21 have been out in the field and have some real  
22 experience behind, rather than ones just

1 tested sort of in a more perfect environment.

2 MS. PACE: Yes, I would just add  
3 that, even when measures have had widespread  
4 use, the expectation is, then, demonstrating  
5 reliability and validity should be relatively  
6 simple because you have lots of data to run  
7 some reliability and validity testing.

8 So, I think, you know, it goes  
9 both ways in terms of the performance  
10 measurement, that at least to date we haven't  
11 viewed, just because it is in use, that you  
12 don't have to provide any demonstration of  
13 reliability and validity.

14 MEMBER HOPKINS: I just think you  
15 have got some very big challenges in designing  
16 the test for an episode grouper.

17 MEMBER LEVINE: Stepping back a  
18 little bit, this discussion makes me think  
19 about the goals for this whole activity. I  
20 wonder how this sheds light on, if you are  
21 evaluating a performance measure, and the  
22 performance measure is framed in terms of an

1 episode. If NQF has certified whatever  
2 sanction, the particular episode grouper  
3 system, does that mean that the evaluators of  
4 that measure, then, can completely ignore the  
5 particular framing of that episode for that  
6 particular performance measure?

7 And I would argue no. Because, as  
8 I think I mentioned yesterday, I mean, when  
9 you look at an episode grouper, it is not  
10 monolithic. You have to look at each  
11 definition of each episode, and is that  
12 appropriate to this particular instance and  
13 particular use, particular measure, or not?

14 So, I am not sure what insights  
15 you are going to get from that or how much  
16 help it is going to give. I think one of the  
17 discussions we kind of had yesterday was, in  
18 fact, perhaps what we are really trying to do  
19 here is help the NQF folks, committees and  
20 others, who are trying to evaluate the  
21 appropriateness of episodes in a particular  
22 context, to give them some guidelines, so that

1 they can make sense, does the episode work  
2 here or not?

3 MR. WILLIAMSON: And I will add  
4 from our group here, we did discuss that in  
5 our group. I think some of the options we  
6 brought up, I guess we will discuss later  
7 during our implications for endorsement.

8 You know, do you create additional  
9 criteria for episode-based measures? Are you  
10 evaluating the episode grouper? What kind of  
11 guidance do you provide to the Steering  
12 Committee when they are evaluating episode-  
13 based measures? So, I think those are all  
14 things that are on the table for this.

15 MEMBER DUNN: And I apologize, I  
16 wasn't here yesterday. But have you spent  
17 time more sort of clarifying or defining what  
18 you mean by reliability and validity?

19 And just as an example, and you  
20 can think of statistical reliability to the  
21 ability to discern differences versus noise.  
22 You can think of the fact you are running the

1 grouper for five different sets of data, and  
2 you get the same result.

3           The validity, to Steve's point,  
4 construct validity, clinical face validity,  
5 actually, the fact that it has been vetted in  
6 the market, which is kind of a squishy  
7 validity. Anyway, I'm sorry if I missed it,  
8 but have you -- because I think that is going  
9 to be important if you include those as  
10 criteria.

11           CO-CHAIR MARTIN ANDERSON: That  
12 was raised in our subgroup, and, Karen, I  
13 think you provided an answer, described how  
14 NQF thinks about validity and the ways that  
15 NQF thinks about it.

16           MS. PACE: Right. So, we have  
17 defined reliability and validity in terms of  
18 performance measurement. We were talking  
19 yesterday specifically about validity. The  
20 same thing applies to reliability.

21           NQF's criteria allows looking at  
22 that for the data that go into a performance

1 measure or in the grouper and at the  
2 performance score level. So, for example,  
3 with a performance measure, you may be looking  
4 at the reliability of the individual data  
5 element, or the validity. So, say you're  
6 using claims data. A validity test might be  
7 looking at claims data in relationship to  
8 medical record abstraction, if you consider  
9 the medical record abstraction kind of the  
10 gold standard or the authoritative source.

11           And you could do sensitivity and  
12 specificity. You know, is the data being  
13 pulled, pulling the right cases? Is it  
14 missing any of the right cases, as a validity  
15 test at the data?

16           When you're talking about the  
17 computed performance score, the score that is  
18 given to the provider on a particular topic,  
19 the validity tends to get more at a conceptual  
20 level. Does that performance score perform in  
21 a way you expect? So, if someone is doing  
22 well on low readmission rates, how does that

1 relate to maybe a process measure about  
2 discharge planning? What is your expected  
3 correlation or relationship, and is it  
4 performing in that way?

5 So, validity of that performance  
6 score is really about how confident you are in  
7 the conclusions you make about quality based  
8 on the score that you have given that  
9 provider.

10 CO-CHAIR MARTIN ANDERSON: And  
11 there was a discussion, also, yesterday again  
12 about how would you go about testing validity,  
13 right, and across groupers? One idea was put  
14 on the table that perhaps there should be a  
15 standard dataset that all the groupers ran,  
16 and you were able to look to see whether or  
17 not the results were as expected.

18 And we talked about the fact that  
19 the problem is there isn't a right answer.  
20 The question is, you know, we talked about, is  
21 there a logical answer, right? So, at least  
22 can they explain why it is that their grouper

1 performed the way it did on a dataset?

2 And again, this was just ideas  
3 thrown out there. Or whether, then, the  
4 groupers just do that on their own, as the  
5 measure developers do, and then, they submit  
6 some set of results that says this is how our  
7 grouper performs.

8 It is highly difficult here  
9 because we are talking about so many different  
10 episodes and different types of episodes that  
11 are all included in one grouper. So, how  
12 would you do it or what line would you draw  
13 for the developer to be submitting that a  
14 committee could reasonably say, "Yes, they've  
15 done the testing and we agree that it appears  
16 valid."?

17 MEMBER DUNN: I think you are  
18 right, there is some question of the  
19 threshold, as to what is enough or whatever.  
20 But there is also the question of what the  
21 criteria is. Because I can think of clinical  
22 validity. I can think of putting a valid and



1 homogeneous unit of analysis, which is more of  
2 a statistical concept rather than clinically  
3 it makes sense.

4 So, I just think when you get to  
5 the point of defining these things, maybe this  
6 is a followup, but I think you need to be more  
7 structured on these concepts about what you  
8 mean.

9 CO-CHAIR MARTIN ANDERSON: If  
10 there are specific ideas people have for  
11 criteria, I think that is part of what we are  
12 trying to get at, right?

13 MEMBER DUNN: If I could just say  
14 one more thing? I think we kept talking about  
15 risk adjustment. Again, I have only been here  
16 for less than hour, but I think maybe the term  
17 is better to think of it as risk assessment,  
18 because risk adjustment is taking sort of a  
19 measure or risk assessment and applying it in  
20 a measure. So, case mix or risk-adjusting a  
21 provider's results using results that that  
22 grouper can tell you in terms of the level of

1 risk or the category of risk that something  
2 falls into. Just sometimes I think we mix  
3 those two birds, and it can be troublesome.

4 MEMBER McLEAN: So, we also talked  
5 about feasibility. And this was an  
6 interesting topic. Like I said before,  
7 everything ties back to the very beginning  
8 when we talked about the bigger concern with  
9 groupers is, you know, the volume of data that  
10 you start with and end with. And in the  
11 feasibility, do I have enough sample size for  
12 what I need to do?

13 And this goes back to even  
14 groupers being able to accommodate many  
15 conditions and many groups all at once. And  
16 it performs at different levels within each  
17 one.

18 For example, a grouper may look at  
19 hypertension and it may look at diabetes. It  
20 may look at COPD. And it may perform as far  
21 as different levels, based on its criteria,  
22 and it may give a different output. It may

1 give 30 percent for one, for hypertension, 75  
2 percent from the episode for diabetes, and so  
3 forth and so on.

4           So, we need to be able to figure  
5 out, is the grouper and the algorithm, what is  
6 going on within it, feasible for the analysis  
7 in the end, and the number of episodes that I  
8 start with? And that goes back to that final  
9 report that we talked about before, being able  
10 to provide in their testing -- this is the one  
11 thing I do think is tangible in their testing  
12 -- to show at each step that you have, each  
13 high-level step that you can explain and put  
14 a definition around, can you show, when you  
15 are testing, the proportion of data that is  
16 being lost in your test runs? And obviously,  
17 you will run more than one test run just to  
18 make sure that it is repeatable and it  
19 consistently happens.

20           But I think that is very  
21 important. I think the group agreed that that  
22 was very important for the end-user to be able

1 to understand, and it is very important to say  
2 that this grouper actually is working from a  
3 value standpoint.

4 Because Kristine brought up very  
5 well that you could communicate that to the  
6 plans, I mean not to the plans. Excuse me.  
7 You can communicate that to the end-user, but  
8 at the same time my response was that you can  
9 tell a user that they will lose data due to  
10 membership eligibility, continuous enrollment.  
11 But the number that they have in their head  
12 would never be as large as what it really is.  
13 They will think they will lose 10 percent of  
14 their episodes, when, in reality, they may  
15 lose 40 percent of their episodes or 50  
16 percent of their episodes due to various  
17 reasons.

18 So, a test file or a test report  
19 demonstrating that range, so to speak, would  
20 be very helpful from an end-user standpoint.  
21 And I think the NQF can evaluate that and say,  
22 "Well, this is good. This is a good range.

1 This is an acceptable range for an episode  
2 grouper."

3 MR. DE BRANTES: Hi. This is  
4 Francois.

5 Can someone expand a little bit on  
6 that because I'm not getting this particular  
7 point?

8 CO-CHAIR MARTIN ANDERSON: So,  
9 Francois, I think the conversation was about  
10 there are certain, for each grouper, there are  
11 certain events or circumstances that would  
12 cause data loss, right, whether it is whatever  
13 requirement you have for continuous  
14 enrollment, whatever. Another example is  
15 maybe clean periods. Another example was,  
16 what if you are missing pharmacy data? So,  
17 there's multiple different ways that the  
18 developers know when they are working on their  
19 grouper that there would be an exclusion of a  
20 set of claims.

21 And so, I think the comment within  
22 our Working Group was, part of knowing whether

1 or not it is feasible to use a grouper is at  
2 least taking each of those risks and saying,  
3 "What is the range of claims that one might  
4 lose in this circumstance typically?" And I  
5 don't think there was an answer on how someone  
6 would get to that because the datasets all  
7 differ. But it was just this sense of this  
8 was an "aha" for folks after they had started  
9 to use this grouper, that they found that it  
10 wasn't feasible or usable in the end because  
11 it turns out that they didn't have a dataset  
12 that would support that particular grouper.

13 So, it was really about  
14 transparency in terms of what are those  
15 impacts on feasibility or usability of the  
16 grouper system. And that came from MD users  
17 really more than developers in the room.

18 MR. DE BRANTES: Okay. So, just  
19 playing it back, having clarity on the impact  
20 of potential missing fields or other data  
21 elements that can impact the total number of  
22 episodes that get retained in the outputs?

1 CO-CHAIR MARTIN ANDERSON: That's  
2 right.

3 MR. DE BRANTES: Okay.  
4 Conversely, I think the group, though, the  
5 developers need to be also potentially clear  
6 about the risks involved in taking in episodes  
7 that might end up by being fragments.

8 So, for example, eligibility is a  
9 good point. If you relax enrollment  
10 eligibility rules, then you can end up with  
11 folks who have episodes that cover four months  
12 as opposed to nine months or as opposed to  
13 twelve months.

14 CO-CHAIR MARTIN ANDERSON: Right.  
15 The same idea.

16 MEMBER McLEAN: Yes, that's a good  
17 point, Francois. That is the same idea. I  
18 agree with you. We agree.

19 MEMBER MIRKIN: So, this is Dave,  
20 Dave Mirkin. There are so many Daves here.

21 So, I have a question for the  
22 group. Are we saying that -- I think this is

1        what Kristine said -- is that what is  
2        important, and Francois said, is that there be  
3        transparency to the potential users on these  
4        issues, not that they are going to be criteria  
5        for NQF endorsement. Am I correct in saying  
6        that that was what the group was thinking?

7                    CO-CHAIR MARTIN ANDERSON: I think  
8        the group did not differentiate, sort of  
9        starting out early, between what are the  
10       things that they felt like we needed to have  
11       versus what should actually be in criteria.  
12       So, it started with here are some things that  
13       ought to be disclosed, right?

14                   So, there were no thresholds  
15       discussed that say, "Hey, if you had a  
16       circumstance like this," for instance, a  
17       grouper that really doesn't work without  
18       pharmacy data, well, we all know they all work  
19       less well without pharmacy data.

20                   So, it was really a matter of  
21       disclosure. Really, we didn't get into  
22       whether or not there was an appropriate way



1 you could use that in a criteria of saying  
2 this grouper is not feasible. I mean, again,  
3 they are all going to have loss of data, and  
4 some of it is to protect the user.

5 MEMBER MIRKIN: Right. Because I  
6 just think it is okay, as a developer, I think  
7 it is okay to have -- I think most of us who  
8 are developers, this is what we provide to  
9 somebody, or at least they demand from us  
10 before they purchase our tools or products.  
11 But I guess new ones, maybe it is good to  
12 specify that.

13 But I think it would be almost  
14 impossible -- I mean, I look at cost/license  
15 fees; it depends on what you buy, right? I  
16 mean, I am just saying, if you buy a billion  
17 products, if you buy it with consulting, if  
18 you buy it with -- I mean, I just think it is  
19 one thing for us to be able to say, you know,  
20 you need to be able to disclose everything  
21 upfront, so there aren't hidden fees down the  
22 road, which I think most of us who are

1 developers already know that that is the kiss  
2 of death, right?

3 But, anyway, that was it.

4 CO-CHAIR MARTIN ANDERSON: I think  
5 we are going to get at those issues in the  
6 future, right? Don't we have another -- we  
7 have a whole market implications conversation.

8 But, normally, within feasibility  
9 for measures at least, because, again,  
10 measures are not software systems. These are  
11 different. I mean, they can be embedded in  
12 software systems, but they are not, in and of  
13 themselves, a software system.

14 There is a requirement that there  
15 be at least disclosure if there is a cost to  
16 somebody who adopts an NQF-endorsed measure.  
17 I think we are going to wrestle with that a  
18 little bit later today, of how parallel is  
19 that when you are talking about software  
20 systems where, in general, there will be fees.  
21 I mean, even open-source systems are not free.

22 Nancy?

1                   MEMBER GARRETT: I just wanted to  
2 add a little bit to that cost/license fee and  
3 the feasibility discussion. You know, one of  
4 the reasons we're here is my understanding is  
5 that eventually NQF is going to be asked to  
6 endorse the CMS publicly-available grouper.

7                   And from a user perspective, cost  
8 is certainly one aspect of feasibility, but,  
9 also, how accessible is it really to the  
10 public to be able to use? So, for example, I  
11 work at a small safety-net provider. We  
12 downloaded the code for the CMS HCC Risk  
13 Model, and we implemented it with our  
14 Electronic Health Record data. And it was  
15 free to us, other than our internal resources.  
16 We really wouldn't have been able to invest in  
17 a more expensive market system. Those are  
18 really aimed a lot at health plans.

19                   But I encourage us to think more  
20 broadly, both about the data sources -- you  
21 know, we have been talking a lot about claims  
22 data, but providers need to do this work, too.

1 And so, can the groupers be built to handle  
2 EHR data? But, also, feasibility from a  
3 perspective of, is the information there in a  
4 form that is easy to use and implement?

5 CO-CHAIR CACCHIONE: David  
6 Hopkins.

7 MEMBER HOPKINS: I am a little  
8 troubled by the discussion around data and  
9 missing data because it doesn't strike me as  
10 a property of a grouper. It is the property  
11 of the database to which it is applied.

12 And in terms of what could be  
13 expected of the vendor or the grouper, I  
14 think, you know, all of the strictures around  
15 make sure that your data are consistent and  
16 complete, and all of that, should be provided  
17 as part of the user interface with the system.  
18 But I don't see how we could consider, you  
19 know, what data might be fed into it. You can  
20 feed any data into these things, and they will  
21 produce an output. That is a user use issue.

22 CO-CHAIR MARTIN ANDERSON: The

1 point that the group was making is, is the  
2 grouper articulating what elements of its  
3 design will throw data out, right? So, for  
4 instance, now some of them have user-  
5 controlled toggles, right? So, it's all over  
6 the place.

7 But where are the places in the  
8 design where data, those episodes will be  
9 kicked out or those data elements will be  
10 kicked out, if it doesn't meet a certain  
11 criteria?

12 MEMBER HOPKINS: So, for example,  
13 is it the case that, generally, where you feed  
14 the database where there is some missing  
15 pharmacy data, is the grouper supposed to know  
16 that?

17 MEMBER McLEAN: No, no, the  
18 grouper is not.

19 Can you hear me?

20 They are not. The grouper will --  
21 for example, we go back to the pharmacy data;  
22 we can go to the member eligibility issue.

1 There are very valid reasons why things could  
2 happen, but there are also reasons why  
3 groupers throw out episodes.

4 For example, if they are looking  
5 for a condition and a procedure code  
6 combination, but they may drop certain  
7 episodes due to certain outlier-type episodes  
8 that are higher-risk because they want to  
9 normalize the populations. That is something  
10 the grouper has embedded in its code. It is  
11 the data you're feeding it. It is not an  
12 issue with your data. It is more about that  
13 combination.

14 And so, that needs to be  
15 disclosed, and then, maybe a potential range  
16 in their testing. Because a lot of times the  
17 summary page that most of us read about  
18 groupers, the one-pager, it doesn't specify  
19 that. And so, it needs to be disclosed, so  
20 that you can say, "I understand that I do have  
21 this range of population." For a physician or  
22 someone, they can see, well, that range seems

1 reasonable about this type of patient or this  
2 type of condition. And then, they may  
3 understand the output a little bit better.  
4 And I think that can be disclosed.

5 We talked about data-sourcing. I  
6 think where we are going here is what type of  
7 data that is needed. Am I correct, on the  
8 right path here? I think this might have been  
9 when I stepped out.

10 MR. WILLIAMSON: We listed that on  
11 our feasibility. Again, it goes back to what  
12 Nancy had mentioned earlier, just about are we  
13 going to implement EHR.

14 MEMBER McLEAN: Different types of  
15 data sources that may be available --

16 MR. WILLIAMSON: Yes.

17 MEMBER McLEAN: -- to use  
18 groupers? I think this might have been when  
19 I stepped out. But I definitely can relate to  
20 her and this topic about you don't want to  
21 build groupers, I mean, you don't want to  
22 build criteria that is focused solely on

1 claims because things may evolve. We expect  
2 groupers to evolve. We expect them to get  
3 better. It is also a competitive market. So,  
4 they are going to build on that.

5 And what Nancy alluded to is that  
6 providers are using this as well, and they  
7 want to use other data sources. And I am sure  
8 payers would like to as well, and the other  
9 stakeholders would like to.

10 And so, there are data sources.  
11 They are not saying the grouper is just by  
12 data availability at this current moment or  
13 just haven't been built that way so far, but  
14 they may be. And you don't want to build  
15 criteria that limit what a grouper can bring  
16 and what a grouper can do.

17 And I think this was the key point  
18 here, and I think it is very important. I  
19 don't know the answer and the solution to  
20 that. You know, how do you look at something  
21 that you have never seen before? But I do  
22 think it is very important and you have to



1 take serious consideration into that.

2 CO-CHAIR MARTIN ANDERSON: Yes,  
3 not all these sentences make sense, but we did  
4 totally --

5 (Laughter.)

6 This is what happens at the end of  
7 the day. I think that literally got lifted  
8 off of a slide, I mean, a thing on the wall.

9 I know the one thing we really  
10 talked about here was this current or planned  
11 use, right? Who is currently using it? What  
12 does your installed base look like? To your  
13 point, David, about where is this actually  
14 actively in use or where is it planned to be  
15 used.

16 MR. WILLIAMSON: And one thing I  
17 will add to that, and it is on our white sheet  
18 over there that we kind of list on here, the  
19 one think we talked about was the quality  
20 signals. You know, should an episode have  
21 occurred? And it is something that might be  
22 outside the scope of the usability and use,

1 but it is something we wanted to at least  
2 cover as far as an episode of prevention, an  
3 episode of care management. You know, how are  
4 those considered in this?

5 CO-CHAIR MARTIN ANDERSON: There  
6 was also a conversation we had about gaming.

7 MR. WILLIAMSON: Yes.

8 CO-CHAIR MARTIN ANDERSON: Again,  
9 we didn't know what to do about it, but that  
10 there is a susceptibility to gaming, if you  
11 know it is going to be used particularly in a  
12 payment scenario, where you can start to see  
13 severity float up, et cetera. They were  
14 adding codes. People talked about what  
15 happens when you add additional diagnosis  
16 codes and how it changes the severity. All  
17 these are covered in the literature. There  
18 was no answer to that. It was just a comment  
19 that was made around that this is a real  
20 issue.

21 MEMBER HOPKINS: Could you say  
22 more about the second bullet?

1 CO-CHAIR MARTIN ANDERSON: I think  
2 that was Jelani's point about planning beyond  
3 claims data.

4 MEMBER HOPKINS: I mean, is that  
5 something that a vendor of a current system  
6 built on claims data is supposed to provide  
7 some statement about how you do chart data or  
8 something?

9 CO-CHAIR MARTIN ANDERSON: No,  
10 again, these were just comments people had  
11 about usability and use into the future.  
12 These were not, you know, shaped into  
13 criteria. It was just various conversations.

14 MEMBER McLEAN: No, I don't think  
15 it was directed at the developer and what they  
16 need to submit, but more about NQF and how  
17 they need to design the criteria to be able to  
18 account for different types of data sources,  
19 different types of groupers that may account  
20 for different types of data.

21 Because not only are we looking at  
22 how we are going to evaluate the development

1 of the grouper, but, also, how is NQF going to  
2 set the framework to evaluate these groupers.  
3 And various groupers, various types of  
4 groupers may come in.

5 And what we were thinking about  
6 was the future, you know, and are we going to  
7 be prepared for the future. It may happen  
8 next year. It may happen in five years or ten  
9 years, but we don't know. But the question  
10 is, are we prepared for that?

11 MR. WILLIAMSON: It was also  
12 mentioned about the episodes of prevention or  
13 care management. It goes back to the payment  
14 scenario where, if they are being paid on  
15 episodes, how does prevention and care  
16 management fit into that framework? Again,  
17 not in a criteria sense. This was toward the  
18 end of our session where we were just trying  
19 to get everything, get all of our ideas out.

20 MEMBER BODYCOMBE: Can I add to  
21 that? You know, I would argue that we already  
22 have a healthcare system that emphasizes with

1 activity. So, we pay for people to do things,  
2 which is a very non-preventative thing. It  
3 favors specialists. It favors extensive care.

4           Once we implement a payment system  
5 based on episodes, let's grind up those  
6 episodes and have as many as possible. Right  
7 now, attribution systems favor specialists.  
8 The specialists are going to get lots of money  
9 out of this. They are going to be very happy,  
10 and it is going to be counterintuitive to what  
11 we are trying, what might really help drive  
12 costs down, which is prevention and avoiding  
13 episodes entirely. So, that is part of that  
14 point.

15           MR. WILLIAMSON: And again, yes,  
16 this was framed, this discussion was kind of  
17 framed around our current usability and use  
18 criteria. And one of those is progress  
19 towards achieving the goal of a high-quality,  
20 efficient healthcare system. So, I think,  
21 again, the link isn't quite there on these  
22 slides or even, I guess, in our discussion,

1 but we just, again, wanted to get these  
2 discussions out on the table, you know, these  
3 things out on the table.

4 So, move on to the next one, which  
5 we were kind of wrapping up with where we had  
6 a discussion about acute versus chronic  
7 episodes. And then, Mark brought up the idea  
8 of a claims analysis and how that differs from  
9 actually an episode, where if you do a 30-day  
10 lookback on an operative episode, is that  
11 actually part of the episode or are you doing  
12 claims analysis?

13 So, I think this is the type of  
14 stuff where we started really getting high  
15 level about defining an episode. I will let  
16 somebody elaborate on that, but I think that  
17 this was more, again, of just trying to get  
18 some of these topics out on the table.

19 MEMBER DUNN: So, is that criteria  
20 or that just the discussion topic?

21 MR. WILLIAMSON: Just a discussion  
22 topic.

1 CO-CHAIR MARTIN ANDERSON: These  
2 were just discussion topics, things that came  
3 up.

4 MEMBER DUNN: Okay. Thank you.

5 MR. WILLIAMSON: I guess we will  
6 kind of try to wrap this up here.

7 One of the last things that we  
8 wanted to talk about was the maintenance, and  
9 something that we really hadn't talked about  
10 before was -- and again, David Redfearn  
11 brought this up -- is the cost of implementing  
12 a new version of a grouper. I know we kind of  
13 touched on this earlier.

14 But the process for keeping, you  
15 know, if we do endorse groupers or if we do  
16 collect this information, what is the process  
17 for keeping that current? Does it go through  
18 an annual update process? Do we need to set  
19 minimums for the length of time? What if  
20 there are new guidelines? How do we handle  
21 that process is something that we will need to  
22 discuss. I guess that kind of falls under our

1 implications for endorsement section. But is  
2 there a difference between logic and features  
3 of a grouper that cost a lot of money to  
4 implement versus a mapping table or something  
5 that can be implemented just as switching out  
6 a data file or something? So, again, just  
7 more topics that we want to discuss beyond the  
8 submission elements and criteria, but things  
9 about how you keep this current.

10 CO-CHAIR MARTIN ANDERSON: I think  
11 this is a big deal because maintenance of  
12 endorsement today for a measure, because it is  
13 narrow, right, either someone can raise an  
14 issue and say this measure no longer reflects  
15 current practice and it needs to go through an  
16 immediate maintenance cycle or not be endorsed  
17 while it is being fixed, et cetera.

18 But, when you have got something  
19 like an episode grouper that is trying to use  
20 the totality of all of the data, well, there  
21 would be an emergency maintenance all the  
22 time, if it was required to stay up-to-date



1 constantly.

2 And so, how to think about a  
3 framework for maintenance of endorsement for  
4 episodes needs to look very different than a  
5 framework for measures. And that is really  
6 something that we didn't really delve into in  
7 detail to say, hey, this is an issue.

8 MEMBER REDFEARN: The specific  
9 example is NQF might have some motivation to  
10 encourage constant improvement for these  
11 models that are risk adjustment, that are  
12 clinical logic. And there is a value to that.

13 But, then, if the vendors do that,  
14 and the vendors roll the products out to their  
15 customers, they are going to get pushback from  
16 the customers. And I can tell you, I was on  
17 the product enhancement evaluation team for  
18 Optum and Symmetry product. When they would  
19 talk about a major new release coming out, you  
20 would get WellPoint, United, Aetna, Cigna,  
21 Humana, all standing up in the room and  
22 saying, "No, please don't because we can only

1 implement one of these changes like every two  
2 to three years. Literally, there is so much  
3 complicated IT process, there are so many  
4 downstream processes that depend on this  
5 source, when you change it, we have to change  
6 everything."

7 So, the practical thing is the  
8 vendor comes out with a new version, and  
9 nobody adopts it for two years. So, there is  
10 this dynamic in which you want to improve the  
11 product and make it better, but it is not  
12 going to get adopted.

13 MR. WILLIAMSON: Okay. Do you  
14 want to break? All right. I taketh and I  
15 giveth back; there we go. Come back at 10:30,  
16 10:40. All right, 10:40.

17 (Whereupon, the foregoing matter  
18 went off the record at 10:18 a.m. and went  
19 back on the record at 10:42 a.m.)

20 MR. AMIN: All right, we're going  
21 to get started.

22 So, in terms of a time check, what

1 we are going to try to achieve in this next  
2 session before lunch is to try to understand  
3 where there are areas of consensus in terms of  
4 the charge of the group, which is around the  
5 submission elements that NQF would want to  
6 see, if it was to evaluate an episode grouper  
7 and potential criteria that would be related.  
8 Obviously, there's a lot of differences of  
9 opinion here, but we wanted to at least  
10 capture some of the areas where it appeared to  
11 be that there was some consensus.

12 So, we are not going to be  
13 updating this list as we go. We just wanted  
14 to walk through it at a high level. Maybe,  
15 Kristine, you can help me with this. I will  
16 sort of leave it with Kristine to kind of walk  
17 through some of these elements. And then, we  
18 can talk through the actual criteria.

19 Again, the goal of these  
20 submission elements is not to predefine what  
21 should be in these elements or preferences,  
22 but what type of information would we want

1 developers to submit.

2 So, I will turn it over to  
3 Kristine, unless, Evan, you have anything  
4 else. Oh, he's not in the room.

5 Kristine?

6 CO-CHAIR MARTIN ANDERSON: Okay.

7 So, this is a summary that Taroon and the rest  
8 of the staff put together while we were  
9 talking. So, there they are showing their  
10 talent again.

11 They just pulled together what are  
12 the submission elements. So, this is meant to  
13 answer the question, what would you ask a  
14 developer to submit as part of the form at a  
15 high level, though the details can be worked  
16 behind the scene?

17 So, just to go through it quickly  
18 once all the way through, and then, we will  
19 come back and talk about each major bullet.

20 So, inclusion and exclusion  
21 criteria was really around information, how  
22 the data is used as it feeds into the system.

1 We can talk about where it really needs to fit  
2 in this.

3 Exactly how services are assigned  
4 to an episode. So, a full description of the  
5 steps and the tiebreaker logic and any  
6 statistical inferences.

7 How the grouper is handling the  
8 issue of risk, the assessment issue that was  
9 discussed.

10 This transparency element on  
11 fallout of data. How is data lost? How can  
12 data be lost? What are the elements of the  
13 design that would push data out or episodes  
14 out?

15 How the product is maintained.  
16 So, it is not really keeping endorsement  
17 current, but the process of keeping the  
18 episodes current.

19 What the current and planned used.  
20 Who are your users and what is the planned  
21 use?

22 And then, information on testing

1 broadly. And we will get into in a few  
2 minutes what we might mean by the criteria for  
3 adequate testing.

4 So, first, are there major  
5 categories that are missing? Mark?

6 MEMBER LEVINE: I wonder if a  
7 section on input requirements, that if you  
8 want the grouper to work, here's what you have  
9 got to feed it with. Sort of like the Little  
10 Shop of Horrors, it constantly needs --

11 CO-CHAIR MARTIN ANDERSON: Yes, so  
12 what's the data that is required to run the  
13 grouper?

14 MEMBER LEVINE: It constantly  
15 needs to be fed.

16 CO-CHAIR MARTIN ANDERSON: Right.

17 MEMBER LEVINE: Right.

18 CO-CHAIR CACCHIONE: I'm sorry.  
19 Is it enough to say, what is the input  
20 required? Or do you have to disclose what the  
21 inputs are into that?

22 MEMBER LEVINE: If you want an

1 output of "X", you've got to supply it with  
2 "Y". And so, the grouper will take it from  
3 "X" to "Y" or from "Y" to "X", but you've got  
4 to be explicit in terms of what the grouper  
5 needs in order to give you a given product.

6 MEMBER DUNN: Actually, I agree  
7 with that. I would maybe add to it. It gets  
8 a little bit into your fallout of data. But  
9 there is a sensitivity of all these  
10 methodologies to how complete your input data  
11 are and such. So, I think there should be  
12 some sense of sort of required elements, maybe  
13 optional, and then, for any given element,  
14 some of the key things you've got to make.  
15 You know, obviously, complete diagnostic  
16 coding.

17 CO-CHAIR MARTIN ANDERSON: Maybe  
18 the data validation rules or the --

19 MEMBER DUNN: But it is more this  
20 sensitivity of the results to the inputs.

21 CO-CHAIR MARTIN ANDERSON: To the  
22 input? Okay, I think that does fit under the

1 transparency on the followup, yes.

2 MEMBER DUNN: Okay.

3 CO-CHAIR MARTIN ANDERSON: We  
4 could expand that to its overall, the  
5 sensitivities to the data.

6 MEMBER HOBART: So, I think it is  
7 basically the same thing. But under  
8 transparency, I think if you could add the  
9 end-to-end sort of data flow. So, what does  
10 a user need to put into it? What data  
11 profiling does the tool, then, provide? Then,  
12 what logic is applied to inclusion/exclusions  
13 to the data, and how is that documented? So,  
14 I think just putting that all into the start-  
15 to-finish data flow would be a way to handle  
16 it. Incorporate all that.

17 CO-CHAIR MARTIN ANDERSON: Okay.  
18 Other additions?

19 MEMBER DUNN: Dan Dunn again.  
20 So, where is the validity and  
21 reliability? Is that on the next slide?

22 CO-CHAIR MARTIN ANDERSON: We will



1 talking about it on another slide. Right now,  
2 it is only a little smidgeon of it is into  
3 that, and how is the grouper tested and test  
4 results. So, we will be talking about  
5 validity and reliability even more on the next  
6 page.

7 MEMBER BANDEIAN: So, by testing,  
8 you mean what validation has been performed,  
9 what reliability testing?

10 CO-CHAIR MARTIN ANDERSON: Right.  
11 Reliability and validity, and both clinical  
12 validity and, also, construct validity, base  
13 validity, right.

14 MEMBER DUNN: Okay. So, that is  
15 under your tested, the last bullet?

16 CO-CHAIR MARTIN ANDERSON: Right.  
17 Testing and test results.

18 MEMBER MACURDY: So, I guess there  
19 are two things I wanted to mention. One is --  
20 and this was discussed yesterday as well -- is  
21 there is often kind of a presorting or pre-  
22 organization of the data that is done. It is

1 kind of the same as inputs, but it is often  
2 done kind of without the group. You know, it  
3 is like it is separate. It is not just plain  
4 claims; it is grouping of claims. And there  
5 is a whole variety of ways to do that.

6           And that is something that has got  
7 to be kind of done as a separate step. When  
8 you say "all these steps," it is in there  
9 somewhere, but I think it is worth fleshing  
10 that part out.

11           And then, the other part, I mean,  
12 if we are trying to get something that -- as  
13 I expressed yesterday, one of my biggest  
14 concerns is I really know how difficult it is  
15 for a group who is not very familiar with a  
16 lot of the -- even if you are familiar with  
17 the intricacies of how to get a handhold on  
18 what the grouper is doing, and does it do  
19 something I would expect it to, I think you  
20 should have something there that has scenarios  
21 that maybe it is not provided by whoever is  
22 submitting it, but is provided by the group.

1 So that there is some intuition built up as  
2 to, does it work the way I expect it to work  
3 in a simple case to start with? And then, put  
4 it in a more complex case. Something that  
5 gives whoever is doing the evaluation  
6 assessment some handhold as to what it does  
7 and why it does what it does.

8           And I can't overemphasize that.  
9 If you don't, I mean, those of us that are  
10 even familiar with this, it takes forever to  
11 really get into these and get a sense of what  
12 is going on. So, you've got to give people as  
13 much of a chance as possible, so that there is  
14 a simple case they can think of first, and  
15 then, try to make it more complex.

16           So, anything that could be done  
17 there, and while you kind of put it under  
18 here, this is going to be a case where it kind  
19 of has to be done in a couple of stages, where  
20 whoever is doing the assessment has to first  
21 kind of think about it for a while and, then,  
22 figure out this is the sort of case I would

1 like to look at, or something of that nature.

2 But it is something that is  
3 motivated by the Committee, not so much  
4 motivated by --

5 CO-CHAIR MARTIN ANDERSON: Right.  
6 So, what you're describing is something quite  
7 different from what NQF does, but you have  
8 been making a good case for it, which is that,  
9 instead of the normal process, the current  
10 process, which is that the submitter would  
11 send in their results of testing where they  
12 are assuring the Committee and proving to the  
13 Committee they have tested and gotten adequate  
14 results themselves, you're also saying that  
15 the Committee will have difficulty with that,  
16 and the Committee would be better served if  
17 they were to ask all of the groupers that are  
18 under consideration for endorsement to do  
19 something common --

20 MEMBER MACURDY: Yes.

21 CO-CHAIR MARTIN ANDERSON: -- both  
22 something simple and something more complex,

1 that the Committee could, then, evaluate the  
2 results of?

3 MEMBER MACURDY: I mean, an  
4 example would be where there are a couple of  
5 very simple scenarios that members of the  
6 Committee are comfortable with. And that may  
7 vary depending on the composition of the  
8 Committee. And then, what is handed to the  
9 group that is doing the submission is that  
10 scenario in a more complicated environment.  
11 And if it doesn't pop out the way you expect  
12 it to, then ask the question, "What happened?"

13 Something that gives a very  
14 concrete anchor, so you can say, well, if this  
15 scenario didn't pop out the way I expected  
16 with 25 claims, it is different with 100  
17 claims or 500 claims. Why is it different  
18 with 500 claims?

19 You might even, then, have, yes,  
20 whoever is doing the submission then run it  
21 with just the 25 claims to see if it works  
22 then, something of that nature. But something

1 where whoever is doing the submission doesn't  
2 exactly know what everybody is looking for, so  
3 that the Committee does and they don't. And  
4 that's going to help because it anchors; it  
5 gives you an anchor. That is what you are  
6 really looking for, some kind of anchor.

7 CO-CHAIR MARTIN ANDERSON: I think  
8 the NQF staff has heard this. So, I think  
9 that they will be weighing between something  
10 like that or just saying, "Look, the developer  
11 would have had to do it." So, in this case,  
12 you know, for the role that you're playing at  
13 CMS, CMS would just submit what you did,  
14 right?

15 So, the question is, what do you  
16 really want to require of the developer? I  
17 think you guys have captured these two  
18 different options, right? Okay.

19 Okay. Others?

20 MEMBER DUNN: Dan Dunn.

21 Are we looking at missing  
22 elements? Do you want to talk about --

1 CO-CHAIR MARTIN ANDERSON: We are  
2 looking for comments, anything you want.

3 MEMBER DUNN: Comments? I think  
4 the fallout data one could be a lot more  
5 specific. I guess, what is even fallout? So,  
6 one could be that services didn't group and  
7 they weren't able to find an episode. But  
8 that gets tricky. Because if you have a  
9 comprehensive clinical breadth grouper like  
10 there are on the market, what drops out are  
11 things that just you couldn't find a clinical  
12 spot for them anywhere, which is interesting  
13 and important.

14 But more important is, did things  
15 not group that actually should have grouped,  
16 and did they group to the right place? If you  
17 had sort of a diabetes, heart failure, joint  
18 degeneration of the back alone grouper, what  
19 are you going to do with what falls out?  
20 Because there's going to be 90 percent of the  
21 records aren't going to find a place to go.

22 That would just be one comment.

1     What that means depends on the context you are  
2     putting it in.

3                     Second was I just would  
4     distinguish that between sort of fallout of  
5     episodes. So, episodes that were validly  
6     created and, for whatever reason, were either  
7     not included in output -- but just as a note,  
8     a lot of these systems we are going ours,  
9     including ours, will not throw anything out,  
10    but they will actually mark it as incomplete  
11    or a financial outlier. And it is up to the  
12    user to decide what to do with it in  
13    measurement.

14                    So, I just have a little trouble  
15    with that bullet in general.

16                    MEMBER MACURDY: I mean, Dan,  
17    yesterday we talked about those kinds of  
18    complications a fair amount. And even just  
19    the exposition you went through, they are even  
20    more complicated than that, as you well know.

21                    To try to figure out how to handle  
22    that, do you have a suggestion as to a



1 systematic way to kind of organize how you do  
2 that? Because I'm not sure I do. Because  
3 there are so many different combinations and  
4 so many things that can happen.

5 MEMBER DUNN: Yes. Make a  
6 distinction first between records that didn't  
7 group. And again, you need to understand the  
8 context of why they didn't group. It could be  
9 because there was no place for them to go.

10 MEMBER MACURDY: Yes, I think that  
11 is less of a challenge --

12 MEMBER DUNN: Okay.

13 MEMBER MACURDY: -- than the ones  
14 where you will change the environment a little  
15 and grouping gets changed.

16 MEMBER DUNN: Actually, I would  
17 have that one -- I think reliability came up.  
18 I put that one more in the kind of  
19 predictability of the outputs, given the  
20 methodology rather than fallout.

21 MEMBER MACURDY: Well, I don't  
22 know if I would call that reliability. I

1 mean, your grouper will do that. If I have 25  
2 claims and I have 200 claims, the claims will  
3 get regrouped, often for very logical reasons.

4 MEMBER DUNN: But I don't know why  
5 you would drop the claims and --

6 MEMBER MACURDY: No, they are not  
7 dropped. They are grouped to a different  
8 spot. They are grouped in a different way.

9 MEMBER DUNN: Right. So, maybe  
10 that is less, again, I think that is less  
11 fallout data than the --

12 MEMBER MACURDY: Well, I think  
13 that is what they mean by "dropped" here. I  
14 don't think they mean that it went -- I mean,  
15 if you are looking at a particular episode,  
16 not the whole grouper but a particular part of  
17 it, it could be dropped in the sense it went  
18 somewhere else. It doesn't mean it is dropped  
19 because it never got grouped.

20 CO-CHAIR MARTIN ANDERSON: I think  
21 we get the issue, right? And so, as they try  
22 to write it up, we will all get a chance to

1 edit and see if it meets our needs.

2 MEMBER DUNN: I agree transparency  
3 is important and letting people know why  
4 something did. But, if you have a criteria  
5 that someone was trying to make a judgment  
6 based on what fell out, either episodes or  
7 claims --

8 CO-CHAIR MARTIN ANDERSON: Right.

9 MEMBER DUNN: You just need to  
10 understand.

11 CO-CHAIR MARTIN ANDERSON:  
12 Exactly, and I think right. This is more, I  
13 think, about understanding how the grouper  
14 works than about setting a criteria that says  
15 it can't drop data like that. Okay.

16 MEMBER DUNN: Right.

17 CO-CHAIR MARTIN ANDERSON: So, why  
18 don't we go to the next slide? Do you have  
19 control? Oh, Evan? Okay.

20 So, then, we tried to narrow down  
21 the dialog that we have had around each of the  
22 categories that are in the criteria. So, for

1 example, there is importance, then scientific  
2 acceptability, which includes validity and  
3 reliability, feasibility, and then, usability,  
4 right? So, we took that construct and took  
5 the conversation from yesterday and today. We  
6 will do each one one-by-one, okay?

7           So, under importance, the only  
8 area that importance was really raised was in  
9 saying, if you're trying -- this is the  
10 scoping-in, right? You're trying to say,  
11 should NQF evaluate this submission from a  
12 developer? And on the measure side, it is  
13 defined as an important-to-do.

14           I think it was Francois who threw  
15 on the table, well, maybe it could be on the  
16 number of lives covered or the number of  
17 dollars spent that is covered by this grouper.

18           We wanted to raise the question,  
19 should we even have an importance criteria?  
20 Because if you do something like that, what  
21 you would exclude would be narrow groupers.  
22 Let's say somebody developed a pediatric-only

1 grouper or a grouper that only worked for  
2 cancer care, or fill in the blank. Would we  
3 want to filter those out and not have them  
4 evaluated by NQF because it doesn't cover a  
5 broad enough population? Or would we want to  
6 say we actually don't want this kind of  
7 criteria and any kind of grouper can come in?

8 Mark?

9 MEMBER LEVINE: Would it be  
10 appropriate to require the developer to  
11 identify the use cases for which is intended?

12 CO-CHAIR MARTIN ANDERSON: As a  
13 way of determining importance? And are there  
14 use cases that would not be important?

15 MEMBER LEVINE: That would depend  
16 upon the user. But at least the user would  
17 know what they are getting.

18 CO-CHAIR MARTIN ANDERSON: This is  
19 now how NQF evaluates a grouper, right?

20 MEMBER LEVINE: Yes, but what I am  
21 suggesting is --

22 CO-CHAIR MARTIN ANDERSON: Okay.

1 Oh, so you're going --

2 MEMBER LEVINE: -- that one of the  
3 valuation criteria would be an expression of  
4 what this grouper can be used for. It is not  
5 appropriate for pediatric cancer or it is  
6 appropriate for -- you know, we also talked  
7 about the two basic approaches to grouping,  
8 which is sort of population-based and, then,  
9 provider-based, and an expression of which  
10 approach is being taken, or if it is flexible  
11 enough to be able to do both, depending upon  
12 the use case, et cetera.

13 But I think the developer needs to  
14 express as part of the evaluation criteria  
15 what this grouper is intended to be able to  
16 accomplish and what it can't.

17 CO-CHAIR MARTIN ANDERSON: Okay.  
18 I think that would actually be on the first  
19 page, too, right? So, we didn't have anything  
20 on the first page around things they would  
21 submit that would tell us anything about the  
22 purpose of the grouper. So, I think we missed

1 that there.

2 And then, what is sort of being  
3 raised here is, could NQF evaluate that and  
4 say this grouper is appropriate for that  
5 purpose? And I think that would still  
6 probably come out across all of the other  
7 criteria.

8 We can take that and figure out  
9 what to do with that?

10 CO-CHAIR CACCHIONE: Tamara?

11 MS. SIMON: I just wanted to say I  
12 think it is important to include children. I  
13 am stating I think what is the obvious. But  
14 I would hope that NQF would be wanting to  
15 endorse pediatric groupers, for instance, if  
16 they're really interested in promoting the  
17 health of large populations of people, which  
18 I believe you are.

19 MEMBER MACURDY: So, I guess I  
20 have concerns about both of the criteria you  
21 have up there. And it really relates to the  
22 point that Mark brought up.

1 I think a lot of the sort of  
2 groupers that NQF is going to be asked to be  
3 involved in are going to be provider-centric  
4 groupers. And you can imagine a provider  
5 having not very many lives and not very much  
6 money. It is a lot to their practice, but it  
7 is not a lot to any other broader scope.

8 So, I mean, almost any criteria  
9 you use there, I think it is going to be  
10 somewhat restricted. I think there is going  
11 to be tons of those sorts of things. So, it  
12 is not just going to be pediatric groupers.  
13 It is going to be really very specific.

14 MS. WILBON: So, I just have a  
15 clarifying question. This is something that  
16 came up in our group, the Clinical Logic  
17 Group, yesterday. I thought I had it  
18 straight, but as you guys continue to talk, I  
19 am getting confused again.

20 When you guys say "provider-  
21 centric" versus "patient-centric," are you  
22 saying that the logic within the grouper is



1 based -- the claims are grouped based on the  
2 provider or that it is based on the patient  
3 episode? And then, at the end the results  
4 come out and you use it to determine the  
5 performance of the provider? I am just trying  
6 to understand, is the provider or patient  
7 focus in the logic of the grouper or is it how  
8 the grouper is being used?

9 MEMBER MACURDY: No, it is in the  
10 logic of the grouper. So, the notion would be  
11 you could have two different providers deal  
12 with the same sort of illness for a patient.  
13 And what one would deem as services that a  
14 provider might be held accountable for would  
15 be different in those two circumstances.

16 I mean, these are going to be used  
17 in Value-Based Purchasing. That is really  
18 coming at CMS. It really is coming. That is  
19 why NQF, I'm sure it is one of the reasons why  
20 CMS is kind of anxious for NQF to set up this  
21 process, because these are coming like in  
22 spades. I mean, it has been mandated by

1 Congress for a while, and there is not that  
2 much time before it happens. And it is going  
3 to be basically true in every payment system.

4 We are developing those sorts of  
5 Value-Based Modifiers, and they have already  
6 been implemented for hospitals. But it is  
7 going to go across the board. It is  
8 physicians or --

9 CO-CHAIR MARTIN ANDERSON: Yes.

10 MEMBER MACURDY: So, it is going  
11 to be pretty involved. And that is going to  
12 be a main kind of --

13 CO-CHAIR MARTIN ANDERSON: So, I  
14 think this scope question here really gets to,  
15 you know, when you look at the way we have  
16 even started to define episode and episode  
17 grouper, which are also being modified, there  
18 really isn't a scope difference that would let  
19 you say, you know, if someone were to put  
20 together something that might be more like a  
21 bundle, right -- so, I used the examples of  
22 the Geisinger Total Care Program, right? So,

1 they are going to take a period of time post-  
2 cardiac surgery.

3 If someone wanted to call that a  
4 grouper and submit it, you know, should those  
5 types of submissions go through this process,  
6 right? So, if we don't bound it at all,  
7 anything can come in. And how does NQF decide  
8 is that a grouper or not? Because our  
9 definitions won't tell you.

10 So, we want to really think about  
11 this issue. I don't think we can solve it  
12 today, but do we want to bound this?

13 MEMBER MACURDY: Well, that is one  
14 reason I mentioned before that I see  
15 continuing between a bundler and a grouper.  
16 It is true there are bundles that go across  
17 different kinds of providers, but the kind of  
18 logic you use for those is really not very  
19 different.

20 So, there really is a complete  
21 continuum, and there is going to be a  
22 continuum. That is kind of where a lot of

1 activity and action is.

2 And so, I could see a case to be  
3 made where on an ACO it is called a bundler  
4 because all the services are supposed to be  
5 done in that ACO.

6 The only place you really have the  
7 coincidence of the two is when you do managed  
8 care because, then, the patient-centric and  
9 the provider-centric are the same.

10 CO-CHAIR MARTIN ANDERSON: Right.

11 MEMBER MACURDY: But if you look  
12 at ACOs, ACOs come in kinds of varieties --

13 CO-CHAIR MARTIN ANDERSON: Yes.

14 MEMBER MACURDY: -- in terms of  
15 services they cover. Or physician groups, I  
16 mean, they come in all kinds of varieties in  
17 terms of the particular kinds of categories  
18 and services they cover.

19 CO-CHAIR MARTIN ANDERSON: Yes.

20 MEMBER MACURDY: And kind of a way  
21 a lot of the payments are going is to kind of  
22 pay them kind of based on a performance of

1 whatever those services are.

2 CO-CHAIR MARTIN ANDERSON: Okay.

3 MEMBER MACURDY: And those vary by  
4 a lot.

5 CO-CHAIR MARTIN ANDERSON: Right.  
6 Right, and I think that's --

7 MR. DE BRANTES: Yes, if I can  
8 just for a second make a -- hi. This is  
9 Francois. Just a comment.

10 I don't think these things are  
11 mutually-exclusive.

12 MEMBER MACURDY: No, I didn't mean  
13 to suggest they were.

14 MR. DE BRANTES: Okay.

15 MEMBER MACURDY: No, I was even  
16 saying the opposite, that there is such a  
17 continuum, that they are not for sure.

18 MR. DE BRANTES: Okay.

19 MEMBER MACURDY: Yes. No, I  
20 didn't mean to suggest that even a little.

21 MR. DE BRANTES: Because any  
22 grouper you can use for -- and again, this

1 gets us to the use more than the grouper  
2 itself -- but you could use it for multiple  
3 purposes, as long as the outputs have enough  
4 detail that you can resort the data.

5 Yes, if it fancies you to evaluate  
6 anesthesiologists just based on what they do  
7 in the hospital, then, fine, you should be  
8 able to do that with any output from a  
9 grouper.

10 CO-CHAIR MARTIN ANDERSON: Thank  
11 you, Francois.

12 Mark?

13 MEMBER LEVINE: At the same time,  
14 if the grouper is being used to evaluate a  
15 group of providers, it has got to be an output  
16 that is understandable and usable for the  
17 purposes of quality improvement, which is a  
18 very important bottom line.

19 And I would think it is one of the  
20 most important criteria that we can come up  
21 with for the eventual acceptance of a grouper  
22 by the provider community. It has got to be

1 evolved in partnership with them, so that they  
2 feel a sense of ownership of the criteria that  
3 are evolving. And it must support an  
4 appropriate level of clinical drilldown to  
5 enable clinicians to understand what they can  
6 do better in order to improve. And those are  
7 enormously-important bottom lines.

8 MEMBER MACURDY: The term that is  
9 often used is it has got to be "actionable".  
10 That is kind of the word I would use, is that  
11 providers --

12 MR. DE BRANTES: Yes, but who is  
13 going to decide? I think, again, you guys are  
14 getting into details of uses of the output  
15 that are completely subjective. And so, who  
16 is going to evaluate whether something is  
17 actionable?

18 CO-CHAIR MARTIN ANDERSON: Yes, go  
19 ahead, Mark.

20 MEMBER LEVINE: Yes. I think that  
21 is one of the purposes that we need to get the  
22 developer to express what their intent is in

1 the use of a grouper. And if the intent is to  
2 use it for provider performance improvement  
3 through Value-Based Purchasing or some other  
4 mechanism, that it must support an appropriate  
5 level of clinical understanding, clinical buy-  
6 in, and opportunity for usability and clinical  
7 utility.

8 CO-CHAIR MARTIN ANDERSON: Okay.  
9 So, we'll take that under consideration for  
10 the usability area and think about how to walk  
11 that line, right, where we're not -- NQF  
12 doesn't play user, right? So, at some level,  
13 it has got to be, is it acceptable? Has it  
14 met some criteria? And we have to figure out  
15 how to deal with that.

16 So, I get the issue. So, we'll  
17 capture that, right? Okay.

18 Let's move on from importance.  
19 But I didn't hearing anyone saying for sure  
20 that things should be cut out, right?

21 David, do you have an idea there?

22 MEMBER HOPKINS: I was actually



1 going to be radical --

2 CO-CHAIR MARTIN ANDERSON: Well,  
3 go ahead.

4 MEMBER HOPKINS: -- and say that  
5 the groupers, at least the ones I'm familiar  
6 with, should get a pass on importance.

7 CO-CHAIR MARTIN ANDERSON: Well,  
8 don't you think they would already?

9 MEMBER HOPKINS: Huh?

10 CO-CHAIR MARTIN ANDERSON: We're  
11 actually proposing there not be any importance  
12 criteria.

13 MEMBER HOPKINS: So, you are  
14 saying the same thing?

15 CO-CHAIR MARTIN ANDERSON: Take  
16 out importance.

17 MEMBER HOPKINS: Okay.

18 CO-CHAIR MARTIN ANDERSON: Because  
19 we can't think of a way to bound it right now,  
20 right?

21 MEMBER HOPKINS: I would leave it  
22 that way.

1 CO-CHAIR MARTIN ANDERSON: We  
2 might come back to it. For the next six  
3 months, we can change our mind.

4 MEMBER HOPKINS: Because that  
5 didn't make sense to me.

6 CO-CHAIR MARTIN ANDERSON: Right.

7 MEMBER HOPKINS: Okay.

8 CO-CHAIR MARTIN ANDERSON: But  
9 this was something was raised before that said  
10 it had to have a certain scope in order to be  
11 considered important.

12 MEMBER HOPKINS: Yes.

13 CO-CHAIR MARTIN ANDERSON: And  
14 we're saying, well, maybe not so much. We  
15 can't anticipate what is going to come in the  
16 future for something that might be defined as  
17 a grouper for managed care, carveout for  
18 cancer, as an example.

19 MEMBER HOPKINS: Okay.

20 CO-CHAIR MARTIN ANDERSON: So, we  
21 are not going to a priori eliminate it by  
22 saying there is some criteria that has to

1 cover the full population.

2 MEMBER HOPKINS: Good.

3 CO-CHAIR MARTIN ANDERSON: So, if  
4 over the next six months you all come up with  
5 a good definition for importance, then we can  
6 add it. But, for now, we don't have one. Is  
7 that fair? Okay. One knocked down. Okay.

8 Now we are into the hard one, the  
9 scientific acceptability. The team took a  
10 stab at describing how validity might be  
11 assessed. And so, here are some things up  
12 there. Why don't you all look at that? And  
13 then, we will take comments on that.

14 (Pause.)

15 This is, again, what they have to  
16 demonstrate that they have tested and give  
17 results to the Committee, so the Committee  
18 could determine whether or not they thought  
19 they did it adequately.

20 MEMBER HOPKINS: So, this is back  
21 to raising the issue about, you know, for how  
22 many different conditions do they have to do

1 this? Because each condition will have those  
2 questions associated with it.

3 CO-CHAIR MARTIN ANDERSON: You say  
4 for every condition?

5 MEMBER HOPKINS: It is not  
6 feasible.

7 CO-CHAIR MARTIN ANDERSON: What's  
8 feasible?

9 MEMBER MACURDY: Well, I mean, the  
10 problem you run into is the safest way to do  
11 this is to make each experience for each  
12 patient to be their own episode and it is  
13 homogeneous.

14 So, the real problem in these, and  
15 if you look at all the groupers, I mean, they  
16 will have a way of expanding the number of  
17 episode types even, but that is a challenge  
18 all by itself, is to have to put all kinds of  
19 experiences into, say, 500 buckets is pretty  
20 hard, and the groupers do it in a different  
21 way. And how homogeneous they are is a real  
22 challenge.

1                   So, it is not that I don't think  
2                   you should have it there. I just think it is  
3                   almost like one of the core problems in  
4                   developing groupers. You know, you could have  
5                   two different groupers who have different  
6                   buckets. In fact, they tend to. That is why  
7                   it makes it hard to compare them.

8                   And then, if you really press them  
9                   to say, "Well, can you make this more  
10                  homogeneous," well, they can break up the  
11                  buckets more and more. And then, pretty soon  
12                  you have 3,000 buckets and you've got two  
13                  people per bucket or two people per bucket per  
14                  provider, something of that nature. And that  
15                  is really where it is like, okay, well, great,  
16                  you've got them homogeneous, but you can't use  
17                  them.

18                  And so, that is the balancing  
19                  problem here. I think everybody recognizes  
20                  that that would be nice to do, but that is  
21                  really the tradeoffs that the people who  
22                  develop groupers face.

1 CO-CHAIR MARTIN ANDERSON: But you  
2 are agreeing that they at least have to  
3 discuss how they actually tested homogeneity  
4 and what they did about it?

5 MEMBER MACURDY: Yes. I mean, it  
6 basically is saying, how do you define the  
7 episode? I mean, what are you going to call  
8 a bucket?

9 CO-CHAIR MARTIN ANDERSON: Right.

10 MEMBER MACURDY: So, they are kind  
11 of the same thing. So, once again, it is not  
12 that I object to what is there. I mean,  
13 that's fine. It is just operationalizing I  
14 think is where the real -- I mean, any grouper  
15 is going to do -- anybody who is going to give  
16 a description of the grouper is going to have  
17 this. It is just --

18 CO-CHAIR MARTIN ANDERSON: Have  
19 the right three buckets. Now we just have to  
20 deal with how do you operationalize it. But  
21 this is the right three buckets. Someone said  
22 give me something broad that just says what's

1 the real threats; what do they perceive the  
2 threats to validity to be, and how would you  
3 address them. And there was a very specific,  
4 you've got to at least deal with the clinical  
5 validity, right? And then, also, the  
6 construct validity -- are the three we heard.

7 Are there more? Dan, I think you  
8 had something to add?

9 MEMBER DUNN: Maybe first a  
10 clarification. What do you mean by threats to  
11 validity, meaning what we feel are the holes  
12 in the -- well, I'm sorry -- what the  
13 developers feel are the holes in the  
14 methodology? So, you are expecting them to  
15 say, "We think this works well except for" X,  
16 Y, and Z?

17 CO-CHAIR MARTIN ANDERSON: In  
18 yesterday's discussion, somebody on this side  
19 of the room proposed that there be a  
20 systematic way of having the developers talk  
21 about where there were risks in validity and  
22 how they address them.

1                   And so, if we can't get more  
2                   specific than that, then we shouldn't have it  
3                   on there.

4                   MEMBER DUNN:   Again, so validity  
5                   and the application or validity and the --

6                   CO-CHAIR MARTIN ANDERSON:  
7                   Results.   The validity of the results.

8                   MEMBER DUNN:   You mean where the  
9                   developers don't -- for example, with a  
10                  diabetes episode, it is built the following  
11                  way, but the developer thinks this part of it  
12                  isn't going to work well?  I just don't know  
13                  how you're going to get folks to comment --

14                  CO-CHAIR MARTIN ANDERSON:  I don't  
15                  think we meant that specifically.  It was more  
16                  it is almost like their philosophy and how  
17                  they even approach the groupers, right?  So,  
18                  how they may have handled the differences in  
19                  the risk profile of people that have diseases  
20                  where there is a great variability in the  
21                  overall risk within an episode, right?

22                  So, they handled it by breaking



1       them into separate episodes. They handled it  
2       by assigning -- I don't know. These are  
3       examples people used yesterday.

4                        So, I don't know, Steve. We can  
5       strike it. If no one understands it, it  
6       should not be on here.

7                        MEMBER MACURDY: Actually, I would  
8       recommend you strike it. Because, I mean, you  
9       can easily put that under the other two in  
10      some way.

11                      CO-CHAIR MARTIN ANDERSON: Okay.  
12      We've got some --

13                      MEMBER DUNN: Maybe the  
14      recommendation would be think of -- Tom was  
15      touching on this a little bit -- there are  
16      certain challenges inherent in episode  
17      grouping. You are often left with making a  
18      choice on which way to go or the other.

19                      If you could identify those and  
20      ask folks to comment on how they approached it  
21      and the pros and cons of what they did, if you  
22      make it more tangible, I think it could --

1 CO-CHAIR MARTIN ANDERSON: I think  
2 we could follow up on that and put that in  
3 what we would ask them to submit. I think  
4 that might be a good idea for how we get more  
5 clear on what we want, other than all the  
6 steps in the process.

7 MEMBER DUNN: Because if you open  
8 wide up -- I would somewhat limit the list of  
9 real challenges here and tradeoffs and I think  
10 get to the real -- the decisions people make  
11 and how their grouper works along those can  
12 really tell you a lot about how well things  
13 are going to go and how they can be used.

14 CO-CHAIR MARTIN ANDERSON: Okay.  
15 Jelani?

16 MEMBER McLEAN: Yes, I wouldn't  
17 say strike it. I would say rewording it.  
18 Because if you do any research, you have  
19 limitations to your research. And I think  
20 that is what Dan is getting at, is having them  
21 express their known limitations and, then, how  
22 they addressed them. And just wording it that

1 way.

2 I think what is striking, what is  
3 alarming is the threats related to the  
4 comment, I think. But, really, what you are  
5 trying to say is everything is going to have  
6 some sort of limitation. And then, how do you  
7 address those known limitations when you build  
8 your grouper?

9 CO-CHAIR MARTIN ANDERSON: I think  
10 we can put that in the previous section,  
11 though, what they should disclose. It kind of  
12 reminds me of our public reporting process,  
13 why we have to tell people why our revenue  
14 might not be achieved.

15 David?

16 MEMBER REDFEARN: Well, the  
17 concrete example, Dan, is that Optum has  
18 expressed the opinion that, because we  
19 typically don't have staging, cancer staging,  
20 information in administrative claims data, you  
21 have to be cautious about interpreting  
22 episodes for cancer, particularly if you're

1 trying to build case rates and stuff like  
2 that.

3 So, that is the developer saying,  
4 "Well, here is a limitation of the underlying  
5 data that limits the validity or usefulness or  
6 utility of these types of episodes." That is  
7 the one specific example I know of in this  
8 area.

9 CO-CHAIR MARTIN ANDERSON: Okay.  
10 Mark?

11 MEMBER LEVINE: Which is another  
12 of saying, should we be looking at validity  
13 and reliability in terms of the entire  
14 functioning of the grouper as a system or are  
15 we looking at validity and reliability for  
16 each of the episodes that are produced by the  
17 grouper?

18 And I think that is a very  
19 important distinction because, you know, you  
20 could have an overall picture that looks  
21 pretty okay, but it doesn't function in the  
22 areas that you need, that you think are

1 important.

2 CO-CHAIR MARTIN ANDERSON: And  
3 this is criteria for validity. So, are we  
4 saying that the Committee should evaluate the  
5 performance of each grouper for every type of  
6 episode?

7 Now you know there will be another  
8 standing committee that works continuously.

9 (Laughter.)

10 Steve?

11 MEMBER LEVINE: That is really a  
12 workflow issue.

13 MEMBER BANDEIAN: At least for a  
14 sample of conditions, if not all of them.

15 Actually, I have a question and  
16 maybe several comments, not surprisingly.

17 What is exactly is the difference  
18 between clinical face validity and construct  
19 validity? So, I am a little confused about  
20 the language. I mean, and I can, instead,  
21 propose an alternative, but I am just a little  
22 confused exactly what the words mean.

1 CO-CHAIR MARTIN ANDERSON: There  
2 was a case made amongst this group that you  
3 have to think about both clinical validity,  
4 right -- in other words, some evidence that  
5 the reasonableness of the episodes in terms of  
6 acceptance from the clinical community is  
7 there, right?

8 And then, the question is, can you  
9 also test, statistically test, your episodes  
10 to say whether or not they actually show  
11 properties that would say that they are, in  
12 fact, homogeneous as intended?

13 MEMBER BANDEIAN: Okay. Let me  
14 try this and see if this is useful either as  
15 an amendment, a supplement, or a replacement.

16 One test of validity or one  
17 concept of validity would be -- probably have  
18 a few tests, subparts to it -- but the basic  
19 question is, have we captured the cost of a  
20 condition accurately, to the extent that that  
21 can be done?

22 And so, that actually has a first

1 preliminary question, which is, was there  
2 actually even really an illness here? Because  
3 you can often have claims that will say  
4 pneumonia or ankle fracture, or whatever, and  
5 actually it was just a ruleout or just some  
6 sort of fluke information.

7           There also are issues about  
8 whether we are accurately distinguishing  
9 between one case of pneumonia versus two cases  
10 of pneumonia. And then, finally, whether all  
11 of the costs and services associated with the  
12 care of that pneumonia are captured in some  
13 way, shape, or form.

14           And I would say not just the cost  
15 of the pneumonia, but perhaps to some extent  
16 some discussion sequelae of the pneumonia.  
17 So, if you did not include the fact that the  
18 person had sepsis as a sequelae of the  
19 pneumonia, it would be a little bit of an  
20 incomplete representation of the total cost of  
21 the pneumonia.

22           So, I'm not quite sure what the

1 right word for that is. I guess I thought  
2 that was actually a construct, validity  
3 concept, meaning, is this thing representing  
4 a real condition episode and is it containing  
5 everything that relates to that one patient's  
6 condition?

7 Now the second question sort of  
8 merges into risk adjustment a little bit. But  
9 let's assume for the moment that all of the  
10 episodes that have been constructed represent  
11 genuine illnesses that we have accurately  
12 distinguished between one case and two cases  
13 of pneumonia, and that we have included all of  
14 the costs that really are reasonably  
15 associated with pneumonia.

16 So, then, the next question is --  
17 and this kind of mirrors some of the earlier  
18 discussion, but I am trying to stay away from  
19 the use case a little bit -- are there  
20 ingredients in the system so that one can say  
21 this case of pneumonia is comparable to this  
22 case of pneumonia? And so, therefore, it



1 would be reasonable to compare the costs of  
2 the two.

3           So, that, for example, might  
4 entail a couple of different things. It would  
5 be maybe we need to distinguish between a  
6 community-acquired pneumonia versus one that  
7 is related to a person being on chemotherapy  
8 or a fungal pneumonia or some such. So, these  
9 are different types of pneumonia that have  
10 different costs and risks associated with  
11 them.

12           But the other part would be, you  
13 know, does the patient have comorbidities or  
14 sociodemographic factors that would affect the  
15 cost of the pneumonia. So, recognizing that  
16 there is sort of a use case issue, I would at  
17 least wonder -- I think there is a question  
18 of, is there enough in the system so that one  
19 can actually make a valid comparison  
20 potentially, theoretically, a valid comparison  
21 between case one of pneumonia and case two of  
22 pneumonia?

1                   So, those would be the two types  
2 of things that one might want to look for.

3                   CO-CHAIR MARTIN ANDERSON: Let me  
4 try this a different way. You're a committee.  
5 Now we're all a steering committee. And the  
6 developers have submitted their test results.  
7 Are you looking for two things or one thing?

8                   This is just to everybody. When  
9 you're saying it is valid, is there a  
10 distinction between you say, hey, it's  
11 clinically valid. They have proven that they  
12 have done all this testing with their clinical  
13 panels, and their panels have accepted this  
14 particular grouper as valid. Our Cardiac  
15 Committee signed off on it. Go all the way  
16 down the list, right?

17                   Is there that plus something else  
18 that says, in addition to that, we have done  
19 the following types of statistical tests, you  
20 know, either comparing the results we received  
21 to what is known in literature around what the  
22 total variability is in cost of care for this

1 type of condition? Are there two types of  
2 things you are assessing or is there only one  
3 thing you are assessing, which is that, hey,  
4 if the clinical community says this is valid,  
5 and these guys can prove that to me, I'm good?  
6 So, where are they? Where is everybody on  
7 that?

8 Chris?

9 MEMBER TOMPKINS: Well,  
10 unfortunately, it is all the above. But, for  
11 example, there are what we call inputs to the  
12 episode grouper, which should say this is the  
13 list of codes that we say, when looked at  
14 together, constitute a condition with a  
15 certain label and a certain definition.

16 And then, when we say that there  
17 are certain services that are, quote,  
18 "relevant" to that condition, then the  
19 clinicians review these. Is this a fair  
20 representation of that condition? Is it  
21 leaving something out? Is it including too  
22 much, et cetera? Are these services really

1 plausible, and so forth, like that? So, the  
2 validity of the inputs.

3           And then, as you ascribed, there  
4 is another what you call criterion validity,  
5 which is to say you have external criteria,  
6 such as, if you are going to trigger heart  
7 failure conditions, then is there a prevalence  
8 rate that the episode grouper expresses in the  
9 population that rings true or corresponds with  
10 expectations or what is observed in using  
11 other means or other ways of calculating  
12 things like prevalence rates?

13           And then, similarly, if you are  
14 constructing an episode that says this  
15 purports to be heart surgery, then you expect  
16 there to be knowing what the DRGs is, knowing  
17 what the procedural or the professional bills  
18 are. So, you have a sense of how expensive  
19 that is, and that has been calculated in  
20 various ways, and you expect the grouper to  
21 approximate that, not to be wildly off, right?  
22 So, that is the second type.

1                   And then, in the middle, which I  
2 think is more of this face validity part of  
3 it, although the inputs is part of that, is a  
4 mechanism in which you actually mechanically  
5 walk through what the computer is trying to  
6 emulate. And what we are trying to emulate is  
7 to say that, if you see a medical history,  
8 relevant information about a patient, a  
9 physician can look at that and start to say,  
10 "I see what the conditions are. I see when  
11 they started. I see what the treatment  
12 patterns were. I see when the condition  
13 resolved. And I see when there is another  
14 condition that probably exacerbated the first.  
15 I see another condition that probably resulted  
16 by way of complication from the surgery or  
17 complication from the treatment or non-  
18 treatment of an illness."

19                   And you can tell the story, the  
20 clinical story, of what happens with a  
21 patient. So, you show them the chronology of  
22 the services. The physician can recreate what

1 the medical history or what the status was at  
2 any point in time. And that is what the  
3 computer is trying to emulate. Of course, it  
4 is trying to emulate it over hundreds of  
5 conditions and millions of patients, and the  
6 complexity of the comorbidities and the  
7 overlapping and the rest.

8 And so, in the middle there, in  
9 addition to purely the inputs, here are the  
10 codes, or purely the outputs, here is the  
11 prevalence and the average cost, you have this  
12 corroboration that the computer is, in fact,  
13 emulating the clinical logic that physicians  
14 would apply, understanding each patient's  
15 medical history.

16 CO-CHAIR MARTIN ANDERSON: Thank  
17 you. That is very helpful.

18 Jelani, did you want to add more?

19 MEMBER McLEAN: No, actually.

20 CO-CHAIR MARTIN ANDERSON:

21 Marjorie, do you want to add more?

22 MEMBER KING: Just as a clinician,

1 I would want more than just attestation that  
2 you've got a board of clinicians looking at  
3 it. You also need testing.

4 CO-CHAIR MARTIN ANDERSON: Right,  
5 but there is a test process. Right.

6 MEMBER KING: You know, we need  
7 evidence. Yes.

8 CO-CHAIR MARTIN ANDERSON: And  
9 Mark?

10 MEMBER LEVINE: Yes, I was going  
11 to pick up, I think, similar to what Marjorie  
12 was saying. The quality of the peer review I  
13 think is something that needs to be defined.  
14 Is there adequate clinical review of the  
15 grouping methodology, the clinical logic?  
16 Does it make clinical sense? Have the right  
17 people looked at it in order to come up with  
18 the groupings that are being used?

19 CO-CHAIR MARTIN ANDERSON: I would  
20 argue that NQF might figure out a scoring, a  
21 high, medium, low of how much. I think, right  
22 now, if you are comparing to literature, you

1 know, or whether or not it is based on solid  
2 evidence, et cetera, it gets sort of rated.  
3 But I think in this case the evidence ratings  
4 might be something like, is it just a clinical  
5 panel that went and reviewed it? Was there,  
6 in addition to that, corroboration with  
7 external data sources that say that the  
8 outputs look right? And in addition to that,  
9 what is the level of validity testing that was  
10 done with clinicians on the output level, not  
11 just the input level?

12 Okay. I could imagine something  
13 that might shape itself on that.

14 David?

15 MEMBER HOPKINS: Just one more  
16 piece on that because that sounded right to  
17 me, but is it condition-specific, what you  
18 just said? I'm sorry, but we have got --

19 CO-CHAIR MARTIN ANDERSON: I think  
20 the question is, for all the episodes that you  
21 create, did you do this for all of the  
22 clinical conditions?



1                   MEMBER HOPKINS:   Okay.  You can  
2 describe the process --

3                   CO-CHAIR MARTIN ANDERSON:  Right,  
4 right.

5                   MEMBER HOPKINS:  -- and the peer-  
6 review mechanism.

7                   CO-CHAIR MARTIN ANDERSON:  And  
8 what was the scope of what you did in terms of  
9 the --

10                  MEMBER HOPKINS:  And you did  
11 review the literature for 500 different  
12 conditions?

13                  CO-CHAIR MARTIN ANDERSON:  Well,  
14 you know --

15                  MEMBER HOPKINS:  Uh-hum.

16                  CO-CHAIR CACCHIONE:  I don't think  
17 there is a way around it not being condition-  
18 specific.  I mean, frankly, we can prescribe  
19 how it should be done, but, frankly, I mean,  
20 it is going to be condition-specific because,  
21 otherwise, there is no way around it.  You  
22 can't compare apples and oranges and be

1 effective.

2 MEMBER HOPKINS: No, but, I mean,  
3 I can see how it would be logical to have your  
4 clinical panel somewhat specific to an area.  
5 Cardiovascular, so we had a cardiovascular  
6 panel. They reviewed all of those episodes,  
7 and something about that.

8 CO-CHAIR CACCHIONE: I think that  
9 that is even difficult today because there are  
10 electrophysiologists. There are heart failure  
11 specialists. And unfortunately, the  
12 literature, keeping up in your own  
13 subspecialty area is often difficult, let  
14 alone keeping up on the broad field of  
15 cardiovascular disease and saying that this is  
16 adequate.

17 And, listen, it is going to fall  
18 apart; these bundles will fall apart if the  
19 clinicians don't believe that they are  
20 meaningful.

21 MEMBER HOPKINS: Well, what is  
22 your validity test?

1 MR. DE BRANTES: Right. So, this  
2 is Francois.

3 I mean, I guess, again, we need to  
4 be cautious because -- Joe, was that you  
5 saying --

6 CO-CHAIR CACCHIONE: Yes, that was  
7 me, Francois.

8 MR. DE BRANTES: Yes, yes. So,  
9 expand on that and think about it. The  
10 burden, therefore, for a developer would be  
11 not just to have, say, a cardiovascular  
12 working group, but to have a working group for  
13 congestive heart failure, a separate working  
14 group for ischemic heart disease, a third  
15 working group for essential hypertension, and  
16 so on and so forth.

17 The cost of doing so, the burden  
18 of doing so would basically negate anyone  
19 bringing their grouper through for  
20 endorsement. I am just being realistic, guys.  
21 I mean, you're talking about five years' worth  
22 of development time to put all of these

1 working groups together to review every single  
2 code and every single episode definition.

3 MEMBER LEVINE: I believe that  
4 there is actually some legislation before  
5 Congress at the moment that is going to call  
6 for exactly that kind of review, open and  
7 public review of things.

8 And to make Marjorie's point  
9 again, once a peer group reviews a condition  
10 or a procedure or an episode of one nature or  
11 another, one of the essential feedback loops  
12 is back to that group. After you construct  
13 the logic, let's run it through the program  
14 and see what it is that it actually does  
15 accomplish. Does it accomplish what the group  
16 wanted? And is it now at a level of peer  
17 acceptance? Not only peer discussion and  
18 recommendation, but it needs to go through  
19 another phase of actual acceptance.

20 MR. DE BRANTES: Mark, certainly  
21 legislation can apply to Medicare in any which  
22 way it wants, which that is the prerogative of

1 Congress. Fortunately, Congress doesn't have  
2 that same prerogative on all of the rest of  
3 the industry.

4 And I am just voicing a concern  
5 that, if you establish that level of burden  
6 for any grouper to go through the process of  
7 endorsement and to demonstrate that it has an  
8 ongoing process to have that review done  
9 continuously -- because, to Joe's point, it is  
10 almost difficult for anyone to follow up on  
11 the changes in the evidence in their own  
12 medical specialty -- you're killing off any  
13 potential for an innovator to enter into the  
14 market.

15 CO-CHAIR MARTIN ANDERSON: I think  
16 we have --

17 MR. DE BRANTES: That would be the  
18 net result, is that no innovation will occur  
19 because you are stacking the deck towards the  
20 multibillion dollar companies.

21 CO-CHAIR MARTIN ANDERSON: So, I  
22 just want to make sure, as we add comments on

1 here. I think we have the range of opinion  
2 around how much testing could happen between  
3 every clinical condition, multiple points in  
4 time in the development, and then, also, maybe  
5 that's not so feasible. So, I think we have  
6 that range.

7 Is there anything else that is in  
8 addition to that anyone wants to add?

9 MEMBER LEVINE: I think there is a  
10 relationship to use case, and there may be  
11 different criteria for different use cases.  
12 If this is being used on a national level to  
13 modify physician payment, for instance, that  
14 is a very important high-level use case that  
15 must be specifically addressed in the  
16 criteria. Are there criteria that set that  
17 bar may be different from criteria that would  
18 set other bars?

19 CO-CHAIR MARTIN ANDERSON: Okay.  
20 Thank you.

21 Can we go on to reliability? It's  
22 not over, right?

1                   So, the only example captured so  
2                   far I reliability was really how does this  
3                   grouper perform across data sources, different  
4                   size data sources, multiple different time  
5                   periods, and that could be length of the data  
6                   period or over time. These were ideas that  
7                   were thrown out in terms of thinking about  
8                   reliability.

9                   Thoughts on reliability?

10                  Okay, Tom?

11                  MEMBER MACURDY: Well, I mean, I  
12                  definitely don't think an episode should go  
13                  across, you know, be required to go across  
14                  multiple data sources. In fact, I could even  
15                  make a stronger statement that often groupers  
16                  are dependent upon the particular payment  
17                  source or payment rules that are in a payment  
18                  system.

19                  Let me not use Medicare. Let's  
20                  suppose I use Medicaid.

21                  CO-CHAIR MARTIN ANDERSON: You  
22                  didn't mean sources? You meant like, if you

1 have a claims dataset, have you tested it  
2 against multiple different datasets, not just  
3 one you developed in one and, then, just  
4 pushed it? I mean, you did your testing and  
5 your development --

6 MEMBER MACURDY: So, if you  
7 started with the universe of Medicare data,  
8 you mean subsets of the Medicare data or --

9 CO-CHAIR MARTIN ANDERSON: Or a  
10 different time period of Medicare data.

11 MEMBER MACURDY: You are saying  
12 the same data source?

13 CO-CHAIR MARTIN ANDERSON: He  
14 meant databases. So, in other words, if you  
15 developed it on one, have you at least tested  
16 it on a different data source or a different  
17 data source with a different period of time?  
18 So, if you develop it so that you at least can  
19 talk about how it performs in different data  
20 sources, databases, not data sources.  
21 Datasets maybe I should say.

22 MEMBER REDFEARN: I think testing



1 these groupers across time makes a lot of  
2 sense because they tend to be easy to do. But  
3 the complication is, then, you have to keep in  
4 mind what version of the grouper are you  
5 using. Okay? Because coding can change  
6 underneath you as you go across time, is the  
7 grouper updated?

8 So, if you run a grouper that was  
9 developed three or four years ago against  
10 current data in which there is new coding, new  
11 medical practice, and things like that, it  
12 might not do very well.

13 And so, you have got the  
14 underlying data is changing, and you sort of  
15 want the underlying model to change, too, to  
16 keep up with these kinds of things. So, I  
17 like that across time. That is really nice,  
18 but it is complicated. It is difficult.

19 CO-CHAIR MARTIN ANDERSON: Steve?

20 MEMBER BANDEIAN: Yes, if I  
21 understand the basic idea of reliability, it  
22 is kind of like we know this car is moving.

1 I'm a policeman, a state policeman, and we  
2 know it's going 65 miles an hour. And I've  
3 got my radar gun and I do 10 measurements of  
4 the care, and the issue is, do I always get 65  
5 miles an hour or what is the spread around  
6 that?

7 Having said that, it is picking  
8 up, I think, really on what David said. It is  
9 a little hard for me to see how one can have  
10 -- but maybe Tom is going to -- anyway, it is  
11 a little hard for me to see how one does  
12 reliability testing in this context.

13 Now, ideally, one would be able to  
14 say, "Dr. Jones does too much of X in time  
15 period one and time period two." And you  
16 would see some persistence of the pattern over  
17 time.

18 That strikes me as setting a  
19 really high barrier because of all of the  
20 factors that go into the calculation of Dr.  
21 Smith's score. And so, I could easily imagine  
22 that the system is actually functioning really

1 well, and in time period one Dr. Smith has a  
2 good score; in time period two he has a bad  
3 score, or vice versa.

4 So, I, myself, am having a little  
5 trouble understanding how to make a meaningful  
6 reliability test, but, again, maybe I am  
7 missing something.

8 CO-CHAIR MARTIN ANDERSON: Tom?

9 MEMBER MACURDY: Yes, I have the  
10 same sort of question. I think the best way  
11 for me to kind of express my concerns is with  
12 a particular example.

13 I mean, I can have a sequence of  
14 claims that are the same for two beneficiaries  
15 or two individuals, and you get a different  
16 grouping. And often, when you drill down, it  
17 is reasonable that you got a different  
18 grouping. Now is that reliable?

19 I mean, you guys just want to add  
20 yet a third enrollee and, then, a fourth, et  
21 cetera. But I guess I am not sure. You know,  
22 reliable, it sounds nice; across multiple

1 databases sounds fine. But I am just not sure  
2 operationally what that means or what kind of  
3 criteria you guys would use to make that  
4 judgment.

5 Because, like I said, I can just  
6 take a case where I will do one individual,  
7 two individuals, three individuals, and you  
8 can often get different answers as you go  
9 across, though, simply because the  
10 circumstances are different and it is  
11 reasonable that it happened. And then, yes,  
12 you have to understand each one of those  
13 scenarios. But I don't know; is that  
14 reliable?

15 CO-CHAIR MARTIN ANDERSON: But I  
16 presume it shouldn't be happening that you run  
17 the same data through the episode grouper  
18 multiple different times and get different  
19 results, right?

20 MEMBER MACURDY: Well, you can re-  
21 sort data and get a different answer.

22 MEMBER LEVINE: Yes, and the

1 sequence in which you present the data can  
2 also influence it.

3 CO-CHAIR MARTIN ANDERSON: Maybe  
4 we can think about a different way. Maybe at  
5 least that should be disclosed, right? So,  
6 maybe there is no an easy way. So, high  
7 reliability of an episode grouper sounds  
8 unlikely at the moment, right, from what I'm  
9 hearing?

10 You're saying you can't, for  
11 instance, say, "I developed this system, and  
12 if WellPoint runs it and, then, United runs  
13 it, they can at least reliably assume that  
14 they have gotten comparable results."? You  
15 can't prove that, right? Is that what you are  
16 saying?

17 MEMBER MACURDY: Yes. I mean, a  
18 good example there is WellPoint may have a  
19 different kind of payment system or the way it  
20 provides services, the way it registers  
21 services, compared to another plan.

22 I mean, it is the same problem you

1 run into when you try to do drug safety  
2 studies and formularies have different step  
3 therapies. They are not the same thing, and  
4 it is a challenge.

5 So, what a procedure or a set of  
6 services means in WellPoint is different than  
7 what it means in another one. That is kind of  
8 fine, but there is a context there.

9 CO-CHAIR MARTIN ANDERSON: I guess  
10 I am just having trouble with saying that we  
11 can't say that episode groupers could be  
12 reliable. We need to figure this out.

13 (Laughter.)

14 MEMBER MACURDY: I just did. It  
15 is not that I want to say that's why --

16 CO-CHAIR MARTIN ANDERSON: Right.  
17 We have to wrestle this one to the ground.

18 Jelani?

19 MEMBER MACURDY: I am just saying  
20 the planning it is a challenge.

21 MEMBER LOISELLE: This is Jim.  
22 Sorry to interrupt.

1                   To a certain extent, we are still  
2                   somewhat arguing over what you do with the  
3                   results, and that WellPoint and Aetna, or  
4                   whomever, if they are fee-for-service, one  
5                   needs to look at how the grouper processes the  
6                   claims or detail and/or assigns the clinical  
7                   categories. What you do with it, whether it  
8                   is a cost or a servicing issue or an analysis  
9                   issue, that is post-grouper. That is not what  
10                  a grouper does.

11                   MEMBER MACURDY: I disagree.

12                   CO-CHAIR MARTIN ANDERSON: No, my  
13                   examples wasn't that. It was just to say  
14                   that, normally, you would say that this  
15                   program works if you change datasets. You  
16                   would want to be able to say that for  
17                   reliability, that we have confidence in this  
18                   grouper if you switch datasets.

19                   MEMBER LOISELLE: Correct.

20                   CO-CHAIR MARTIN ANDERSON: That's  
21                   what we are after here, not that the results  
22                   that they would get would be somewhere

1 comparable, but how do you know that it  
2 doesn't only work on the dataset it was  
3 developed for?

4 MEMBER LOISELLE: Correct.  
5 Correct. My point was you can't use those  
6 values, and you mentioned like cost, as the  
7 reason to determine that.

8 MEMBER McLEAN: I think, if I  
9 could interject here, yes, I agree with  
10 Kristine. You know, a grouper has input  
11 requirements. They went back to it and they  
12 said, "This is how you have to submit the  
13 data." Whether it is one plan's data or  
14 another plan's data or another user's data,  
15 you have to conform to that grouper's input  
16 requirements regardless.

17 Now I agree, the output is  
18 different for your business. That is your  
19 business. And so, that is what you have to be  
20 able to understand, how to interpret the  
21 output.

22 But what we are doing here is



1 saying, does the grouper work? And does it  
2 work based on your input requirements and does  
3 it do what it is supposed to do?

4 And I think you have to be able to  
5 say that. Otherwise, certifying on a national  
6 level, groupers would be useless if you can't  
7 make that determination.

8 CO-CHAIR MARTIN ANDERSON: We are  
9 saying that the developer must be able to  
10 demonstrate reliability. Now what we have to  
11 struggle through is what would we accept as  
12 such a demonstration.

13 MEMBER McLEAN: Right.

14 CO-CHAIR MARTIN ANDERSON: Okay.

15 MEMBER BANDEIAN: At least in  
16 terms of what I'm familiar with -- and,  
17 obviously, there are lots of things that I'm  
18 not familiar with -- but in terms of what I am  
19 familiar with, the logic is actually  
20 fundamentally deterministic. And so, if you  
21 rerun it 10 million times, you will get  
22 exactly the same results 10 million times

1 because it's a computer; it doesn't make  
2 mistakes, and the logic is deterministic.

3 Now it may be that some of the  
4 systems are not deterministic, and that would  
5 be interesting to see, to take the same exact  
6 -- and to Tom's point about sorting the data,  
7 again, at least that would be interesting to  
8 test because, obviously, if the sort order  
9 changed the result, that would be a  
10 reliability issue that would, I think, be  
11 something that would be noteworthy.

12 But now I did have an idea, which  
13 is vastly overly-difficult to do. It would be  
14 interesting to see, okay, if we go back to  
15 what I was saying previously about the  
16 pneumonia case -- that is to say, did we  
17 properly identify the episode of pneumonia;  
18 did we properly identify the costs associated  
19 with the pneumonia, et cetera, et cetera, that  
20 type of validity concept -- I think it would  
21 be interesting to take the same system and run  
22 it off data from health plan A, B, C, D, E, F,

1 and G and see if we are still seeing that the  
2 pneumonia episodes that are being constructed  
3 are valid, given our validity criteria.

4 Now that strikes me as a huge job,  
5 but it would be important to know that in this  
6 test set of data, where the validity looks  
7 good, it may not be really representative of  
8 all possible uses.

9 CO-CHAIR MARTIN ANDERSON: Yes, I  
10 hear you. And I think there is a parallel  
11 here to what NQF is doing in looking at  
12 e-measures, right? And the way that sort of  
13 came down for the short-term was you had to  
14 have tested your e-measure in at least three  
15 different EHRs, as an example, right? It  
16 assumes the software itself would be reliable,  
17 but that you had at least tested it in  
18 different places.

19 But I don't think we are going to  
20 resolve this. I will take any more comments  
21 on this topic. We may have to come back to  
22 it.

1 David, I know you had -- Jelani  
2 feels good. David and Dan will get the last  
3 two words on reliability for today, not  
4 forever.

5 (Laughter.)

6 MEMBER HOPKINS: Never forever.  
7 It goes on.

8 I really like the way you framed  
9 it. And again, in a practical sense, I am a  
10 physician and I contract with, let's say, two  
11 health plans for a lot of my patients. And  
12 each of them is doing this kind of analysis  
13 and coming up with either similar or  
14 dissimilar results.

15 And what can NQF do, if anything,  
16 to assure that these results are comparable?  
17 That is a tough one.

18 Do you know where it takes me? It  
19 takes me to all-payer claims data. This is  
20 not an NQF endorsement issue. It is, again,  
21 a use issue. I keep coming back to use issues  
22 distinct from endorsement of groupers.

1                   MEMBER DUNN:  Yes, maybe just a  
2                   comment.  And actually, I think Steve's  
3                   comment was on the right track and you  
4                   followed it, Kristine.  But it is almost more  
5                   of, is the grouper robust, meaning it can  
6                   produce an expected result with validity  
7                   across different scenarios.  Because at this  
8                   point, the same set of data, it is going to  
9                   produce the same result again and again and  
10                  again.

11                  But can it produce a valid result  
12                  across different nuances, which could be  
13                  different health plans?  It could be different  
14                  cases, and so on.  I think that is probably  
15                  the more important point.  And maybe  
16                  reliability isn't even the right term.

17                  CO-CHAIR MARTIN ANDERSON:  That  
18                  was a good discussion.

19                  Anyone --

20                  MS. WILBON:  I just have a  
21                  question.  Is that feasible?  I'm just saying,  
22                  if we were to kind of have a criteria and say

1 like what our high bar, not saying that that  
2 would have to be the mechanism to test it, but  
3 if we were to consider that a high bar, is  
4 that feasible for a developer to do?

5 MEMBER DUNN: A good question.  
6 Well, obviously feasible. But the bottom line  
7 is it is not -- see, three different health  
8 plans, you run three different pneumonia  
9 patients through. To really tell whether it  
10 worked well across all, you would have to  
11 actually go through and clinically validate,  
12 do a methodologic. Did it do what it was  
13 supposed to do, given the methodology and,  
14 two, does it make sense? I think you have to  
15 get to that extent to be able to assess that.

16 MEMBER MACURDY: I think I can  
17 answer it best by saying, suppose you have an  
18 episode grouper that works well for Medicaid  
19 in South Carolina and that's it, only in South  
20 Carolina. And I would use California as an  
21 example, but there are 58 Medicaid programs.  
22 So, there isn't a California program.

1                   Okay, if it just worked well in  
2                   South Carolina, it doesn't work in any other  
3                   state, would you say it's not valid or it is  
4                   not reliable? I mean, Arkansas is developing  
5                   its own right now for its particular program.  
6                   And if it works well for that program, that  
7                   seems fine.

8                   CO-CHAIR MARTIN ANDERSON: Okay.  
9                   And then, there's always this other question,  
10                  which we don't have to get into in detail.  
11                  But there will always be organizations that  
12                  choose not to be endorsed, right, that choose  
13                  not to get whatever they are doing endorsed  
14                  because they are doing it internally, or  
15                  whatever. So, the question is, if you want  
16                  national endorsement, what should the bar be,  
17                  right?

18                  MEMBER DUNN: Two seconds.

19                  CO-CHAIR MARTIN ANDERSON: Yes,  
20                  yes.

21                  MEMBER DUNN: Okay. Tom's point  
22                  is a good one. If something is built for a

1 specific purpose, then how valid is it when  
2 applied outside of that purpose? That is a  
3 test of its usability and reliability and  
4 robustness.

5 CO-CHAIR MARTIN ANDERSON: Right.

6 MEMBER MACURDY: And I can't  
7 imagine a state wanting --

8 CO-CHAIR MARTIN ANDERSON: Right,  
9 right. And if they want it, then they may  
10 want -- once it is endorsed, it is assumed  
11 others will use it, right? So, you don't  
12 really necessarily want to endorse something  
13 that only that one developer is only going to  
14 use, right? And, you know, in theory; whether  
15 or not that happens in practice I don't  
16 actually know.

17 So, let's go on to feasibility.

18 So, the only two topics --

19 MR. DE BRANTES: Yes, I have  
20 some --

21 CO-CHAIR MARTIN ANDERSON: I'm  
22 sorry. Is someone on the line?



1 MR. DE BRANTES: Yes, this is  
2 Francois.

3 I am still going to make the case  
4 of you don't want to stifle innovation. Well,  
5 I and a lot of other people in the country  
6 would not want NQF to be responsible for  
7 stifling innovation.

8 CO-CHAIR MARTIN ANDERSON:  
9 Francois, can you tie that back to the  
10 conversation? You mean by requiring, by  
11 making --

12 MR. DE BRANTES: By making  
13 requirements --

14 CO-CHAIR MARTIN ANDERSON: For  
15 endorsement?

16 MR. DE BRANTES: -- of various  
17 aspects for endorsement so unachievable by  
18 anyone but huge, established companies, you  
19 will immediately stifle all innovation.

20 MEMBER BODYCOMBE: Now, as a  
21 follow-on to Francois, what I have been  
22 hearing for the last two days is a lot of

1 instances of "depends" -- depends, depends,  
2 depends. And you know, we all at the start of  
3 this session had to talk about our conflicts  
4 of interest. And I have a question for NQF.  
5 Is "We don't think you should do this" a  
6 viable option? Is that acceptable? Or does  
7 your contract with CMS say, "Thou shalt  
8 produce this and, otherwise, you don't get  
9 paid."?

10 (Laughter.)

11 MR. AMIN: So, we will have  
12 discussion. Yes, we'll have that discussion  
13 after lunch.

14 MEMBER BANDEIAN: And actually, we  
15 also don't get lunch.

16 (Laughter.)

17 CO-CHAIR MARTIN ANDERSON: Okay,  
18 we'll leave that there.

19 Okay, let's go on to feasibility.  
20 So, the two observations made about  
21 feasibility, potential criteria, one was  
22 around, is the data that is required to run

1 this grouper generally available, right? So,  
2 that's one of feasibility, and this is  
3 feasibility that this could be adopted by, an  
4 NQF standard could be adopted by others.

5 And the other one that has come up  
6 is cost, which is, are there barriers to  
7 access to this grouper that are related to the  
8 cost to run it, which is one of our panelists  
9 mentioned earlier?

10 So, comments on those two?

11 MEMBER HOBART: I just had a  
12 question. Does NQF usually have a gait about  
13 cost of applications? I mean, I just didn't  
14 see it in the criteria you showed the other  
15 day.

16 CO-CHAIR MARTIN ANDERSON: It has  
17 to be disclosed, and sometimes committees do  
18 take that into account if they have an  
19 alternative that does not have a cost.

20 DR. BURSTIN: The Committees  
21 consider the cost under feasibility now.

22 CO-CHAIR MARTIN ANDERSON: Right,

1 but it is not a pass/fail, right?

2 MEMBER HOBART: It is a  
3 transparency of cost structure.

4 CO-CHAIR MARTIN ANDERSON: Yes.

5 MEMBER HOBART: Is that what we're  
6 saying?

7 CO-CHAIR MARTIN ANDERSON: Yes.

8 MEMBER HOBART: Okay. That is not  
9 to me feasibility. I mean, that is providing  
10 the information. I mean, it is a judgment  
11 whether it is a cost that is acceptable or  
12 not. That is what I am trying to say: do you  
13 judge this as too high a cost or is it just  
14 you need transparency of what the licensing  
15 cost structure is?

16 CO-CHAIR MARTIN ANDERSON: Every  
17 one of these criteria within have judgments  
18 applied by the Steering Committee for whether  
19 they were high, medium, or low in feasibility  
20 or reliability. So, it is possible that a  
21 very expensive grouper might be rated lower in  
22 feasibility than one that did not have a cost.

1 MR. DE BRANTES: So, this is  
2 Francois.

3 Just as a point of clarification,  
4 you could have and there are some of these  
5 applications are so that software is a  
6 service. With the software in the Cloud, you  
7 load up your data. It does all this wonderful  
8 stuff and returns results, in which case your  
9 cost would likely be a licensing fee and there  
10 might be the dance points of additional services  
11 that the organization might sell around that.

12 On the flip side, there might be  
13 another software application whose license fee  
14 is relatively low or lower than the software  
15 as a service option, but would require the  
16 organization installing a whole slew of  
17 hardware and operating system software and all  
18 kinds of other stuff before they can even run  
19 the software. So, it obviously is a cost.

20 And so, how do you distinguish  
21 these things?

22 MR. AMIN: Francois, this is

1 Taroon.

2 The way that we have handled that  
3 in the past is that we ask the question of, if  
4 any user who had access to the data wanted to  
5 get the measure results, regardless of which  
6 method a developer uses, the software as a  
7 service or he actually is buying all of this  
8 and putting it in-house, how much would that  
9 cost for you to be able to do that?

10 And so, we would assess both of  
11 those types of costing models. And then, the  
12 Committee would have to evaluate whether that  
13 was undue burden, to be able to actually run  
14 the data themselves.

15 MR. DE BRANTES: I think you would  
16 have to be a little bit more precise here,  
17 simply because part of this would likely be  
18 asking the developer to provide a list of all  
19 the technical hardware and software  
20 requirements that would be needed by someone  
21 who would host the software.

22 Because you can't make an

1 assumption. I mean, it is incredibly  
2 difficult to price these things out. It  
3 depends on multiple factors. I mean, if you  
4 are going to rent Amazon space, it is very  
5 different than if you are going to buy the  
6 hardware and host it internally.

7 CO-CHAIR MARTIN ANDERSON: Thank  
8 you.

9 MEMBER JONES: What we talked  
10 about at our subgroup was perhaps considering  
11 the requirement of a very standard way of  
12 submitting their total cost structure, as well  
13 as I would suggest that they would disclose  
14 when other billable hours kick in.

15 So, for example, if you get output  
16 that you did not expect, what is their planned  
17 response to that? What is the availability of  
18 support there? Because what I have found is  
19 oftentimes you will get very unexpected large  
20 bills.

21 CO-CHAIR MARTIN ANDERSON: I think  
22 that we are going to hit this again and market

1 impacts, too.

2 But, Dan?

3 MEMBER DUNN: I probably should  
4 recuse myself from commenting, but just a few,  
5 given we obviously are involved in this piece.

6 But, one, there is the methodology  
7 part of a grouper. And then, there is the  
8 software that implements it. Two different  
9 things. And then, to Francois' point, it is  
10 really hard to disentangle that these systems  
11 are usually embedded in other systems that do  
12 all the post-grouper parts, as well as all the  
13 services around supporting them. So, again,  
14 you need to be really precise and people need  
15 to interpret the value of everything you get  
16 for what you pay for.

17 The other point is, you know, this  
18 tension between wanting it to be better,  
19 current, maintained, all the work to do the  
20 clinical validation, and so on, that tension  
21 between having to spend more money to keep it  
22 valid and, also, to maybe potentially have it



1 endorsed goes right against this idea of  
2 looking at the cost of people.

3 So, you know, I see the budget  
4 that it takes to stand up our groupers, and it  
5 is not small. Unless you have a public entity  
6 financing all this work, I have a hard time  
7 seeing how this one -- if people perceive  
8 there is value in what they get and how it is  
9 delivered, that, to me, is more important than  
10 the price, the specific price, that is  
11 attached to it.

12 CO-CHAIR MARTIN ANDERSON: Thank  
13 you.

14 CO-CHAIR CACCHIONE: I would come  
15 back to the intended use. And so, I guess I  
16 made the case for this idea of this refreshing  
17 and this has to be updated. It is really  
18 about the intended use. And depending on what  
19 the intended use of these things is -- I mean,  
20 the DRG system has been around forever. It  
21 got updated in increments of DRG, then MS-DRG,  
22 and now AP-DRGs. And that worked, and people

1 sort of learned to adapt to it and there were  
2 minor modifications.

3 So, I guess what I am saying is,  
4 depending on the intended use, if you are  
5 going to get the provider buy-in, depending on  
6 what they intend to use this for, it may  
7 require that, if we plan to use it for public  
8 reporting and people are going to be judged  
9 unfairly based on clinical information that is  
10 dated, boy, you're not going to get provider  
11 buy-in.

12 But if you are going to use it for  
13 payment and it is not going to meaningful  
14 change the payments to providers, then they  
15 buy in. They bought into the DRG system that  
16 way.

17 But if you are going to hold  
18 people accountable and tell them that they  
19 somehow look bad or they are not good  
20 providers, you are going to have a lot of  
21 pushback by the provider community.

22 MR. DE BRANTES: Yes, but, again,

1 I think we need to be careful about, are we  
2 establishing criteria here for the CMS  
3 grouper? Or are we establishing criteria here  
4 for all potential applicants? Many of these  
5 groupers have nothing to do with the Value  
6 Modifier that CMS is working on.

7 CO-CHAIR CACCHIONE: Well, but  
8 they could be used by private payers. They  
9 could be used by private payers to create  
10 public reports around providers. In cases  
11 now, they are deselecting people based on  
12 economic profiles, and they are getting pushed  
13 out of the network. So, these things are  
14 being used in ways that are disadvantaging  
15 providers.

16 MR. DE BRANTES: So, are you  
17 suggesting that that ought to stop  
18 unilaterally?

19 CO-CHAIR CACCHIONE: No, I'm --

20 MR. DE BRANTES: I'm having a  
21 tough time here because NQF so far has never  
22 gone down the pathway of saying, "Here is a

1 measure, hemoglobin Alc, and you measure it  
2 this way." And there are lots of people out  
3 there who are using those measures, as you  
4 know, to deselect or rate physicians based on  
5 whether or not they meet a certain threshold  
6 of their patients with hemoglobin Alc's less  
7 than something or above something else. And  
8 NQF has never gotten involved in any of that  
9 stuff.

10 CO-CHAIR CACCHIONE: Yes. I would  
11 like to say we can stop here because we have  
12 a public comment period.

13 I would just say that it needs to  
14 be fair, both for the vendors as well as the  
15 providers.

16 CO-CHAIR MARTIN ANDERSON: Yes, I  
17 think, again, this is an area where we have  
18 got the range of opinion. NQF has been down  
19 this road before that says, do you really get  
20 into different bars for different uses? And  
21 so, you've done your job by expressing the  
22 range of opinion, and that will get carried

1 back.

2 So, do we want to go to public  
3 comment and pick up on usability after lunch?

4 MR. WILLIAMSON: Yes, let's do  
5 that.

6 Do we have any public comments in  
7 the room?

8 MS. McLLRATH: I'm Sharon McIlrath  
9 with the AMA.

10 I just would like to say I am not  
11 exactly sure where you should put it, but sort  
12 of picking up on the question about different  
13 specialties and subspecialties, that when you  
14 are looking at whether the data is reliable  
15 across different data sources and different  
16 time periods, that it would be important to  
17 look and see, is it sort of consistent across  
18 different subspecialties? Because we have  
19 heard that is one of the problems with a lot  
20 of what is out there.

21 MR. WILLIAMSON: Do we have any  
22 other public comments in the room?

1 (No response.)

2 Operator, can you please open the  
3 lines for public comment?

4 THE OPERATOR: Yes, sir.

5 If you have comments or you would  
6 like to ask a question, please press \*, then  
7 the number 1 on your telephone keypad.

8 (Pause.)

9 At this time, there are no  
10 questions or comments.

11 MR. WILLIAMSON: Thank you very  
12 much.

13 We will now break for lunch and  
14 reconvene at 12:30.

15 (Whereupon, the foregoing matter  
16 went off the record for lunch at 12:03 p.m.  
17 and went back on the record at 12:38 p.m.)

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A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

1:08 p.m.

MR. WILLIAMSON: Okay. We will be moving on now. We are going to talk about implications for NQF and market implications for endorsing episode groupers, so really challenges and the path forward.

And so, at this time I will turn it over to our Co-Chairs -- or turn it over to Taroon, who will prime us for this discussion.

MR. AMIN: Okay. So, I know this is the discussion everybody has been looking forward to.

(Laughter.)

So, you know, I will preface the discussion by saying that, as we started this work -- well, the first, the time, the way we are sort of going to structure this conversation.

So, we have until about 2:30 to walk through this. We originally talked about structuring this discussion in terms of

1       implications for NQF endorsement and, then,  
2       having some discussions around the  
3       implications for application.  So, I don't  
4       want to take for granted that -- this may be  
5       a new effort for some folks and folks may not  
6       really know the full scope of NQF activities  
7       to have additional conversation around  
8       implications.

9                        So, firstly, I think most are  
10       familiar with the fact that NQF endorses  
11       measures as national consensus standards for  
12       use for broad reporting and accountability  
13       applications.  However, NQF does not endorse  
14       particular measures for particular programs.  
15       So, I mean, we ask the question about how a  
16       measure will be used, and it could be used in  
17       a particular program, but we are not  
18       necessarily looking at the question -- I mean,  
19       criteria doesn't change depending on whether  
20       it is being used for a public reporting  
21       program versus a Value-Based Purchasing  
22       Program.



1                   So, NQF also convenes the Measures  
2                   Applications Partnership, which is tasked with  
3                   making recommendations to HHS in terms of  
4                   rulemaking, in terms of recommendations of  
5                   measures that should be used for programs.

6                   In this last report that was  
7                   submitted to HHS on February 1st of this year,  
8                   actually five days ago, the MAP reviewed 46  
9                   condition-specific episode grouper measure  
10                  concepts. So, they were submitted to the MAP  
11                  to provide preliminary guidance on, and they  
12                  were submitted in the form of measurement  
13                  concepts, so measure concepts, very much in  
14                  the typical construct of NQF-endorsed  
15                  measures.

16                  So, this relates to the  
17                  conversation that we have been having in a  
18                  number of ways. The first is that the  
19                  question of use case was a dominant part of  
20                  our conversation over the last two days. And  
21                  typically, NQF does not -- you know, this  
22                  question of how a measure is intended to be

1 used is not something that is considered an  
2 endorsement, but, more or less, something that  
3 is considered under the Measures Application  
4 Partnership.

5 So, in a lot of ways, what we are  
6 suggesting here is that these two are blended.  
7 And so, the original way that this  
8 conversation was structured was to have  
9 discussion on implication for endorsement and,  
10 then, some conversations around applications.  
11 And this conversation will obviously be  
12 blended for the next session. So, I just  
13 wanted to say that upfront.

14 So, I want to just walk through --  
15 Evan, actually, going back to the slide -- in  
16 terms of implications for endorsement, to walk  
17 through some of the questions that we wanted  
18 some feedback on and guidance from the group  
19 on. And I will walk through the questions and  
20 I'll turn it over to Kristine to lead the  
21 discussion on.

22 So, what are some of the benefits

1 and unintended consequences that may come from  
2 endorsement of episode grouper systems,  
3 episode groupers broadly, is one of the  
4 questions that is outstanding. I think this  
5 would be the place to have a conversation of  
6 recommendations of whether, to David  
7 Bodycombe's point earlier today, should NQF be  
8 doing this at all?

9           Given that many of the episode  
10 groupers that could be considered for  
11 endorsement are commercially-owned and contain  
12 proprietary components, how might the  
13 evaluation, the endorsement of these groupers  
14 impact the market?

15           Further, should future efforts  
16 seek to align the public and private sector in  
17 terms of the use of a single endorsed episode  
18 grouper system? And again, that fits under  
19 the domain of the Measures Application  
20 Partnership which is tasked with the goal of  
21 trying to align the public and private sector.  
22 Obviously, there is a lot of methodological

1 limitations to being able to do, from the fact  
2 that the data structures/datasets are  
3 different. But should this implicitly be a  
4 goal of our efforts with episode groupers?

5 Moving on to the next slide,  
6 further, I think we have had some discussions  
7 about this to a certain end, but I will just  
8 raise it again as another consideration, that  
9 we, as staff, continue to consider and be  
10 concerned about. It is that, given that many  
11 of the episode groupers contain user options  
12 that might impact the measure score, is it  
13 actually feasible to endorse a national  
14 standard that would be consistently, that  
15 could be consistently applied across users,  
16 given that is the function currently of  
17 endorsement?

18 Further, given the complexity of  
19 episode groupers -- and this goes back to at  
20 least my breakout group where Tom MaCurdy and  
21 others noted -- given the complexity of  
22 episode groupers, is it actually feasible for

1 a multistakeholder group to evaluate them and  
2 make endorsement recommendations? The  
3 consensus development process by its structure  
4 requires the multistakeholder group to be  
5 evaluating these products. And is that truly  
6 feasible, given the complexity of what is  
7 before us?

8 Further, is it an expectation that  
9 groupers -- let's just not use the term  
10 "grouper measure" -- let's just say, how do we  
11 think the grouper should be used in  
12 combination of quality measures and, broadly,  
13 should we be expecting a quality signal within  
14 episode groupers? Or is that not a function  
15 of episode groupers that we would expect?  
16 Again, with the assumption that, if you just  
17 compare with NQF's position on this, just  
18 comparing resource use assumes a stagnant  
19 level of quality, which we know is not true.

20 And finally, what are some of the  
21 considerations for the path forward for  
22 evaluating and endorsing episode groupers?

1 So, again, I think it would probably be  
2 helpful if we maybe take a step back now to  
3 the beginning -- Evan, if we can go back a  
4 slide? -- and maybe take a few of the sort of  
5 questions and concepts at a time. I know this  
6 ranges a number of different topics for  
7 people, but, as we move forward with this  
8 work, these are obviously things that we want  
9 to keep in the forefront to ensure that, if  
10 and when we start to look at the endorsement  
11 of episode groupers, that we are approaching  
12 it in an appropriate fashion.

13 So, I will turn it over to  
14 Kristine.

15 CO-CHAIR MARTIN ANDERSON: So, we  
16 saved the really easy stuff for last.

17 (Laughter.)

18 Let's go to the first page. Oh,  
19 this is the first page. Okay.

20 So, why don't we just go question-  
21 by-question because there's a lot and they are  
22 very different topics. And let's start with

1 unintended consequences. What might happen  
2 if/when NQF endorsed an episode grouper, one  
3 or more?

4 Mark?

5 MEMBER LEVINE: I think the key is  
6 what you were saying about use cases, that not  
7 every use case is important for endorsement.  
8 But I think there is one overarching use case  
9 that is important for endorsement, and that is  
10 the public acceptability of a grouper that is  
11 going to change, potentially impact the  
12 physicians of America and how we take care of  
13 people, how we treat our clinicians with  
14 fairness and openness. And that is a special  
15 use case that is actually required by law to  
16 be presented to you for consideration. I am  
17 not sure that every other use case is as  
18 important.

19 CO-CHAIR MARTIN ANDERSON: You are  
20 noting both the use and the scale of the use,  
21 correct? Okay.

22 Dave Mirkin?

1                   MEMBER MIRKIN: I just want to go  
2 back to something Francois said, which is,  
3 depending upon -- I mean, I am assuming that  
4 there will be a bunch of hoops to jump through  
5 to get endorsement. And I think one concern  
6 would be to really have an effective, an  
7 appropriate endorsement process. I have just  
8 been struggling with how and why, other than  
9 the public source grouper, why anybody else  
10 would go through that. And then, it becomes  
11 less meaningful in a broad way.

12                   So, I think that would be, in  
13 other words, all this work might just be for  
14 the CMS grouper, which is okay, which, then,  
15 I think would help focus us. And you don't  
16 have to worry about all the applications that  
17 might be outside of that.

18                   CO-CHAIR MARTIN ANDERSON: Nancy?

19                   MEMBER GARRETT: And sort of  
20 adding to that, I think one possible  
21 unintended consequence is that, if the  
22 endorsement process is really time-consuming



1 and onerous, then what is in it for the  
2 commercial companies to actually go through  
3 the process? And if they abstain, then what  
4 are the downstream effects? Okay, then, does  
5 that mean that a whole set of cost and  
6 resource use measures are not going to have  
7 NQF endorsement, and we are going to have kind  
8 of two levels of measures in this country? We  
9 are going to have endorsed measures and not-  
10 endorsed measures? And does this start to  
11 water-down the effect of NQF endorsement? I  
12 think that is one scenario you could see  
13 playing out.

14 CO-CHAIR MARTIN ANDERSON: So, you  
15 are raising the specter that, well, then, what  
16 if there is non-endorsed episode grouper and  
17 a measure that comes in that relies on a  
18 commercially-available grouper that might not  
19 be endorsed or in your case is not endorsed  
20 then? Does that have implications for whether  
21 or not that measure could get endorsed? Okay.

22 MEMBER GARRETT: But even a little

1 bit taking it further, will the measure  
2 developers even bring those measures forward  
3 to be endorsed? Or do they just throw up  
4 their hands and say NQF endorsement isn't that  
5 important anymore in this space because it  
6 doesn't mean anything?

7 CO-CHAIR MARTIN ANDERSON: In this  
8 particular space. Okay.

9 Others? Francois, I know you have  
10 an opinion out there.

11 (Laughter.)

12 Okay. No one else in the room?

13 MEMBER BODYCOMBE: You know, I  
14 really appreciate what Mark says. I think it  
15 is absolutely right on, and we have got to  
16 applaud CMS for taking this whole thing on.  
17 I wonder if NQF endorsement is the best  
18 modality or strategy for CMS to promulgate  
19 their episode grouper, though, just to throw  
20 that out as a thought.

21 CO-CHAIR MARTIN ANDERSON: Okay.  
22 Marjorie?

1                   MEMBER KING:  As a provider, I  
2                   would ask, what do the provider organizations  
3                   feel about NQF endorsement?  Because if the  
4                   provider organizations feel strongly that NQF  
5                   endorsement is very important for what their  
6                   members are going to be paid against or judged  
7                   against, then that is very important.  In  
8                   other words, how would NQF endorsement impact  
9                   acceptability by providers?

10                   CO-CHAIR MARTIN ANDERSON:  Okay.  
11                   David?

12                   MEMBER HOPKINS:  I hadn't thought  
13                   about this distinction, but I can see how CMS  
14                   would want to have outside peer review of the  
15                   system that is being built specifically for  
16                   it.  And I can see why logically it might look  
17                   to NQF to perform that function.  I wouldn't  
18                   want to not see that happen, but I can't see  
19                   how, getting back to the comments that were  
20                   made by others, how we are going to pull all  
21                   these commercial vendors in and, then, the  
22                   potential startups for the future into this

1 whole arena. So, maybe there is an answer,  
2 which is let NQF serve the needs of CMS  
3 directly in some way, and then, let's just  
4 struggle with the commercial vendors somehow.

5 But, again, I really think we have  
6 to answer that question about what happens  
7 when you have specific Steering Committees at  
8 NQF looking at measures of cost and resource  
9 use that are generated by these episode  
10 groupers. And can we somehow help them get  
11 past some of the basic questions that always  
12 come up around the grouping?

13 CO-CHAIR MARTIN ANDERSON: Can you  
14 imagine a benefit, any of you, imagine a  
15 benefit to an entity with a commercial grouper  
16 being endorsed? What is the benefit to them?

17 MEMBER BODYCOMBE: If I could,  
18 just from a purely economic perspective, it  
19 blocks entry in a sense for our competitors.  
20 So, being endorsed, theoretically, means your  
21 product is -- you know, you have a distinct  
22 group of products that basically have the

1 monopoly, and the new entrants are kind of  
2 blocked.

3 And as Francois' point, the  
4 innovators who are really out of the box and  
5 coming up with whole new conceptualizations of  
6 this are completely blocked out because  
7 they're not playing by the rules.

8 CO-CHAIR MARTIN ANDERSON: Other  
9 thoughts?

10 Nancy? And then, Tamara.

11 MEMBER GARRETT: One other kind of  
12 different flavor of unintended consequence,  
13 depending on exactly what endorsement meant,  
14 I would worry that it could mean that the  
15 episode grouper logic is somehow frozen. And  
16 we have talked about that a little bit. This  
17 is software that is constantly being improved,  
18 and there is an iterative feedback loop. Is  
19 that going to be included in the "what does it  
20 mean to be endorsed?" Because it was endorsed  
21 on a given day in its current state, but we  
22 don't want to stop it from changing and

1 improving.

2 CO-CHAIR MARTIN ANDERSON: Change  
3 your mind? Okay.

4 Dave Mirkin?

5 MEMBER MIRKIN: One potential  
6 advantage would be, I guess, or maybe it is a  
7 prevention of a disadvantage, I think NCQA  
8 accreditation would help if plans all went  
9 through that, of course, that's quite  
10 expensive. And then after a while they  
11 decided it really wasn't important in order  
12 for them to market, and then all of a sudden  
13 it became important again because the employer  
14 community said we expect spent at least parts  
15 of your business to have that certification.

16 So, I wonder if that is something  
17 that might happen in the future to make NQF  
18 endorsement quite relevant for the commercial  
19 profits; i.e., if the big employers said, you  
20 know, "We only are going to use -- we want you  
21 as our carrier to use NQF-endorsed metrics of  
22 all kinds." And then, if you didn't have

1 that, obviously -- I can't imagine any of the  
2 major players in that market not, then, going  
3 for NQF endorsement if the big employers said,  
4 "That's what we want." I would ask the big  
5 employers.

6 CO-CHAIR MARTIN ANDERSON: Tom?

7 MEMBER MACURDY: Well, I think  
8 that has already been said, but I just wanted  
9 to emphasize. I mean, I really strongly don't  
10 think that NQF should try to align public and  
11 private and get a single endorsed grouper. I  
12 mean, first of all, I think it is a fool's  
13 errand. I mean, it gives part to Francois'  
14 point, but a lot of points. But you want a  
15 lot of flowers blooming here because this is  
16 technology we want to develop over time, and  
17 we really do want to allow for innovation.

18 I don't think it can be done, but  
19 I don't think you should even put it down  
20 there as even trying. I mean, you are not  
21 going to have a single grouper within  
22 Medicare. It is going to depend upon the

1 context. And Medicare, it is a particular  
2 kind of payment system. So, it is not going  
3 to work in commercial. So, one, I just think  
4 it makes no sense.

5 CO-CHAIR MARTIN ANDERSON: Thank  
6 you. So, your comment is on the third bullet?

7 MEMBER MACURDY: Yes.

8 CO-CHAIR MARTIN ANDERSON: Chris?

9 MEMBER TOMPKINS: This might be a  
10 little bit off-point. It is just sort of  
11 flipping the question backwards.

12 NQF is or wants to be or should be  
13 in the business of evaluating resource use  
14 measures, right? And under the rubric of the  
15 resource use measures, it came out, as far as  
16 I know, simultaneously with the consensus view  
17 that the resource measures are looked at from  
18 the point of view of patient-focused episodes,  
19 right? All right. So, NQF already has some  
20 official -- I don't know if that is what you  
21 call them -- official public published stands  
22 on what your business is and how things ought



1 to be done right by consensus opinion,  
2 correct?

3 And then, in the process of call  
4 for measures for resource use measures, you  
5 got some measures which maybe not only did not  
6 emanate from a grouper and maybe some of it  
7 did, right?

8 The question that I would ask is,  
9 how do you know that the ones that did not  
10 emanate from a grouper, how do you know that  
11 they are valid? And the reason I put it that  
12 way is because the purpose of the grouper is  
13 to make logical judgments about how the  
14 resources were used, often in situations where  
15 there is both a competition for determining  
16 how those resources were used and in some  
17 cases there is actually a joint production  
18 that results from the same dollar.

19 So, when you say that the resource  
20 use for this condition or this procedure was  
21 "X" dollars, you have already, at least  
22 implicitly, done something that the grouper is

1     trying to do explicitly, which is to look at  
2     all the possible ways that dollar might have  
3     actually been used.  Sometimes it is for more  
4     than one thing.  You go to the doctor, and the  
5     doctor you for several conditions at once.  
6     Sometimes you're in the operating room and you  
7     get two different operations which may or may  
8     not be clinically-related.

9                     And when you say that the resource  
10    use is "X", how do you get there?  In other  
11    words, how can NQF do the job of evaluating  
12    resource use measures unless it is implicitly  
13    saying something about the logic that was used  
14    to parse out how the dollars ought to be  
15    allocated to this episode versus the other?

16                    So, I will just end it on sort of  
17    a half-joking, dramatic way.  How can you go  
18    forward in the business of resource use  
19    measure endorsement unless they emanate from  
20    a grouper?

21                    CO-CHAIR MARTIN ANDERSON:  Thank  
22    you.

1 Jennifer?

2 MEMBER HOBART: I think even from  
3 a health plan perspective, there is probably  
4 a continuum about how much alignment is  
5 optimal the episode groupers and how much  
6 variation you want. So, if you are working on  
7 trying to change the whole community behavior,  
8 you might to go to a collaborative where you  
9 all want to be using the same grouper because  
10 you are trying to look at the whole claims for  
11 the state. If you are dealing with your  
12 providers, you might want something that is  
13 most familiar to them to facilitate the  
14 interaction? And if you are just doing  
15 analysis sort of behind the scenes, you could  
16 have a lot more variety and niche things that  
17 is helping you figure out places you may want  
18 to go.

19 So, I don't think there is a  
20 single answer because, even within a health  
21 plan, depending on exactly what you're doing,  
22 you are going to kind of need possibly

1 portfolio tools.

2 CO-CHAIR MARTIN ANDERSON: Thank  
3 you.

4 Mark?

5 MEMBER LEVINE: I think, again, we  
6 are back to use case and, also, the gray area  
7 between what is the difference between claims  
8 analysis and an episode grouper. There are  
9 many measures that come about as a result of  
10 claims analysis that are not dependent upon  
11 grouping technology.

12 The use case that I am most  
13 concerned with, obviously, is a publicly-  
14 acceptable one that does require regular  
15 feedback and updating in order to be  
16 acceptable. If Medicare were to come up with  
17 a process of using a grouper, and the clinical  
18 criteria for grouping claims and judging  
19 performance, how often should that be looked  
20 at again in terms of changing codes, changing  
21 care patterns, and things like that?

22 I think the physicians of America

1 need to know and to have standards for how  
2 reliable, how valid is the technology that is  
3 being used in this particular use case. So,  
4 anyhow, enough said.

5 CO-CHAIR MARTIN ANDERSON: Okay.

6 Anyone on the telephone want to chime-in?

7 (No response.)

8 Can they hear us yet? Okay.

9 MEMBER LOISELLE: We can now, but  
10 we missed --

11 MR. DE BRANTES: Yes, we missed  
12 the first half-hour or so of this  
13 conversation.

14 CO-CHAIR MARTIN ANDERSON: Oh,  
15 okay. So, I guess what I'm asking is, do you  
16 want to say anything about the benefits or  
17 unintended consequences that might result from  
18 the endorsement of an episode grouper system?

19 (No response.)

20 Okay. The second question was  
21 around impact on the market. So, how might  
22 evaluation and endorsement of groupers impact

1 the market itself for groupers?

2 MR. DE BRANTES: Well, it is  
3 likely -- Francois here -- it is likely they  
4 would, and that kind of gets us back to the  
5 unintended consequence. Because,  
6 unfortunately -- or maybe fortunately, I don't  
7 know; some days I honestly wonder -- there is  
8 a tendency of the herds to kind of move in the  
9 same direction and to say, because this is  
10 NQF-endorsed, that is the way it has got to  
11 be, which probably is good for NQF, but not  
12 necessarily good for the rest of the country.

13 And so, I think there is an  
14 unintended consequence. Because, depending on  
15 how these criteria are a set -- and we were  
16 able to hear Tom's comments. So, to the point  
17 he made, depending on how the criteria are a  
18 set, how these standards are defined, you  
19 might prevent anyone who is innovating in this  
20 field for being able to qualify for NQF  
21 endorsement of their grouper, which would,  
22 then, kill off their ability to innovate in

1 this field. So, I think, to me, is one of the  
2 biggest unintended consequences of this  
3 effort.

4 CO-CHAIR MARTIN ANDERSON: Thank  
5 you.

6 Dave?

7 MEMBER BODYCOMBE: I am really  
8 interested to hear more, of course, from the  
9 folks who actually make episode groupers. For  
10 instance, when CMS came out HCCs that are  
11 heavily dependent of what is now the Verisk  
12 DxCGs, I guess you might argue, oh, well, now  
13 there's this free system out there; everybody  
14 will stop using Verisk HCCs and use the CMS  
15 HCCs, and that never happened. So, Verisk is  
16 still, as far as I know, a very healthy  
17 company.

18 CO-CHAIR MARTIN ANDERSON: Okay.  
19 Any more on this?

20 (No response.)

21 I know we had one comment already,  
22 a "no" on No. 3: "Should future efforts seek

1 to align the public and private sector in the  
2 use of a single endorsed episode grouper?"

3 And Taroon gave a little bit of background  
4 around the MAP there, too.

5 Let's hear additional comments,  
6 and Tom will get us started.

7 MEMBER MACURDY: Yes, I just  
8 wanted, on the commercially-owned, I mean, I  
9 would have thought that would be something  
10 that NQF would want to stay far from. I mean,  
11 really, you guys are really going to get in  
12 the decision process of saying, if we endorse  
13 a grouper, it may become the more prominent  
14 and other competitors -- I mean, suppose it is  
15 a really good grouper. I just think that  
16 those kind of criteria, the conflict of  
17 interest is going to be huge. It is just  
18 something I would completely steer away from.

19 I mean, if you happened to think  
20 that a grouper that is very commercially-  
21 successful is a good grouper, it's a good  
22 grouper and move on. The fact that people are



1 going to see that and say, "Oh, it's a good  
2 grouper," and they're going to get a stronger  
3 market position, it is like, okay, but I can  
4 imagine a set of circumstances where you say,  
5 "We're not going to do that because we're  
6 going to get a stronger market position." I  
7 mean, I just don't know how that conversation  
8 would go. Conflict of interest, it would be  
9 pretty involved.

10 CO-CHAIR MARTIN ANDERSON: I'll  
11 take any more comments on this particular page  
12 before we go on.

13 (No response.)

14 Okay. Evan, let's flip.

15 Okay. Now this is, the first  
16 bullet is really about, is this even feasible,  
17 right? So, we have heard a lot over the last  
18 day and a half about how groupers have --

19 MR. DE BRANTES: The slides  
20 haven't shifted in the webinar.

21 CO-CHAIR MARTIN ANDERSON: Okay.  
22 He will take care of it.

1                   So, the question, "Given that many  
2 groupers allow for user options that may  
3 impact the measure score, is it feasible to  
4 endorse a national standard that could be  
5 consistently applied across users?"

6                   So, in other words, there is  
7 already a lot of flexibility built into these  
8 systems. And when you endorse something, is  
9 that feasible? Is it feasible to say --  
10 Taroon, is this question to ask, is it  
11 feasible to say that certain options are the  
12 right options or the national standard  
13 options?

14                  MR. AMIN: One of the goals of NQF  
15 up to this point, when we are looking at  
16 performance measures, is to actually seek to  
17 have a national standard. So, the question  
18 here is, given that there are many different  
19 user options and, as we discussed, depending  
20 on the use case, there might be different  
21 variations, is it really even feasible to have  
22 a national standard in this area? And

1 obviously, that would have some implications  
2 for what endorsement means going forward. So,  
3 it is actually more around that.

4 MEMBER DUNN: Maybe a  
5 clarification. What do you mean by "options"?  
6 Can you be more clear? I am trying to think  
7 of options that affect the grouping rather  
8 than post-grouping.

9 CO-CHAIR MARTIN ANDERSON: The  
10 examples that have come up over the last day  
11 and a half are clean periods, you know, time  
12 continuously enrolled, a bunch of things that  
13 the users can set.

14 And I think the question from NQF  
15 is, could there be a national standard on  
16 those types of options?

17 MR. AMIN: Well, actually, it is,  
18 can there be a national standard, given those  
19 options?

20 CO-CHAIR MARTIN ANDERSON: Given  
21 those options?

22 MR. AMIN: Yes.

1                   MEMBER DUNN: I think it depends  
2                   on the options. Some of those, like clean  
3                   periods, you probably could. I think some  
4                   people have a preference one way or the other,  
5                   but it probably doesn't affect -- maybe we can  
6                   talk to David here -- but it probably doesn't  
7                   affect greatly the use. You know, it doesn't  
8                   vary by use cases. It is almost more of a  
9                   preference. So, it would depend on the --

10                   MR. DE BRANTES: That is actually  
11                   incorrect. So, I want to make sure that is  
12                   clear. The use of a clear period is almost  
13                   impossible if you are going to use a grouper  
14                   for bundled payments because you need to have  
15                   a defined time period for payment.

16                   MEMBER LOISELLE: There are other  
17                   ways of doing this besides clean periods.

18                   CO-CHAIR MARTIN ANDERSON: So,  
19                   that was both of you on the phone.

20                   And again, diversity of opinion  
21                   again, that's okay.

22                   (Laughter.)

1                   MEMBER BODYCOMBE: Just to pose  
2 another comment, I wonder how many options the  
3 CMS episode grouper has. To make it work, it  
4 probably doesn't have any options.

5                   MR. DE BRANTES: It actually has  
6 lots of options.

7                   CO-CHAIR MARTIN ANDERSON: Okay.  
8 I don't think we need to get into the details  
9 of the individual groupers. But I think the  
10 question really is, do you even have a  
11 standard if there is just inherent  
12 flexibility, and when users change their  
13 options, it can produce different results?  
14 So, it is even a standard even when you  
15 endorse a grouper if it can be run many  
16 different ways? Is that a standard?

17                   MEMBER MACURDY: So, I would  
18 answer the question as definitely not. You  
19 can't do this.

20                   I mean, let me go back to the  
21 example I was using for Medicaid. So, you  
22 said that, if it is one state, it is not

1 national. Suppose it's two states, three  
2 states, four states, states in different  
3 regions? So, pretty soon, it is like, okay,  
4 is 10 state national?

5 I mean, there is not going to be a  
6 national standard because what you do for one  
7 set of states isn't going to be applicable for  
8 other sets of states. And if you say, well,  
9 it's not applicable for one state, is it  
10 applicable for two states? Do they have to be  
11 in different regions?

12 And then, I could get into  
13 healthcare plans and the same thing, but I  
14 will just stay within government plans. I  
15 mean, you can't even do this.

16 So, I think the answer is there is  
17 absolutely no way. I mean, I was going to ask  
18 what a national standard was, but if you say  
19 if it is applicable, it is like, okay, is it  
20 applicable to the Medicaid program? That is  
21 a reasonable thing to ask in various kinds of  
22 ways.

1                   Like I said, in California there  
2 isn't even one; there's 58. So, there isn't  
3 even a State standard.

4                   CO-CHAIR MARTIN ANDERSON: Okay.  
5 So, let's go to the next one. It has come up  
6 a lot.

7                   Is it feasible that you could get  
8 a multistakeholder group? And NQF defines  
9 their multistakeholder groups as having some  
10 purchaser, consumer, provider, research  
11 organization, et cetera, those entities all  
12 present in the group. Could a group like that  
13 evaluate episode groupers and make endorsement  
14 recommendations?

15                   MS. WILBON: I would say not  
16 necessarily. I think we were trying to pose  
17 this question in the framework of our current  
18 process. Even for measure evaluation, not  
19 everyone is a technical expert on the panel.  
20 There may be some methodologists. We have  
21 consumers who may be interested in the topic,  
22 but have maybe some interest in understanding

1     how costs are going to be applied in different  
2     ways or measured in different ways.

3                     So, I guess it is a broad question  
4     on whether or not a multistakeholder group  
5     could take on this task, if we were to ask  
6     them to do it. It is more complex than most  
7     of the work that we have taken on before. So,  
8     that is really kind of the added nuance.

9                     MEMBER HOPKINS: If you think  
10    about it, you are going to get constant  
11    resource use measures that have this buried  
12    within them. And those groups are going to be  
13    evaluating it. So, how can you obviate that?

14                    CO-CHAIR MARTIN ANDERSON: Nancy?

15                    MEMBER GARRETT: So, I think the  
16    answer is no. I mean, I just don't think the  
17    current process lends itself to this type of  
18    work.

19                    Again, as Dan said, there is kind  
20    of two elements here. There is the algorithm  
21    and, then, there is the software that applies  
22    the algorithm. And for groups to come



1 together in a day and a half, and even with  
2 some advanced technical review, I just don't  
3 see that it would work.

4 And you were describing at the  
5 break to me what happened with a couple of the  
6 measures last year that I thought was  
7 instructive. I don't know if we want to talk  
8 about that.

9 MEMBER LEVINE: Actually, it is  
10 going to constructive. I think because we  
11 went through this process before with NQF, the  
12 idea of the TAG, I think you called them,  
13 which had a clinical element, there was a  
14 methodologist/statistician group, which  
15 actually I thought they asked good questions  
16 and it was a good process.

17 I think the challenge was, when  
18 all that rolled up to the Steering Committee,  
19 did the Steering Committee have enough  
20 background to actually make a final  
21 assessment? And my opinion is actually some  
22 of them, yes. And David was on that group.

1 I would say you probably need to  
2 give greater weight to what the TAG had to say  
3 and not let that be overruled by folks who  
4 hadn't had the time to immerse in it. You  
5 know, nothing against their backgrounds. It  
6 was a very esteemed group. It is just they  
7 didn't have the amount of time to invest in  
8 what was going on that the TAG did.

9 So, you would probably need in  
10 this case to give more weight to the TAG and  
11 have them either explain their assessment or  
12 reach back to them in a way that the  
13 multistakeholder group can be successful.  
14 Because they are going to need to subcontract  
15 that work out to different folks who have and  
16 the abilities to understand it to make a good  
17 judgment.

18 CO-CHAIR MARTIN ANDERSON: Mark?

19 MEMBER LEVINE: While what you  
20 said is I think very appropriate for  
21 commercial groupers and others in the space,  
22 I think there is a different case to be made

1 for the particular use case of a Medicare  
2 episode grouper, which I think does require  
3 multistakeholder input in order to be  
4 acceptable in its implementation.

5 It has got to hear from everybody,  
6 methodologists and particularly from those  
7 people who are going to be affected by the  
8 output of such a grouper. These people are  
9 essential to the proper functioning of the  
10 grouper and its acceptance and its utility for  
11 actually improving care, which is the bottom  
12 line that we need to address.

13 CO-CHAIR MARTIN ANDERSON: So,  
14 maybe if you blend those two comments  
15 together, the traditional process may not work  
16 well, but could NQF design a process that  
17 would work well? Maybe.

18 MEMBER DUNN: A quick  
19 clarification. I apologize.

20 Yes, I wasn't saying that group  
21 doesn't have a role. It is just that you may  
22 need to rely on --

1 CO-CHAIR MARTIN ANDERSON: Right.

2 MEMBER DUNN: -- the experts to  
3 inform that group.

4 CO-CHAIR MARTIN ANDERSON: I think  
5 similar things have come up on other  
6 technically-complex topics. So, it doesn't  
7 sound brand-new.

8 Marjorie?

9 MEMBER KING: Yes, and I just want  
10 to go with what Mark said. Mark's group has  
11 groomed -- how many hundreds of doctors are  
12 involved, providers are involved in clinical  
13 work groups through the Medicare groupers?

14 So, we have a little knowledge is  
15 dangerous knowledge, but, given a lot of  
16 guidance from a Technical Advisory Panel, I  
17 think it could give some meaningful input, not  
18 just for the Medicare grouper, but also for  
19 the commercial groupers as well. So, I think  
20 it is doable to have a multistakeholder  
21 process.

22 CO-CHAIR MARTIN ANDERSON: Thank

1 you.

2 Any comments on the telephone?

3 MEMBER LOISELLE: Yes. This is  
4 Jim Loiselle.

5 I agree with that. It seems, if  
6 we are focusing on just the needs of CMS and  
7 what their full plans are for deploying this,  
8 that in a different forum with the right time,  
9 that we could come to sort of consensus on  
10 supporting CMS and their activities.

11 I think a broader question around  
12 commercial groupers for non-CMS business is  
13 probably, as others have stated, probably more  
14 problematic.

15 MR. DE BRANTES: Yes, this is  
16 Francois.

17 So, that, though, doesn't sound  
18 like a, quote/unquote, "endorsement," more  
19 than setting up a series of expert panels,  
20 independent, maybe convened by the NQF, that  
21 would have a role in reviewing and providing  
22 input to, but falling short of an endorsement.

1 Because, again, I think as we said, there are  
2 implications of that endorsement which create  
3 problems and lots of unintended consequences.

4 One of the roles that I think NQF  
5 could have that would be very helpful for  
6 everyone in the field, commercial groupers,  
7 Medicare, you know, anyone, is to focus on the  
8 definitions of the episode. Because I think  
9 of those very much like the definitions of a  
10 quality measure or any other measure where you  
11 have to define what is the population that  
12 would be included in this particular measure.  
13 So, in other words, what is the denominator?

14 As Chris Tompkins mentioned  
15 earlier, all these groupers have at least one  
16 similar feature, which is they have lists of  
17 codes, diagnosis codes and procedure codes,  
18 that are assigned to any given episode.

19 And I think that having really  
20 significant heterogeneity in different  
21 groupers around the country of those specific  
22 definitions is problematic. And so, that is

1 an area where I think NQF could have a very  
2 powerful role in creating needed alignment.

3 After that, the specific  
4 decisions, as we have discussed, around do you  
5 single assign a service, do you multi-assign,  
6 do you do this, do you do that, what are you  
7 going to use it for, how are you going to  
8 measure, is a different issue. But at least  
9 if we have a common set of core definitions of  
10 what is the denominator for a diabetes  
11 episode, that would be very helpful.

12 CO-CHAIR MARTIN ANDERSON: Thank  
13 you.

14 Mark, did you still want to say  
15 something? Okay.

16 So, the next question I am going  
17 to rephrase because I think it is hard to  
18 understand it the way that it is written  
19 there. So, Taroon has given me a new way to  
20 say this, which is:

21 "Would you expect to see a quality  
22 signal in an episode?" So, the relationship

1 between an episode and quality, not just cost,  
2 looking forward.

3 So, David?

4 MEMBER HOPKINS: So, from the  
5 nature of the data that drives the episode  
6 grouper, I could see some signals about  
7 process quality. I can't see serious outcomes  
8 being judged. And I hope when we talk about  
9 quality, we keep driving towards outcomes, and  
10 that is not in these data, for the most part;  
11 some are.

12 CO-CHAIR MARTIN ANDERSON: No,  
13 only financial outcomes is the ones that --

14 MEMBER HOPKINS: Yes, I mean, I  
15 get the complications, things like that, you  
16 can sometimes pick up.

17 MEMBER MACURDY: Wait. I mean, if  
18 you have a hospitalization, that is high-cost.  
19 If you got a lot of that, it is high-cost.  
20 Those are outcomes.

21 MEMBER HOPKINS: Yes, but they're  
22 not clinical outcomes.



1                   MEMBER MACURDY: Well, it depends  
2                   on --

3                   MEMBER HOPKINS: Did the patient  
4                   get better?

5                   MEMBER MACURDY: -- what gets  
6                   counted as hospitalization.

7                   MEMBER HOPKINS: Yes.

8                   MEMBER MACURDY: All  
9                   hospitalizations may not get counted. Suppose  
10                  it is one related with a particular kind of  
11                  service --

12                  MEMBER HOPKINS: Yes.

13                  MEMBER MACURDY: -- that was  
14                  provided.

15                  MEMBER HOPKINS: Well, what I am  
16                  talking about is the result of healthcare; did  
17                  the patient get better? That is what I mean  
18                  by an outcome.

19                  CO-CHAIR MARTIN ANDERSON:  
20                  Immediate outcomes. He's looking at final  
21                  outcomes.

22                  Marjorie?

1                   MEMBER KING: It may not be part  
2 of the endorsement of this measure, but it  
3 needs to linked to in some way eventually.  
4 The example of the hip fracture patient, so  
5 the hip fracture patient goes home, doesn't  
6 get home care services, doesn't get anything,  
7 and is stuck at home. It needs to be linked  
8 in some way to a functional outcome or a  
9 health outcome or something.

10                   Again, I think it will increase  
11 acceptability by providers and it will  
12 increase acceptability by patients. An  
13 unintended consequence could be driving the  
14 cheapest cost at the expense of outcomes,  
15 functional outcomes and medical outcomes.

16                   CO-CHAIR MARTIN ANDERSON: Okay.  
17 Mark?

18                   MEMBER LEVINE: There are some  
19 clinical outcomes that you can get from a  
20 grouper, occurrence of post-op infections and  
21 complications of various natures,  
22 readmissions, and things like that, which are

1 measurable quality measures, not really good  
2 ones, the kinds of ones that all of us --

3 MEMBER HOPKINS: They are measures  
4 of bad quality, though.

5 MEMBER LEVINE: I'm sorry?

6 MEMBER HOPKINS: They are measures  
7 of bad quality.

8 MEMBER LEVINE: Well, yes, yes.  
9 Yes, they are measures of bad quality.

10 But, also, we need to evolve a  
11 structure -- I am going to call it a  
12 "skeleton" -- upon which we can eventually  
13 graft the muscles and the ligaments and the  
14 organs in order to have a fully functional  
15 system that will inform simultaneously upon  
16 both resource use and quality in terms of  
17 positive outcomes as well as negative  
18 outcomes. And it has to start someplace.

19 So, what I am hoping is that we  
20 can evolve such a skeletal system coming from  
21 the grouper looking at available information,  
22 which is basically claims, but in the near

1 future be able to add to that quality measures  
2 that might come from our PQRS system or from  
3 electronic data or from the Hospital Quality  
4 Reporting System, a variety of other things.  
5 Eventually, who knows? Registries and other  
6 kinds of activities that might, then, further  
7 populate this kind of data, which is starting  
8 with claims data, but might eventually get  
9 someplace that would be a better place for it  
10 to be.

11 We can't put it where we want it  
12 now. We have got to start someplace.

13 CO-CHAIR MARTIN ANDERSON: Okay.  
14 Steve?

15 MEMBER BANDEIAN: Actually, I  
16 think Mark pretty much said 98 percent of what  
17 I would have said.

18 I do think that the grouper  
19 technology actually does have the capability  
20 of generating a huge number of meaningful  
21 outcome measures at this point in terms of  
22 complications, readmissions, retreatments,

1 even a very simple thing, which is how long  
2 does the episode last, meaning kind of that is  
3 sort of a mark of how long it took to get  
4 resolved.

5           Depending upon the actual grouper  
6 system, we could look at issues such as delay  
7 in diagnosis, misdiagnosis, acute  
8 exacerbations, disease progression in terms of  
9 stage.

10           And you put these all together  
11 and, yes, they are not an SF-36 or SF-12, but  
12 these are actually pretty important, as you  
13 say, negative outcomes, I suppose. But if you  
14 don't see those, what that is saying is that  
15 the patient sailed through the process, got  
16 better, and everything was fine.

17           CO-CHAIR MARTIN ANDERSON: Thank  
18 you.

19           Dan?

20           MEMBER DUNN: Yes, I agree with  
21 the points so far. Just maybe one comment,  
22 though. It is not always going to work well

1 to try to think of step one; an episode  
2 grouper runs. You have all the instance of an  
3 episode, all the service that gathered to it,  
4 and so on.

5 You may have a case, I think,  
6 Steve, a few good examples, where you may be  
7 able to mine the data that went through that  
8 episode and create a quality measure. But in  
9 many cases you are going to need to have the  
10 quality measure and the episode methodology be  
11 separate.

12 An example could be that a service  
13 that is really important falls outside the  
14 episode or it could be even collecting  
15 together episodes that make sense. So, they  
16 don't necessarily go together. It is not  
17 always going to work, but it is worth thinking  
18 about when they can.

19 CO-CHAIR MARTIN ANDERSON: Thank  
20 you.

21 Tamara?

22 MS. SIMON: I finally got to the

1 comment that I was thinking about making  
2 earlier. And I apologize because this is a  
3 little bit of a secular comment.

4 But I would certainly hope that an  
5 episode grouper would ultimately be tied to a  
6 quality measure. And I guess I am a little  
7 bit concerned about some of it. My comment I  
8 guess goes back to intended use, as well as  
9 unintended consequences.

10 And there has been this push in  
11 the adult world to look at readmission rates,  
12 and that has trickled down into the pediatric  
13 world, where our providers are getting dinged  
14 for readmissions. We have really found in  
15 children readmissions -- I know there is the  
16 debate in the adult world about how much  
17 readmissions are preventable, but they are  
18 really not preventable in the vast, vast  
19 majority of pediatric cases.

20 So, I guess I just think these  
21 specifications need to be made very  
22 explicitly, narrowly, or at least with the

1 knowledge that they may be broadly applied and  
2 have huge ramifications.

3 CO-CHAIR MARTIN ANDERSON: Thank  
4 you. That's a good point.

5 Anyone on the telephone want to  
6 comment on this particular question?

7 (No response.)

8 Okay. Oh, David, sorry.

9 MEMBER HOPKINS: Just sort of a  
10 summary of what I think I have heard is two  
11 different questions. That last one is the  
12 bigger one: outside of the episode grouper,  
13 are there quality measures? That is a whole  
14 issue that NQF I think is looking at.

15 Inside the episode grouper, what  
16 we have heard is there are, in fact, markers  
17 of quality, usually bad quality, that you can  
18 use a grouper to identify and diagnose and,  
19 hopefully, use for quality improvement. That  
20 is all great stuff.

21 I would just point out that, from  
22 a measurement point of view, it is sort of



1       redundant to look at the resource use and say,  
2       gosh, there are a lot more resources going  
3       into the care of this patient. Why is that?  
4       Because they had complications that shouldn't  
5       have happened, or whatever you guys cited.  
6       That is an issue in itself.

7                   And then, what led up to it is  
8       kind of under the surface and important to  
9       understand if you are going to do quality  
10      improvement, but I am not sure it is an  
11      independent signal.

12                   CO-CHAIR MARTIN ANDERSON: Helen?

13                   DR. BURSTIN: Just a quick build-  
14      on to David's comment. I think that is a  
15      really important consideration. I think that  
16      in this day and age the idea that we would be  
17      putting a lot of emphasis on quality measures  
18      emerging from claims only without thinking  
19      about a more hybrid approach of bringing in  
20      increasingly the available good clinical data  
21      coming off of electronic systems or patient  
22      self-reports, it is just I think we would want

1 to see this as part of that bigger system, but  
2 I don't think we want to go back to the days  
3 where quality signals are completely driven  
4 off claims alone.

5 CO-CHAIR MARTIN ANDERSON: Great.

6 Okay. So, now the very broad  
7 question: "Any other considerations, if you  
8 think about the path forward, to evaluate and  
9 endorse episode groupers?" These are maybe  
10 some of our summary comments, anything you  
11 feel like you haven't shared that the Working  
12 Group, whose full-time job it is to take into  
13 account all of these wonderful comments should  
14 have on their minds.

15 I have one I will just offer,  
16 which is that we are talking about -- I think  
17 the word "path" is right. You know, we are  
18 talking about going potentially down a path of  
19 endorsing what is effectively software.

20 And there are some little pieces  
21 of that in the past, say around risk  
22 adjustment, which is usually represented in

1 software ultimately, and more and more so as  
2 e-measures come onboard we start to look at  
3 implementation of measures in software.

4 I don't think that is something  
5 NQF should take lightly. It may have future  
6 implications for how you think about  
7 endorsement. And the systems, right now, we  
8 can separate the measure from the system it is  
9 embedded in. And in this case, it is hard to  
10 do that, to take this algorithm and divorce it  
11 from the system it is embedded in.

12 So, there may be some other  
13 thinking that NQF could do about where are we  
14 headed that this might be just a signal for.  
15 So, on the one hand, you could say maybe we  
16 just won't go down this road right now; we are  
17 not ready to deal with that, but it doesn't  
18 mean it is going away. There will be another  
19 instance of embedded measurement and software  
20 that will take a different form. So, maybe  
21 thinking about that more broadly might help  
22 decide what to do with episodes.

1                   MR. DE BRANTES: Well, Kristine,  
2                   this is Francois.

3                   Just to emphasize your point, and  
4                   so that the rest of the Committee members can  
5                   think about these types of unintended  
6                   consequences, last year the NQF endorsed the  
7                   HealthPartners Total Cost of Care measure,  
8                   which has embedded in it the Johns Hopkins  
9                   Severity Adjustment Formula. And the measure  
10                  was adopted with that severity adjustment  
11                  software specifically.

12                  And today you have got communities  
13                  around the country who are doing some pilots  
14                  and testing this measure, and they have all  
15                  been handcuffed because the endorsement  
16                  included very specifically the commercial  
17                  software for which there is a license fee, and  
18                  as a result of which they feel that they can't  
19                  move away from that particular software and  
20                  using the HealthPartners Total of Cost of  
21                  Care, although there is no evidence whatsoever  
22                  that that particular risk adjustment software

1 any better. And with all due respect, because  
2 I know someone from Johns Hopkins is here, but  
3 there is no real true evidence that a severity  
4 adjustment model is significantly better than  
5 another one.

6 So, I just think we need to be  
7 very cautious about this. Because when you do  
8 get into the business of endorsing more than  
9 just a measure, but software, it does have  
10 unintended consequences.

11 CO-CHAIR MARTIN ANDERSON: Dan?

12 MEMBER DUNN: I am not disagreeing  
13 with Francois' point or yours, Kristine, but  
14 maybe it is a point of clarification. I think  
15 you need to make a distinction between  
16 methodology, which ACGs is a methodology.  
17 Some of these groupers are a methodology in  
18 software.

19 Because even with HEDIS measures  
20 there's probably a hundred different software  
21 systems out there that take the same exact  
22 methodology from HEDIS. So, just in terms of

1 terminology, I think you should describe it,  
2 if it is a more global methodology or  
3 something that you are picking one piece out  
4 of, but it is really not -- NQF shouldn't be  
5 in the business of endorsing software I guess  
6 would be my thought then.

7 CO-CHAIR MARTIN ANDERSON: Yes.  
8 Yes, I get your point. There can be  
9 distinctions there. I think just that they  
10 are embedded.

11 Largely, it would be hard, though,  
12 to take a measure you can do by hand, like  
13 literally you do it; you write it all out; you  
14 could do it by hand. It would be very hard to  
15 do episodes by hand, right?

16 MEMBER DUNN: I think it depends  
17 on the system.

18 (Laughter.)

19 Yes, I'm serious.

20 CO-CHAIR MARTIN ANDERSON: You're  
21 smarter than me, yes. Not by hand, sorry. I  
22 hear you. But I hear you. The language is

1 important is the point you're making.

2 MEMBER DUNN: Yes.

3 CO-CHAIR MARTIN ANDERSON: And I  
4 think that is a very good point.

5 MEMBER DUNN: Because you could  
6 endorse, say ETGs, for example, as a  
7 methodology, and say there was someone else  
8 who took it and built it into their own  
9 software. That is a whole totally different  
10 thing, right?

11 CO-CHAIR MARTIN ANDERSON: Thank  
12 you. Right, right.

13 Your point is that we're not  
14 actually endorsing an application, a software  
15 application. It is really the methodology.  
16 I get that, yes.

17 Chris?

18 MEMBER TOMPKINS: Maybe we are  
19 reacting a little bit to the tying together  
20 you did sort of emphatically about software.  
21 There are some things that sort of we all have  
22 in common, like we're human and with similar

1 anatomy -- (laughter) -- and healthcare  
2 conditions, and so forth. I mean, these sort  
3 of rise above groupers.

4 And so, part of what might be --  
5 again, just in the spirit of that last bullet  
6 -- you might want to just break down the  
7 problem and say we can evaluate some things,  
8 but we would prefer not to or we can't get  
9 into other things.

10 So, just to be a little bit sort  
11 of parochial, we think of and the people that  
12 I was in the Clinical Logic Group with  
13 yesterday sort of got this from me, which is  
14 to say that we have a software application.  
15 The software application embeds in it rules,  
16 generic rules, and it offers some options.

17 But all the clinical intelligence  
18 resides elsewhere for the most part, outside  
19 the software. In other words, what is a  
20 condition? And I have sort of said this  
21 before. What are the diagnosis codes that  
22 clinicians agree on are a useful, clinically-



1 meaningful concept of that condition? And  
2 then, within that, what are various what we  
3 call subconditions that might differ in terms  
4 of etiology or manifestation or relevant  
5 services or complication risks, and so forth?

6 And then, on the procedures side,  
7 what do people actually do and bill and pay  
8 for? And to what extent are they done  
9 jointly? Or to what extent is one done  
10 subordinate to another, et cetera, like that?

11 It could be possible that that's  
12 what, as humans, we want some consensus  
13 around. And I think Francois said it in  
14 passing earlier, to say that you probably  
15 don't want groupers that are just interpreting  
16 human anatomy or healthcare differently. Why  
17 start off on something that is so basic for  
18 which there actually might be a reasonable  
19 consensus? And there might be a reason to  
20 have various perspectives meld down into a  
21 consensus about what it is.

22 And then, the software that reads

1 that can have a lot of different -- it could  
2 be written in a different language. It could  
3 be written, you know, as a large enterprise,  
4 and all these variables we talked on the  
5 software side may be left to the industry or  
6 other users in terms of how to interpret the  
7 information that essentially clinical and  
8 essentially has to do with how healthcare is  
9 provided and paid for.

10 CO-CHAIR MARTIN ANDERSON: Thank  
11 you.

12 Steve?

13 MEMBER BANDEIAN: A whole  
14 elaboration on what Chris just said. Some of  
15 the clinical logic I kind of personally regard  
16 as not matters of opinion, but kind of matters  
17 of fact.

18 And one of the sort of big sort of  
19 problems I sort of see in the general world  
20 is, if you were to ask somewhere, where is a  
21 listing of all the ICD codes that are symptoms  
22 that are recognized as being caused by

1 condition A, B, C, D, or E, to my knowledge,  
2 that does not exist anywhere.

3 And so, part of the logic that is  
4 being constructed is really sort of almost a  
5 medical encyclopedia that sort of displays  
6 more factual information rather than opinion  
7 information, that actually is pretty useful  
8 for a broad variety of purposes. I mean, that  
9 may be irrelevant for your question, but I was  
10 just amplifying on what Chris was saying.

11 CO-CHAIR MARTIN ANDERSON: No, I  
12 think that is helpful. So, what you are  
13 saying -- and I think it was said in a  
14 different way a little bit earlier -- is  
15 perhaps there is value in separating out the  
16 inputs, the clinical inputs, from the routines  
17 that they are used for in software, I mean  
18 just as a consideration.

19 The one thing that comes to my  
20 mind, though, is that, then how do you do that  
21 without getting all the way to best I class,  
22 right? Because would you recognize multiple

1 different inputs for the same clinical  
2 conditions. Just two parts.

3 And then, secondly, what, then,  
4 would be the impact, say, of payment rules?  
5 Because data often look a certain way because  
6 of the way the payment system is structured  
7 which it operates in. Would they be similar?  
8 And enough limitation on that variability that  
9 you actually could come up with a  
10 comprehensive definition across multiple  
11 different payment data sources?

12 MEMBER BANDEIAN: So, actually  
13 having worked on a fairly wide range of data  
14 sources, and seeing how they work, I actually  
15 like the Medicare data. It has got some  
16 really nice features.

17 So, yes, there are some major  
18 problems in implementing some logic off of  
19 something that is not Medicare data. However,  
20 this highly-abstract concept of let's get some  
21 medical facts out there is really not so much  
22 affected by that.

1                   Again, I am just simply saying,  
2                   for example, what are the signs, symptoms,  
3                   complications associated with various  
4                   conditions? Yes, there are business  
5                   implications and competitive implications  
6                   about that, and I have no opinion about any of  
7                   the above. But I am saying that some of the  
8                   content of the grouper, I would assume -- I  
9                   can't, obviously, speak to all groupers in the  
10                  entire universe -- but some of the content of  
11                  the grouper really is, hopefully or ideally,  
12                  things which clinicians with knowledge of that  
13                  subject area would nod their head and say,  
14                  "Yes, that's right. That's just what we all  
15                  know. We just don't have it in machine-  
16                  readable form."

17                                   CO-CHAIR MARTIN ANDERSON: Chris?

18                                   MEMBER TOMPKINS: Well, it depends  
19                                   on just how far you want to take it. I mean,  
20                                   I started with the very basics, right,  
21                                   humanity? And then, you say, okay, let's go  
22                                   from here and decide when the necessity or the

1 compelling reasons for consensus start to drop  
2 off.

3 But just picking up on what you  
4 said, this medical encyclopedia, which is the  
5 way Steve characterized it, could have either  
6 footnotes or separate chapters that say that,  
7 when you are articulating the procedure codes  
8 through a certain type of billing system,  
9 these adaptations or modifications are notable  
10 and acceptable, something like that.

11 I'm just saying that it shouldn't  
12 be a barrier to the fact that there could be  
13 different administrative systems out there.  
14 It shouldn't be a barrier to that more  
15 compelling, in my view, benefits of consensus  
16 that have to do with areas of extreme  
17 commonality that might become a useful  
18 encyclopedic reference from which NQF could  
19 say, if you're using the encyclopedia as  
20 written, then we endorse that aspect of it.  
21 And if you deviate from it, so note the  
22 deviations.

1 CO-CHAIR MARTIN ANDERSON: Thank  
2 you.

3 Taroon?

4 MR. AMIN: I was just going to  
5 say, are we --

6 CO-CHAIR MARTIN ANDERSON: That  
7 was our last question.

8 (Laughter.)

9 MR. AMIN: Well, first of all, we  
10 wanted to add one into this implication.

11 CO-CHAIR MARTIN ANDERSON: Okay,  
12 go ahead.

13 MR. AMIN: And we also have the  
14 Measures Application portion.

15 CO-CHAIR MARTIN ANDERSON: Oh, no,  
16 I meant of this section. So, I turn to you  
17 when the section is over.

18 MR. AMIN: Yes. Oh, okay. Okay.  
19 Great.

20 So, there is one additional  
21 question that we wanted to add into this  
22 implication-for-endorsement section, and one

1 of the questions Ashlie brought up, which I  
2 think is a really good one. So, we talked a  
3 little bit about the implications of endorsing  
4 essentially a methodology that would be  
5 updated on a fairly regular basis. The  
6 current endorsement/maintenance infrastructure  
7 that NQF maintains assumes that, as guidelines  
8 are updated, measures get re-reviewed to  
9 ensure that they are -- or as the evidence  
10 gets updated, that measures are re-reviewed  
11 and we have an ad-hoc review process. But,  
12 typically, measures are reviewed on an every-  
13 three-year basis.

14 What type of maintenance  
15 infrastructure would be needed to support a  
16 continued or appropriate continued endorsement  
17 of an episode grouper that we could describe?

18 MEMBER LEVINE: I could envision a  
19 process where CMS might publish these measures  
20 are due for reconsideration this year. Here  
21 is a list of them. Here are their  
22 specifications. Please comment. And just



1 make that an open and public input into the  
2 definitions that are being used to define the  
3 episodes, et cetera, and the clinical logic  
4 that is underlying their utility. And that  
5 can be done, I think, on a regular and  
6 recurring basis in an open and a public  
7 manner, similar to rulemaking.

8 MR. AMIN: Okay. If there are no  
9 other comments, I just want to remind the  
10 group, separate from endorsement, but related,  
11 obviously, in very clear ways, NQF convenes  
12 the Measures Applications Partnership who is  
13 tasked with providing HHS with guidance in its  
14 pre-rulemaking activities. And this February  
15 the MAP reviewed 46 condition-specific  
16 measures that were the result of the episode  
17 grouper, and the MAP specifically  
18 conditionally supported these measurement  
19 concepts, pending NQF endorsement, recognizing  
20 that these measures were critical to the  
21 Value-Based Payment Modifier.

22 So, there are some questions here

1 that we have that I will just run through, and  
2 then, I will turn it back to Kristine again.

3 The first is, what is the  
4 implication -- so, I will say this is we are  
5 departing a bit from a general conversation  
6 about episode groupers and going to specific  
7 conversation about the Medicare grouper and  
8 its particular application for the Physician  
9 Feedback Reporting Program and the Value-Based  
10 Modifier.

11 So, the questions we have here  
12 are: "What are the implications of NQF  
13 endorsement on the use of the episode grouper  
14 for the specific applications; for instance,  
15 the Value-Based Payment Modifier?"

16 "Is there specific implementation  
17 guidance that the Committee would offer future  
18 MAP Work Groups in the evaluation and  
19 selection of episode grouper measures for the  
20 Physician Feedback Program and the Physician  
21 Value-Based Modifier?"

22 Third, "The MAP currently

1 evaluates episode grouper by selecting  
2 individual measure concepts within it; for  
3 example, a lung cancer condition episode. Can  
4 individual episodes within a grouper be  
5 selected for implementation of the Value-Based  
6 Modifier without considering the cost assigned  
7 to other co-occurring conditions for an  
8 individual patient?"

9 And finally, "What are some of the  
10 considerations for the path forward in  
11 selecting episode grouper measures for  
12 specific applications?"

13 CO-CHAIR MARTIN ANDERSON: I just  
14 want to verify some common knowledge. Does  
15 everyone here know what the MAP does? Can you  
16 raise your hand if you know what it does? If  
17 you do know?

18 (Show of hands.)

19 Okay, that is a very small group  
20 to have the conversation. So, Taroon, I think  
21 you're going to have to give them more context  
22 on the scope of the MAP and why they are

1 looking at this issue.

2 MR. AMIN: Okay. So, maybe Mark  
3 can help me, too, because there is a lot of  
4 this pre-rulemaking activities that I am  
5 actually not that familiar with, either.

6 But, from my understanding, the  
7 MAP -- actually, Helen, why don't I turn it to  
8 you?

9 (Laughter.)

10 DR. BURSTIN: I am sure you could  
11 do it.

12 So, the MAP is a group that is a  
13 multistakeholder partnership as well that is  
14 charged by HHS with providing input to CMS, in  
15 particular, on pre-rulemaking. So, when  
16 measures are up for particular programs --  
17 should this measure be part of the Value-Based  
18 Purchasing Program for hospitals, should this  
19 measure be part of PQRS for physicians, for  
20 example -- that group is, then, charged with  
21 looking specifically at whether that  
22 particular measure would be beneficial to that

1 program, and not necessarily looking at the  
2 scientific acceptability of the measures in  
3 the way we have been talking for the last two  
4 days.

5 So, more so, does it fit within  
6 the context of that program? Does this offer  
7 an important piece of measurement that would  
8 help improve that program? So, a much more  
9 programmatic view, it is a recommendation to  
10 CMS about whether that measure should be  
11 included in the various programs for  
12 rulemaking going forward.

13 CO-CHAIR MARTIN ANDERSON: Clear?  
14 Did that help? Okay. So, now we will go back  
15 to the questions.

16 So, Taroon, I just want you to  
17 help me with one thing.

18 MR. AMIN: Yes.

19 CO-CHAIR MARTIN ANDERSON: When  
20 you say, "What are the implications of NQF  
21 endorsement on the use of an episode grouper  
22 for specific applications" -- yes?

1 DR. BURSTIN: Having sat through  
2 this discussion at the MAP, for example, part  
3 of what -- and Corette is here from CMS as  
4 well -- so, part of what came to NQF as part  
5 of the review for the MAP this year were  
6 several of the episode-based grouper measures.  
7 And so, the question is, it was difficult, I  
8 think, for the MAP to evaluate those measures  
9 without a lot of context, without a lot of  
10 information, frankly, about how they would be  
11 constructed.

12 So, I think the question here is,  
13 how would the endorsement process for those  
14 potentially be helpful to the broader process  
15 of thinking about which measures are  
16 appropriate for which applications, pay-for -  
17 performance, penalties, et cetera?

18 MR. AMIN: And maybe the goal here  
19 is just to really address maybe Question 3,  
20 yes, Question 3, which, effectively, the MAP  
21 was given the 46 condition-specific episode  
22 measures. And so, there is this broader

1 question I think we have sort of alluded to,  
2 had some conversation around. But,  
3 essentially, they are selecting individual  
4 measure concepts from the episode grouper.  
5 So, the main question is, can individual  
6 measures within the grouper be selected for  
7 implementation without considering how costs  
8 are associated with other co-occurring  
9 conditions for an individual beneficiary or  
10 patient? Well, in this case, the beneficiary.

11 CO-CHAIR MARTIN ANDERSON: Chris?

12 MEMBER TOMPKINS: That is a  
13 variation of the question I asked before. So,  
14 I will just take out the phrase "within a  
15 grouper". Can individual measures be selected  
16 for implementation without considering how  
17 costs were assigned to other co-occurring  
18 conditions?

19 That is what I am saying, is that  
20 as soon as you say that here is a resource use  
21 measure for a condition, you either have a  
22 grouper that has in front of you a hopefully

1 consistent, logical basis for doing that or  
2 you have a standalone measure. And it is left  
3 to the imagination of the reviewer as to how  
4 the costs are individually assigned to that  
5 condition versus other ways in which the same  
6 dollar may have been used.

7 MR. AMIN: So, when you asked the  
8 question the first time, I was debating  
9 whether we should go down this road. I think  
10 it is obviously a very important question.

11 I think the difference in the way  
12 that NQF has looked at that, those two types  
13 of resource use measures in the past, is the  
14 complication of measures that are outputs,  
15 essentially, of an episode grouper is that the  
16 decision logic or the tiebreaker logic, as we  
17 have discussed here the last two days, is not  
18 always clear, transparent, or understandable,  
19 meaning that when there are potentially two  
20 co-occurring conditions, how the individual  
21 dollar is either single-counted, double-  
22 counted, or just attributed to another episode



1 that is present for the patient is not always  
2 clear. When you are looking at just an AMI  
3 sort of measure that is coming out of a  
4 grouper, you might not know that that cost  
5 went to, for example, the diabetes measure.

6 CO-CHAIR MARTIN ANDERSON: And  
7 Chris is making the point that that is at  
8 least discoverable, if it is an episode  
9 grouper, and it is not discoverable if it is  
10 just a standalone measure, right?

11 MR. AMIN: And that's fair.

12 CO-CHAIR MARTIN ANDERSON: Right.  
13 So, the same issue is present is your point,  
14 right?

15 MEMBER TOMPKINS: It seems to me  
16 it is worse if you don't have the grouper --

17 CO-CHAIR MARTIN ANDERSON: Right,  
18 because it is not discoverable.

19 MEMBER TOMPKINS: -- because you  
20 don't have that articulation of the rules that  
21 were used.

22 CO-CHAIR MARTIN ANDERSON: Right.

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Mark?

MEMBER LEVINE: If there were an NQF-endorsed episode grouper for Medicare resource use, then that would obviate and shortcut your having to review individually in great detail each one of those 46 measures. You could, instead, concentrate on whatever other aspects of the measure that you wish, but you would be confident that the construction process that led to the measure met a certain degree of standard, stakeholder input, peer review, a variety of other kinds of things that would be useful.

So, I think it would make your review of the individual MAP measures to be much more efficient if there were the presence of an endorsed Medicare episode grouper.

CO-CHAIR MARTIN ANDERSON: David?

MEMBER HOPKINS: I am thinking exactly like Mark. So, MAP is in the business of providing advice to CMS specific to their use of measures for the Medicare program.

1 CMS is also developing an episode  
2 grouper. It seems to be very logical that NQF  
3 have a mechanism for evaluating the grouper,  
4 you know, as a grouper. Take all the great  
5 ideas that have come up here and apply those  
6 in that process, and set up a process to do  
7 that.

8 Medicare is not using commercial  
9 groupers. So, why bog it down with that? Why  
10 bog NQF down with that? It is a separate  
11 issue.

12 CO-CHAIR MARTIN ANDERSON: Okay.  
13 Yes, I hear you.

14 And my take on the specific  
15 question around without considering -- it  
16 seems to me that the MAP would want to  
17 understand what the rules were, right? So,  
18 they know at least what it is they are  
19 accepting as an episode relative to other  
20 common conditions that would be co-associated  
21 with that episode.

22 But, to David's point, if they

1 were comfortable with the grouper, over time  
2 that would get easier, right, because they  
3 would come to understand how the grouper  
4 operates, and it would be transparent, but for  
5 this purpose of specifically to advise  
6 Medicare.

7 Something else you want to get out  
8 of this part of the conversation?

9 We have exhausted Taroon.

10 MR. AMIN: Well, we still have  
11 Evan.

12 CO-CHAIR MARTIN ANDERSON: Yes, I  
13 know. Okay. It is time for Evan.

14 MR. AMIN: I will turn it over to  
15 Evan for the next steps.

16 MR. WILLIAMSON: Okay. We'll see  
17 if I can get through this.

18 So, at this point, we will take  
19 all the feedback we received over the last day  
20 and a half, almost two days; we'll say two  
21 days, the last two days, what feels like four  
22 days. And we are going to summarize that into

1 a report that we will provide back to you for  
2 comment.

3 We are going to have two post-  
4 meeting calls. They will be needed. We are  
5 anticipating to use both of those. I think  
6 there is a lot of reacting to what we put  
7 together that we are still going to want input  
8 from the group on before this goes out for  
9 public and member comment.

10 So, we are anticipating to be able  
11 to put that report out by March 24th. We have  
12 a post-comment call on May 14th where we will  
13 consider all the comments we receive. If we  
14 receive a lot of comments, we may need to  
15 schedule additional time, but I am hoping we  
16 can just use that two-hour block to get  
17 through all the comments.

18 And then, following that, we will  
19 adjust the report as necessary and get our  
20 CSAC and Board approval by July.

21 I guess, at this point, are there  
22 any questions or comments, concerns, feedback

1 about the meeting? Anything you want to share  
2 with us?

3           Again, we will take some comments  
4 right now, but if something comes to you after  
5 the meeting and you want to send us an email  
6 or provide feedback, we are happy. I know  
7 last night someone mentioned that they were  
8 thinking about something that they wanted to  
9 send afterwards. Please feel free to send us  
10 any post-meeting feedback, whether it be about  
11 the meeting itself or about the content area,  
12 anything that we are going to be putting into  
13 the report. Please do that.

14           So, I will open it up. Are there  
15 any final comments, questions?

16           Everybody just wants to get out of  
17 here?

18           (Laughter.)

19           CO-CHAIR MARTIN ANDERSON: I would  
20 just like to thank all of you. Really, really  
21 great input, and you made this job a lot  
22 easier.

1 MR. AMIN: And thank you for the  
2 Chairs, obviously.

3 (Applause.)

4 MR. WILLIAMSON: At this point, I  
5 will open it up. Are there any public  
6 comments in the room?

7 (No response.)

8 Operator, can you please open the  
9 lines for public and member comment?

10 THE OPERATOR: If you would like  
11 to ask a question, please press \*1.

12 (Pause.)

13 There are no questions at the  
14 moment.

15 MR. WILLIAMSON: Thank you very  
16 much.

17 This ends the call. Thank you.

18 (Whereupon, at 1:55 p.m., the  
19 meeting was adjourned.)

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22

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