

# Episode Groupers

## Key Considerations for Implementing Clinical Episode Models



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## Executive Summary

As the health care industry pushes forward on value-based payment and care delivery, sustaining focus on commercial-sector value models is crucial. In particular, uptake of clinical episode payment models (also referred to as bundled payment initiatives) in commercial contracting has been decidedly slower and more fragmented compared to federal efforts such as the Medicare Bundled Payment for Care Improvement program.

Part of the challenge to widespread commercial insurer adoption lies in the identification and implementation of infrastructure to support clinical episode payments. Among the digital infrastructure required are episode groupers, which are software programs that organize fee-for-service claims into a predetermined package of services for a particular condition or procedure. The claims are linked using clinical logic that aggregates related services within a specified time period. Episode groupers have widespread utility, yet this paper focuses solely on their application to clinical episode payment models.

Episode groupers are key to successful bundled payment implementation, but the vast array of permutations in how they can be applied has made it difficult for the industry to assess available options and develop guidance. Limited evaluations have concluded that endorsement of episode groupers is challenging because the software is highly customizable and technology is changing rapidly, and any further evaluation of episode groupers should be based on criteria that evaluate intended use, transparency, and reliability/validity.

This paper delves further into the evaluation criteria described above. It examines episode groupers and clinical episode payments within context of the following four categories: (1) defining the focus and duration of the episode; (2) differentiation across patient groups; (3) differentiation between subgroups within similar diagnosis groups; and, (4) attributing services and costs to the episode.

Key insights from each of the four categories include:

### **Defining the Focus and Duration of the Episode**

- Clinical data limitations are a factor in decisions about the focus and duration of episodes.
- Rules on how an episode is triggered vary, but strength of a chosen trigger can be measured by factors such as the number of false positives and false negatives.

### **Differentiation Across Patient Groups**

- There are challenges in how episodes are grouped together; they can be split into smaller groups or lumped together in larger bundles.

- Lumping can result in wide clinical variation and inaccurate payments, while splitting can result in narrowly defined episodes that occur infrequently and for which estimating appropriate payments prove difficult.

### **Differentiation Between Subgroups Within Similar Diagnosis Groups**

- Accounting for variations in risk and severity of clinical conditions is important because it allows providers to be measured on outcomes or processes they can influence, rather than underlying differences in patient severity.
- Strategies for addressing risk within patient subgroups may include historical cost assessment, risk stratification, and use of post-grouping supplemental risk modification.

### **Attributing Services and Costs to the Episode**

- Fairly and appropriately attributing services and costs to an episode can be challenging. Grouper rules for cost attribution are often complex due to multiple diagnosis and procedure codes that may fall within a single patient episode.
- Grouping claims into episodes requires making decisions about whether to assign each line of a claim separately or assign claims in their entirety. Similarly, grouper logic should decide whether multiple codes within a line should be grouped together or split apart.

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## **A. Introduction**

While adoption of commercial-sector bundled payments has gained some traction in recent years, there is relatively little freely accessible, detailed information on the costs and benefits of those programs. Implementing a clinical episode payment contract requires setting a reasonable price and monitoring whether the actual costs of the medical episode were greater or lower than the negotiated price. Given payers have historically paid providers for each unit of service, most providers are challenged to determine the comprehensive price for an episode of care that accounts for both clinician and facility costs.

Software applications referred to as “groupers” sort through claims data and group individual fee-for-service claims into an episode of medical care. Grouping is one of many approaches that have been used to measure costs across an episode of care. Groupers apply a series of decision points to patient data to ultimately assign the patient’s episode to a specific category. Episode groupers determine the way claims are bundled together, the events that trigger (initiate) or include an episode, and the quality of data outputs that can be used to assess performance or resource utilization.

As interest grows in defining episodes that extend beyond the discharge from the hospital, or

apart from hospitalizations altogether (e.g., disease-based episodes), episode groupers play an increasingly important role. Payers need to be able to reliably predict the costs to treat certain types of patients and pay accordingly. At the same time, providers desire a way to assess their own costs relative to the episode payments, in order to identify opportunities for improvement. Ultimately, the design of the episode is dependent upon the capabilities (and limitations) of the chosen grouper.

Evaluation of episode groupers has been historically challenging because of the large number of permutations, and because technology continues to evolve at a rapid pace. In a 2014 report, the National Quality Forum (NQF) addressed episode grouper evaluation, the result of several months of technical review.<sup>1</sup> The report concluded that endorsement of episode groupers is inherently challenging due to the factors described above, and further evaluation of episode groupers should be based on criteria that evaluate intended use, transparency, and reliability/validity.

Building upon the NQF report, this paper touches upon four key areas:

- (1) defining the focus and duration of the episode;
- (2) differentiation across patient groups;
- (3) differentiation between subgroups within similar diagnosis groups; and,
- (4) attributing services and cost to the episode.

The use of episode groupers to better understand healthcare costs, in concert with the limited transparency and inherent complexity of their methodologies, has created the need for an evaluation framework. This paper focuses on the most common, yet critical, decision points that distinguish groupers for clinical episode payment models and provides a basic framework for grouper evaluation. It is intended to assist organizations as they pursue bundled payment contracting and advance industry knowledge of clinical episode grouping.

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## B. Background

### Understanding Episode Groupers

Episode groupers are software applications that define episodes based on choices made using available data. Specifically, a grouper is the software and underlying decision logic that assigns

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<sup>1</sup> National Quality Forum. 2014. Evaluating Episode Groupers: A Report from the National Quality Forum. [http://www.qualityforum.org/Publications/2014/09/Evaluating\\_Episode\\_Groupers\\_A\\_Report\\_from\\_the\\_National\\_Quality\\_Forum.aspx](http://www.qualityforum.org/Publications/2014/09/Evaluating_Episode_Groupers_A_Report_from_the_National_Quality_Forum.aspx). Accessed December 5, 2018.

patient claims to clinically relevant episodes of care. Defined by the NQF Episodes of Care Measurement Framework, an episode is “a series of temporally contiguous healthcare services related to the treatment of a given spell of illness or provided in response to a specific request by the patient or other relevant entity.”<sup>2</sup>

Groupers can either be provider or patient-centric. Provider-centric groupers focus on the patient care claims that are assigned to the provider and are typically used for tracking provider resource utilization. Patient-centric groupers are focused upon total cost of care for an individual.

The role of episode groupers is to determine what constitutes an episode, define how claims are bundled together, and weigh the quality of data outputs that can be used to assess performance or resource utilization. Groupers can create hundreds of condition-specific episodes using complex decision logic to decide which episode a claim should be attributed to. This logic is driven by the intended use of the grouper and can be applied to identify the events that initiate or conclude an episode, determine inclusions and exclusions, and address risk and severity.

There are several possible components of a grouper’s decision logic, including:

- **The definitions of episodes of medical care.** These definitions typically include the groups of diagnosis and procedure codes that are considered relevant to that episode, the time period during which the episode is deemed active/open, the mechanism by which the episode would be considered triggered or initiated, and any other variable that could be specific to that episode.
- **The rules to group/assign claims to the episode.** The purpose of these rules is to determine the set of criteria that a claim must meet in order to be assigned to a specific episode and for the costs of the services on the claim to be attributed to the episode.
- **Adjusting for severity of the patient and/or the episode.** This step is typically taken to adjust prices based on a reasonable expectation that a given patient or episode “sub-type” could justify a higher/lower use of services and, therefore, a higher/lower overall price for the bundle of services associated with the episode of medical care.

For example, Hospital Diagnosis Related Groups (DRGs) were one of the first groupers used to implement payment bundles. DRGs begin and end based on the patient’s hospital admission and discharge dates. The initial assignment criterion is the principal diagnosis for the admission, but there are additional assignment criteria such as whether a procedure occurred, and the clinical and resource similarity of cases grouped within each DRG. The DRGs are then further split based on the presence or absence of comorbidities or complications. With few

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<sup>2</sup> National Quality Forum. Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care. 2010. [http://www.qualityforum.org/Publications/2010/01/Measurement\\_Framework\\_Evaluating\\_Efficiency\\_Across\\_Patient-Focused\\_Episodes\\_of\\_Care.aspx](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework_Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx). Accessed December 6, 2018.

exceptions, all hospital costs are attributed to the DRG payment.

## Benefits and Limitations of Episode Groupers

With a grouper, a user can group services to manage a specific condition or procedure and analyze utilization patterns to glean a better understanding of an episode's total cost and link services administered by different providers in different settings to an episode. Groupers also enable users to examine concurrent clinical episodes by capturing costs for multiple conditions during the same time frame.

Despite their shared purpose, groupers are designed by various developers and significantly differ in their approach to claims attribution. Combined with differing use based on the needs and preferences of specific markets or populations, this limits the comparability of groupers and their results.

Furthermore, despite an aspiration to capture the cost for “appropriate” care, most groupers sort and attribute all eligible claims by relevance to the clinical condition rather than selectively attributing claims that represent clinically-appropriate care based on guidelines. The role of clinical guidelines in assessing the cost for appropriate care is limited to post-grouper analysis when user-defined rules can intervene.

Most episode groupers today are designed to break down administrative claims into clinical episodes, leaving groupers reliant on only administrative claims data. However, development efforts are exploring how data from electronic health records and clinical registries can be used to supplement administrative claims data to more fully capture and understand utilization.<sup>3</sup> Groupers are constantly subject to refinement and modernization to retain maximum effectiveness.

Episode grouping software generally uses a retrospective approach, using administrative claims data to identify and attribute services previously provided to the episode of care. This approach provides information on cost and performance based on the end of the measurement period. To move out of fee-for-service, episode grouping ultimately needs to transition from a retrospective to a prospective approach, where grouping attributes relevant and appropriate care services to the episode of care prior to its start. This way, providers know what they will be accountable for at the start of an episode and what services fit appropriately within that scope, so they can better provide quality care at a lower cost for patients.

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<sup>3</sup> National Quality Forum. 2014. Evaluating Episode Groupers: A Report from the National Quality Forum. [http://www.qualityforum.org/Publications/2014/09/Evaluating\\_Episode\\_Groupers\\_A\\_Report\\_from\\_the\\_National\\_Quality\\_Forum.aspx](http://www.qualityforum.org/Publications/2014/09/Evaluating_Episode_Groupers_A_Report_from_the_National_Quality_Forum.aspx). Accessed December 5, 2018.

## C. Assessing Episode Groupers

As organizations convert clinical episodes into medical informatics, they must make decisions about which components to include in the software and/or rules that will facilitate the implementation of the clinical episode payment program. These decisions often reflect a certain approach to the delegation of financial risk to providers. In other instances, they can and should be based on empirical evidence. Ultimately, many of these decisions reflect trade-offs that should be understood and made explicit by all parties.

In order to evaluate which episode grouping tool is the best fit, users must consider how specific episode groupers make choices regarding key decision points using available data. These decision points distinguish groupers by their implicit episode definitions and approach to claims groupings. Determining which tool will be most effective for a given organization or situation depends on how they align in approach.

To assess episode groupers, a user must first identify those that match the scope of the episode of interest, examine the extent to which the groupers split or lump distinct patient subgroups, look at whether they establish different categories to address varying complications or severity for patients with the same diagnosis or procedure, and how the groupers attribute services and costs to the episode of care. The following is a guide to delineate some of these decisions and their implications.

### 1. Defining the Focus and Duration of the Episode

Identifying what triggers an episode and what type of clinical episode should be started are key to how a grouper defines and constructs an episode. The first step in evaluating groupers is to identify those that match the scope of the episode of interest. The scope of episodes captured by existing groupers ranges from hospital outpatient encounters to population health risk-adjusters. Because most payers and providers are already familiar with groupers for single-provider episodes, the focus here is on episodes that span across multiple providers and sites of care.

Generally, defining acute episode duration is a transparent process. It uses distinct points in time, starting with the onset of illness or injury and extending until it has been treated or healed. Procedure bundles are focused on a clearly definable scope of intervention and related follow-up care and can also be defined by a discrete time period. Framing episode scope for chronic conditions or diseases is more complex, as these clinically do not end. Typically, a 12-month period is used to capture the related services and resources utilized to treat that specific condition or disease, even though this timeframe may be unrelated to its clinical course. By definition, it is hard to define a set time frame for fully addressing chronic conditions.

It is important to understand that clinical data limitations are a factor in many decisions about

episode definition, particularly regarding focus and duration. This is particularly true for disease-specific episodes, where diagnosis codes on the claim may not be sensitive to underlying clinical variations in the stages or severity of a disease. Groupers may or may not use readily available claims data or collect additional data to increase sensitivity.

It is also important to recognize the specificity and sensitivity of triggers or rules used to begin an episode. Because payers must rely on medical claims to determine the costs of episodes and price bundles, grouper software includes rules about when to open an episode. It can be helpful to think of claims as signal carriers: those signals are diagnosis codes, revenue codes, procedures codes, or other codes. The decision to open an episode can vary based on the perceived strength of the signal carrier (e.g. facility claim) and/or the strength of the claim signal. Trigger rules can be evaluated by the number of false positives (episodes that are not real but nevertheless triggered) and false negatives (episodes that are real but not triggered) that are created. Testing can be done by taking samples of plan members with known conditions, illnesses, injuries and associated treatments, and comparing the actual clinical vignette with the software results.

The defined focus and duration of an episode can also vary depending on the scope and context of care:

- **Hospitalization and Post-Discharge Episodes** – Many payers reimburse for episodes that begin with a hospitalization and extend for a specified time (e.g., 30, 60, or 90 days) after discharge. The duration of the episode is generally dependent on the typical course of treatment and recovery.
- **Disease or Condition-Specific Episodes** – Another approach to episode definition is based upon a patient’s illness, where avoiding complications that may lead to hospitalization is a desired outcome. Defining the episode focus is often complicated because many patients have more than one chronic illness. This may be addressed by limiting the episode to the treatment of one illness (e.g., chemotherapy for cancer), or through risk adjustment. For an ongoing illness, the episode may cover an entire year. For a specific condition, the episode is based on the expected treatment period.
- **Population Health Management** – The broadest episode definition involves all care provided to a defined population within a specified period, generally one year. While it may be useful to utilize multiple groupers for hospitalizations and those addressing particular disease states, there are also significant efforts to identify and stratify high-cost individuals holistically.

## 2. Differentiation Across Patient Groups

Another critical factor in episode group analysis is the extent to which groupers split distinct patient subgroups versus lumping them together. Illnesses, diseases, injuries and other

medical events have historically been grouped into “families.” For example, a single DRG usually contains multiple diagnoses or procedure codes. The decision to lump different types of cases within a single DRG generally reflects diagnoses associated with a single anatomical system (e.g., cardiovascular) with similar average resource requirements.

As the understanding of these events has grown, so has the specificity with which each is defined, diagnosed and treated. That specificity does not always translate to a meaningful distinction for payment purposes because the resources used to treat the different types of an illness, disease or injury can be similar or almost identical. As such, when selecting the diagnosis codes that identify an episode of care for a bundled payment, decisions must be made about whether to maintain a high degree of specificity (“splitting”), or to group more broadly (“lumping”).

There are both challenges and consequences associated with defining episodes narrowly or broadly. When assessing groupers, it is important to consider the inherent trade-off between broadly defining an episode for larger, statistically valid sample sizes to evaluate costs and resource use, as opposed to narrowly defining an episode to ensure greater clinical homogeneity.

When episodes are broadly defined, probability risk arises. The more patient categories that exist within a grouper, the more clinical and resource variation will be preserved. However, if episodes are designed too broadly, specific treatments and associated resources can vary so significantly that a change in the internal mix of episode sub-types will have a significant effect. Maintaining too many patient categories will mean some have excessive variation in predicted costs, leading to inaccurate payments. While case mix adjustment can compensate for some of that risk, it may not always reliably do so.

On the other hand, when episodes are narrowly defined, related services are grouped by their own episode. If episodes are defined too tightly, the frequency of a medical event can be so low that it becomes challenging to reliably estimate a price. An insufficient number of categories to reflect actual clinical and resource use heterogeneity will result in a grouper that is not clinically meaningful and poses excessive financial risk for providers.

Some indications of a lack of reliability could be a high coefficient of variation (related to standard deviation), and/or significant and repeated differences between expected and actual observed costs. This variability can create substantial unmanageable risk for providers because there is a high likelihood of result misclassification.

The extent to which patient subgroups should be split or lumped together is further complicated by the scope and context of care:

- **Hospitalization and Post-Discharge Episodes** – Episodes are currently distinguished based on the DRG to which the patient was assigned during hospitalization. This

approach has the benefit of being well understood by hospitals. However, the DRG grouper is not sensitive to post-discharge clinical characteristics and further consideration needs to be given to whether additional, or different, patient categories are needed.

- **Disease or Condition-Specific Episodes** – While the episode focus is specific to a disease or condition, the ability to differentiate between disease subtypes should be considered in the design of disease-specific groupers.
- **Population Health Management** – Determining the appropriate number of grouper categories is especially challenging for the purpose of population health management. For Medicare Advantage, CMS calculates a risk score for beneficiaries based on their predicted resource use (e.g., reflecting prior diagnoses, age), rather than assigning them to pre-determined patient categories.

### 3. Differentiation Between Subgroups Within Similar Diagnosis Groups

In addition to establishing different categories for patients with different diagnoses, another key consideration is whether to establish different grouper categories for patients with the same diagnosis or procedure but with varying complications or severity of illness. Within a given episode, all patients may not respond the same to the clinical course of care. Moreover, depending on the type of condition and patient-specific factors, an individual may move bi-directionally through the course of care, rather than linearly. For example, a patient may regress from receiving follow-up care back to needing evaluation and treatment.

Like inadequately recognizing predictable cost variation across patient groups, failing to account for predictable variation within patient groups may lead to risk avoidance behavior through patient selection (*i.e.*, avoiding sicker patients likely to be high-cost). This is a critical issue for any episode grouper, because failing to adjust for complications and comorbidities can result in inadequate access for the sickest patients, and place undue risk upon providers who are still willing to care for these patients. Ultimately, it can lead to failure of the model.

Accounting for variations in risk and severity of clinical conditions is an important step in episode grouping. By accounting for pre-existing conditions and patient-related clinical or socio-demographic factors, risk or severity adjustment ensures providers are accurately measured on outcomes or processes they can reasonably influence, rather than underlying differences in patient severity.

There may be multiple strategies for addressing risk, and each of the different approaches may be appropriate depending on the intended use of the grouper. First, many episode models mitigate this risk by utilizing providers' historical costs, reflecting their actual patient mix. A second option is to stratify patient risk through grouping by creating new episodes for increased risk. However, this option presents many of the same challenges and trade-offs as

narrowly defined episodes. Third, groupers can offer supplementary risk modules that can be applied post-grouping.

There are also some inherent limitations in the handling of risk in episode development. As with determining the episode beginning point and distinguishing between patient groups, groupers that rely on claims data may be limited in their ability to differentiate within patient categories. Since many episode groupers rely solely on administrative claims data, there may not be enough detail in the data to capture clinical characteristics or severity for certain episode types. Groupers that utilize additional clinical data beyond claims may improve differentiation but are administratively more challenging due to the need to collect additional data.

The extent of differentiation between subgroups to account for patient variation in risk and severity can also vary depending on the scope and context of care:

- **Hospitalization and Post-Discharge Episodes** – As noted previously, these episodes tend to rely on DRG groupers to differentiate patient groups. While these groupers are reliable for differentiating for patient severity based on the hospitalization, testing has been limited for their ability to predict post-discharge resource use, particularly risk of readmission during the episode.
- **Disease or Condition-Specific Episodes** – Groupers utilized for disease- or condition-specific episodes must be able to capture and adjust for predictable clinical and resource differences within the disease or condition. Oncology care is an illustrative example. More advanced cancers may require different and more costly treatment regimens than early stage cancers. However, the limitations of available diagnoses codes may limit groupers' sensitivity to these distinctions. Linking with data registries and ICD-10 coding may assist in differentiation.
- **Population Health Management** – The issues with distinguishing between subgroups within larger patient categories are as challenging as those associated with distinguishing across patient groups. Calculating patient-specific risk scores will only be as accurate as the underlying data permit.

#### 4. **Attributing Services and Costs to the Episode**

Another key decision point for grouper analysis is deciding the rules for how claims are assigned to clinical episodes. Claims assignment approaches can vary between groupers based on their intended use and decision logic. At a fundamental level, groupers are designed to categorize patient episodes into groups. The process of attributing costs is a second step, after the groups are defined and identified. However, because groups also tend to be defined based on resource similarities, the steps tend to be iterative.

Deciding how to fairly and appropriately attribute services and costs to an episode, including any complications that occur as part of the underlying condition or procedure, can be challenging. Depending on the grouper's focus, the rules for cost attribution are often complex due to multiple diagnosis and procedure codes that may fall within a single patient episode. For example, should the care provided to a patient who was injured in a car accident on the way home from the hospital following hip replacement surgery be included in the episode bundle for the hip replacement?

As previously discussed, large sample sizes may mitigate variations or overlap in episodes. On the other hand, episode overlap may cause excessive risk if there are insufficient numbers of cases to offset the distortion caused by a few outliers.

Patient attribution to specific providers is also a significant challenge. While not an issue that is inherent to grouper design, it is inseparable from attributing costs and determining payment. Organizations such as the NQF and the Health Care Payment Learning and Action Network (HCP-LAN) have supported bringing greater consistency to this issue.

When evaluating episode groupers, it is important to examine the consistency and reliability of claims assignments. This is because claims have several features that must be addressed in grouper rules.

Because claims usually include one or more lines, with each line representing a specific service, each line must be addressed. Lines typically include a procedure or revenue code, and one or more diagnosis codes to denote the medical reason for the service. Some can be very ambiguous, representing signs or symptoms of a condition or illness rather than the specific condition. Grouping claims to episodes requires making decisions about whether to assign each line separately or assign claims in their entirety.

Multiplicity of diagnosis and procedure codes is another consideration. Individual claim lines can include more than one diagnosis code; this may reflect the routine practice of managing a patient for multiple conditions simultaneously. Grouper software must include decision logic to assign a claim/line item to a specific episode, or alternatively divide the claim into multiple episodes.

Deciding how to attribute services and costs to an episode varies by scope and context of care:

- **Hospitalization and Post-Discharge Episodes** – If episode groups are formed based on the hospital DRG, group distinctions should be clear. During the episode, however, decisions must be made about which services and costs to include or exclude from the episode.
- **Disease or Condition-Specific Episodes** – Attribution of services and costs can be

challenging for these episodes since patients often have multiple chronic conditions. Models that attempt to isolate a particular disease or condition will face the greatest challenge, while those that attempt to incorporate associated complications and comorbidities will face fewer cost attribution challenges, but more risk-adjustment challenges. Patient attribution may also be a challenge.

- **Population Health Management** – For these models, patient attribution is the key challenge; cost attribution tends to follow once the patient is attributed to a provider.

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## D. Implications for Providers and Payers

Ultimately, the episode grouper considerations described above translate to a few important factors that may impact a provider’s ability to reliably assess the financial risks and rewards of entering into a bundled payment contract with a payer. They include:

- **Perceived arbitrariness in decisions to allocate costs to an episode of medical care.** Without a robust understanding of episode grouper logic and/or well-designed algorithms, providers may not feel comfortable with the claims attribution process. Key considerations for providers include: whether the episode can be adjusted for case mix severity; whether grouper results may differ based on the order that procedural and diagnostic codes are recorded; and to what degree patient mix heterogeneity will impact grouping and payment logic.
- **Whether managing patients appropriately will be commensurately rewarded.** Providers need to know that diligent efforts to effectively manage patient outcomes and costs will be reflected in their reimbursement. For example, ensuring that providers who reduce or prevent complications will be rewarded, and controllable downstream patient management factors are considered in financial risks and rewards.

For payers, specific questions to ask, both internally and to the vendor, before implementing episode grouper software include:

- **The primary use of the grouper.** Will the software be used for prospective/retrospective payment, for performance measurement, or both? The intended use of the software will inform the type of product purchased and the relative importance of certain attributes.
- **Whether the product provides specific episode definitions.** If definitions are open, the payer will have the opportunity to define and customize episodes as appropriate and make tweaks/adjustments over time. Proprietary definitions may require less work to implement in the short-term and may allow greater

synchronicity/standardization for providers who participate in multiple bundled payment arrangements but offer less flexibility for payers in the long-term.

- **Whether the grouper has an associated quality measurement tool or resource.** This is especially critical if the episode grouper is being used for performance measurement. Payers may opt to utilize their own quality measurement tools and standards, however, in lieu of resources associated with the grouper.
- **The cost of implementation.** Limited use of bundled payments has historically been linked to the cost of infrastructure development and use, including proprietary tools. While this has become less of a hurdle over time, implementation and ongoing use costs may still play a role in the decision to use a specific tool.

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## E. Conclusion

As industry commitment to alternative payment models grows, so too hopefully will the interest in commercial bundled payment arrangements. Episode grouper technology continues to evolve; as it does, payers will have access to more sophisticated tools.

The issues presented above reflect the main consideration points for selecting an episode grouper that best matches the needs and goals of the organization. There is not a “one-size-fits-all” approach to episode grouper technology, and the vast array of customizable options can pose significant challenges for both payers looking to implement these technologies and providers who are considering entering into payment arrangements. The information provided in this report will hopefully serve as guidance for those seeking to better understand the underpinnings of episode grouper design. For more guidance on bundled payment contracting, readers are encouraged to review the Health Care Transformation Task Force’s resource titled *Clinical Episode Contracting for Commercial Payers*.<sup>4</sup>

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## About Us

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. The Task Force is committed to rapid, measurable change, both for itself and the country. It aspires to have 75 percent of its members’ business operating under value-based payment arrangements by 2020.

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<sup>4</sup> <https://hcttf.org/clinical-episode-contracting-commercial-payers>