

NATIONAL QUALITY FORUM

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ATTRIBUTION: PRINCIPLES AND APPROACHES COMMITTEE
IN-PERSON MEETING

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TUESDAY
JUNE 14, 2016

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:30 a.m., Ateev Mehrotra and Carol Raphael, Co-Chairs, presiding.

PRESENT:

ATEEV MEHROTRA, MD, MPH, Co-Chair

CAROL RAPHAEL, Co-Chair

MICHAEL BARR, MD, MBA, MACP, National Committee
for Quality Assurance

JENNY BEAM, MSc, University of Louisville
Physicians

JILL BERGER, MAS, IBM Watson Health

ANNE DEUTSCH, PhD, RN, CRRN, RTI International

ELIZABETH DRYE, MD, SM, Yale Center for Outcomes
Research and Evaluation (CORE)

TROY FIESINGER, MD, Village Family Practice of
Fort Bend

CHARLES HAWLEY, MA, Utah Department of Health

ARI HOUSER, AARP Public Policy Institute

KEITH KOCHER, MD, MPH, MPhil, University of
Michigan

ROBERT KROPP, MD, MBA, MACP, Aetna Accountable
Care Solutions

DANIELLE LLOYD, MPH, Premier, Inc.

EDISON MACHADO, MD, MBA, IPRO

IRA MOSCOVICE, PhD, University of Minnesota
School of Public Health

JENNIFER NOWAK, RN, MSN, Blue Cross Blue Shield
Association

BRANDON POPE, PhD, Baylor Scott & White Quality
Alliance

LAUREL RADWIN, PhD, RN, Boston Veteran
Administration Healthcare System

MICHAEL SAMUHEL, PhD, Booz Allen Hamilton

ROBERT SCHMITT, FACHE, FHFMA, MBA, CPA, Gibson
Area Hospital & Health Services

NATHAN SPELL, MD, Emory University School of
Medicine

SRINIVAS SRIDHARA, PhD, MS, The Advisory Board

BHARAT SUTARIYA, MD, FACEP, Cerner Corporation

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer

DONNA HERRING, MPH, Project Analyst

KIM IBARRA, Project Manager

ELISA MUNTHALI, MPH, Vice President, Quality
Measurement

ERIN O'ROURKE, Senior Director

ASHLIE WILBON, RN, MPH, Managing Director

MARCIA WILSON, PhD, MBA, Senior Vice President,
Quality Measurement

ALSO PRESENT:

TAROON AMIN, PhD, Independent Advisor

SOPHIA CHAN, PhD, MPH, Center for Clinical
Standards & Quality

DAN MULDOON, MA, Federal Liaison, Center for
Medicare & Medicaid Innovation

* present by teleconference

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

2 9:34 a.m.

3 MS. WILBON: Good morning, everyone.

4 I want to welcome everyone and thank you all for
5 coming to join us today. We're really excited
6 about today's meeting.

7 I am Ashlie Wilbon. I'm one of the
8 Senior Directors here at NQF and will be helping
9 to hopefully guide you guys to meet our goals of
10 the day and for the two-day meeting.

11 So, I'm going to hand it over to our
12 Project Manager, Kim Ibarra, to walk us through
13 some of the housekeeping items and the agenda for
14 the upcoming day.

15 MS. IBARRA: Hi, everyone. I'm Kim
16 Ibarra, I'm the person who has been emailing you
17 over the last couple of weeks.

18 So, just a couple of housekeeping
19 items. If you haven't figured this out already,
20 the restrooms are out the door, past the glass
21 doors, past the elevators, to the right.

22 Your name tent cards are a way for us

1 to know who everyone is, but also for you to
2 indicate that you'd like to make a comment or to
3 speak throughout the meeting. So, if you do want
4 to say something, place it up like this and our
5 chairs will call on you to make a comment.

6 Also, when you're making a statement
7 or speaking, we'd ask that you use the
8 microphones that are in front of you by pressing
9 the speak button. There can only be three on at
10 a time. So, if you're speaking and the
11 microphone doesn't come on, it might be because
12 some else has theirs on. So, we'll be making
13 periodic reminders about that throughout the day.

14 The microphone use is important not
15 only for people to hear us in the room but also
16 because we are streaming to the public and those
17 who can't be here with us today. And also
18 because we are recording this and there is a
19 transcriber who will be transcribing our meetings
20 and we publish those publically so that what we
21 discuss here is open and transparent.

22 There are a couple of breaks

1 throughout the day. We would ask that you try to
2 use those break times for any calls or work that
3 needs to happen.

4 Of course, if you need to leave the
5 room, you can do so. But, to minimize or to make
6 sure that we have everyone at the table when
7 we're discussing these important issues, we
8 encourage you to use the break time for making
9 phone calls and any other sort of issues that
10 might come up.

11 And, lastly, please make sure that
12 your cell phones are on mute or on vibrate.

13 Thank you.

14 MS. WILBON: So, I've introduced
15 myself already. I'm Ashlie.

16 We're going to just introduce the
17 team, we'll have everyone kind of go around so
18 you know, then you can put a face to the names
19 that you've probably seen on some of the
20 documents.

21 I'll introduce myself again. I'm
22 Ashlie, I'm a Senior Director here. I've been at

1 NQF for several years now. I've worked on
2 primarily the cost and resource use work.

3 I'm also now practicing as a family
4 nurse practitioner, so am keenly aware of some of
5 the issues that go on in clinical practice in
6 terms of being a primary care provider and trying
7 to coordinate care and be a gatekeeper.

8 So, really interested in hearing
9 comments and discussions around that today.

10 And, yes, so that's all I've got. We
11 can move on to Erin.

12 MS. O'ROURKE: Good morning, everyone.
13 I'm Erin O'Rourke. I'm a Senior Director
14 supporting this project. I've been at NQF about
15 five years now, primarily working on the Measure
16 Applications Partnership supporting the work of
17 the Post-Acute Care/Long-Term Care Workgroup, the
18 Hospital Workgroup and the Coordinating Committee
19 and recently getting involved in some of our
20 endorsement work around readmissions and cost and
21 resource use.

22 MS. IBARRA: Hi, again. I'm Kim

1 Ibarra. I've been at NQF for just under a year.
2 I work on this attribution project, home and
3 community-based services, framework project and a
4 population health framework project as well.

5 My background is in health services
6 research and bioethics and policy.

7 MS. HERRING: Hi, everyone. I'm Donna
8 Herring, I'm the analyst on this project.

9 While I also work on the attribution
10 project and the population health project with
11 Kim, I work on the cardiovascular project here,
12 also our Advanced Illness Care Action Team and I
13 kind of bounce around and help out where I can on
14 other projects as well.

15 If you have any questions at any point
16 today about anything technical, if you need to
17 hop on to the wireless, please let me know.

18 And, I'm exciting to get the meeting
19 started.

20 DR. AMIN: Hi, everyone. My name's
21 Taroon Amin. I'm an Advisor to NQF on various
22 activities related to measurement science and

1 also readmissions and cost and resource use.

2 MS. MUNTHALI: Good morning, everyone.
3 My name is Elias Munthali. I'm Vice President
4 for Quality Measurement.

5 I want to welcome you and thank you so
6 much for being on the committee.

7 So, I'll turn it over to Helen for
8 disclosures.

9 DR. BURSTIN: Good morning, everybody.
10 I'm Helen Burstin. I'm the Chief Scientific
11 Officer here at NQF. Delighted to have you here.

12 We'll lead off our introductions and
13 disclosures in a moment with Ateev and Carol.

14 I just want to say a couple words and
15 then give you a sense of what we'd like you to do
16 in disclosures.

17 So, first, we are really excited to
18 have this meeting today. This is an issue we
19 feel like we wind up readjudicating every time a
20 measure comes to this table. This is where we
21 tend to do all of our map work, our endorsement
22 work.

1 And so, the thought was, is there a
2 possibility of us kind of thinking of some
3 principles, some approaches, so that we don't
4 readjudicate every time this comes up but
5 actually have something on which to ground our
6 thinking.

7 So, we're excited about the next
8 couple of days and I think it'll be a really
9 exciting opportunity for all of us.

10 So, what we're going to ask you to do,
11 as we go around the table is combine your
12 introductions with your disclosures of interest.
13 And, all of you know, you submitted forms to us,
14 disclosures of interests as well as your CVs.

15 We do not need a recitation of your
16 CV. We've seen them all, they're great. That's
17 why you're here.

18 So, what we'd ask you to do as you go
19 around the room is, you know, say who you are,
20 where you're from, but then, specifically
21 indicate if there's anything you would like to
22 disclose about work you're doing that may have

1 some bearing on the kind of discussion we'll be
2 having for the next couple of days.

3 Again, it's a little different than
4 some of our usual work. We're not picking
5 measures, we're not selecting measures, but it
6 would still, I think, be helpful if you have any
7 particular orientation or events that you would
8 want the committee to share to share with the
9 committee and we'll get started.

10 So, we'll start with Ateev.

11 CO-CHAIR MEHROTRA: Hi, Ateev
12 Mehrotra. I work -- I'm actually an NQF want-to-
13 be, obviously, by sitting here in the front.

14 But, actually, in reality, I work at
15 Harvard Medical School in the Beth Israel
16 Deaconess where I'm a physician health services
17 researcher.

18 I don't have any particular
19 disclosures and some of the work that I think is
20 most relevant here is one of the papers was part
21 of your -- unfortunately, part of your reading
22 which is related to some of the work I've done in

1 cost utilization measures, our physician cost
2 profiling.

3 And so, that's some of my background
4 that will inform my comments today.

5 CO-CHAIR RAPHAEL: I'm Carol Raphael
6 and I was the CEO of the Visiting Nurse Service
7 of New York for over 20 years and also Chaired
8 the MAP Post-Acute Long-Term Care Workgroup at
9 NQF for four years.

10 I'm on the Readmissions Workgroup
11 Committee as well and have been on the Commission
12 on Long-Term Care appointed by President Obama.

13 I've been on MedPAC and I've been on
14 the New York State Medicaid Redesign Commission
15 as well.

16 The only other things I'm involved in
17 that may have relevance is that I've been the
18 Chair of the Health Information Technology Board
19 in New York State and very involved in trying to
20 attain interoperable healthcare platform.

21 I chair the Long-Term Quality Alliance
22 and I'm chairing for CMS at TEP on dual eligibles

1 and quality as well.

2 So, with that, I think we're going to
3 go around and have everyone else.

4 MEMBER POPE: Good morning, everyone.
5 I am Brandon Pope. I'm the Director of
6 Analytics, Baylor, Scott & White Health
7 Integrated Delivery Network out of Dallas, Texas.

8 My background in mathematics and
9 systems engineering. But, my role is essentially
10 to steward all the data and measures and analysis
11 for the ACO.

12 I don't have any particular
13 disclosures.

14 MEMBER DRYE: Hi, I'm Elizabeth Drye
15 and I'm from the Center for Outcomes Research and
16 Evaluation at Yale.

17 And, my primary role the last almost
18 ten years has been to develop outcome measures
19 that are used in national reporting, including
20 the readmission measures that for hospitals over
21 the last four or five years have been more
22 focused on developing outcome measures for

1 ambulatory care and currently are working on
2 measures that would draw on the strategies that
3 we're going to talk about here today.

4 But, otherwise, I don't think I have
5 anything to disclose. I'm also a pediatrician.

6 Thanks.

7 MEMBER MOSCOVICE: Hello, I'm Ira
8 Moscovice. I'm a professor and the head of the
9 Division of Health Policy and Management at the
10 School of Public Health University of Minnesota.

11 And, I've been head of a federally
12 funded rural health research center for over a
13 couple of decades and have been on a couple of
14 committees for NQF.

15 I've served previously on the MAP
16 Partnership and also on the task force for
17 developing relevant rural measures.

18 And, it's a pleasure to be here and I
19 have no disclosures.

20 MEMBER SAMUHEL: Hi, I'm Mike Samuhel.
21 I'm with Booz, Allen, Hamilton. I guess in the
22 way of disclosures, we have multiple projects

1 with U.S. government agencies involving quality
2 measurement as well as program assessment.

3 And then, more recently, looking at
4 the value-based programs that are being
5 demonstrated and looking at their effectiveness
6 and return on investment and those kinds of
7 issues.

8 Very happy to be here.

9 MEMBER KROPP: Good morning. I'm Bob
10 Kropp and I'm trained as a child neurologist.
11 I'm here representing the American Academy of
12 Neurology.

13 Currently an independent consultant
14 but I recently retired from two positions that
15 may have some contribution to this committee.

16 And, that's -- I was a Vice President
17 and Senior Medical Director for Aetna's
18 Accountable Care Solutions. So, my team and I
19 were responsible for the clinical programs for
20 the 70-plus ACOs that Aetna had across the
21 country. So, I just recently retired, so I have
22 an ACO perspective as well as a clinical practice

1 perspective.

2 Pleasure to be here, look forward to
3 meeting you all.

4 MEMBER SPELL: Good morning, I'm Nate
5 Spell. This is my first NQF meeting.

6 I am a general internist and primary
7 care physician. I am the Chief Quality Officer
8 for Emory University Hospital in Atlanta and I'm
9 representing the American College of Physicians.

10 MEMBER LLOYD: Good morning, I'm
11 Danielle Lloyd. I head up policy for Premier
12 which is an alliance of 3600 hospitals and
13 120,000 alternate sites, so physicians, skilled
14 nursing, et cetera.

15 And, I would say our bent is provider-
16 oriented and specifically, we run one of the
17 largest accountable care organization
18 collaboratives in the country with about 400
19 hospitals right now.

20 We run a bundling collaborative with
21 almost 200 hospitals and we are a facilitator
22 convener within CMS' Bundled Payment for Care

1 Improvement Program.

2 And then, last, we have our Hospital
3 Quality Improvement collaborative where we are
4 also a CMS contractor as a hospital engagement
5 network.

6 MEMBER MULDOON: Good morning. I'm
7 Dan Muldoon. I work at the Center for Medicare
8 and Medicaid Innovation primarily on our episode-
9 based payment models doing work there on the
10 financial aspects as well as some of the design
11 and implementation.

12 And so, I think I'm bringing that
13 perspective as the federal liaison to the
14 committee and really also hoping to learn from
15 the discussion on any principles that we lay out
16 here sort of as we continue to work on
17 implementing our models.

18 MEMBER MACHADO: Hi, good morning,
19 everyone. My name's Eddie Machado. I'm the
20 Chief Quality Officer and Vice President for
21 Strategic Planning for IPRO.

22 I'm here representing the American

1 Health Quality Association which is the trade
2 association for QIN-QIOs.

3 You know, the QIN-QIOs play an on-the-
4 boots role working with Medicare providers with
5 implementing measures as part of the quality
6 improvement efforts. So, you know, we have a
7 particular interest in this topic and its
8 effects.

9 Personally, I'm a physician by
10 training and have background in performance
11 measurement, an alumni of NQF, so it's nice to be
12 back.

13 And, in terms of direct relevance to
14 the project, I'm just finished up as part of a
15 subcontractor around the CMMI project for the
16 episode grouper for Medicare project which just
17 concluded this past May.

18 So, happy to be a part of the group.

19 MEMBER BERGER: Hi, I'm Jill Berger.
20 I am with IBM Watson Health, but this is pretty
21 recent.

22 Before I was with IBM, I was with

1 Marriott helping to run employee benefits working
2 with Bob occasionally because Aetna was one of
3 our partners.

4 So, I'm bringing the perspective of
5 the employer and what we want to see when it
6 comes to attributions. So, that's going to be my
7 role here.

8 MEMBER FIESINGER: Good morning, I'm
9 Troy Fiesinger. I'm a family physician at
10 Houston, Texas. It's nice to be back at NQF.

11 I'm a purely amateur at quality
12 measurement, but I represent the American Academy
13 of Family Physicians and my disclosures and
14 interests are, I'm a full-time family physician
15 trying to navigate all of this mess.

16 I learned when you move a mile and
17 change taxpayer IDs, the payers, with all due
18 respect, make a complete hash of attribution.

19 I'm also chair of the Quality
20 Committee of our Next Generation ACO Project.
21 So, we have a vested interest in how this plays
22 out. But, also on behalf of my organization, how

1 can physicians and patients navigate this.

2 Thank you.

3 MEMBER NOWAK: Hi, I'm Jennifer Nowak.

4 I am from Blue Cross Blue Shield Association.

5 It's the association -- the national association
6 for our 36 Blue Plans across the country.

7 My focus is in our Blue Distinction
8 programs and I particularly work on our value-
9 based programs.

10 MEMBER HAWLEY: Hi, I'm Charles

11 Hawley. I'm with the Utah Department of Health.

12 I'm the analytics lead working with the all-payer
13 claims database to develop total cost of care and
14 quality performance reporting.

15 MEMBER HOUSER: Hi, I'm Ari Houser.

16 I work at the AARP Public Policy Institute mostly
17 working on long-term care policy. But my
18 background as a statistician so when numbers are
19 involved I work on just about any issue area that
20 we get involved in.

21 And, I am on a number of quality
22 committees and projects relating to mostly to

1 long-term care, but no conflicts with the
2 attribution.

3 MEMBER KOCHER: Good morning. My
4 name's Keith Kocher. I'm an emergency physician
5 at the University of Michigan. I'm also a health
6 services researcher. I have a career
7 development, I work from AHRQ.

8 I also direct large statewide projects
9 and quality improvement in emergency care. It's
10 sort of the physician level.

11 And, I was nominated by the American
12 College of Emergency Physicians.

13 Pleasure to be here.

14 MEMBER RADWIN: Hi, I'm Laurie Radwin.
15 I'm a research health scientist at the VA in
16 Boston.

17 I've been on the NQF Person and Family
18 Centered Care Steering Committee and my
19 measurement interests have been in patient
20 centered care both in ambulatory and acute care
21 and quality improvement.

22 I was nominated by the ANA and I'm a

1 nurse by training.

2 MEMBER DEUTSCH: Good morning, Anne
3 Deutsch, Registered Nurse by training, PhD in
4 epidemiology.

5 I work at RTI International, the Rehab
6 Institute of Chicago and I also have a research
7 associate position at Northwestern University.

8 I was nominated by the Association of
9 Rehab Nurses and I work mainly as a measure
10 developer these days and so that's part of my
11 disclosure. Most of the measures are in the
12 post-acute care world, post -- skilled nursing
13 facilities rehab hospitals and long-term care
14 hospitals.

15 MEMBER BEAM: Hi, my name is Jenny
16 Beam. My work experience related to attribution
17 most recently was the Vice President of
18 Operations at University of Louisville
19 Physicians.

20 We were over PQRS Meaning Use various
21 quality initiatives. Also served as the
22 strategic consultant for Humana being in provider

1 and clinical analytics and served over the
2 attribution team there.

3 Worked for Rapid City Regional Health
4 System of Care in Rapid City, South Dakota,
5 Kaiser Permanente, so in all of those different -
6 - they're all kind of different spaces, HMO,
7 providers, hospitals. So, been all around this
8 space working in cost, quality and value-based
9 purchasing.

10 MEMBER SCHMITT: Good morning, I'm Rob
11 Schmitt. I'm the CEO at a rural critical access
12 hospital in East Central Illinois.

13 I'm here representing the National
14 Rural Healthcare Association.

15 Thank you.

16 MEMBER SRIDHARA: Hello, I'm Srinivas
17 Sridhara. I've actually recently made the
18 transition since joining this group, I'm now the
19 Managing Director for Clinician Analytics at the
20 Advisory Board.

21 So, part of the disclosure would be
22 the Advisory Board is a member-driven

1 organization serving hospitals and healthcare
2 systems and a lot of ACOs and CINs now. So,
3 that's part of my vantage point here.

4 Previously, I was the APCD Director
5 for the State of Maryland and working on various
6 provider-based transparency initiatives and PCMH
7 program and so forth.

8 So, happy to be here and I was
9 nominated by the ENRI, so happy to be here on
10 their behalf as well.

11 MEMBER BARR: Good morning, everybody.
12 I'm Michael Barr, the Executive Vice President
13 for Quality Measurement and Research at the
14 National Committee for Quality Assurance.

15 Under me is our performance
16 measurement team, so we develop measures under
17 contract. We have our research and analysis team
18 and our quality solutions group which has a
19 consulting arm.

20 I'm neither a health services
21 researcher, performance measure developer, but I
22 bring the physicians perspective as well as the

1 strategic perspective.

2 I was Senior Vice President at the
3 American College of Physicians for practice and
4 Nate's representing ACP, but I still have that
5 background of practice in community health
6 centers, in military, in the academic environment
7 and currently still practice part-time internal
8 medicine a few hours a week.

9 DR. BURSTIN: All right, excellent.

10 We have two more members who are going
11 to be joining us on the phone, but they're not on
12 yet so we'll do the same thing for them when they
13 join us.

14 So, thanks to all of you. So, you
15 could tell this was a really fun committee to put
16 together. You have an amazing array of
17 perspectives and backgrounds and have great
18 confidence you'll be able to get this task done.

19 Two quick things, one of which is a
20 reminder that, although many of you have been
21 nominated by other organizations, at this table,
22 you sit as individuals. So, we specifically put

1 committees together so we get that multi-
2 stakeholder perspective. But, don't feel like
3 you're here and you need to say, you know, the
4 ACP would like to have me say, Nate. No, it's
5 really what Nate Spell really thinks.

6 So, again, you can have that
7 perspective at this table, that's what it's
8 intended to do.

9 And, secondly, we just want to have an
10 opportunity for you to ask if you have any,
11 having now heard this amazing recitation around
12 the table, do you have any questions of anybody
13 at the table? Any concerns about any disclosures
14 anyone has made?

15 I think overwhelmingly, the
16 disclosures were about how wicked smart you all
17 are which is great.

18 But, if you have any concerns or
19 questions at any point during the meeting, if you
20 begin feeling like there's somebody who is just
21 not even so much conflicted, but just clearly is
22 pushing on a bias, feel free to come forward to

1 any staff or the chairs.

2 Always easier for us to kind of deal
3 with those issues in real time. We spend a lot
4 of time trying to reach consensus. We're not
5 going to do a lot of voting today as we often do
6 at our meetings. But, we very much want to make
7 sure everybody's been heard, everybody has an
8 opportunity to state their opinion and try to
9 reach consensus.

10 So, if at any point, you feel like
11 that's getting a little tilted, please let us
12 know and we'll be happy to kind of see if we can
13 get it back on balance.

14 CO-CHAIR RAPHAEL: And, just one
15 request. Can I ask you if you can just move your
16 name tags and turn them so we can see your names.
17 We hope to get to know all of you, but we don't
18 yet and we want to be sure that we can call on
19 you when you put up your cards.

20 Thanks a lot.

21 MS. WILBON: Just really briefly, one
22 of the authors that have put together the draft

1 paper that was shared with you guys via email is
2 supposed to be joining us by phone.

3 Ariel, are you there? Okay, he was
4 supposed to -- he'll hopefully be able to join us
5 on the -- via phone today. So, if anything comes
6 up that is related to some of the work that's
7 been done by the authors, we can certainly call
8 on them and they can feel to chime in when
9 they're on the phone.

10 And, I think we have a couple of other
11 committee members that should be joining us on
12 the phone.

13 And, other than that, I think we'll go
14 ahead and get started.

15 So, next slide?

16 Okay. Okay, so I think we've probably
17 hammered this all into your heads multiple times
18 since we've had a couple calls before today's
19 meeting.

20 But, again, the purpose of this
21 project is, as Helen has already stated this
22 morning, is, again, taking into account where

1 we're headed with healthcare in terms of shared
2 accountability and various care delivery models,
3 we're really looking for some guidance to the
4 field on this attribution issue that can be used
5 foundationally and to help us as an organization,
6 but also others out there who are developing
7 measures, implementing measures, to provide some
8 guidance out there for how to address some of
9 these challenges.

10 So, we're going to be spending some
11 time really talking through and clarifying what
12 those challenges are, why they are challenges and
13 attributing healthcare services, developing a set
14 of guiding principles, exploring some of the
15 strengths and weaknesses of some attribution
16 approaches currently in use, which we'll spend
17 most of tomorrow doing as we review the paper and
18 the environmental scan that's been done to date
19 by the authors.

20 And then, ultimately, providing some
21 guidance across measure development endorsement,
22 measure selection and use, which we'll probably

1 spend most of our meeting in August doing.

2 But, so, all of these bullet points
3 kind of span today's meeting as well as the
4 meeting that will be convened for in August.

5 So, next slide? Okay.

6 So, again, for today's -- or for the
7 meeting this week, today we'll be focusing
8 primarily on getting a good foundation and
9 understanding of why this issue is important to
10 us in a little bit more detail.

11 We'll also have some presenters from
12 CMS to talk about their perspective. They also
13 are funding this work, so a lot of the goals of
14 this project are also related to some needs that
15 they have and helping them to clarify some of the
16 challenges that they have in attribution.

17 We'll spend a great deal of time
18 primarily the second half of the day dividing you
19 guys up into workgroups to really do a deep dive
20 on some really concrete examples of where this
21 has been an issue and particularly in NQF
22 experience with particular measures.

1 We've also got a clinical case study
2 and another more kind of policy population health
3 oriented case study. So, that will be a big part
4 of today's activities as well.

5 And, through that work and using those
6 case studies, we're hoping that we'll be able to
7 identify some initial set of draft principles
8 that you guys are able to pull together by
9 exploring some of those challenges.

10 And, Day 2, as I mentioned, we'll be
11 joined by Andy Ryan who is the lead on the paper
12 that -- for the Commission -- the author that was
13 commissioned to help us with this work. So,
14 he'll be here tomorrow and largely guiding the
15 committee through the work that they have done
16 already, giving a summary of some of what they
17 found in the environmental scan and giving you
18 guys an opportunity to provide them feedback on
19 what they've done so far as well as have some
20 other discussions about strengths and weaknesses
21 and ways that some of the models might be
22 modified for future use.

1 So, I'm going to hand it over to Erin
2 to talk a little bit more about what we'll be
3 doing in the breakout groups.

4 MS. O'ROURKE: Thanks, Ashlie.

5 So, as Ashlie was noting, one of our
6 goals of the meeting today is to come to a set of
7 challenges and draft principles to address those
8 challenges, if you will.

9 You want to help the committee think
10 of how you want to think of attribution issues,
11 if you will. And, if there are certain
12 principles that you can look to as you start to
13 develop your recommendations, both as you review
14 the current models that our authors will be
15 presenting tomorrow and looking forward to the
16 meeting in August where we'll be asking you to
17 make a more concrete set of recommendations.

18 To help you think about what those
19 principles might be, we're going to be breaking
20 you into three groups and asking you to take a
21 turn exploring the attribution challenges from a
22 number of different perspectives.

1 As we were drafting out this project,
2 we realized attribution challenges come up in
3 quite a few different ways and especially as
4 Helen was mentioning, they've come up in our work
5 in a number of different ways.

6 First, as NQF is endorsing measures,
7 we've heard a lot of concerns about how an
8 individual measure is attributed as part of its
9 specifications just in and of itself, not
10 thinking of how you would use it.

11 Secondly, through our MAP work, we've
12 had some challenges arise about how you would
13 apply that measure and how the use of a measure
14 might affect its attribution methodology and how
15 you would think about if a quality initiative
16 program, particularly as we move more to
17 accountability and paying for performance, might
18 affect attribution and how you ensure a quality
19 initiative program as appropriately attributed,
20 especially as I think we all have the desire to
21 move forward and start to pull in some more
22 crosscutting challenging topics into

1 accountability programs, particularly the use of
2 readmission measures, cost and resource use
3 measures, population health and to hold the
4 system accountable for those types of measures.

5 But, we need to ensure that they're
6 attributed fairly and accurately.

7 So, we'll be giving you one case from
8 our MAP work where we were -- the MAP was asked
9 to weigh in about the use of a population health
10 measure in a pay-for-reporting program.

11 Finally, we've developed a case based
12 on a fictional patient to ask you to think about
13 attribution from the patient perspective and when
14 we -- what you think about the care that a real
15 person might be receiving, how it would be fair
16 to attribute the care, what measures might be
17 touching that patient and how that person would
18 be -- being attributed and their providers held
19 responsible for their care.

20 Next slide.

21 So, just thinking ahead to our next
22 meeting, we did just want to perhaps draw the

1 line a little bit for you about what we'll be
2 covering today and tomorrow and what we'll be
3 discussing in August.

4 In August, we'll be bringing you the
5 public and member comments that we receive on the
6 draft paper and environmental scan.

7 We'll be using the work that we do
8 here today, in particular, the guiding principles
9 as well as the results of the environmental scan
10 to take a look at models that are in use in the
11 world today as well as ones that are more based
12 from the literature, perhaps not in use, even
13 theoretical models that could be developed and
14 see which models adhere to the principles that
15 the committee's put together.

16 We'll be taking a look at how current
17 models could be modified to perhaps fit our
18 guiding principles better.

19 We'll also be exploring threats to the
20 reliability and validity of those models,
21 particularly in the context of CMS applications.

22 And, finally, we will ask the

1 committee to provide guidance to NQF's other
2 committees, in particular, our endorsement and
3 Measure Applications Partnership committees on
4 how they should think about attribution issues
5 when they're reviewing measures for endorsement
6 and selection purposes. In particular, we'll ask
7 you to focus on how attribution impacts the
8 evaluation of the reliability and validity
9 criteria when the standing committees are looking
10 at a measure for endorsement.

11 So, I think we're happy to take any
12 questions on the purpose of the project, our plan
13 for both this meeting and August, make sure we're
14 just all on the same page about what we're hoping
15 to accomplish.

16 If not, Ashlie is going to give you a
17 little bit of a deep dive of some of the
18 attribution challenges that have come up as NQF
19 has been doing its work in recent years.

20 MS. WILBON: Thanks, Erin.

21 So, I also just wanted to point out
22 that, while we're bringing two perspectives today

1 within NQF's work as well as CMS representatives
2 will discuss a little bit about their challenges,
3 we did also have quite a bit of dense background
4 reading for you guys.

5 There's been work done by other
6 organizations around population health challenges
7 and attribution.

8 So, we're going to do our best to
9 bring some of those perspectives in and tie them
10 in throughout our discussion for the next couple
11 days and the next meeting as well to make sure
12 that our work is building on work that's already
13 been done and try not to, you know, duplicate or,
14 you know, replicate stuff that's already been
15 done.

16 So, we do have that in mind and we're
17 going to do our best to weave those -- the prior
18 work in to the best of our ability over the next
19 couple of days.

20 So, to start out, Erin has already
21 mentioned the two primary areas within our work
22 where we encounter the attribution issues in our

1 CDP work, our Consensus Development Process and
2 the Measure Applications Partnership.

3 As a part of the Consensus Development
4 Process, I'm going to spend a little bit of time
5 talking about our risk adjustment trial for
6 adjusting measures, risk adjusting measures using
7 socioeconomic and other demographic factors which
8 has some relationship to how measures are
9 specified and the comparability. So, we'll talk
10 a little bit about that as well.

11 Next slide.

12 So, I think there's a few people at
13 this table who are new to the NQF process, so I
14 just wanted to very briefly go over kind of what
15 we do and how this work particularly weaves into
16 our endorsement and Measure Applications
17 Partnership work.

18 So, the Consensus Development Process
19 is the process that we use to endorse measures.
20 We seek committees across about 20-plus different
21 topic areas.

22 Each committee is tasked with

1 evaluating measures against four established
2 criteria that we have, importance to measure on
3 reports, scientific acceptability of measure
4 properties which focuses primarily on reliability
5 and validity and then assesses the usability and
6 feasibility of the measure.

7 So, as you might imagine, the
8 attribution issue, as we talked about before,
9 comes up within the discussion of the measure
10 specifications, whether or not the measure is
11 reliable and valid.

12 And, currently, we don't -- outside of
13 the cost and resource use topic area which we've
14 done work to specifically include discussion
15 around attribution, are other topic areas and
16 measures don't explicitly carve out a space to
17 talk about attribution.

18 It obviously comes up during
19 discussion of the measures, but we don't
20 explicitly have that built in.

21 So, that'll be something we'll be
22 looking to explore with you guys at the next

1 meeting.

2 So, again, that process we use to
3 evaluate the measures. And then, again, the
4 topic areas that we tend -- that we have seen the
5 greatest challenges is in cost and resource use
6 measures, readmission measures and with the
7 population health measures.

8 And, we actually do have case studies
9 based on each of these three topic areas, so
10 we'll do a little bit more -- there will be some
11 concrete examples and more of a deep dive on that
12 a little bit later.

13 So, some of the key issues that come
14 up kind of repeatedly across all three of those
15 topic areas in terms of the measures for resource
16 use, readmissions and population health is this
17 idea of the locus of control, whether or not the
18 attributed entity actually has control over the
19 care that was provided either over the time
20 period or for the measure focus that is specified
21 within the measures.

22 For various reasons, you know, system

1 barriers, lack of infrastructure and
2 efficiencies, communication, things like that,
3 again, very tightly tied to the locus of control
4 is the appropriateness of the selected
5 accountable entity and then the time period for
6 which the measure is specified and whether or not
7 the accountable entity, again, has influence over
8 the quality of care and patient outcomes for that
9 entire time period.

10 So, those are some of the key issues
11 that have come up and then to kind of manifest
12 themselves around those in slightly different
13 ways but around those three kind of core issues.

14 So, there's certainly more challenges
15 around attribution than that, but I think that
16 those are the three that we encounter the most
17 and we'll have you guys exploring those in a
18 little bit more detail.

19 So, I'll just talk a little bit about
20 the trial that NQF -- what affectionately call
21 the SDS trial which is the trial for which we
22 implemented in 2015 where we are then allowed

1 measure developers to submit measures, risk
2 adjusted measures including risk factors that
3 were sociodemographic or socioeconomic factors
4 with some caveats that they have done some
5 analysis on whether or not there's a conceptual
6 link for that factor to the measure focus or the
7 outcome of the measure or whether or not there
8 has been some, you know evidence in the
9 literature that those factors are related to it.

10 So, the issue that's come up with
11 this, obviously, is that there are some
12 practitioners that care for patients that are --
13 have more challenges in terms of SES and SES
14 factors and their panel of patients in terms of
15 comparing that are attributed to them in term so
16 of comparing their performance may be
17 disproportionately impacted by the
18 characteristics of their patient population.

19 So, the goal of the trial is to really
20 evaluate the impact of having these factors
21 included in the risk adjustment model and how
22 much that does impact comparability and the

1 measure results.

2 So, more of an FYI, I just wanted to
3 let you know that this is going on and that there
4 is some relationship to the attribution issue to
5 this but we won't spend as much time on this
6 issue, but I just wanted you guys to be aware
7 that that's going on and that will be making
8 connections where possible to that.

9 Next slide.

10 So, I'm going to hand it over to Erin
11 to talk a little bit more about the challenges in
12 the Measures Application Partnership work.

13 MS. O'ROURKE: Thanks, Ashlie.

14 So, the second big bundle of work that
15 NQF does is through the work of the Measure
16 Application Partnership, MAP. You'll often hear
17 us refer to this as our selection work.

18 As I know you are all too well aware,
19 in the era of value-based purchasing to improve
20 quality, public and private sector payers and
21 purchasers have launched a number of quality
22 initiative programs that are built on the use of

1 performance measures for public reporting and
2 payment purposes.

3 In the MAP, we really focus on the CMS
4 quality initiatives, the Affordable Care Act
5 requires HHS to contract with the consensus-based
6 entity that is NQF to convene multi-stakeholder
7 groups to provide input on the selection of
8 quality measures for public reporting payment and
9 other purposes.

10 The pre-rulemaking process, just to
11 keep you all informed on the jargon, is the work
12 that we do to provide this input.

13 Every year, by December 1st, CMS is
14 required to provide the MAP with a list of
15 measures they're considering implementing and
16 their various reporting and payment programs
17 through the rulemaking process.

18 We convene the four multi-stakeholder
19 workgroups as well as the Coordinating Committee
20 that has oversight of the process to take a look
21 at each of those measures and make a
22 recommendation about whether they would support

1 the implementation of that measure in the various
2 programs.

3 The three workgroups that are really
4 focused on the pre-rulemaking task are the
5 clinician workgroup, they take a look at programs
6 such as the new merit-based incentive payment
7 system, the hospital workgroup, they take a look
8 at programs including the readmissions reduction
9 program and the hospital value-based purchasing
10 program, as well as the post-acute care and long-
11 term care workgroup. They are dealing with a lot
12 of the work that has come out of the IMPACT Act,
13 taking a look at things such as the SNF Quality
14 Reporting Program, the SNF VBP, the IRF Quality
15 Reporting Program, LTAC Quality Reporting
16 Program, the Home Health Quality Reporting
17 Program.

18 Carol is racking up five years now as
19 our chair, so I'll look to her if I missed any of
20 the important work that group is doing.

21 Then, as I said, we have one final
22 workgroup that takes a look at dual eligible

1 beneficiaries and provides input on the measures,
2 if there's any particular considerations that
3 need to be noted for that population.

4 Next slide.

5 So, a number of key issues have arose
6 around attribution, particularly as we see a
7 greater number of measures being used for payment
8 purposes rather than simply reporting or quality
9 improvement.

10 In particular, we've see challenges
11 around the application of measures in program
12 does not always align with the level of analysis
13 that the measure is specified for or the
14 attribution approach specified in the measure.

15 We might see say a population level
16 measure under consideration for a program like
17 the Medicare Shared Savings Program and when
18 there's this mismatch of how a measure is
19 specified and how it would be applied and the
20 attribution challenges inherent in that.

21 Also, as I was saying a little bit
22 earlier, seeing a lot of challenges arise as

1 we're really hoping to move the programs forward
2 and hold the system accountable and drive better
3 outcomes for patients.

4 But doing that really involves holding
5 providers accountable for things that are outside
6 their direct locus of control, issues such as
7 readmissions, costs, population health where we
8 want to encourage providers to work together and
9 hold them accountable for that.

10 But by the nature of doing so, does
11 create a number of attribution challenges and who
12 is responsible for a particular patient and the
13 results of their care.

14 Next slide.

15 So, I am not a graphic person, so bear
16 with me on this. It causes more confusion than
17 it solves.

18 But, we wanted to provide a little bit
19 more context about the challenges we've
20 encountered using measures for accountability
21 purposes.

22 This is an attempt to diagram out the

1 Hospital Value-Based Purchasing Program and to
2 illustrate the relationships between the
3 hospital, the Medicare Hospital VBP Program, and
4 the spending per beneficiary measure used in that
5 program.

6 So, just to give you a little bit of
7 background, Medicare bases a portion of hospital
8 reimbursement on performance through the VBP
9 program. Medicare began withholding one percent
10 of its regular hospital reimbursement from all
11 hospitals paid under the inpatient perspective
12 payment system to fund a pool of incentive
13 payments.

14 The amount withheld increases over
15 time. We're currently in fiscal '16, I believe,
16 so withholding is 1.75 percent and it increases
17 to 2 percent in fiscal '17 and beyond.

18 So, the scoring is a bit fluid and
19 subject to change year over year through the
20 rulemaking process. But, generally, measures are
21 grouped into four domains, assessing clinical
22 care, patient and caregiver experience,

1 efficiency and cost reduction and safety.

2 So, this is an attempt to show you how
3 the efficiency domain relates.

4 In fiscal year 2017 and beyond, the
5 efficiency domain would make up 25 percent of the
6 hospital score.

7 So, if you take a look on the box on
8 the far left, you'll see that we have the
9 program. It's attributed to the hospitals and a
10 portion of their reimbursements are determined by
11 this program.

12 Going to the next box, 25 percent of
13 that score, as I just said, is determined by the
14 efficiency domain. Currently, there's only one
15 measure in that domain, the Medicare Spending Per
16 Beneficiary.

17 So, essentially that measure counts
18 for 25 percent of the hospital's VBP score.

19 That measure captures the cost for
20 both the hospitalization as well as 30 days
21 beyond that indexed hospitalization. So, really
22 holding the hospital accountable for care

1 delivered in outpatient and post-acute settings
2 and using those results to determine part of
3 their score and, therefore, their payment.

4 So, again, just an attempt to help you
5 diagram out how the program works, the
6 interaction between the program and the measure
7 and how that would ultimately affect a provider
8 and their payment.

9 So, again, we're happy to take any
10 questions about the --

11 CO-CHAIR MEHROTRA: And, can you
12 clarify what the challenge was that you faced at
13 NQF with that last set of -- on the last slide?

14 MS. O'ROURKE: Sure.

15 So, this was a little bit of a simple
16 example because that spending per beneficiary
17 measure is required by statute.

18 So, the challenge is not quite as
19 straightforward as where the MAP has a little
20 more discretion about what measure to put in or
21 out, this was perhaps oversimplifying a bit.

22 But, I think the fundamentally -- MAP

1 struggled a little bit with the use of cost
2 measures that capture 30 days post-hospital and
3 whether it's accurate and fair to hold a hospital
4 accountable for those costs going 30 days forward
5 when there is other providers starting to touch
6 that patient.

7 They're either discharged back to the
8 community and incurring costs and having their
9 care driven by an outpatient physician or other
10 practitioner. Or, they might be in a post-acute
11 setting where the costs could really vary by what
12 type of post-acute providers are available in
13 their community where there was a bed open, when
14 they're getting discharged.

15 But, all of those factors would tie
16 back to a hospital and their VBP score and
17 therefore, impact their payment.

18 So, starting to get into the
19 challenges of using cost measures for
20 accountability purposes.

21 CO-CHAIR RAPHAEL: Okay, Troy?

22 MEMBER FIESINGER: It's a valiant

1 attempt to make something sound very simple. So,
2 thank you.

3 Have you looked at the impact to the
4 overall complexity of these rules on all the
5 people trying to use them? Meaning, we have a
6 lot of years of education and a lot of years
7 trying to figure all this stuff out. I still
8 don't feel I totally understand it.

9 How much is that actual complexity
10 impact individuals' abilities to use these
11 programs correctly, whether payer side, hospital
12 side, clinician side, patient side?

13 MS. O'ROURKE: Absolutely. I think
14 that's a theme we've heard quite a bit in the MAP
15 work over the years, particularly, as you know
16 noted, the programs are getting more complex and
17 through each rulemaking cycle, CMS is moving the
18 ball forward, if you will.

19 And, just the challenge that we've
20 heard from our stakeholders, both implementing
21 the programs and trying to improve on the
22 measures in the program and that's certainly a

1 theme we've heard quite a bit over the years at
2 the MAP tables and something that we're hoping to
3 get some concrete guidance from this committee
4 that they can think about when they're being
5 asked to provide input on a measure where the
6 attribution is not clear.

7 And, it could be asking a provider to
8 be accountable and either have their results
9 publically reported or be paid under a measure
10 that they might not have total control over and
11 the ability to fully improve their score within
12 themselves.

13 So, that's certainly a challenge we've
14 heard and we know is a pain point for many in the
15 field.

16 CO-CHAIR RAPHAEL: Taroon?

17 DR. AMIN: If I could just add a
18 little bit to Erin's description on the last
19 comment related to the cost measures.

20 Part of this is also -- there's an
21 intersection between Ashlie's discussion of the
22 measures and then, obviously, Erin's discussion

1 of the programs.

2 But a good example that Erin brought
3 up was that, at the measure level when you're
4 seeing a 30-day cost measure, where the
5 significant portion of the variation is actually
6 in the post-acute portion of the measurement, it
7 begs this question again thematically that both
8 Erin and Ashlie described around the locus of
9 control.

10 If, you know, basically, all of the
11 risk adjustment is neutralizing what's happening
12 in the hospitalization and all of the variation
13 is happening in the post-acute care, is it
14 appropriate to hold the hospital accountable
15 either through the program or in the design of
16 the validity of the measure in that way?

17 And so, I think the intersection of
18 those two can be best described in that way as
19 well.

20 CO-CHAIR RAPHAEL: Okay. Ateev?

21 CO-CHAIR MEHROTRA: I just wanted to
22 -- I don't want to -- this is very challenging

1 work that NQF and all the other people are
2 working on. I'm also just thoughtful of the
3 scope issue here.

4 When I'm looking at this issue of
5 whether it's fair to profile a physician and pay
6 them based on the care that happens in 30 days
7 post, that's an important question.

8 But, I don't know, is that an
9 attribution question in the sense that it's
10 pretty clear which hospital they were in
11 beforehand.

12 So, I push back, I just wanted to at
13 least get it in my head that it was like that's
14 an important question, but is it really the scope
15 of this committee to address?

16 DR. AMIN: So, I would welcome other
17 input from our NQF colleagues.

18 The reason why that -- whether it's an
19 attribution question or not, I think it would be
20 helpful to get guidance from this committee on
21 that topic.

22 I would just say, from our

1 perspective, not necessarily from a measurement
2 science question, but from a -- the interesting
3 intersection where we sit in terms of policy and
4 measurement science. That issue is unresolved in
5 terms of what happens in the 30 days post-
6 discharge.

7 And, we see it over -- we trip over
8 that over and over again in terms of our
9 endorsement projects.

10 So, to a certain extent, it would be
11 helpful, even if we are going to resolve it, to
12 provide guidance -- if the committee could
13 provide guidance on that issue, because the truth
14 is, I think we're -- it would be helpful to get
15 guidance on that.

16 Secondly, when we go to public
17 comments, I can guarantee that question will
18 generate a significant amount of feedback from
19 the stakeholders and it would be helpful to at
20 least spend some time reflecting on that question
21 as we undergo with our -- as we undergo this
22 work.

1 CO-CHAIR RAPHAEL: Nate?

2 MEMBER SPELL: I think this example
3 describes nicely the intersection between
4 accountability measurement and actually policy.

5 So, there' some policy decisions in
6 here in that you're, by creating a measure like
7 this, it forces hospitals to start thinking about
8 and pondering, do I need to take accountability
9 for the post-acute care, for example, because
10 there's dollars tied to it.

11 So, that's, again, it's probably out
12 of scope, but one thing that strikes me, and
13 particularly during the pre-reading, is that this
14 is such a complex field and the answers are not
15 intuitive, that one of the principles we might
16 consider is that as attribution models are chosen
17 for a particular measure, if we can ensure that
18 there is transparency around the reason for the
19 choice, what the rationale is and, perhaps what
20 the tradeoffs were in making the choice of the
21 particular attribution model.

22 CO-CHAIR RAPHAEL: Danielle?

1 MEMBER LLOYD: So, I see why it's
2 harder to see the relationship with attribution
3 given this particular example.

4 I think an example that might be
5 easier to think about is, from the physician
6 perspective, if we think about how one of the
7 papers, I don't remember which one, it might have
8 been, I don't which one, but one of the papers
9 described an attribution level of -- at the
10 patient level or at the episode level. Right?

11 So, physicians will have a much better
12 -- an easier time having control over an episode
13 than they might a total cost of care measure.

14 So, that is a step in the attribution
15 that is still about locus of control. You know,
16 I can't control necessarily an entire year of a
17 patient's total care, but I can control within an
18 episode. And that's one decision that has to be
19 made as we're deciding what attribution steps
20 we're going to take.

21 So, one might argue that within
22 something like physician profiling, you shouldn't

1 ever have a total cost of care measure, you
2 should have an episodic-based measure and that
3 would be within attribution.

4 CO-CHAIR RAPHAEL: Troy?

5 MEMBER FIESINGER: I have more
6 questions than answers, but, to me, when I'm
7 thinking of my practice, my staff, it's what can
8 I change to improve the measure? What is
9 actionable?

10 So, in terms of attribution, yes, I
11 mean, don't hold me accountable for total cost,
12 but I can maybe affect the cost of care.

13 But I can give you a different
14 example. My father is in a nursing home, been
15 very ill for two years. He gets admitted about
16 every three months. Is that a bad thing or a
17 good thing? Maybe he's just sick.

18 So, one, what can we modify in terms
19 of what can we change? Any program, by changing
20 an action in a clinic, what can a nurse do
21 differently? A doctor do differently?

22 But also, how much of this is just

1 statistical noise that we can't affect and what
2 can we actually change?

3 My father is very ill, he almost died
4 two years ago. There's a lot that can't be
5 changed, what can actually be tweaked? I don't
6 want to hold anyone accountable for what is just
7 the way things went.

8 Thank you.

9 CO-CHAIR RAPHAEL: I was just going to
10 say this issue that, you know, a hospital can say
11 45 to 60 percent of the cost variation really is
12 attributable to post-acute care and the settings.

13 But, when you're in post-acute care
14 and you're held responsible for what happens for
15 30 or 60 days, you have the same issues.

16 You know, you have someone admitted to
17 a home care setting and it turns out the
18 medication they're given isn't in the formulary
19 for the insurance company. So, they can't get
20 the medication they're supposed to get.

21 So, you try to get back to the
22 hospital to get the medication changed which

1 takes two to three days where there's a
2 deterioration.

3 Then this person can't get a follow-up
4 appointment with the physician for two and a half
5 weeks. And so, that is a complication that you
6 have no control over.

7 And then, this patient was sent to you
8 because they had a hip fracture and surgery but
9 they have hypertension that's out of control and
10 you call the surgeon. And the surgeon says,
11 that's not my responsibility, you have to go to
12 the primary care physician to deal with the
13 hypertension.

14 So, you have this, I think, from both
15 ends of the spectrum and the whole issue of
16 what's under your control, what's actionable, and
17 where can you really make a difference. So, I
18 just want to be sure that we look at both sides
19 of this as we evaluate it.

20 I think that Eddie, you are next.

21 MEMBER MACHADO: Thank you.

22 I think this may be a bit obvious, but

1 I just felt it's important to state this that,
2 when we think about the aspect of locus of
3 control, that we not get tied up in this idea of,
4 you know, 100 percent control versus no control.

5 Because I think a lot of similar
6 efforts to this get tripped up because of that
7 issue because folks want to look at it as a black
8 and white issue. Because, I don't think many --
9 in most cases, folks will argue that there isn't
10 some aspect of control or some aspect of
11 accountability, and I think the challenge that we
12 have really is to really work in that gray area.

13 But, I would really just stress to
14 everybody that we not really try to oversimplify
15 this into a yes or a no or a 100 percent or a
16 zero percent issue because, you know, as we know,
17 most of healthcare is very much about, you know,
18 team-based care, shared accountability, shared
19 attribution.

20 CO-CHAIR RAPHAEL: Thank you.

21 Ari?

22 MEMBER HOUSER: So, I think the main

1 reason I'm on this committee is that I'm not a
2 provider and I don't approach this issue from the
3 point of view of a provider and I certainly
4 understand that providers have a huge stake in
5 whether or not they're being held accountable for
6 something that they have partial control over.

7 I come at this from another
8 perspective which is that if we look at it at the
9 patient level, there is -- patients are seeing a
10 lot of providers potentially or potentially very
11 few and the sum total of those provider
12 interactions, say, have a -- there's a lot of
13 responsibility total.

14 And, the risk -- there's a risk in not
15 being able to attribute that to individual
16 providers, that if no attribution is made to any
17 provider then there's no incentive for the system
18 to serve that patient well.

19 And so, I think there's a balance
20 where it's harder to see the risks to the patient
21 in the system from the attribution and I think
22 that's the real other side. It's not whether

1 it's attributed or not to the provider, it's
2 whether there's attribution in the system.

3 And, just there's other stakeholders
4 than just the providers.

5 CO-CHAIR RAPHAEL: Elizabeth?

6 MEMBER DRYE: I think just to answer
7 Taroon's question directly, I would keep this
8 locus of control question within our scope.
9 Because I think, actually, in this space, just to
10 echo what other people have said about
11 transparency -- Nate said, and Eddie said about,
12 you know, it's never 100 percent or yes, you have
13 control or no, you don't.

14 There are a couple of interacting
15 pieces to this that I think we want to look at
16 and if we could lend any clarity to how they
17 interact, it might be really helpful. Which
18 there is the question of how much control do you
19 have over the outcome or the cost being scored.

20 And, there's also a question of how --
21 which I think we're going to delve into -- how
22 well do algorithms attribute the patient to the

1 provider. And those are never 100 percent either,
2 at least based on our reading and sometimes
3 they're way lower than that in terms of their
4 accuracy of the -- there's always a portion, you
5 know, of that gets attributed.

6 And then there's the programmatic use
7 and how things are weighted ultimately. And,
8 there's also -- I would just bring in as a
9 measure developer, developing measures in the
10 shared accountability space, you can deal with
11 some of these issues through good risk
12 adjustment.

13 You know, you can counteract and
14 mitigate a lack of control over certain factors
15 by adjusting for those factors. So there's at
16 least these four pieces to the approach to the
17 measure for an outcome measure or a cost and also
18 the algorithm for attribution and the
19 programmatic use.

20 And those, you can tailor around what
21 you want to -- what you really are trying to do,
22 as you're saying. If you're trying to drive more

1 shared accountability, you're going to tolerate
2 less, you know, control. But, you still have to
3 be fair. So, I would just put all of -- I'm kind
4 of being broad in my scope here, but I think
5 that's the challenge that we have really in
6 implementing this work.

7 For example, in the MIP space for
8 provider groups and where there's a lot of shared
9 accountability that it's all four of those
10 things, accountability and locus of control, risk
11 adjustment and attribution and programmatic use,
12 at least in our initial discussion should be in
13 the mix. Maybe that's too ambitious, but I think
14 we can do it.

15 CO-CHAIR RAPHAEL: Okay, Ira?

16 MEMBER MOSCOVICE: I guess I would
17 agree with what Elizabeth just said about the
18 locus of control issue. But, I'm surprised that
19 we really haven't, in all the comments here,
20 talked about the issue of unit of analysis.

21 And, everybody's talking about this as
22 if it's at the individual provider level and --

1 in the agenda initially sent out and stuff -- at
2 some point we're going to be talking about is
3 that the right level. And, do we get around a lot
4 of these issues if we decide it's not the
5 individual provider level. And with the move
6 towards integrated delivery systems, accountable
7 care organizations, et cetera, within those
8 organizations, I'll bet they'll be able to figure
9 out how to attribute real well real quickly.

10 But, I think up front we need to talk
11 about what is the right unit of analysis focus.

12 CO-CHAIR RAPHAEL: Okay, thank you.

13 Jenny?

14 MEMBER BEAM: My comment is just
15 around the risk adjustment and the social
16 determinants. And, I know with the social
17 determinants of health and everything, when we're
18 talking about risk adjustment, to me, I guess my
19 question is, does that really belong in the
20 attribution model itself or is that part of the
21 measurement process to say, attribution -- here
22 are the rules. They're pretty straightforward,

1 we do this, this and this.

2 And then -- but with the risk
3 adjustment, yes, something needs to be done for
4 those particular patient populations, but that
5 would be more in the profiling and the
6 measurement and the groupings of that to say,
7 here's the adjustment on the back end for that.

8 That's my only question.

9 CO-CHAIR RAPHAEL: Ateev, do you want
10 to make a comment?

11 CO-CHAIR MEHROTRA: Just two things on
12 that.

13 I think the -- maybe what I'm coming
14 away with is that these are really important
15 issues in terms of both locus control,
16 socioeconomic status and we're really interested
17 in that intersection between the attribution
18 rules in those.

19 And so, maybe this is a measure that's
20 less where who's responsible, it's going to be
21 either the hospital -- if it's a hospital-based
22 measure, it would be the hospital that we would

1 attribute it to and which hospital is pretty
2 clear cut because that's where the patient was
3 hospitalized.

4 But, in the example, I would think of
5 where we read the paper in relation to what was
6 happening in Minnesota and there were different
7 attribution rules. And, do you include the
8 inpatient E&M services in there. That's an
9 example where that locus of control and
10 attribution rule I think really intersects.

11 Similarly with socioeconomic status,
12 there are mechanisms where we could see that
13 intersection and maybe among our principles, we
14 need to be thinking about that.

15 For example, I'm just going to -- one
16 case that I was working on, I think I might have
17 mentioned on the phone was, for lower
18 socioeconomic status groups -- in particular this
19 Medicaid population -- they were seeing a lot of
20 behavioral health providers.

21 If behavioral health providers were
22 included as a potential provider you could

1 attribute to, whether it be a provider or a
2 physician group, et cetera, made a big difference
3 and that's an important intersection between
4 socioeconomic status and attribution rules.

5 So, I think maybe that's the thing I'm
6 taking away from this conversation is that we
7 have to be thoughtful of those. We can't really
8 make a clean box here that that's attribution,
9 that's something else.

10 CO-CHAIR RAPHAEL: The kind of
11 takeaways that I had were, you know, just sort of
12 Troy's point, that we have to keep coming back to
13 what can you really change and what's actionable
14 here.

15 The point, Ari, that you made, I think
16 is very important that we can't sort of back away
17 and throw up our hands because this is very
18 complex, that there is an importance to
19 attribution in terms of really creating
20 incentives and advancing a policy agenda and that
21 there are some risks attendant to not engaging in
22 attribution.

1 And then, you know, I think the point
2 you made, Ira, that we have to come back to which
3 is what is the unit of analysis, I think is
4 important. And, Eddie, the sort of it's not zero
5 percent or no control versus 100 percent control.
6 It's never going to be that either/or. We're
7 going to have to find some of the middle grounds
8 here as we forge ahead.

9 Is there anyone else who wants to
10 weigh in at this early stage in shaping our
11 thinking on this?

12 I'm sorry, can you introduce yourself
13 as well? Not only weigh in.

14 DR. BURSTIN: And let us know if you
15 have any disclosures you'd like to share with the
16 committee. I've got to do my job, sorry.

17 MEMBER SUTARIYA: Sure.

18 My name is Bharat Sutariya and I'm
19 Vice President and Chief Medical Officer for
20 Cerner's population health effort.

21 And, fortunate enough to serve on
22 various different executive committees on behalf

1 of some of our bigger client who happen to be
2 leading a huge ACO organizations of various
3 different types across the nation.

4 I'm also a practicing physician, so I,
5 of course, see the issue from a practicing side
6 as well as enabling healthcare systems to perform
7 within this accountability structure.

8 My interest here -- and this has been
9 fascinating comments -- my interest here is, how
10 do we optimize attribution for the entire
11 healthcare delivery ecosystem as opposed to just
12 provider. Whether that provider is just
13 physician or hospital or post-acute.

14 Because if we don't tackle this at the
15 ecosystem level and optimize it for any one
16 group, then we haven't solved the problem.

17 CO-CHAIR RAPHAEL: Brandon?

18 MEMBER POPE: The comments that --
19 about the different levels of unit analysis and
20 the different units that can receive an
21 attribution are really resonating with me.

22 And to me, it seems like we're talking

1 about this concept of like we have a measure, we
2 have a unit of analysis and an attribution and
3 then, that tuple, really, there's some measures
4 on that tuple which include this locus of control
5 concept, which include the relevance or
6 importance of the measure itself.

7 But, also, should include the
8 implementability of this, right. So, a lot of
9 times, we could come up with a theoretical
10 measure, an attribution which says, oh attribute
11 this to the patient's PCP. Right? But how easy
12 is that to discern in different data systems that
13 are out there in the real world is an important
14 concept not to lose sight of.

15 CO-CHAIR RAPHAEL: Charles?

16 MEMBER HAWLEY: So, to kind of -- I
17 guess I'm going to maybe throw a little bit of a
18 monkey wrench in here -- but to the conversation
19 about unit of analysis and locus of control, I
20 think I would just maybe propose that we think
21 about the simplest ways to do attribution.

22 And, not only, you know, when we're

1 talking about the unit of analysis, I think that
2 applies to the provider side. But it also
3 applies to we always talk about patients.

4 But I wonder if -- for the sake of
5 locus of control -- if, instead, you could look
6 at services. So, instead of attributing patients
7 -- and this doesn't necessarily work for quality
8 measures, but it might work for total cost of
9 care.

10 So, attributing -- you know what
11 claims you generated and the costs that are
12 associated with them. If you risk adjust those,
13 then you don't have to -- you're still
14 attributing claims I guess, but not quite in the
15 way that we typically think about it.

16 So, I would just maybe advocate for
17 simple attribution methodologies and maybe
18 thinking a little bit outside the box about even
19 attributing patients.

20 CO-CHAIR RAPHAEL: Thank you.

21 So, I think we're going to go on to
22 hear from CMS.

1 MR. MULDOON: Okay, so I guess I'm up
2 first. I think Sophia has some talking points
3 about CCSQ's perspective as well.

4 But, again, I'm Dan Muldoon. I work
5 at the Medicare Innovation Center, primarily on
6 our episode-based payment models, so that's the
7 Bundled Payments for Care Improvement initiative,
8 the Comprehensive Care for Joint Replacement
9 model and the Oncology Care model.

10 And, I think a lot of what we talked
11 about in the previous conversation also
12 translates into some of the challenges that we
13 experience at CMMI as well, primarily in terms of
14 the unit of analysis and the entity to which
15 you're attributing.

16 And, I think that, for us, occurs at
17 the intersection of a lot of our -- the models we
18 run, particularly -- or an example that we
19 discuss and are working on a lot is a beneficiary
20 in our models can be both aligned to an ACO,
21 either a shared savings program, Pioneer or Next
22 Generation ACO.

1 But also, be eligible to have an
2 episode in one of our episode-based payment
3 models.

4 And so, that intersection of how do
5 you align that beneficiary? Which entity is
6 responsible for the risk by the financial side or
7 on the quality performance side? How does the
8 beneficiary know, you know, which entity they
9 should be focusing on, working on for their care
10 coordination, et cetera.

11 I think another thing that's sort of
12 paramount for us as we work on attribution
13 methodologies across our models is sort of
14 balancing the timeliness of a perspective or a
15 first touch type of attribution approach with
16 maybe potentially more accuracy if you do observe
17 sort of over a longer period of time where a
18 beneficiary receives their care.

19 And then, also the notification that
20 comes sort of later in the fact if you do opt for
21 sort of a plurality-based retrospective approach,
22 which makes it sometimes difficult for

1 beneficiaries and the providers or hospitals or
2 other entities to really know who -- which
3 beneficiaries they are sort of responsible for
4 coordinating care and working to change aspects
5 of that care.

6 And then, another thing that's been
7 coming more recently is also who has access to
8 those designations, i.e., is an ACO able to go
9 and see when one of its beneficiaries is also
10 going to be part of an episode in one of our
11 episode-based payment models and vice versa for
12 those participants and providers in the episode-
13 based payment models and when they can see when a
14 beneficiary is aligned to an ACO or a primary
15 care practice in our comprehensive primary care
16 model and things like that.

17 And then -- so I guess to help maybe
18 frame this up, I figured I'd talk a little bit
19 about some of the episode-based payment models we
20 have and some of the specific challenges there.
21 And then, if people have questions or comments as
22 I go along, please, just feel free to jump in.

1 I'm hoping to frame this as like a conversation.

2 So, in our Bundled Payments for Care
3 Improvement initiative, we currently have around
4 1,475 entities that are participating in
5 initiating episodes and those can be either acute
6 care hospitals, post-acute care providers, SNFs,
7 long-term care hospitals and patient rehab
8 facilities and home health agencies or physician
9 group practices.

10 And, we initiate episodes there sort
11 of either starting with an inpatient stay or the
12 initiation of post-acute care following a
13 qualifying inpatient stay.

14 And, I think there, because we have so
15 many different types of providers to which we can
16 attribute episodes, we have this complicated set
17 of precedence rules that we call them about which
18 -- when a beneficiary, say, goes to an acute care
19 hospital that's participating but then is
20 discharged to a post-acute care provider, how do
21 we attribute to either a hospital or the post-
22 acute care provider?

1 And so, I think hearing feedback from
2 the committee in terms of a hierarchy or guiding
3 principles about -- within an episode of care and
4 when multiple entities could sort of have a
5 beneficiary attributed to them for that episode
6 of care -- how guiding principles for sort of
7 determining which entity should be responsible
8 for that beneficiary's care and the quality
9 during the episode of care.

10 I think Allison touched a little bit
11 on where the issues with -- when a beneficiary
12 who is also aligned to an ACO presents at a
13 bundled payments hospital or a comprehensive care
14 for joint replacement hospital, you know, that
15 beneficiary is eligible to start a bundled
16 payments episode.

17 And currently, it's said that
18 generally the bundled payments provider currently
19 -- typically is the savings and quality
20 performance first accrued to the bundled payments
21 provider and the ACOs are typically not really
22 accountable for that care during that episode.

1 But, we hear that creates a lot of
2 issues for accountable care organizations who,
3 you know, perceive that their beneficiaries have
4 better quality and lower costs ahead of time and
5 that there's a tension there between those
6 providers when the episode-based payment provider
7 isn't always directly integrated with the
8 accountable care organization.

9 And so, guidance there on different
10 ways in which we could potentially be more
11 flexible or work to sort of help integrate those
12 entities when there might not be a formal
13 preexisting business relationship.

14 CO-CHAIR MEHROTRA: Your comments make
15 me think about one principle I was -- I thought
16 might be useful for our committee and so I'll
17 pose the principle -- I'll put the principle out
18 there then ask you your reaction to it which is
19 that, as I looked at -- and I've been equally
20 guilty of it in some of the work I've done -- but
21 it's always been this idea that I've got to find
22 the provider, physician group, whatever, who is

1 responsible. It's always the provider, singular.

2 And, I wondered, in this particularly,
3 you have these precedence rules. I mean a
4 principle could be is that it doesn't always have
5 to be one person given the nature of this. So,
6 just to take the, you know, hospitalization plus
7 the post-acute care, why can't it be both?

8 Because there is a shared
9 responsibility so the attribution rules should go
10 to both and potential savings could go to both in
11 that manner. And so, the guiding principle could
12 be for the group, think about multiple rules that
13 attribute to multiple providers. It doesn't
14 always have to be a single person.

15 But, maybe that's not really a
16 feasible approach. Let me turn that back to you,
17 Dan. What do you -- what's your reaction?

18 MR. MULDOON: So, I think that that is
19 something that we would be interested in. I will
20 say we do have the ability to sort of set up
21 business relationships and different types of --
22 we call it game sharing payments -- between, say,

1 a hospital provider and a post-acute care
2 provider.

3 But, again, I think something where
4 there was this type of attributing to multiple
5 different types of providers or entities, if it's
6 not a -- if it's a non-provider that that would
7 be something that we would be interested in
8 soliciting feedback for and hearing different
9 perspectives in terms of the feasibility
10 approaches to how to structure that.

11 I think one of the things we struggle
12 with is that if you try to set up that -- if CMS
13 or maybe other payers -- but I can't speak for
14 them -- try to set up attribution for an episode
15 of care to multiple providers, we are -- it's not
16 always clear how to come up sort of with the
17 proportion of that episode that you sort of
18 attribute to either of the providers.

19 You know, even if the inpatient
20 spending typically accounts for a higher
21 percentage of the episode but a lot of the
22 variation in spending does occur in the post-

1 acute care portion of an episode, how is it --
2 how do you go about sort of constructing a split
3 between or attributing those providers that it
4 doesn't feel arbitrary or maybe giving them
5 additional flexibility in terms of how they
6 contract with each other. So, that type of
7 feedback I think would be helpful.

8 Do others --

9 CO-CHAIR MEHROTRA: Let me comment
10 then go to other people.

11 It's not clear to me you have to split
12 it up. You could just double account. But, that
13 was just one thought, this is my observation.

14 MR. MULDOON: Yes.

15 CO-CHAIR MEHROTRA: So, do you want me
16 to call?

17 CO-CHAIR RAPHAEL: Yes, Michael?

18 MEMBER BARR: Yes, thanks.

19 Throughout the opening comments and
20 then just through this dialogue, I'm wondering
21 how the call for patient relationship and
22 category codes affects the strategy that we're

1 talking about.

2 And, I mean it's in MACRA, there's a
3 call out for August 15th for comments. It would
4 seem that we're trying to impute these
5 relationships when trying to document them at the
6 point of care allows you the attribution to the
7 multiple different clinicians or entities.

8 And, I'm just wondering if there's
9 hope that these categorization and codes might
10 help some of the vagueness and the lack of
11 clarity in sort of the conversation we're having
12 in attribution and accountability.

13 MR. MULDOON: I do think that there is
14 hope and I know that we've sort of already
15 started talking about a little bit -- sort of
16 now, it's only, you know, a white boarding
17 session of thinking about how those types of
18 fields could be used on claims in order to sort
19 of try to, again, make this relationship and
20 responsibility for care and quality more
21 explicit. Whereas the current approaches are sort
22 of using implicit based approaches that are often

1 I think perceived that they're -- it's going to
2 be perceived as somewhat nebulous and it's not
3 always apparent to the providers or
4 beneficiaries.

5 MEMBER BARR: Yes, I mean, because I
6 can see the energy being used to try and take
7 claims and all these other things to figure out
8 the -- being used to sort of develop an algorithm
9 that takes those relationship codes and assigns
10 responsibility based upon an agreed upon set of
11 rules as opposed to trying to develop those rules
12 to figure what those attribution and
13 responsibilities are.

14 CO-CHAIR RAPHAEL: Bob?

15 MEMBER KROPP: Just a question for
16 Dan.

17 Ateev suggested that, you know, we
18 consider trying to find multiple -- or consider
19 the possibility of finding multiple entities.
20 And, there's -- and this perception may be wrong,
21 that's really the question, is it seems to me
22 that Medicare beneficiaries might be eligible for

1 multiple programs, depending on where they are
2 and who they are and the kind of services they're
3 getting. And, it is -- and yet, the CMS programs
4 sometimes specifically exclude certain patients
5 from being eligible for the hierarchy of programs
6 that they might otherwise participate in.

7 So, my question is, is it conspicuous
8 to anyone which -- what that hierarchy is and
9 what program a patient really falls into so that,
10 as Ateev suggests, we can really find the correct
11 accountable entity.

12 MR. MULDOON: So, I think we sort of
13 strive for that, but I think fall short some of
14 the time. I think it's hard, I think currently,
15 we're limited to what information we typically
16 can glean from the administrative claims which
17 currently don't contain those things like the
18 patient responsibility fields.

19 I think some of the programs do try to
20 move a step in the right direction by when a
21 beneficiary is aligned, they allow for sort of
22 this what's called voluntary assignment where a

1 beneficiary can reaffirm their attribution to a
2 Pioneer, a Next Generation ACO.

3 But, I think that we do struggle with
4 sort of making that hierarchy explicit across
5 models or when a beneficiary is eligible for
6 multiple models, really coming up with a way that
7 balances the different perspectives of the
8 entities in the different models such as the ACO
9 and episode-based payment model to ensure that
10 it's sort of mutually agreeable to the different
11 entities.

12 And then also, not -- also trying to
13 keep in mind the beneficiary's perspective in
14 terms of if their care is being managed through
15 providers under these different entities, how
16 that could potentially sometimes receive
17 conflicting advice and guidance as they go
18 throughout the period of time the beneficiary is
19 aligned to one of those entities.

20 CO-CHAIR RAPHAEL: Danielle?

21 MEMBER LLOYD: So, I, too, my policy
22 walks off. Part of the -- I was thinking about

1 the relationship codes as well and sent it to the
2 staff. I think they came out like the day after
3 our last call or something like that. I think we
4 do have a timing problem, though, because it's
5 not even going to be on the claims until 2018.

6 So, we might need to have a bucket of
7 things that we put somewhere or a parking lot or
8 things that are future state issues like, to the
9 extent that at some point we'll be able to get
10 EHR information to work in the attribution, the
11 relationship codes, the beneficiary choice
12 issues. Those can't really mechanically be done
13 right now. So, we need a kind of a second
14 bucket.

15 I think the other thing is, as Dan was
16 speaking, my blood pressure is getting higher and
17 higher and I love Dan and his work, but we
18 struggle with these things every day.

19 And so, there are -- it causes us
20 great angst. But, I think this whole issue --
21 this whole notion of overlapping programs and
22 precedence setting, I almost feel like we need to

1 set aside because their scope is so huge already.
2 It's sort of like once you all decide who you're
3 going to tag, what unit of analysis is it, then
4 what are the steps that you take to decide
5 specifically which provider, right, is in my mind
6 where I'm starting.

7 Because, otherwise, I think I'm going
8 to get overwhelmed personally. So, we decide the
9 mechanism after you all decide the policy piece
10 of it.

11 MR. MULDOON: You know, and I think
12 that's fair enough. I'm just trying to, I guess,
13 give a perspective of what we do struggle with.
14 And, although that is, I think, probably a
15 broader scope in this overlap, it is something
16 that we are struggling with and does, I think --
17 maybe it's about also just it is broader than
18 what we're dealing with here.

19 But, it is something that we are sort
20 of actively working through.

21 MEMBER LLOYD: And, I'll give you my
22 thoughts over lunch.

1 But, setting that aside, I think the
2 other principal piece that I think we need to
3 consider is, when it is in the context of one of
4 these payment policies, these payment programs,
5 to the extent to which the attribution can be
6 common among the spending measures and the
7 quality measures, I think it's very important
8 that that attribution is common.

9 And, sometimes we see disconnects and
10 CJR is an example. You've got quality measures
11 that are like HCAHPS that's for the entire
12 hospital and way before the bundle actually
13 happens.

14 So, trying to make sure that when
15 we're thinking about attribution, there's some
16 consistency between those sides of the houses, I
17 think, is very important.

18 MR. MULDOON: No, thanks for that
19 feedback.

20 I guess one other sort of point,
21 noting that and then sort of stepping into some
22 of the other types of work we do, I think one of

1 the other things we struggle with and we've been
2 working on with the Oncology Care model is that a
3 lot of times, some of the more established
4 attribution mechanisms are less applicable or
5 sort of have to be modified when we're dealing
6 with situations in which are -- so, the Oncology
7 Care model attributes episodes that sort of are
8 based around the initiation of chemotherapy and
9 receipt of those services for a six-month period
10 of time after the initiation of chemotherapy.

11 And, things like a typical prospective
12 attribution model don't really work there because
13 you have -- before you start receiving
14 chemotherapy or other types of services from
15 other specialists but this is -- the model is
16 focused on the receipt of chemotherapy.

17 You know, you obviously haven't been
18 receiving those types of services prior to when
19 that begins. And so, some of the sort of
20 approaches that I think we read about in our
21 papers and other things don't always -- aren't
22 always directly applicable.

1 And so, I think hearing perspective
2 about other types of thinking about when you have
3 sort of an episode that starts with an acute
4 event that isn't necessarily at a hospital or a
5 post-acute care provider, but that then is
6 something that we're working on and developing a
7 model or other quality measures about how to
8 attribute when you see those types of events that
9 occur that sort of start and look a lot different
10 than what a beneficiary's patterns of care looked
11 like prior to such an acute event.

12 CO-CHAIR RAPHAEL: Okay, this is what
13 we're going to do. We're going to hear from
14 about six people and then we have a break at
15 11:00 and then we're going to hear from Sophia
16 when we return.

17 So, I have, in order, Brandon and
18 Elizabeth, Ateev. I have Troy, Jenny, Michael
19 and -- Ari, did you have yours up? And Ari.

20 Okay, let's take it away.

21 Brandon?

22 MEMBER POPE: Thanks, Carol.

1 So, to your point about are we finding
2 just the provider. I just want to clarify. I
3 mean, we're attributing in some sense events and
4 outcomes for, for example, you know, Medicare
5 patients to multiple providers today. Right? I
6 mean, for example, we're participating in both
7 MSSP and our hospital obviously have VBP.

8 So, when MSSP based we go to the
9 hospital. I mean, this is already happening
10 today, so I just want to clarify and say, is that
11 -- I mean that's correct, right?

12 MR. MULDOON: Yes, no, that is
13 correct. I'm just thinking about that we're
14 still, I guess, working through and sort of
15 hearing from parties that are involved in
16 different entities.

17 And, I think a lot of times, it also
18 happens when the entities and the different
19 models that are running through the Innovation
20 Center are not integrated such as the system you
21 describe. That there is where some more of the
22 tension can emerge when the entities aren't as

1 integrated.

2 MEMBER POPE: And, I'm mostly on the
3 ACOs -- carrying the ACO's perspective, but as a
4 patient, right, I mean I find that to be a good
5 thing, right, that both my, for example, primary
6 care provider and the hospital I go to are
7 aligned that we have the same outcome in mind. So
8 -- and I don't think that we're trying to get
9 necessarily in all cases to the person that we
10 can hold accountable for a specific outcome.

11 MEMBER DRYE: This is just an -- I
12 wanted to raise another scope issue because I'm
13 really -- I think we should think explicitly
14 about whether we should think about when people
15 are using are different languages. I can't
16 remember when I read the MACRA rule, actually
17 pretty recently, whether it's relationship codes
18 or responsibility fields.

19 But, this is, as I understand it, the
20 law is saying providers will designate what their
21 relationship is with the patient. So, it's a
22 provider initiated or a physician or other

1 provider initiated determination that could
2 really play an important role in attribution.
3 And, I don't think of 2018 as that far away just
4 because it starts next October.

5 So, I think I would actually -- and I
6 usually tell -- because I don't usually argue to
7 expand the scope of committees to uncontrollable,
8 but I would -- I think it would be really helpful
9 for this committee or a subgroup or something to
10 think about that while we're thinking about
11 attribution.

12 What are the -- what's the
13 gameability? What are the opportunities? How
14 might it work to really strengthen attribution?

15 CO-CHAIR MEHROTRA: I think my comment
16 really builds on those, too, which is basically -
17 - I'll tell you, I'm conscious of our goal here
18 which is to try to outline the challenges. I
19 think we got that easy, that's pretty easy in the
20 attribution rules.

21 Then it's the principles where I'm
22 really struggling. So, what I'm hopeful I can do

1 is throughout the day -- and I'd love for others
2 to do this -- is throw out principles that you
3 might think we can try them out for size. Does
4 this really resonate with us or not?

5 And so, one that I would love to -- I
6 was on another -- in a very different format
7 mostly related to a commercial plan, so maybe
8 less relevant to Medicare -- at least for now --
9 which was that the guiding principle for
10 attribution was these attribution rules that are
11 based on claims is always the default if we don't
12 have the patient or the provider somehow
13 assigning this is the doctor who is in charge of
14 my care, this is the hospital, et cetera.

15 And that the attribution rules are
16 only -- these algorithms only come in if such a
17 rule does not -- if such a relationship has
18 already been not declared.

19 And that's an interesting principle to
20 have there. I will throw out the caveat that it
21 always -- it sometimes doesn't work perfectly, so
22 that works really well for something like a

1 primary care physician relationship where I would
2 say this is my primary care physician like many
3 HMOs have.

4 For example, when Dan was describing
5 the Oncology Care episode, obviously, if I had
6 designated my primary care physician, that may
7 not apply to that. So, I want to be conscious of
8 the limitations of that.

9 But, again, the principle that I want
10 to throw out there and see what your reaction is,
11 is that if we have an opportunity to have either
12 the patient or the provider or some combination
13 of the two declare who the responsible provider
14 is, that trumps the attribution rule. Those will
15 only come in later.

16 CO-CHAIR RAPHAEL: Okay, so we're
17 going to go down this side. I think Troy and
18 then Jenny, Michael, and Ari. Okay.

19 MEMBER FIESINGER: Sorry to finish my
20 danish. Thank you and I love what the Innovation
21 Center is doing, it's very exciting.

22 Two thoughts I had is, one, I know we

1 rely on claims data out of necessity and I know
2 you have a massive database and lots of really
3 smart people analyzing this. But, when I think of
4 me in a hurry and a medicalist or a nurse quickly
5 coding just a PQRS stuff, our overt error rates
6 and our own inability to attribute what is
7 relationship, et cetera. So, I worry about the
8 overall accuracy of the data. We're, with best
9 intentions, trying to report to you.

10 Two is, unintended consequences. Many
11 of these things we're talking about, attribution
12 is one, drive the healthcare ecosystem -- to
13 borrow your term -- toward the integrated
14 delivery systems. In my county of four million,
15 there is five hospital systems fighting over all
16 those patients and lives and everyone who is not
17 aligned is struggling to find their place.

18 And the third point is, I really like
19 the idea of patients saying this is who my
20 specialist, my physician is. It's so simple, it
21 took us a while to think of it.

22 Thank you.

1 CO-CHAIR RAPHAEL: Okay, Jenny.

2 MEMBER BEAM: And, I'll give the flip
3 side of both of those just because, again, in my
4 time at Humana, we dealt with self-selection
5 where a patient actually said this is my
6 provider. And, what we often found and even in
7 one of the articles that was submitted, you know,
8 I think it said every year a third of patients
9 change providers.

10 So, how often is that going to be
11 updated? How is that going to be updated?
12 What's the mechanism for that happening?

13 And then, also, what you find out is
14 you may be my provider, but you weren't
15 available. So, really, I went and saw you and
16 then I liked you so I kept seeing -- I'm sorry,
17 and for the people on the phone, I'm pointing to
18 different people in the room. But, you know,
19 ultimately, so those things start to change and
20 who really was responsible for that care during
21 the year. So, I guess I would really exercise
22 some caution in that just from what we've seen

1 historically.

2 And I guess my other comments when I
3 flipped my name badge up earlier was just around
4 kind of the same thing, Brandon, that you had
5 brought, you know, are we really trying to get to
6 the single provider because I really don't want
7 to limit ourselves, depending on what the use and
8 purpose of the attribution is, we really need to
9 allow some flexibility, cost and quality -- I
10 mean, you know.

11 And then, the specialist and the
12 hospitals, there's just so many different aspects
13 of things that we need to attribute and each of
14 those are going to have a little bit different
15 principles.

16 But, I think we can cover -- to your
17 point -- and I'm sorry, the gentleman down at the
18 end, I didn't catch his name -- but, you know,
19 really look at the ecosystem. And I think maybe
20 when we get to the case studies, things will
21 become really a lot more clear and we'll have a
22 lot more meat to put around this.

1 MEMBER BARR: My original comment was
2 stolen by Elizabeth, that 2018 doesn't seem that
3 far away, especially when we're looking at all
4 the work that needs to be done to get this done.

5 But then, it tees to me another
6 thought. I like your formulation about, you know,
7 these rules come into play -- the claims-based
8 rules come into play with the relationship codes.
9 But, I think, back to Eddie's point, it doesn't
10 have to be either/or. It's sort of what gets us
11 the most accurate representation of what's
12 happening in the ecosystem? And that would
13 respond to some of the concerns that Jenny's
14 raising and Ari has raised.

15 MEMBER LLOYD: Just saying that, God
16 help me if we use the codes in the first year in
17 which we're coding them. So, can we make that
18 2019 before available?

19 CO-CHAIR RAPHAEL: Okay, Ari?

20 MEMBER HOUSER: I was going to make
21 something that was very close to Ateev's comment
22 from like 20 comments ago which is why not just

1 double attribute and not partially attribute?

2 And, I think I've read in the
3 literature and in our discussion this kind of
4 unstated assumption that each patient has 100
5 percent of responsibility that has to be
6 attributed to -- in aggregate to providers or to
7 providers plus patient action plus social
8 determinates.

9 But, there's no reason it has to be
10 that way. Attribution is just a rule, it doesn't
11 have to -- you don't have to think of it as each
12 patient has attribution and you have to allocate
13 it to providers.

14 It's just a rule and it's part of the
15 measure definition. And it might -- a certain
16 attribution rule might not be a good measure
17 definition or it might not be part of a good
18 measure definition or it might be part of a good
19 measure definition. And it really -- it depends
20 on what you want to do with that measure.

21 So, from my statistical perspective,
22 there's no reason that attribution has to match

1 this concept of, well, we have to allocate, what
2 happens to every patient one to one to the
3 provider space?

4 Also from the measurement perspective,
5 I'm not sure I like the idea of allowing patients
6 and providers to override the attribution rule
7 because if you're -- somehow then you have a
8 different measure. If the attribution rule is
9 through claims but you can override that with
10 patient and provider saying, well, this is the
11 person responsible, I don't think you have the
12 same attribution model.

13 CO-CHAIR RAPHAEL: I thought what he
14 was saying -- and, Ateev, you can correct me --
15 was, in fact, you start with a patient or
16 provider and your default is to claims. Not the
17 reverse.

18 MEMBER HOUSER: Well, I don't think
19 there's a -- again, I think it's just a rule.
20 And I think by -- it may make -- not always --
21 let me stop.

22 I just -- if you have two different

1 methods of attribution, I don't think they're the
2 same. And so, I don't think that you can
3 necessarily -- they both might be good and
4 different and not -- be careful I don't mix them
5 without acknowledging that they could be quite
6 different.

7 CO-CHAIR RAPHAEL: Okay, on that note,
8 we are going to take a break and we're going to
9 come back at 11:20 and, Ira, I won't forget that
10 you have a comment, we will circle back to you.

11 But, at 11:20, we're going to turn it
12 over to Sophia.

13 So see you in 11 minutes.

14 (Whereupon, the above-entitled matter
15 went off the record at 11:07 a.m. and resumed at
16 11:21 a.m.)

17 CO-CHAIR RAPHAEL: Okay. We're going
18 to resume. Dan, do you have any concluding
19 comments before I turn it over to Sophia?

20 MR. MULDOON: No, I think we can move
21 over to Sophia. Thank you, though.

22 CO-CHAIR RAPHAEL: Sophia, take it

1 away.

2 DR. CHAN: Hi, good morning. My name
3 is Sophia Chan. I'm with the Center for Clinical
4 Standards and Quality at CMS.

5 Since very beginning -- and by that I
6 mean 2008 -- CMS has been talking about
7 importance of care coordination, of patient-
8 centeredness in care delivery. However, if you
9 look at the Affordable Care Act of 2010 for the
10 quality-based or value-based payment programs
11 that we are implementing, the statute tells us
12 which provider to either reward or penalize. And
13 the fact that the statute tells us so doesn't
14 mean that everybody agrees or is happy about
15 that.

16 In fact, for lack of better word, the
17 disconnect between what we say our goal is and
18 what our statute requires us to do in terms of
19 attribution, I think that partly bring forth a
20 project like this one to understand and examine
21 the current methods for attribution and to try to
22 develop principles that provide better practice.

1 And two ongoing issues that I'm quite
2 familiar with because of my work, the use of
3 outcome measures in two of the ACA sections, 3025
4 and 3008, the Hospital Readmissions Reduction
5 Program and the HAC Reductions Program. For both
6 programs the hospitals are held responsible for
7 outcomes that may be the results of teamwork of a
8 group of providers completely dropping the ball.

9 CMS' argument is that the hospital is
10 in the best position to coordinate care, even in
11 the post-acute care setting to reduce
12 readmissions and also to reduce likelihood of
13 HACs or other hospital-associated infections.
14 Also, clearly not everybody agrees to it, and as
15 a result we have this ongoing discussion about
16 whether the hospitals should be held responsible,
17 whether other providers should be held
18 responsible, whether it is the patient himself or
19 herself who should be held responsible for
20 repeated readmissions, for instance.

21 And you can also see that after the
22 ACA of 2010 the new laws that have been enacted,

1 including the IMPACT Act of 2014 and also MACRA
2 of 2014 -- these two acts are moving away from
3 attributing the outcomes to a specific provider
4 and continue to focus on care coordination, on
5 shared accountability, on shared decision making
6 and also patient-centeredness.

7 And other efforts, including the
8 Medicaid Innovation Acceleration Program of 2014,
9 which is still ongoing, that program focuses on
10 four major areas that also require teamwork and
11 also bring the issue of attribution into sharp
12 focus, like the integration of behavioral and
13 physician health, the care of high-cost users
14 with complex care needs, the integration -- the
15 community integration of patients with long-term
16 care needs and the reduction of substance use,
17 substance abuse.

18 And obviously without a good
19 understanding of the rules for attribution it is
20 difficult to encourage providers to work
21 together, because who knows whether one's effort
22 will be correctly and fairly attributed, and who

1 knows whether the patient would be given the
2 right care from the right provider, and whether
3 somebody would be held accountable if the
4 outcomes turn out to be not as good as expected?

5 The NQF MAP Hospital Workgroup has
6 observed that CMS is indeed capturing the big
7 picture of healthcare quality and rulemaking.
8 And the measures that CMS are proposing for
9 rulemaking are shifting from narrow clinical
10 topics and moving toward big picture of care.

11 And so again, the need for coming out
12 with principles that guide us through the process
13 of attributing to providers in a scenario when a
14 patient is being touched by multiple providers,
15 it becomes more acute.

16 At the same time, because hospitals
17 and other providers complain that they have been
18 swarmed by multiplicity of measures for either
19 quality reporting or for value-based payment
20 programs, the MAP Workgroup advocated the need
21 for cross-cutting measurement and also to drive
22 toward the parsimony of measurement.

1 At the same time, as we all know,
2 healthcare interventions are constantly being
3 funded by different funding streams, and each
4 time a new funding stream comes in, the patient
5 population might change a little bit, the program
6 design might change a little bit, certain data
7 sources become available. And as a result it
8 actually makes the picture of attribution murkier
9 because the -- how am I going to understand
10 whether I should attribute the outcome of a
11 particular point in time to a particular funding
12 source, to a protector or provider when patients
13 are being touched by different providers at
14 different times?

15 And in another report that the MAP
16 Workgroup has put together they rightly point out
17 that because of the increased emphasis on outcome
18 measures the issue of attribution becomes more
19 acute. And if done accurately and thoughtfully,
20 attribution could encourage providers to take a
21 greater role and become more accountable for the
22 quality of care.

1 And also, more importantly perhaps, it
2 sheds light on the fact that providers are not --
3 may not be able to control and influence every
4 aspect of care delivery efforts and also every
5 aspect of the social factors or clinical factors
6 that bring forth certain health outcomes.

7 So what are the aspects of attribution
8 in quality measurement that we would love to have
9 your input? Well, as I mentioned, when a patient
10 is being touched by multiple providers at
11 different times, how are we going to establish
12 who to hold accountable for?

13 And also we had talked about coming up
14 with strategies to deal with upstream factors.
15 What about the association among these factors?
16 For instance, a patient's outcome could be
17 directly or indirectly affected by hospitals'
18 organizational characteristics, the physicians'
19 financial incentives and the provider behaviors.
20 What is the association among these attributes
21 and these factors?

22 We talked about the potential role of

1 socioeconomic factors, race and ethnicity,
2 community attributes and their impact on health
3 outcomes. Do we understand the association among
4 these factors and how they might work together to
5 bring forth a particular health outcome, or do
6 they cancel out each other?

7 We also noticed that there's a weak
8 relationship between process measures and outcome
9 measures, which means a provider can do
10 everything that he or she is supposed to do, and
11 then what outcomes are still undesirable? What
12 are we going to do with that? Does it mean that
13 we should just hold providers, a certain provider
14 responsible, or should we look further behind the
15 delivery, care delivery process?

16 And for intervention models or
17 initiatives that spend multiple years with
18 providers coming and going, with patients coming
19 and going, how are we going to attribute health
20 outcomes over time? And for models that are
21 being implemented at the same time as other
22 unrelated models, models that have similar

1 purposes, but are either funded by other sponsors
2 or implemented by other payers, how are we going
3 to tease out the main effect of a particular
4 model even though the outcomes for the patients
5 that are being touched by that model may be
6 affected in a certain way by other co-occurring
7 activities?

8 I can tell you something about a
9 Maryland all-payer model. It's something I know
10 a little about. The implementing the global
11 budget model. At the same time the state itself
12 has been implementing the Maryland Hospital
13 Acquired Condition Program and the Quality-Based
14 Reimbursement Program at the same time. Maryland
15 is also a place where ACOs proliferate. At the
16 same time, each of those 47 acute-care hospitals
17 are implementing their own quality improvement
18 programs.

19 So even if CMS or the State of
20 Maryland is interested in reducing the rates of
21 hospital readmissions or the rates of hospital
22 acquired conditions, how are we going to tell

1 whether any change in those rates are the result
2 of the global budget model, or is it actually the
3 results of the ACOs' or the hospitals' own
4 effort? How are we going to tease that out? Do
5 we have the data to inform us about that? And
6 even if we have data, is there a time lag?

7 Currently, for instance, it takes two
8 or three years to get clean, accurate and
9 complete Medicaid data. Can we wait for that
10 long? And even if we go directly to the source
11 of the data to request Medicaid claims data, I
12 can tell you from direct experience, despite the
13 best efforts, despite the best intentions, it has
14 been an uphill battle.

15 And if you want to compare a model or
16 an initiative that has been implemented across
17 several states, and if the Medicaid claims data
18 are not uniform, are we going to be able to trust
19 the results? Are we going to be able to tell
20 which particular state has more successful
21 performance in outcomes because it is the
22 reality, or can we say for sure that it is not a

1 result from methodological artifact?

2 And also, as one of you have alluded,
3 how are we going to make attribution information
4 actionable? How are we going to make that
5 information meaningful to the patients, to the
6 caregivers, to the plans, to the providers and to
7 policy makers?

8 I look forward to hearing your
9 feedback on these issues. Thank you.

10 CO-CHAIR RAPHAEL: Okay. Well, thank
11 you, Sophia. You have given us what I recorded
12 as seven challenges.

13 (Laughter.)

14 CO-CHAIR RAPHAEL: I think you kind of
15 covered the proverbial waterfront. And the first
16 is if someone -- and increasingly our clients and
17 patients are touched by multiple providers,
18 especially if they have multiple chronic
19 conditions, the issue of all the upstream
20 strategies that you talked about and the
21 relationship among those to attributes, I'm
22 interested and I would like to hear a little bit

1 more about the weak relationship between process
2 and outcomes. The time period which we talked
3 about earlier as well.

4 I think, Dan, you brought this up.
5 There are a number of models that are being
6 implemented at the same time, and they're not
7 formally linked. How do we deal with that? The
8 whole issue of data: the fragmentary nature, the
9 lack of uniformity, the data lags. I myself did
10 not realize it took two to three years to get
11 accurate clean data from our Medicare system.
12 And the point that was made earlier by Troy and
13 several other people about how to make sure that
14 whatever is done is actionable and meaningful to
15 multiple constituencies.

16 So here we have seven challenges. So
17 let me turn to everyone and see if there are any
18 questions for Sophia or any challenges that you
19 think have not been cited.

20 Okay. Ira, you get first dibs.

21 MEMBER MOSCOVICE: So let's make this
22 real rather than hypothetical. I work at the

1 University of Minnesota. When I started there
2 many years ago I had 12 insurance options. Now I
3 have four. If I choose one, HealthPartners, I
4 have to stay in the system; I have to get a
5 referral from my primary care physician. It's
6 pretty clear.

7 Well, as you age you sort of move away
8 from that, and you say -- you take the I'm free
9 as a butterfly. I'm willing to pay. I can go
10 wherever I want. People as they age, who were
11 just in this healthcare system occasionally,
12 well, guess what, they get chronic illnesses,
13 including cancer, where you talk about the
14 oncology care model.

15 So let me give you a real situation.
16 A person who's been going to a primary care
17 doctor. That's their usual source of care, so
18 forth. Gets cancer. Clearly he still sees for
19 non-cancer things the primary care doctor, but
20 certainly has two usual sources of care at that
21 point and is getting two different sets of care.
22 Oh, gets a second opinion on cancer and now is

1 using two systems of care for the cancer stuff,
2 somewhat coordinated because of efforts of care
3 givers. This is not random variation. This is
4 the world we live in. Cancer is being treated as
5 a chronic illness now.

6 And from all the conversations we've
7 had up to now, I'm hearing people say, well, we
8 want to attribute this -- well, guess what? This
9 patient really has -- this person has three usual
10 sources of care. It's legitimate, and it would
11 be foolish to try to attribute that person to one
12 provider. And, so, yes, and if you went for the
13 total course of care, by God, the primary care
14 provider would go by the wayside.

15 And I think as our population ages,
16 this is going to become more and more you talk
17 about multiple chronic illnesses. This is not
18 simple. This is really, really complicated. I
19 think it gets back to what Ateev was saying in
20 terms of the notion that we're going to attribute
21 every patient to one provider. That's just not
22 realistic. It really, really isn't.

1 And as we go to ACOs and everything
2 else, if we don't take into account the insurance
3 plan we have and the options we have as
4 individuals, that would be foolish I think,
5 because we really have -- that influences this
6 whole process so, so much in terms of what we can
7 do and its impact on both cost of care,
8 coordination.

9 I'll throw in one last thing and then
10 stop talking, which is what's remarkable is all
11 those providers have the same electronic health
12 system, and the ones that are within the same
13 integrated delivery system can talk to each
14 other, and the ones who are not in the same
15 integrated delivery system with the exact same
16 electronic health record cannot talk to each
17 other.

18 CO-CHAIR RAPHAEL: Okay. Ateev?

19 CO-CHAIR MEHROTRA: Carol's got that
20 covered in New York, by the way. The
21 interoperability things. No worries about that.

22 CO-CHAIR RAPHAEL: I have to have

1 pride. Not only are both presidential candidates
2 attached to New York --

3 (Laughter.)

4 CO-CHAIR RAPHAEL: -- but I have to
5 take pride that New York is actually making
6 strides toward having that covered.

7 CO-CHAIR MEHROTRA: So just want to do
8 a quick check on the Committee and regroup a
9 little bit. So we have about I think, do I have
10 this right, until about 12:30 or so --

11 CO-CHAIR RAPHAEL: 12:45.

12 MS. WILBON: Well, we do public
13 comment at 12:30, so --

14 CO-CHAIR MEHROTRA: Okay. So public
15 comment at 12:30. We'll see if anyone from the
16 public speaks here. I think the goal of these
17 next 45 minutes or so is to really kind of check
18 in about some of these principles now that we've
19 had a nice rich discussion. I really appreciate
20 the input from CMS as well as NQF in terms of
21 really trying to make this concrete in terms of
22 some of the challenges.

1 What I thought again, just to keep on
2 pushing here to try to make this -- think about
3 what's our end goals, these principles that we
4 want to develop, I thought I'd throw a couple of
5 those, again trying them out for size, not wedded
6 to them, but just more to see what people think.
7 And if you want to either expand or flesh out or
8 reject, please do so.

9 Oh, okay. This says can be revised as
10 needed. Will be revised.

11 (Laughter.)

12 CO-CHAIR MEHROTRA: Let's be clear
13 about that. All right.

14 CO-CHAIR RAPHAEL: You're going to
15 give us our baseline.

16 CO-CHAIR MEHROTRA: Exactly. Exactly.
17 So I think the first principle that I would say
18 that might be helpful here is someone who's
19 developed quality metrics in the past, and others
20 have done this much more than I have, is that the
21 attribution aspect is often an afterthought.
22 It's like, oh, man, I've got to figure that out,

1 too. Well, you're so focused on so much about
2 the -- how am I going to capture the heart
3 attack?

4 And so, I think the first place the
5 principle might be attribution is a big deal and
6 you really should be focused on it. And then it
7 sounds so obvious, but I really wanted just to
8 make that clear, and that in some cases, for us
9 to make the point that the choice of the
10 attribution rule, in some cases, can make a big
11 difference on the performance of an individual
12 provider or health system. And just to really
13 put that out there, saying we need to be focused
14 more in terms of attribution.

15 The second principle I just want to
16 throw out there as an idea is that no single rule
17 is going to be applicable across the board. And
18 so as much as we'd love to have simplicity as
19 well as consistency across a thing, we have to
20 recognize that no single rule is going to work
21 for the oncology bundled payment program and the
22 patient-centered medical home and an ACO, as well

1 as a quality metric on MI mortality.

2 I think the third principle I wanted
3 to throw out there that I'm hearing is to
4 challenge some kind of common expectations or
5 uses of attribution rules. So first is this
6 attribution to the provider. Multiple providers
7 make sense. I'm also hearing a lot that a lot of
8 the attribution rules that I saw in the
9 environmental scan as well as others that I've
10 used have always attributed to a single
11 physician. It's always been the starting place.
12 And then we'll go to physician. Then we'll
13 aggregate up. And maybe that's something we
14 really need to challenge given the nature of many
15 of these -- the goals of these policies is to
16 really do team-based care.

17 And then lastly, in some cases, let's
18 put it this way, self-selection might be
19 helpful --

20 (Laughter.)

21 CO-CHAIR MEHROTRA: All right. Maybe
22 a little pushback -- might be helpful as a

1 adjunct. It's always not just about the claims
2 rule, but having the patients or the providers
3 play a role could be useful. So that's the third
4 thing.

5 And the fourth one I wanted to -- the
6 one I was kind of intrigued with, which I feel
7 might be the most controversial, is that it's the
8 responsibility of someone who's developing a
9 metric, a quality metric, as well as some other
10 policy, to test more than one rule, just going
11 out there and saying principally this is the rule
12 I want. But if you haven't tested a couple of
13 them, we have data here that makes a difference
14 if you choose which rule -- and so, if you go
15 there and choose a quality metric that only has
16 -- you only test one rule, you probably didn't
17 really assess it. We should expect it makes a
18 difference, but at least you should be testing
19 different attribution rules and then assessing
20 from that which is the rule that best captures
21 what you want from that particular metric or
22 policy.

1 So those are just four principles.

2 Let me repeat them again. Attribution makes a
3 big difference, no single rule is going to work,
4 challenge some common expectations of how we
5 build these rules, and make sure you test more
6 than one rule.

7 So with that, let me open up to folks,
8 and say that was bad, good, terrible or others.

9 CO-CHAIR RAPHAEL: Okay. Let's start
10 with Danielle. You were first.

11 MEMBER LLOYD: I actually had
12 something left over from Sophia. Sorry.

13 CO-CHAIR RAPHAEL: Okay. Well, why
14 don't you do that?

15 MEMBER LLOYD: Yes.

16 CO-CHAIR RAPHAEL: Because we don't
17 want to lose that thread either.

18 MEMBER LLOYD: Well, I think something
19 that Sophia said sort of made me think about this
20 in terms of readmissions. And Sophia said let's
21 assume you have to have readmissions and the
22 hospital has to be tagged, right? Set that

1 aside. Part of what the hospital field has
2 argued for a long time is potential exclusions to
3 deal with the locus of control issue.

4 So let's say planned readmissions,
5 burns, et cetera. So what that brought to mind
6 is I think there's a step that is foundational to
7 attribution but isn't necessarily attribution
8 that we need to think about, being what is the
9 patient population for whom you may be applying
10 this attribution, right?

11 So are there specific rules around by
12 payer or -- so within MSSP, as an example,
13 there's a series of criteria first. You have to
14 have A coverage and B coverage. You can't be in
15 Medicare Advantage. You can't -- I forget what
16 all the rest of them are. But there is a step
17 first of who's eligible for attribution? And we
18 need to think about that.

19 But secondly I think on your list --
20 I think these are great. I think it doesn't try
21 to start capturing the concept that I was trying
22 to formulate into a principle, and I don't think

1 I did a good job of getting at it at a principle
2 level, but this notion of trying to make sure
3 that if you're measuring quality and a payment
4 program at the same time that the spending
5 measures and quality measures are using a common
6 attribution model so that there's some sort of
7 matching there. I don't know how you raise that
8 to a sort of principle level. Maybe someone
9 could help with that.

10 But the only one that made me nervous
11 was that you have to test more than one rule. I
12 guess part of this is if we're trying to get to
13 some consistency, do we -- that sort of goes the
14 other way of encouraging people to use different
15 rules. So I'm still thinking on that one. I
16 just wanted to raise the concern.

17 DR. BURSTIN: I'm not quite sure
18 that's what you were saying. My interpretation
19 of what Ateev was saying is before you put it out
20 there, you should have done some testing, and
21 then one rule goes out, but that you should at
22 least have attested a couple of different

1 attribution approaches before you settle on one,
2 not that you would put multiples out there.

3 MEMBER LLOYD: Yes, I think it's that.

4 So let's say you're within an ACO context. Do
5 you really want them testing visits versus cost,
6 patient versus episode, all those things, or is
7 that we're trying to get -- I mean, this is a
8 fundamental question for our charge, right? Or
9 are we trying to get to one sort of common set
10 that everyone tries to use when measuring ACOs,
11 right? Are we trying to get standardization, or
12 are we not? And that seems to be a little bit in
13 both directions.

14 CO-CHAIR MEHROTRA: Let me just react
15 to that and then -- but then I don't know the
16 answer to this question. My own thought here is
17 is that it's unlikely or impossible for us across
18 the very different domains here for us to
19 basically say at the end to the community of all
20 those folks out there who need this here are the
21 rules thou shall use for ACOs and thou shall use
22 for patient-centered medical homes, et cetera,

1 and rather, what I -- at least where I'm headed,
2 and you guys push back, is that we don't know the
3 answer. We think there's going to be different
4 rules you're going to use for different
5 circumstances, but here's almost a checklist or a
6 set of principles you should be thinking about
7 when you choose the rule that you're going to be
8 applying.

9 And going back to that point,
10 Danielle, I mean, I don't expect every person who
11 develops a rule to go through what the folks did
12 on this where they tried seven different rules or
13 fifteen different variations, but at least to try
14 one or two others is kind of where I'm thinking.
15 Because you might have two candidate rules and
16 then you want to at least try them out because it
17 might make a big difference and at least force
18 people to go through that exercise of what's the
19 right think they want to capture here?

20 So that's at least where I was headed,
21 but Carol and others, jump in.

22 MEMBER SRIDHARA: Thanks. So a quick

1 response to that, and then I'll give you my
2 comments.

3 So I agree that we should land on
4 principles rather than being prescriptive, but we
5 probably do need to coalesce around some best
6 practices for at least some major use cases, say
7 ACOs or certain types of groupings or bundles
8 that are commonly considered today. So I would
9 say we should probably push it a little bit in
10 the standardization approach but maybe in some
11 particularly critical areas that we know are
12 common concerns and perhaps where we have some
13 more evidence base. So that would be one.

14 Part two, my comment, sort of in your
15 list of principles, and maybe this is really a
16 subset to your it's complex; it's not so simple.
17 And I guess you framed it around different
18 clinical settings and perhaps just general
19 attribution attestation versus sort of
20 attribution, let's say.

21 But I would also say our goal, is it
22 performance measurement, or is it payment? I

1 think these are overlapping but distinct goals,
2 and I think we should keep that in mind. And
3 what you do in attribution changes a little bit
4 when you're considering those two goals. And so
5 we should consider that in how we discuss this
6 attribution discussion. Some of the questions
7 about responsibility and location data and sort
8 of locus of control and so forth become more
9 important in payment discussions than in
10 performance. And you can do sort of complete
11 attributions to multiple doctors for performance,
12 but you may not want -- you want some sort of
13 allocation in a payment.

14 So I think we should consider these
15 sort of at least overarching broad use cases as
16 ways we frame our attribution discussion.

17 CO-CHAIR RAPHAEL: Thank you.

18 MEMBER KOCHER: Yes, I've been
19 reflecting on a lot on the comments from this
20 morning, and I think it's principle three that,
21 Ateev, you're sort of mentioning. I was sort of
22 arriving at some of those same conclusions. I

1 sort of wonder, just sort of staking out an
2 extreme description of that, like are there -- is
3 it ever fair to attribute at the individual
4 level, given sort of all the challenges around
5 attribution is not really a zero sum game. You
6 could have double attribution. What's the unit
7 of analysis? It's mostly team-based care anyway.

8 Even when you sort of drill down to
9 what you think is very clear sort of patient
10 interaction with provider interaction, it's never
11 one versus one. Even say a surgery. I mean,
12 there's always an anesthesiologist in the room as
13 well. There's ancillary care that goes on.

14 So I guess the question is like could
15 you even -- is it fair to have attribution at the
16 individual level ever? And if so, under what
17 conditions would you want that to occur?

18 CO-CHAIR RAPHAEL: Okay. Laurie?

19 MEMBER RADWIN: So I was stuck on the
20 same principle challenging this assumption about
21 an individual provider being responsible for a
22 patient process or outcome solely alone. And I

1 was struck by your second slide that really
2 focused on attribution overlapping with patient-
3 centered care and coordination, because typically
4 you don't think of attribution that way.

5 But in fact it's all over all of our
6 readings, and really innovative ways of looking
7 at how we deliver care and the importance of a
8 primary care or patient-centered medical home or
9 whatever. And even when you look at the
10 environmental scan, and you read down the titles,
11 it may say pay-for-performance for physicians,
12 but if you read the description, it's actually in
13 the primary care setting or with a team of folks
14 with aftercare and such.

15 Coming from the VA, primary care is
16 huge. Primary care -- we call our patient-
17 centered medical home a PACT. It's a very team-
18 based approach. It works well. If you've been
19 to one VA, you've been to one VA, but when it
20 works well, it works really well. And it drives
21 -- it's sort of an exemplar of this idea that
22 it's a team-based approach with primary care

1 being the attributable unit of outcome assessment
2 and measurement.

3 So I just wanted to remark on that
4 third principle and how it intersects with this
5 whole notion of coordination of patient-centered
6 care, which seems to have an importance in
7 attribution that I didn't expect.

8 CO-CHAIR RAPHAEL: Okay. Nate?

9 MEMBER SPELL: I just wanted to come
10 back to potentially adding in a fifth principle
11 that I mentioned earlier, which was that
12 principle of transparency. And I think it ties
13 into a lot of what we've been saying, so if we
14 are being -- if we're giving attribution its due,
15 we should be thoughtful about the purpose of the
16 attribution and be able to be explicit about that
17 in the measure development and then I think in
18 the description of the measures to the
19 stakeholders who will be measured by it and be
20 trying to use the measure.

21 So being able to be transparent about
22 here's our purpose for this attribution, and even

1 to the point of, we tested several, and here's
2 why we chose this one. What was the rationale
3 for choosing this one? And that helps to provide
4 the accountability to be sure it is aligned with
5 the purpose. So I think being explicit is good.

6 CO-CHAIR RAPHAEL: Troy?

7 MEMBER FIESINGER: I appreciate
8 several of the points that have been made. I
9 like the thoughts of is this attributed for
10 payment or for performance. It's something I've
11 struggled with, especially coming out of 10 years
12 of residency education, is in a clinic with 50-
13 plus physicians at different levels, with nurses,
14 with MAs, what do we attribute at what level?
15 Should we think about an n of 30 minimum to make
16 it realistic or measurable and practical for a
17 provider? That's something that's been
18 researched. Should things even be attributed to
19 individual providers at all? I think that's a
20 very valid question because that's something that
21 harkens back to the old culture of the autonomous
22 physicians? Do we do it just because we've done

1 it?

2 And what I started to evolve to is
3 different levels of attribution within our clinic
4 based on different measures. If it's
5 immunizations, I have little to do with it. It's
6 my nursing team or the nursing team that's doing
7 a great job there.

8 I worry a little bit about what I call
9 the Kitty Genovese effect. I would like enough
10 individual responsibility that people feel
11 accountable for the care that they're giving but
12 not so much they feel they're being unfairly
13 penalized for the care they're giving. I don't
14 have an answer to that, but I think there is a
15 balance. Too much system accountability,
16 individuals lose skin in the game. Too much
17 individual accountability, you demoralize them
18 because they feel they're being unfairly
19 penalized.

20 CO-CHAIR RAPHAEL: Okay. Elizabeth?

21 MEMBER DRYE: A lot of great points
22 just made. I, just before I lose track of it,

1 wanted to agree with Nate that the transparency
2 of the concept that the attribution strategy is
3 trying to achieve is really critical. And I'm
4 struggling in my head with the difference between
5 what we do when we develop quality measures,
6 because I want to disagree with Ateev for a
7 minute here.

8 Actually, we think a ton about
9 attribution. When my group develops outcome
10 measures, for example, the hospital readmission
11 measures or the ACO admission measures, we start
12 by thinking for weeks and months and engaging
13 experts and stakeholders around attribution
14 before we even think about what's the right
15 outcome; what's the right cohort; how do we risk-
16 adjust this?

17 And when we come to NQF for
18 endorsement or we put the measure in a program,
19 we have to really clearly articulate the measure
20 concept. So I totally agree with adding that
21 principle that attribution strategy should be
22 linked to an explicitly stated measure concept

1 that's transparent.

2 And I'm struggling a little bit with
3 how that relates to the quality measure. I'm not
4 100 percent sure if the programmatic use of some
5 of these measures is the same or different than a
6 quality measure. I think it's actually both.

7 Sometimes, like I built an admission measure for
8 ACO that contains an attribution strategy, right?

9 And it's implemented in CMS's ACO, CMS, CMMI's

10 ACO programs with that strategy, but sometimes,

11 many times this drives Helen crazy sometimes.

12 People are just taking measures and applying them

13 and then building an algorithm to attribute say

14 process of care or outcome measures.

15 So I think we should explicitly
16 recognize that the measure concept that we come
17 forward with in measure development doesn't
18 always fully address it, and any attribution
19 strategy needs to have its own clearly stated
20 concept.

21 And I just wanted to echo before I
22 stop this long-winded statement that a couple of

1 other really great ideas I just wanted to agree
2 with, which -- we should I think comment on
3 whether it's ever fair, when it might be fair to
4 attribute an outcome to an individual provider,
5 or at least vet what parameters should be looked
6 at.

7 And I agree with you about -- I would
8 characterize what you're saying about multiple
9 testing is just like a sensitivity analysis
10 around whether that approach -- whether your
11 choice of approach is -- your results is really
12 sensitive, and there might be other ones that
13 should be vetted.

14 So, great. I mean, just so many great
15 ideas.

16 CO-CHAIR RAPHAEL: Okay. Ari?

17 MEMBER HOUSER: I like the original
18 four principles that Ateev articulated, and I
19 agree with transparency as well. And I wanted to
20 suggest one more, which I think also kind of goes
21 without saying, but it also really needs to be
22 said, is that attribution is not accountability.

1 It's not assigning responsibility. It's matching
2 patients and patient-related outcomes to
3 providers or groups of providers. And if you
4 want to hold some providers accountable for
5 patient outcomes, you have to do that, but the
6 process of attribution is not the process of
7 accountability.

8 CO-CHAIR MEHROTRA: Ari, do you mind
9 if I clarify just a little bit? So I think I
10 conceptually understand, but I'm trying to think
11 concretely how the difference was. So maybe you
12 could kind of flesh out the distinction between
13 accountability and attribution rules.

14 MEMBER HOUSER: I mean, an example
15 might be that, and it's going to be kind of
16 contrived, but you could attribute say --
17 readmissions is hard because it's a really easy
18 attribution. But you could -- relatively.

19 PARTICIPANT: No. Not so easy.

20 MEMBER HOUSER: Relatively.

21 (Laughter.)

22 MEMBER HOUSER: But you could

1 attribute a patient outcome to a provider and
2 then use that piece of information in research to
3 see providers that have good outcomes, what are
4 processes that they're doing, organizations that
5 correlate with that outcome. You can kind of
6 find out information. And you're never actually
7 rewarding or penalizing the providers, but you're
8 looking at what provider behaviors seem to be
9 associated with good outcomes.

10 So there's no actual accountability
11 there, but -- so that's a way that you could use
12 a measure that's got attribution in it without
13 doing the accountability piece. Is that clear?
14 I just --

15 CO-CHAIR RAPHAEL: All right. But I
16 did think that one of the reasons that we're
17 spending our time on attribution is to --

18 MEMBER BEAM: -- blocks the podium

19 CO-CHAIR RAPHAEL: Thank you.

20 MEMBER BEAM: Sorry to interrupt,
21 but --

22 CO-CHAIR RAPHAEL: It's all right.

1 That's important to know. Can we --

2 MEMBER BEAM: That's okay. I'll just
3 --

4 CO-CHAIR RAPHAEL: All right. Great.
5 Okay. Well anyway, I thought one of the reasons
6 that we're working so feverishly on attribution
7 is to foster increased accountability in our
8 healthcare system and that in some ways they're
9 much linked.

10 MEMBER HOUSER: I agree. I just think
11 it's important to conceptually distinguish.
12 Accountability is a measure use decision, and
13 attribution is a measure definition piece. And
14 so I think the kind of rules that we --
15 recommendations that we might have could be, if
16 you want to do this kind of accountability, these
17 are properties of your attribution that are
18 useful to have, or this type of attribution
19 presents this type of problem for accountability.
20 And I think that separating them conceptually is
21 something that you need to do to be able to make
22 that kind of statement.

1 CO-CHAIR RAPHAEL: Okay. Jenny?

2 MEMBER BEAM: Thank you. And I'm
3 actually going to tag onto what Ari was saying.
4 I think I was kind of talking about this earlier,
5 too, because I think the distinction between
6 attribution and accountability maybe is saying
7 that assigning patients to providers is one
8 thing, but not necessarily making a judgment on
9 what you're seeing in the results is appropriate
10 or not. I don't know if I'm capturing what
11 you're saying.

12 But for instance, you can have a team
13 of providers where one provider is doing all of a
14 certain procedure because nobody else wants to do
15 it, and they said, oh, they don't bother me; I'll
16 do that. Or maybe you have a certain practice
17 that has some equipment in their offices that's
18 typically not found in other practices. And
19 maybe by having that piece of equipment, they're
20 saving money on the inpatient, so they might look
21 to be over in cost, but yet really they're saving
22 the system money in the long run.

1 I could give example after example of
2 times when just looking at it on the surface is
3 not necessarily giving you the answer that you're
4 really looking for. And if you just take it on
5 the surface, I think that's kind of what Ari was
6 going at. I don't know.

7 I don't want to speak for you, but --

8 MEMBER HOUSER: I haven't really --
9 because I've only been here for a few hours. I
10 haven't really fully thought through the
11 implications, but one thing I would say is I
12 don't want us to write off an attribution because
13 we don't want to use that attribution for a
14 certain kind of accountability.

15 For example, a one-touch attribution
16 rule may have some useful implementation
17 purposes, but certainly we wouldn't want to hold
18 accountable everybody who sees a patient for the
19 outcome of that patient.

20 CO-CHAIR RAPHAEL: All right. Go
21 ahead, Jenny. Why don't you finish up?

22 MEMBER BEAM: Yes, I definitely agree

1 with the first four that you listed, and I do
2 believe that self-selection is helpful with that
3 as well. I completely agree with Srinivas on
4 talking about best cases, best practices on use
5 cases. I'm having a hard time in the discussion
6 because even some comments, like when you hear
7 them you're like, yes, that applies for quality,
8 but not necessarily for cost.

9 So I feel like I'm having a hard time
10 in the discussion even making comments, because
11 I'm thinking about a certain case in my head, and
12 then later I'm thinking but it does apply to that
13 one as well. So I think we have to start kind of
14 breaking this down on a different level.

15 I definitely agree with the
16 transparency as well. And I don't know -- I know
17 we've talked about, in the development of models,
18 you mentioned that you test more than one. What
19 about adding a principle that says that you need
20 to have provider and patient either corroboration
21 of your model, collaboration, so that again when
22 you're setting them a model up that you're

1 actually talking to some providers, having them
2 sit down at the table with you and saying, yes,
3 this seems right or this is way off base.

4 So not necessarily saying, here's your
5 quality results; here's your cost results. What
6 do you think? That's the wrong time to do that.
7 But saying, here's the patient panel that's been
8 identified for me using this attribution model.
9 What do you think? And then in that way, that's
10 really a balance I think that a lot of places
11 don't put in place.

12 CO-CHAIR RAPHAEL: Okay. So we are
13 going to pause, and I don't want anyone to feel
14 concerned that we won't get back and give you all
15 a chance to share your thinking, because I do
16 have a list of everyone who wants to speak. But
17 I think at this point Ashlie wants to give us
18 some guidance, I would say, after the horse left
19 the barn.

20 (Laughter.)

21 CO-CHAIR RAPHAEL: And so, about what
22 the principles, the guiding principles should

1 actually look like.

2 MS. WILBON: Yes.

3 CO-CHAIR RAPHAEL: All right, Ashlie.

4 MS. WILBON: So, no problem. Because
5 you guys are having such a great conversation, I
6 didn't want to interrupt. And a lot of what we
7 had planned for today is kind of happening
8 organically, so we're doing less kind of
9 direction. So we're going to try to figure out
10 when to kind of jump in and provide you guys
11 structure when we're needed. But so far, so
12 good.

13 So what I will do though is go over
14 this last bullet point where we mention that
15 there were some other projects that have been
16 done at NQF where we have had committees convene
17 for a similar purpose in terms of providing
18 guidance around a particular topic area.

19 And so -- if you can move to the next
20 slide. So we just have a couple of examples of
21 some principles from another committee that was
22 convened around the risk-adjustment work. So

1 just to give you an example of what some of the
2 principles looked like, not to say that your
3 principles have to mirror this or anything, but
4 just in terms of structure and the type of
5 guidance that was provided in the principles.
6 And hopefully you guys find this helpful.

7 So the first being that outcome of
8 performance measurement is critical to the
9 National Quality Strategy. Performance
10 measurement and risk-adjustment must be based on
11 sound measurement science. Disparities in health
12 and healthcare should be identified and reduced.
13 And the last one being, when using accountability
14 applications performance measures that are
15 influenced by factors other than the care
16 received, particularly outcomes, need to be
17 adjusted for relevant differences and patient
18 case mix to avoid incorrect inferences about
19 performance. So that obviously was a major
20 principle that they developed in saying that this
21 is something that needs to be accounted for.

22 So just again, this is just additional

1 guidance for you guys to keep in mind as we
2 continue this discussion, but also when we break
3 out into the Case Study Workgroups, that's going
4 to be another deliverable for each of the groups
5 to kind of come up with, principles that may be
6 gleaned from thinking about this through the lens
7 of your particular case studies. So hopefully
8 that's helpful for people that have questions
9 about how they should be put.

10 We're not looking for perfect wording
11 or sentence structure or anything at this point,
12 but continue to throw out ideas. I think that's
13 really helpful for us to just get things on
14 paper. And we can work as a team and with the
15 Committee after to kind of massage these a little
16 bit more into what we're all looking for.

17 So I don't know if we had any
18 additional input from Ateev or Carol, but
19 that's --

20 DR. BURSTIN: Maybe just a --

21 MS. WILBON: Yes.

22 DR. BURSTIN: -- little more context.

1 Maybe just a tiny bit of context.

2 So when we did this work, and we put
3 this report out a couple of years ago now looking
4 at whether outcome measures should be adjusted
5 for socioeconomic status and other demographics,
6 these aren't the recommendations that came from
7 the Committee. There's a whole set of
8 recommendations about when, maybe should you
9 adjust. These were again more of a set of
10 principles. Regardless of what the
11 recommendations might be of how this might flow
12 forward, this was the sort of working principles
13 of the Committee of what they wanted to ensure
14 was sort of really their starting point from
15 which to build. So we thought that was just
16 important context, but Ateev, do you have an
17 example of what principles look like?

18 MS. WILBON: And I did also just want
19 to add to Srinivas's comment earlier about making
20 recommendations for specific use cases, that we
21 did have some plans at the next meeting once we
22 have a set of principles where we're really going

1 to be looking for more concrete recommendations
2 from the Committee, that that will be an
3 opportunity to look at some of the models that
4 came through in the environmental scan and really
5 think about some of the domains that you guys
6 have pulled out and maybe think about it from a
7 programmatic perspective or a delivery system
8 perspective and really come up with some more
9 concrete recommendations that are grounded in the
10 principles.

11 So the principles are really like our
12 foundation for moving forward. So hopefully
13 that's helpful because we will be doing a similar
14 process as what Helen described with the
15 recommendations, but at a later date when we have
16 our brains wrapped around what we're doing here.
17 So hopefully that's helpful.

18 CO-CHAIR MEHROTRA: Ashlie, just one
19 clarification. I would just echo what Jenny just
20 mentioned. I sometimes find myself going through
21 all these use cases and bouncing back and forth,
22 and what's the right thing?

1 From NQF's perspective CMS, who
2 provide the money, are there are particular use
3 cases that are -- you mentioned a couple of them,
4 but have those already been kind of decided upon?
5 If so, it might actually be helpful to articulate
6 those now so that we can, sort of bouncing
7 through 100 different examples, maybe ground
8 ourselves on a couple. Or if that's not the
9 case, that's fine, too.

10 MS. WILBON: I would say that the use
11 cases that we have the most challenges with are
12 in the case studies. And so, I think that was
13 kind of the purpose of having those -- having the
14 case studies so that there is really specific
15 focused discussion on those. I think that more
16 will emerge and we can -- I don't want to bite
17 off more than we can chew, but there may be
18 others that come up as a result of the discussion
19 in the case studies, or a group discussion that
20 we want to add and say in this case study we
21 should also do this.

22 DR. BURSTIN: Yes, and maybe one way

1 to frame this as well is as you're going --
2 because I think those are sort of a blend of use
3 cases and just illustrative examples to help us
4 think through these issues.

5 Maybe one potential way to frame this
6 is, as you're doing the use cases this -- I mean,
7 as you're doing the case examples this afternoon,
8 actually try to kind of come up with what use
9 cases you keep hitting upon. Because I do think
10 that, for example, population health is a use
11 case that isn't specific to the case study, or
12 there may be different ways. The framing of the
13 question earlier about when is individual
14 provider appropriate? I think there may be some
15 that may emerge out of those case studies that we
16 could return to Ateev and Carol. Thank you.

17 CO-CHAIR RAPHAEL: Okay. All right.
18 So now I'm going to go back to all the people who
19 wanted to be able to offer their thoughts on the
20 principles that we're beginning to put together
21 in a preliminary form.

22 Brandon?

1 MEMBER POPE: Just to add a little
2 more language to the conversation that Srinivas
3 started, I think you said payment and
4 performance. And then we talked about
5 attribution is not accountability. I think these
6 are all -- and then use cases, right? I think
7 these are all important.

8 Just to give a little insight to what
9 our physician group has been doing for quite a
10 long time is, we've had the notion of is this
11 measure in attribution used for improvement or is
12 this an audit measure, right? And so there's
13 different levels of reliability, validity, et
14 cetera that are behind certain measures and
15 attributions that would support a use case, like
16 affecting how much you got paid this year versus
17 we want to use this to be able to identify best
18 practice and improvement projects, some of things
19 we talked about. But just add a little color on
20 some of the things that we do today, we have this
21 notion of improvement measures versus audit
22 measures.

1 But I did want to harken back to what
2 we sort of wondered in that conversation. One of
3 the first comments was linking attribution for
4 quality measures and cost measures, utilization
5 measures.

6 And, Ateev, you said, well, there's a
7 whole lot of approaches and different things we
8 want to attribute. We're not going to be able to
9 get to one. I think everybody obviously
10 understands that. But I think standardization is
11 fairly important because otherwise what happens
12 in practice is I'm held accountable to ten
13 different measures for six different payers and
14 all these different outcomes, and I need someone
15 from Jackson Hewitt to help me understand what
16 actually my performance was at the end of the
17 year.

18 So one of the things we've recently
19 done is said, hey, in the ACO we have all these
20 different contracts which all have slightly
21 different flavors of attribution at the
22 contractual level. But when we go to the

1 provider level, and we say, you, sir, these are
2 the outcomes for these patients; we've tried to
3 simplify that and standardize and be able to come
4 up with a single answer of why this patient and
5 outcome are attributed to you and not have all
6 that variation that makes it very complicated.

7 So I think making some recommendations
8 about standardization would be a useful outcome
9 to this Committee.

10 CO-CHAIR RAPHAEL: Thank you. Bharat?

11 MEMBER SUTARIYA: It's Bharat, but
12 that's okay. It's a hard name to pronounce.

13 So two quick comment/questions. One
14 is the clinical and social risk-adjustment a
15 function of measures and how you weigh the
16 measures and how you incentivize or de-
17 incentivize on the measure versus an attribution?
18 Because I'm honestly a bit confused. So I'd love
19 to get clarification on why social adjustment or
20 clinical risk-adjustment plays a role in who do
21 you attribute from an accountability perspective.
22 Because I consider that as a function of more of

1 how much do I incentivize you or not than how do
2 I grade your performance, but not who do I
3 attribute to you from an accountability
4 perspective? So that's the first question I
5 have.

6 And then the second question is for
7 the scope of this Committee's work, are we to
8 assume that the patients always have a choice on
9 where they want to receive care and the
10 attribution that we're trying to achieve is
11 really for the provider side? And in that model
12 there's always going to be issues and challenges,
13 because one side has a choice, and the other side
14 doesn't.

15 So I just want to hear from CMS on the
16 thought. I know it's a bit of a controversial
17 question to ask, but even in the next gen,
18 there's still not full accountability or even a
19 reasonable amount of accountability on the
20 patient side. We're trying to make one side
21 accountable. And again, what I know from the
22 ecosystem work is that, you can't get a balance

1 of the ecosystem by optimizing one side of it.

2 So those are the two questions or comments I

3 have.

4 CO-CHAIR RAPHAEL: Okay. Do you want
5 to, Sophia, try to tackle those?

6 DR. CHAN: Yes, I can answer the first
7 question. In terms of risk-adjustment the
8 position of CMS is that we are adjusting for age,
9 gender and health status in terms of co-
10 morbidities for the readmissions measures and for
11 the mortality and the complication measures that
12 Yale CORE has been developing for us.

13 We look at several factors related to
14 the clinical aspects of health, and we also,
15 based on the recommendations of some of our
16 stakeholders, also look at how the model performs
17 after including some socioeconomic factors along
18 with clinical factors. And we found that the
19 findings, that the results do not change
20 significantly at all. Adding socioeconomic
21 factors do not change the performance scores of
22 the hospitals. Did that answer your question?

1 MEMBER SUTARIYA: Yes, I think that
2 makes complete sense, and that's actually the
3 genesis of my question. There are two different
4 topics. How do you use clinical and social risk
5 to weigh certain amount of incentives? Incentive
6 is a completely independent factor from do I
7 attribute this patient to this provider? So my
8 understanding was this is an Attribution Scope
9 Committee. So why are we talking about how are
10 we going to use social and economic factors and
11 clinical factors? Because it doesn't play a
12 role.

13 DR. CHAN: Some of the stakeholders
14 feel that patients with a minority background or
15 a patient with a low-income background are more
16 susceptible to the physical environments and the
17 socioeconomic factors that have a detrimental
18 effect on their health. And as a result, they
19 feel that say safety net hospitals are
20 disadvantaged because of these factors that are
21 beyond the hospitals' control. And they would
22 advocate including those factors in a calculation

1 of measure scores.

2 MEMBER SUTARIYA: So you're trying to
3 avoid selection bias in many ways? Okay.

4 CO-CHAIR RAPHAEL: Okay. Anne, did
5 you want to say anything? I had you on the list,
6 but it's all right if you want to pass.

7 MEMBER DEUTSCH: Yes, it wasn't
8 directly related to this. I don't know if people
9 want to wrap up this conversation.

10 CO-CHAIR RAPHAEL: Okay. All right.
11 Then I will come back to you. All right?

12 MEMBER DEUTSCH: Okay. Seems like a
13 few people want to --

14 MEMBER SUTARIYA: Can Dan comment on
15 my question about what's the expectation from a
16 patient choice perspective? I mean, are we to
17 assume that patients have a choice for the
18 attribution model?

19 CO-CHAIR RAPHAEL: Okay. Let's answer
20 that. Dan?

21 And, Taroon, I'll come to you after.

22 MR. MULDOON: Yes, I think that's --

1 again, the CMS position is that the beneficiaries
2 in our fee-for-service Medicare Program, that
3 sort of beneficiary choice is still paramount to
4 the different types of both payment models that
5 we're testing and also the measure development
6 and other measures. I don't know if Sophia has
7 other comments or thoughts about beneficiary
8 choice, but I think that's pretty clear.

9 CO-CHAIR RAPHAEL: Okay. Taroon?

10 DR. AMIN: Just on the prior point,
11 and I'd welcome comments from Elizabeth as well.
12 The topic of how we are attributing is
13 intricately linked to the question of what we're
14 attributing. And so, that's why the SDS topic is
15 so linked in this conversation. And I'll just
16 sort of leave it with that.

17 MEMBER DRYE: I mean, and this maybe
18 is another principle, but I would just say, when
19 we're thinking about how to develop a risk-
20 adjusted outcome measure and what to adjust for,
21 or when we're thinking about attribution
22 strategy, sometimes we're aspirational. Like

1 we're trying to drive change in the healthcare
2 system, and that directly affects whether we're
3 going to adjust for something.

4 So for example, in the ACO admission
5 measures just reviewed here last week that are
6 already in use, those are risk-adjusted. In our
7 conceptual model, we really acknowledge that
8 many, many, many, many factors affect admissions
9 besides healthcare delivered. But the ACO
10 Program itself is aspirational. It's trying to
11 get providers to jointly work with communities to
12 address in particular the risks that low-SES
13 patients face, that some communities face that
14 are really tough that require coordination,
15 community services, housing, et cetera.

16 And we know some ACOs are actually
17 really succeeding at that. So we're
18 aspirational. We'll say we're not going to
19 adjust those things away. And we're going to let
20 the measure reveal those really great performers
21 who are performing what we're trying to get the
22 system to move towards in difficult

1 circumstances.

2 The same thing is true with an
3 attribution strategy. So you could say, well,
4 this surgery -- I'll give you an example from a
5 measure we developed that's now the Society for
6 Thoracic -- that the American College of
7 Cardiology runs. We built a PCI readmission
8 measure. And initially certainly interventional
9 cardiologists doing PCI felt like how could we
10 possibly be responsible for 30-day readmissions?
11 We see this patient, then they're out the door.
12 But it was aspirational in the sense that it was
13 like, wait, we want you to think about what
14 happens to this patient afterwards.

15 You could say, well, we're just going
16 to attribute the cost and the outcome for PCI to
17 the interventional cardiologist, or you could say
18 this is really a medical home issue, and it
19 should be about care coordination, selection
20 about whether you even do the PCI. It goes back
21 to the concept of the goal. That's why the
22 transparency piece is really important. What's

1 the goal of the attribution strategy? That's
2 going to affect the approach you take, just like
3 the goal of the measure and whether you're trying
4 to drive change is going to affect your risk-
5 adjustment strategy.

6 CO-CHAIR RAPHAEL: Okay. Ira?

7 MEMBER MOSCOVICE: So following up on
8 the last comment, there's an environmental
9 context to all this, and we really haven't
10 discussed that much. And I hope we could have a
11 principle that starts to address that.

12 Yes, I mentioned before in terms of
13 whether you have a certain type of insurance
14 coverage, you have a closed panel, an open panel,
15 but there's a geographic aspect to this also.

16 And I'm a little concerned that we
17 have a real urban bias here. Not everybody has a
18 choice. Okay? There are plenty of people living
19 in this country who don't have a choice of
20 providers. And when I hear from rural primary
21 care providers, they take care of primary care.
22 Their patients get their specialty care wherever.

1 They come back on a totally different set of
2 drugs, medications, and they have no clue what's
3 happened.

4 And that's a different context for
5 patient attribution, for attribution principles
6 as compared to an urban area where I have great
7 insurance coverage, and I've got lots of choices.
8 And somehow I think if -- we've talked about
9 characterizing the organizational structures, et
10 cetera, but I think if we can have a principle
11 that at least identifies some aspects that we
12 think are key aspects of the environmental
13 context for all this, I think that would really
14 help sort of partition that out. And it's going
15 to come out I think perhaps in some of the case
16 studies, but, yes, I hope we can consider that as
17 part of a principle.

18 CO-CHAIR RAPHAEL: Okay. So trying to
19 kind of make sure that everyone has a chance to
20 weigh in and keep to our time frame, let me just
21 do a check to ask if the following people still
22 want to speak. Eddie, Jill and Charles?

1 Okay. Eddie, take it away.

2 MEMBER MACHADO: I'll let Jill go
3 first b she had her --

4 CO-CHAIR RAPHAEL: Okay. Go ahead,
5 Jill.

6 MEMBER BERGER: So, I'm going to speak
7 from the emergency room point of view. And
8 thinking about Marriott as an organization pays
9 about \$600 million a year in healthcare costs and
10 we really do believe a lot of the way our folks
11 receive care is through their physicians. And we
12 want to -- we know there are great practices out
13 there. We want to support those practices.

14 So when we think about attribution, we
15 are thinking about pay-for-performance. We are
16 thinking about -- I don't know that we
17 necessarily care as much that people --
18 physicians are disincentivized, but for those
19 physicians that are going above and beyond,
20 giving proactive healthcare, helping, the average
21 Marriott associate is not making a lot of money.
22 It's a very culturally diverse population. They

1 do need help. And so, attribution to us is
2 helping us identify those providers that are
3 giving great care.

4 CO-CHAIR RAPHAEL: Thank you. Eddie?

5 MEMBER MACHADO: So I wanted to circle
6 back to this distinction between attribution and
7 accountability that Ari brought up. And what I
8 was thinking is that one possible way to call out
9 that distinction is really through the lens of
10 the locus of control. So just try to follow me
11 through this because it may not be totally
12 thought out.

13 But I think attribution or the
14 decision on whether to attribute a provider, I'll
15 call it, generally to a particular piece of care
16 or a patient really is dictated by whether or not
17 there exists an aspect of control. We're not
18 speaking about the degree of control, just
19 whether or not there is an aspect of control. So
20 a locus of control. But then accountability
21 really speaks to the specific locus of control
22 we're talking about.

1 So let me give you a concrete example.
2 So from an episode of care basis ideally you may
3 want to say, okay, we want to look at the
4 management of ischemic heart disease as a chronic
5 condition. Now, the management, that may involve
6 outpatient care, maintenance care, but it may
7 also involve surgical procedures, right?

8 So from the perspective of the
9 management of the ischemic heart disease you may
10 want to attribute the primary care physician, the
11 cardiologist, the cardiothoracic surgeon to the
12 management of ischemic heart disease. But when
13 it comes to accountability, you may want to then
14 be a little bit more fine and say, okay, the CABG
15 or the PCI, the surgeon is accountable for that
16 piece, or a portion of that. The primary care
17 physician may be accountable for some of the
18 maintenance of care aspects. The cardiologist
19 similarly.

20 So I think that may be a way to
21 distinguish between what we're thinking of as
22 attribution versus accountability. I think

1 they're very closely linked, but I think at a
2 highest level accountability implies attribution
3 always, but attribution does not always imply
4 accountability in all cases.

5 CO-CHAIR RAPHAEL: Okay. Charles?

6 MEMBER HAWLEY: That last statement is
7 exactly what I was thinking earlier. And from a
8 specific sort of example from the states'
9 perspective as we produce total cost in quality
10 measures there's no accountability mechanism.
11 Medicaid does have some, but for us as a
12 reporting entity there's not any accountability.

13 I'm supportive generally of the
14 guiding principles laid out by Ateev and I really
15 would throw my hat in for transparency, and maybe
16 that that be towards the top, because I think as
17 we do the other things, as long as people are
18 clear about the various settings, that that will
19 kind of shake out some of the others.

20 CO-CHAIR RAPHAEL: Okay. Jenny?

21 MEMBER BEAM: Just a couple of
22 comments. And Sophia, I think I heard you

1 correctly. Did you say that for the population
2 that you were studying that there really was not
3 a relationship for the socioeconomic factors and
4 the outcomes? Is that what I heard?

5 DR. CHAN: Whatever relationship there
6 is between socioeconomic factors and the
7 outcomes, as soon as you include clinical factors
8 into the model, that relationship goes away.

9 MEMBER BEAM: Okay. All right.
10 Because I just -- and like I said, my comment was
11 looking at commercial plans, specifically when
12 you're looking at things like deductibles, co-
13 pays, the cost of medication and then you're
14 looking at -- again, that does impact medication
15 adherence and whether your quality measures,
16 whether they are compliant. Because in some
17 studies that we did basically doing heat maps
18 across the entire city and then overlying census
19 data for income across each of the ZIP codes, it
20 was clear, you know, red, green. And then from
21 one side to the other. You switch and go to a
22 different measure and it comes back the other

1 way.

2 So I guess that was just a comment,
3 keeping in mind commercial plans there. And
4 that's it.

5 CO-CHAIR RAPHAEL: Okay. So I have
6 three people. Rob, did you want to be included
7 in this last group?

8 MEMBER SCHMITT: I was just going to
9 expand on what Brandon talked about and just
10 really as we talk about the attributions. And
11 then that's going to be tied to payment, and then
12 payment starts to drive behavior, and ultimately
13 you have to look at what are the unintended
14 consequences of the behavior that we're
15 ultimately going drive through attribution. The
16 old incent the behavior you want, because that's
17 what you're going to get is kind of what I was
18 looking at from the unintended consequences of
19 where we eventually start, but where this ends
20 up.

21 CO-CHAIR RAPHAEL: Okay. So we have
22 two more people who are going to have a chance to

1 speak before we conclude this.

2 Anne?

3 MEMBER DEUTSCH: Great. Thank you.

4 So first of all, I wanted to support the four
5 principles Ateev mentioned and the transparency
6 that Nate mentioned. Also wanted to build on
7 Elizabeth's comment in terms of the measure
8 developers indeed do address attribution in some
9 way when they're developing the measures.

10 Elizabeth also mentioned that
11 sometimes they're used in other programs. And
12 so, that's I think when the MAP would have a
13 role. And so they might be interested in asking
14 about attribution more than perhaps currently
15 they do.

16 And I think the case studies will be
17 really helpful. I think similar to Jenny, every
18 time I think about an idea, I think, well, that
19 would work where -- some type of process measure,
20 but maybe not an outcome measure, maybe not an
21 efficiency measure. So I think these will be
22 really helpful to have these examples. Thanks.

1 CO-CHAIR RAPHAEL: Jennifer?

2 MEMBER NOWAK: Hi, thanks. My comment
3 is actually a follow-up to Eddie, who was a
4 follow-up to Ari. And that's when we're talking
5 about accountability and provider accountability,
6 when I think of attribution, I think of
7 attributing a patient to a provider who's
8 accountable for that coordinated care, the
9 coordination of care, that patient-centered care.
10 And the example Eddie gave kind of distributed
11 that accountability for that coordinated care
12 across groups. And then you know what happens.
13 So that's my comment.

14 CO-CHAIR RAPHAEL: Thank you All
15 right. So I think kind of we have at least the
16 beginnings of some five guiding principles that
17 Ateev started us off with and that we have
18 modified. We've added transparency. I think
19 we've heard about some issues that we have to
20 come back to and think through including our
21 goals that are really important. The issue that
22 we need to go probably beyond guiding principles

1 and be able to compile some compelling best
2 practices on the road to standardization. We
3 heard some cautionary notes about the
4 environmental context and unintended consequences
5 that are important.

6 So the only two comments I would make
7 is I think we have to come back to the patient at
8 some point and really think through that, because
9 patients don't know from programs. They have
10 never heard of ACOs and they've never heard of
11 bundled payments and all of the wondrous things
12 that we are generating here, but they do know
13 about trusting relationships. And if we're going
14 to ever improve quality, I think we have to
15 strengthen those trusting relationships. So we
16 have to think about the patient's role in all of
17 the attribution here.

18 And the second concluding comment,
19 I've been trying to think about this individual
20 attribution versus attribution at a kind of
21 broader system level. And I was thinking about a
22 baseball team, because in a baseball team; and I

1 plead guilty to being a fanatic baseball fan, but

2 --

3 (Simultaneous speaking.)

4 CO-CHAIR RAPHAEL: Can I say Yankees
5 and not be excoriated?

6 (Laughter.)

7 CO-CHAIR RAPHAEL: I knew that was
8 going to be a problem. I saw it in your facial
9 expression.

10 (Laughter.)

11 But anyway, you do have the team. And
12 we've talked a lot about the team. And it's the
13 standing of the team that ultimately is
14 determinative. But you do look at the
15 individuals and each of the individuals also has
16 attribution. So we may have to think about some
17 other models outside of healthcare as we try to
18 put these pieces together in a way that makes
19 sense and is implementable.

20 So with that, I'm going to turn to
21 public comment, and first see if there's anyone
22 -- everyone's shaking heads here.

1 (Laughter.)

2 CO-CHAIR RAPHAEL: All right. Then,
3 operator, can we open the phone lines and give
4 people an opportunity for public comment?

5 OPERATOR: Thank you. At this time if
6 you'd like to make a comment, please press start,
7 then the number one on your telephone keypad.
8 We'll pause for just a moment.

9 And there are no public comments at
10 this time.

11 CO-CHAIR RAPHAEL: Okay. So before we
12 conclude, let me just check. Did we have other
13 Committee members on the call who were able to
14 call in?

15 DR. BURSTIN: Jennifer or Jack.

16 CO-CHAIR RAPHAEL: Are Jennifer or
17 Jack on the phone?

18 OPERATOR: They are not.

19 CO-CHAIR RAPHAEL: Okay. Thank you.
20 Okay. Then I think we are going to break for
21 lunch.

22 Ashlie, are there instructions?

1 MS. WILBON: Kim, go ahead.

2 MS. IBARRA: Okay. I know I am
3 standing in between you and lunch, but in your
4 package of printed materials are the case studies
5 that we're going to be using after lunch. We
6 realize you didn't have these in advance, so the
7 breakdowns of who is going into each group are up
8 on the slides. And you have Challenges in
9 Measurement, which is case 1 that should be on
10 top in the package. Clinical Cases, the second
11 one. And then Challenges in Measure Use, which
12 is more focused on programs, is the third.

13 So as you're having your lunch, we
14 have some time built in for you to review the
15 handouts leading into the breakout sessions,
16 which we'll do after lunch.

17 CO-CHAIR RAPHAEL: And where will the
18 breakout sessions be?

19 MS. IBARRA: I have the updated
20 locations which I will announce after lunch. You
21 don't have to leave the building. They'll either
22 be in this room or staff will -- the staff that

1 are leading or participating in your sessions
2 will bring you to the rooms one floor down.

3 CO-CHAIR MEHROTRA: And we should be
4 back when, 1:15?

5 MS. IBARRA: Yes, 1:15.

6 CO-CHAIR RAPHAEL: Okay. Ateev, any
7 closing for you?

8 CO-CHAIR MEHROTRA: No, this is great.

9 CO-CHAIR RAPHAEL: Okay.

10 CO-CHAIR MEHROTRA: Look forward to
11 the breakout sessions.

12 (Whereupon, the above-entitled matter
13 went off the record at 12:36 p.m. and resumed at
14 1:20 p.m.)

15 MS. WILBON: We're going to jump in to
16 get you guys ready for the breakout sessions, but
17 we spent some time over lunch trying to tease out
18 some of the principles that we heard you guys
19 throwing out, and just very drafty form, I'll put
20 them in front of you so you can kind of see what
21 we've compiled so far and get some initial
22 reactions, and then have you guys kind of go into

1 the sessions, breakout sessions from there, so
2 you have at least a starting idea of where we are
3 when you get into your groups with some initial
4 principles.

5 So bear with us. We're -- oh, there
6 it is. It's not pretty, but it's there. So
7 Ateev graciously sent us some of his notes, so
8 we'll obviously work on these, but I think it
9 might be helpful maybe to maybe have Ateev and
10 Carol walk through these with you guys, and if
11 there are any thoughts, or -- you know I wouldn't
12 worry about language too much right now, but if
13 we can just capture any ideas that aren't either
14 fully fleshed out or that need some additional
15 clarity, those types of -- that type of input is
16 really helpful for us as staff to make sure we
17 have captured, and we can always massage that
18 later, so -- .

19 CO-CHAIR MEHROTRA: All right. We'll
20 try here.

21 So I think the first principle here
22 was attribution makes a big difference, and to

1 really highlight this for the policy audience,
2 that it can really affect reliability and
3 validity of the measures, and in some cases,
4 performance can vary quite dramatically, so
5 that's the first point. Put this as an important
6 thing to focus on.

7 I think to be -- there was a lot of
8 excitement or interest in the idea of
9 transparency, and so before even getting into
10 like the rule itself, it has been important to be
11 transparent about the goals and what -- and --
12 and in some cases, building off Elizabeth's
13 comment, aspirational. Like what are you hoping
14 that will happen from doing this attribution?
15 And that in some cases, attribution may be trying
16 to drive accountability in the case of say 30
17 days post admission.

18 That we should be cognizant that there
19 is no single attribution rule that can be used
20 across every quality metric, application, and
21 policy analyst, so -- and policy intervention
22 payment policy. And so as much as we love

1 simplicity and consistency, we can't expect there
2 to be a single rule.

3 The second bullet point, I am
4 paraphrasing here because I can't remember what I
5 was thinking or what someone else was, let me --
6 let me try here, then please jump in. I think
7 the other point here is that just with almost any
8 policy intervention, you have different
9 stakeholders, and there is no perfect solution
10 that's going to be, you know, perfect for the
11 provider community, the patients, the payers, the
12 employers, et cetera, and so therefore, what
13 we're trying to do is compromise across a series
14 of those different -- all those stakeholders,
15 just as we do for almost any other policy.

16 But there was a pushback, and I think
17 an appropriate pushback, that when you have a
18 single-use case, and the ACO was the example
19 there, was that it's useful to have a single
20 attribution rule used across commercial,
21 Medicare, Medicaid, to whatever degree that's
22 possible, that is going to be helpful because

1 providers are struggling with these different --
2 different folks using different rules, and
3 somebody made the comment that you need to pay
4 somebody else to figure it out for you, which is
5 not a good thing because of the -- the desire for
6 simplicity.

7 So number four is this challenge, some
8 common expectations, this attribution to the
9 provider versus more than one. There was the
10 idea that was brought up by Ari about you don't
11 have to -- or maybe what I'm taking what you said
12 incorrectly, but you don't have to even -- if you
13 attribute it to two different providers, you
14 don't even have to attribute it the full episode.
15 You can do a waiting episode.

16 So there are -- what we're trying to
17 do with this principle is to really push people a
18 little bit farther in terms of what attribution
19 can look like. Is it ever responsible to do it
20 to a single -- I think maybe the word we should
21 use here is physician. Provider can be used
22 loosely, or clinician. And that it's important

1 often to attribute to a system because we want to
2 push coordination of care.

3 Self-selection, either by the provider
4 or the patient, may be helpful in some cases, but
5 we raised some important caveats. And it doesn't
6 have to be -- okay.

7 And then the last principle is test
8 more than one rule, and the idea here is we
9 expected there to be differences between the --
10 it's not like we -- the goal here is when you
11 test more than one rule, you don't expect it to
12 have the exact same response, that Michael is
13 always assigned this patient, but rather, by
14 testing more than one rule, you're doing what we
15 do in many cases, a sensitivity analysis.

16 And to highlight where more
17 measurement testing is necessary. And then
18 lastly, when we're testing these rules, to build
19 off of what Jenny said, really stakeholder input
20 could be really important there. So it's not
21 just you do it all internally, put it out there,
22 show what people -- get people's responses when

1 you're testing these different rules.

2 Is there another slide?

3 MS. WILBON: Yes, from --

4 CO-CHAIR MEHROTRA: Oh, I'm getting
5 tired here. All right.

6 (Laughter.)

7 CO-CHAIR MEHROTRA: Attribution --
8 right. So this idea, and this is kind of
9 building off the self-selection idea that was put
10 in the last rule, is that one principle could be
11 is the attribution based on claims only made if
12 the provider or the patient could not make the
13 designation? And that should trump any algorithm
14 that does so. Again, we had some debate or
15 caveats about that.

16 And then here's another important
17 principle, and we -- I think it will probably
18 garner -- so there was -- people put out the
19 idea, the principle, that if you're going to
20 measure cost and quality together, they should
21 share the same attribution model and level of
22 analysis, and I think I am hearing some I am

1 hearing some faces -- I am seeing some faces, so
2 maybe people agree or disagree, but at least that
3 was another principle that we could at least
4 debate and I think has some merit.

5 Wow, we have a lot. Principle eight,
6 an alignment of the -- this issue of attribution
7 and measure -- so attribution, attribution
8 strategy. I think this might be almost going
9 into maybe that bullet point number two about
10 what the heck is the goal here? Try to be
11 transparent with that.

12 This principle nine, I think this
13 builds in a little bit also related to what we
14 were discussing in rule two. Accountability does
15 not always imply attribution, but --
16 accountability always implies attribution, but
17 attribution does not always imply accountability.
18 And the -- these concepts that Ari was bringing
19 up. And then we already addressed this issue,
20 yes, the model needs provider/patient input.

21 So this is another interesting thing
22 that a couple folks brought up, I know Ira

1 brought up in particular, but what is the
2 environmental context here? How are we going to
3 -- I might take your comment, and this is a
4 difficult one, right? Because an attribution
5 rule that works well in Minnesota may not work
6 well in Connecticut, and may not work in other
7 environments, rural or urban settings, and how do
8 we address that issue? But at least to be -- I
9 think a principle could be we need to think about
10 it.

11 I think Rob brought up the point that
12 I think is important that we need to think about
13 how -- I think an important principle here is
14 when we're -- we want to think about the
15 aspirational, what we hope is going to happen,
16 but we also need to think about, in the evil way,
17 like how are people going to game this system,
18 and what are the potential unintended
19 consequences? And we need to be thoughtful of
20 that.

21 Thirteen is the self-selection issue,
22 which I think we've addressed in some of the

1 other bullet points. And -- and I think actually
2 just building off of Carol's points, consider the
3 voice of the patient and the value of the trusted
4 patient/provider relationship, and how do -- it's
5 an important aspect of this.

6 All right. So let me -- so those are
7 some -- oh. Oh, okay. So we can -- what do you
8 think? Are we going to have comments, or are we
9 going to split out?

10 MS. WILBON: So I guess we can just
11 check the polls here. Are there people that have
12 kind of immediate reactions to what we compiled
13 so far? Are we on the right track with what we
14 captured and what we are hearing from discussion?
15 Are there any major points or principles that you
16 think we missed? I think that would be helpful
17 before we kind of move on, and then we can, you
18 know, jump into the breakout groups. But I think
19 any immediate reactions or other thoughts about
20 what we may have missed, overstated, understated
21 --

22 CO-CHAIR RAPHAEL: So let me --

1 MS. WILBON: -- may be helpful.

2 CO-CHAIR RAPHAEL: -- just start by
3 calling on someone who hasn't yet spoken. Mike,
4 what is your reaction to this?

5 MEMBER SAMUHEL: I thought I was
6 hiding.

7 (Laughter.)

8 MEMBER SAMUHEL: Actually, I am
9 learning. But I have a question. I am not sure
10 how we're defining provider. What about the case
11 of nursing homes, or home health organizations?
12 They are involved in patient care, and I think
13 attribution has to be made to them in terms of
14 their payments too down the line. And so I am
15 wondering, it seems like most of the discussion
16 has been focused on the attending physician.

17 CO-CHAIR MEHROTRA: I will make a
18 comment that I think you're right to raise that
19 issue.

20 At least from my perspective, I am
21 thinking about it very broadly with facilities,
22 SNFs, home health agencies, other providers, but

1 maybe it would be useful to at least acknowledge
2 somewhere, I don't know if it's a principle, but
3 at least somewhere here, say that when we think
4 about providers, we're thinking about that as a
5 very broad term.

6 CO-CHAIR RAPHAEL: You know, I would
7 second that because I don't think you can think
8 about managing chronic conditions without looking
9 outside the even inpatient and ambulatory setting
10 into the home and community, right?

11 CO-CHAIR MEHROTRA: And also I would
12 just say on the clinician side, to say physician
13 is also I think problematic. We have a lot of
14 different other clinicians who are involved with
15 the care, in particular, nurse practitioners
16 there --

17 (Laughter.)

18 CO-CHAIR MEHROTRA: -- I am just --
19 that are really important, so I -- I think we
20 also need to be broad there.

21 CO-CHAIR RAPHAEL: Okay. So let me
22 start with Michael.

1 MEMBER BARR: Just on that one issue
2 real quick, I absolutely agree that, and it's a
3 pet peeve of mine even at NCQA, that we really
4 shouldn't use the term providers without
5 distinguishing exactly who we mean, or what we
6 mean, in the case of facilities, and usually use
7 the word clinicians to represent the full range
8 of practicing clinicians.

9 And I think that makes a difference in
10 terms of thinking about the attributions. I
11 think we should be diligent in our use of the
12 words.

13 CO-CHAIR RAPHAEL: Okay, thank you.
14 Oh, okay, Nate.

15 MEMBER SPELL: So numbers six and
16 thirteen were probably the same item, which was
17 about patient choice, but I would just say it's
18 very desirable, particularly from the patient and
19 clinician perspective, but we also have to run up
20 against tests the more than one model approach
21 because we may find out that in fact it is -- it
22 has implications for -- for the way things are

1 being measured.

2 CO-CHAIR MEHROTRA: I do want to
3 emphasize that point. Jenny brought that up
4 before, but, you know, in some of the work that
5 we did, you know, some of the patients are
6 assigning someone they saw two years ago, and
7 people have busy lives, and they just never
8 updated it, so we had to be very thoughtful about
9 that. In concept we want to do that, but there
10 are some caveats.

11 CO-CHAIR RAPHAEL: Okay, Bob?

12 MEMBER KROPP: Just a reaction to the
13 list of principles. First of all, I think it is
14 reflective of the complexity of this topic. And
15 second of all, the -- the points that we've made,
16 while all valid, I think the discussion this
17 morning as a whole has been reflective of -- of
18 how -- how difficult this discussion has been in
19 the larger community, in a sense, in the whole
20 system.

21 And I think that perhaps, just a
22 thought, that one thing that this committee can

1 do in addition to providing general principles
2 for attribution methods is perhaps, through
3 generating those principles, generate an approach
4 to this topic. How do people talk about this?
5 How do people think about this?

6 Everybody I think -- I'm not a
7 surgeon, but -- and I'll apologize to anybody who
8 is in the -- in the audience, but I think about
9 complexity issues like surgeons think about
10 surgery. There's a plain of dissection that gets
11 you to the issue. And, you know, we have started
12 in a number of different ways. Do we talk about
13 costs or utilization? Do we talk about the ACO
14 or the individual provider? Do we talk about
15 quality versus cost, you know?

16 We have -- we have touched on all of
17 these different aspects of the elephant, but I
18 think that if we could, through our discussions,
19 come to a here's how you really think about
20 attribution, here's an approach to thinking about
21 it, not that everybody is going to accept it, but
22 if -- if this is how you think about it, then

1 these principles apply, and we can then -- we can
2 further the discussion, we can contribute to our
3 constituencies as a whole by giving them a way to
4 -- to deal with an issue that otherwise, in my --
5 you know, in my opinion, has been so complex that
6 people say -- Ari, or Troy, you said it earlier,
7 I wrote it down.

8 The balance of accountability: too
9 much and, you know, there is too much attribution
10 to the system, and you get too little interest.
11 Too much on the individual provider, and you burn
12 somebody out. And in my experience, that -- that
13 actually captures what's happening, okay? And it
14 is because people can't get their arms around the
15 complexity of this issue.

16 So I think that through these
17 principles, if we can give all of our
18 constituencies a better framework, I think we
19 will do a great service to this topic.

20 CO-CHAIR RAPHAEL: Thank you. Jenny?

21 (Laughter.)

22 MEMBER BEAM: I'll learn by tomorrow.

1 My comment was on number seven, about
2 if measuring cost and quality together, they
3 should use the same attribution model. And --
4 and again, this could be a use case issue because
5 the examples I am thinking of, like -- that
6 doesn't seem to make a lot of sense for me, and I
7 was just wondering, I know Danielle, you were one
8 I think that had suggested that, there may be
9 others, could you kind of give me your
10 perspective on what the harm would be in using
11 different models, or what the benefit would be to
12 using the same?

13 Because like in the use cases I am
14 thinking of, I would not want to use the same.
15 So just maybe help me --

16 CO-CHAIR MEHROTRA: And what were the
17 use cases? I think that would be really helpful.
18 What were the use cases you were thinking of
19 where it might not be helpful? That might help
20 ground our --

21 MEMBER BEAM: Well just for instance,
22 I mean, if you're looking at cost and quality and

1 you're going to -- like for cost, I would
2 probably assign that to multiple providers in an
3 outpatient setting, you know, and looking at
4 quality. But again, depending on if you're
5 taking population health type measures, those are
6 going to be attributed more or less to a primary
7 care physician, whereas if you're talking
8 diabetes, that might go to a PCP and to a
9 specialist, so an endocrinologist as well.

10 But depending on, you know, the cost,
11 you are looking at the bulk of the cost could be
12 driven by the endocrinologist because of the type
13 of care that's delivered. I just -- there are so
14 many different variables to consider. Yeah.

15 CO-CHAIR RAPHAEL: Do you want to
16 weigh in?

17 MEMBER LLOYD: Yes, sure. So I think,
18 first of all, it depends on the use case, right?
19 And I shared with Ateev during the break, I sort
20 of have in my head, in my Excel sheet that I was
21 just filling out, I have four buckets in my head,
22 one of which is sort of primary care driven,

1 ACOs, PCMH; one of which is episodes, more
2 specialty-oriented; one that's quality
3 improvement, or physician profiling, or that sort
4 of thing, and that is where I think you might see
5 some differences between the measures; and then
6 the last one is an institutional bucket, not
7 necessarily hospitals, but could be skilled
8 nursing facility. I think there's, you know, a
9 couple of examples of those sorts of things in
10 there, readmission measures, et cetera.

11 But so to give an example within that,
12 so it might be different in each of those cases,
13 but to use this institutional line and use the
14 CJR example that I was starting to say earlier is
15 if you have a 90-day payment episode in that
16 payment model, so if you're working backwards
17 from the payment model, you want a 90-day quality
18 episode.

19 If you have -- you want -- you know,
20 there's an HCAHPS measure in there, that's the
21 entire hospital. It is not just joint
22 replacement patients. So you are attributing the

1 entire HCAHPS score to just whether or not you're
2 doing well for those joint replacement patients.
3 So there's all of these disconnects where you
4 have an accountability level for that 90 days
5 payment, but the quality is way back here and has
6 nothing to do with the population that you're
7 applying that quality score to.

8 So if the quality affects the payment,
9 there needs to be some symmetry in those. Is
10 that a little bit clearer?

11 CO-CHAIR MEHROTRA: If I could push a
12 little bit on just -- I think this is a really
13 important point, and I -- I don't know if I have
14 a great sense which way is the right way. I can
15 understand why you would want that to be similar.

16 But I was thinking, staying with the
17 joint example, let's say the cost is related to
18 the 90 days post-surgery, and we do that for a
19 variety of reasons: that's what the majority of
20 spending is, that's when most of it can be
21 attributed more cleanly. But what if we were to
22 make the quality metric functional status one

1 year out?

2 You could see why you would have that
3 quality metric that is different than --

4 MEMBER LLOYD: But --

5 CO-CHAIR MEHROTRA: -- there --

6 MEMBER LLOYD: -- you do --

7 CO-CHAIR MEHROTRA: -- and wouldn't
8 have --

9 MEMBER LLOYD: -- that metric --

10 CO-CHAIR MEHROTRA: -- the same rule
11 --

12 MEMBER LLOYD: -- only on the patients
13 who were attributed before, right? So it may be
14 one year out, right, but it's only for the
15 population who was -- who were served in those
16 episodes. You are not going to do functionality
17 for heart failure patients for CJR, right? It is
18 the attributed population who you are measuring
19 that would ideally be the same. So sometimes,
20 you could have the time differences, that it is
21 further --

22 CO-CHAIR MEHROTRA: I see --

1 MEMBER LLOYD: -- further out --

2 CO-CHAIR MEHROTRA: -- so I think, and
3 maybe the distinction there is it's a patient
4 population whose inclusion --

5 MEMBER LLOYD: Right.

6 CO-CHAIR MEHROTRA: -- and exclusion
7 criteria are trying to make sure that there's
8 some consistency there, and then the attribution
9 might -- you try to want to --

10 MEMBER LLOYD: Yeah.

11 CO-CHAIR MEHROTRA: -- echo that --

12 MEMBER LLOYD: Yeah.

13 CO-CHAIR MEHROTRA: -- but I guess
14 what I wanted just to say is that I'm not -- the
15 attribution rule from my perspective may not
16 always have to be -- I can see cases where you
17 might want a different attribution rule even
18 though you might have the same patient
19 population.

20 MEMBER LLOYD: So to give another
21 example where I think it's a little bit closer,
22 in the Medicare Shared Savings Program, you

1 finish up the year, you see who is attributed for
2 payment purposes, and then you measure on those
3 same patients. So your quality metrics are on
4 the same patient population as your spending
5 metrics because they do it all retrospectively,
6 so there is alignment between those.

7 You are not using quality metrics on
8 patients that have nothing to do with the ACO and
9 then applying it to their payment, right? It is
10 the same group of patients regardless of which
11 measure it is.

12 CO-CHAIR RAPHAEL: All right. We're
13 going to take two more comments before we wrap
14 and go into our breakout groups. So it's
15 Elizabeth and then Brandon.

16 MEMBER DRYE: Yes, just real quick
17 because I wanted to -- I am with Danielle on
18 this, as I told her over the break.

19 I mean, just to use that word that
20 gets thrown around by leadership in both parties
21 and in Congress and in, you know, the
22 administration and everywhere, private sector,

1 public, we're trying to move from pay-for-volume
2 to pay-for-value, and so I think, you know -- and
3 that -- those clarifications are really helpful.

4 We are really just trying to -- if we
5 want to look at value, we have to say what did
6 this care cost? So in the case of total joint
7 replacement, you know, what did this care cost,
8 and what was the outcome? And things like the
9 time frame, they just totally echo that. They
10 don't have to be aligned, but the patient got the
11 service, we're attributing to a patient, and
12 we're also attributing to some physician or group
13 or, you know, hospital or something, right, and
14 we want to just parallel that so we can evaluate
15 the value that that -- say, for example, our
16 measures are being used in bundle payments and
17 also in a hospital level, but you want to be able
18 to compare across providers who is providing
19 better value, so to do that, you've got to have
20 an attribution strategy that aligns the cost and
21 the quality on a clearly defined cohort of
22 patients.

1 CO-CHAIR RAPHAEL: Brandon, last word.

2 MEMBER POPE: My thought is on the
3 same line. It is not that we're saying there is
4 always going to be quality measures and cost
5 measures with a given attribution, and it is not
6 that this guiding principle does not break down
7 in some specific examples, but it is more from
8 the general thought process of, you know,
9 healthcare is a good which people value for both
10 the cost and quality, and when you start to
11 separate the attribution of those things, then
12 you sort of get some -- you know, I think the
13 unintended consequences become a little less
14 clear what we're doing, whereas when it's clear
15 that this is the cohort or the set of events,
16 whatever may be, and I'm aligned on both the cost
17 and quality of care, I think there is -- it's
18 sort of a general principle.

19 And there's going to be some specific
20 examples where you can say, well, but this. But
21 high level, that's what I think I'd commented on
22 this earlier, so -- .

1 CO-CHAIR RAPHAEL: So Ashlie.

2 MS. WILBON: Yes. I'm going to
3 actually hand it over to Erin to just give a
4 quick overview of, again, remind people where
5 they're going, the goals for the sessions, and
6 hopefully everyone knows where they're going, and
7 we can probably have a meeting place for -- by
8 staff person. So Taroon has the measurement
9 group. I have the clinical case group. And Erin
10 and Helen --

11 MS. O'ROURKE: Helen and I have the
12 program case group.

13 MS. WILBON: So we'll line up, and you
14 can follow us to where you go. But Erin will
15 give you a little bit more information in just a
16 second. Did you have a question?

17 MS. WILBON: Sure, so just -- oh, go
18 ahead, Eddie.

19 MEMBER MACHADO: Going to ask, we can
20 leave our stuff here, is that right?

21 MS. WILBON: Yes.

22 MEMBER MACHADO: Okay.

1 MS. O'ROURKE: So just a quick
2 reminder about the goal of this next session.
3 Again, we took attribution issues from three
4 different perspectives: from an individual
5 measure perspective, from the perspective of a
6 patient, and from the perspective of a measure
7 use case, if you will, to get to a programmatic
8 issue.

9 So we're breaking into three groups.
10 If you are in the measurement group with Taroon,
11 you will be staying up here. If you are with the
12 clinical group with Ashlie or the programmatic
13 group with Helen, we'll be going downstairs. We
14 will guide you down. And again, the goal is to
15 try to test the principles we've already
16 identified as well as think of some more that we
17 might want to put on the list to then come back
18 together as a large group and start to expand or
19 winnow our principles.

20 CO-CHAIR MEHROTRA: And I'm -- when
21 you say programmatic, which one is that? Is that
22 number three, two, or one?

1 (Laughter.)

2 MS. O'ROURKE: That is number three,
3 I believe, the smoking measure.

4 CO-CHAIR MEHROTRA: All right.

5 MS. O'ROURKE: Measure use.

6 CO-CHAIR MEHROTRA: Measure use, all
7 right.

8 MS. WILBON: Also, I would encourage
9 you guys, the discussion questions that we put on
10 there are, you know, to help drive discussion,
11 but there's a lot of things discussed today at
12 the table that we hadn't all included as
13 considerations, so feel free to bring those to
14 your discussions as well and expand as needed, so
15 we're looking forward to hearing what you guys
16 come back with. Thanks.

17 MS. O'ROURKE: So for those on the
18 phone, we will be reconvening at 3:15. Members
19 of the public, if you're interested in listening
20 in to a group, please feel free to join us.

21 MS. WILBON: Yes, so we'll be in
22 breakout groups until 3 o'clock, and then we'll

1 break immediately after the breakout groups and
2 then come back to do report outs about 3:15,
3 okay? All right. All right.

4 (Whereupon, the meeting went off the
5 record at 1:45 p.m. and resumed at 3:20 p.m.)

6 MS. WILBON: Good afternoon, everyone.
7 We are getting towards the end of day one. So
8 hopefully everyone had a good discussion in their
9 breakout groups and we're going to reconvene to
10 hear what happened in the different breakout
11 groups and see what we might be able to add to
12 the list of principles that we started earlier.

13 So we're still not fully back I don't
14 think maybe. I know that Kim has the slides from
15 one of the groups, but why don't we go ahead and
16 get started.

17 Did the measurement group, do you guys
18 want to go first? Do you have slides?

19 MEMBER LLOYD: Yes.

20 MS. WILBON: Can you sit at a
21 microphone? Oh, hand mike. Okay, hold on one
22 second.

1 He's got one for you.

2 MEMBER LLOYD: Thank you.

3 Okay, so we're measure group one. And
4 that was attribution challenges associated with
5 measurement, which probably sounds like most of
6 the other names. So specifically it was -- now
7 that I read it, it's not very informative --
8 total cost of care, total cost of care was one of
9 the measures, as an example; hospital level risk
10 standardized payment associated with 30-day
11 episodes of care; and then standardized
12 readmissions ratio for dialysis facilities were
13 the three that we had to start off our
14 conversation.

15 So I think some of our challenges
16 though, as you can already see up here, re
17 somewhat universal to many of the case studies
18 I'm assuming, and are also things that we started
19 to talk about earlier.

20 So the first issue was around the
21 selection bias. And I forgot to say, please jump
22 in, guys, fellow group members. Selection bias.

1 So, part of the issues around like let's say
2 you're an ESRD facility and with this
3 readmissions to the ESRD, readmissions measures,
4 you know, what if your main feeder is the safety,
5 the local safety net hospital? And so you're
6 getting a lot more acute patients or patients
7 that don't have access to other related services,
8 et cetera, could be a challenge.

9 The second, we were talking about
10 disease state. So, again using that ESRD
11 concept, you know, is there someone who just
12 became end stage renal disease or someone who has
13 been living with it for awhile? Do they have
14 other complications and comorbidities, other
15 things that would affect it?

16 Then we have the temporal -- I'm going
17 out of order, aren't I -- temporal issues, which
18 is somewhere in here. Did we get out of order?
19 Where is timing? Locus of control disease.
20 Well, I don't know where temporal issues fell off
21 our list here so I'm going to say it anyway.

22 There are issues with the attribution

1 in terms of some of these measures. You could
2 end up with certain services attributed to you
3 before you even saw the patient. So there are
4 some issues where you may have had no idea that
5 that patient was going to be yours, and yet they
6 were yours and it's associated with you. And
7 that can be a big challenge.

8 The locus of control issue obviously
9 we've discussed quite a bit today, but we had a
10 little bit of back and forth on some of these
11 issues about whether or not there are exclusions
12 or segmentations or other ways in which you can
13 deal with some of the locus of control issues to
14 make people more comfortable.

15 So if you're giving them a 30-day
16 measure and they don't feel like they have
17 control over 30-day measures, well, can you make
18 it smaller by saying, you know, there are certain
19 patients we're going to exclude and because it
20 sort of gives you some comfort that you'll have a
21 little bit more control over the patients who are
22 going to be attributed to you. So there was sort

1 of a back and forth of is that risk adjustment or
2 not and, you know, how do we, how do we deal with
3 this?

4 The other issue here with the fit for
5 purpose was the, you know, what are we exactly
6 using it for? Jenny, this is some of your things
7 you were saying before as what's the program
8 context? You know, why, why are we doing this
9 attribution? And that that can make a
10 difference.

11 So you're going to have more, you're
12 going to put a little more -- you're going to
13 have a different level of willingness if
14 something is lower stakes and quality
15 improvement, you're going to have, you know, a
16 little bit more tolerance for the attribution not
17 being perfect than if it's high stakes and it's
18 for payment or, you know, extensive payment.
19 Right?

20 So if it's higher stakes you're going
21 to sort of care more about the level of precision
22 and validity and all of those good things.

1 And then we have the volume issues.
2 You know, is there a point at which certain
3 providers should just not be part of the
4 attribution if the numbers are getting too low
5 and there's too much variation. We had some
6 discussions about that.

7 Availability of services: you know, if
8 you have hospitals that tags with readmissions
9 and but there is no availability of home health
10 agencies in the area, you know, how much of it
11 can they, you know, it gets a little bit back to
12 the control issue, but the availability can be a
13 challenge.

14 The unintended consequences feature on
15 the challenge list, we discussed an example of if
16 you use a total cost of care measure and you use
17 something like evaluation of management services,
18 you sometimes might have an ophthalmologist who
19 gets tagged with a diabetic because they've seen
20 them for a number of retinopathy visits. Right?
21 And so sometimes you're going to have those sort
22 of idiosyncrasies that we'll have to figure out a

1 way to get around. Right?

2 So in terms of the -- and, sorry, the
3 last one is evolution of the care team is if you
4 only have one physician who ever treats a patient
5 then attribution is pretty easy. But to the
6 extent that we're practicing team-based care
7 more, it's just making the charge of this group a
8 little bit more difficult. And so that evolution
9 of changing care team and sites of care and other
10 aspects made me think of new technology and where
11 we're getting care. That's going to be --
12 basically make this more challenging.

13 So, in terms of the guiding
14 principles, we were saying that we do want to try
15 to build into the principles somewhere that we
16 are trying to really derive accountability and be
17 aspirational in these attribution methodologies.
18 But in the same respect, there will have to be
19 some sort of phase-in if you do that.

20 So the examples of, you know, MSSP,
21 how you sometimes do pay for reporting and then
22 you do pay for performance. Or maybe using an

1 episode measure before you use a total cost of
2 care measure, or something that there are step-
3 wise fashions.

4 Somebody else had a good example and
5 now I'm forgetting what it was. I can't, you'll
6 have to jump in if there was another, another one
7 there.

8 And then we want to make, we want to
9 put a marker out there for three to five years of
10 what do we -- where do we want to go? So as
11 people are developing measures right now and
12 they're thinking about their attribution models,
13 what signal do we want to give them now so that
14 their measures when they come up in front of NQF
15 in three to five years are adequate and meet some
16 of the expectations.

17 And we also want to err on the side of
18 over-tagging at first. So we talked about if you
19 have a cardiologist, an endocrinologist and a
20 primary care physician and none of them did an
21 A1C, perhaps you start with them all being
22 responsible, multiple responsibilities, and

1 eventually you can narrow in over time onto more
2 specific accountability. And perhaps, as the
3 organizations coalesce around payment programs or
4 something, or become ACOs, et cetera, when it's
5 sort of less diffused then you might narrow the
6 accountability.

7 Testing: the testing these models is
8 key. We talked about the earlier. Resources
9 have to match. So if, you know, if you have
10 expectations for an area that, you know, certain
11 providers, providers or clinicians or whatever
12 that don't necessarily have the resources to make
13 good on what you're asking them do, do they have
14 to find other programmatic ways to make it match?
15 Which I don't, I think we kind of strayed out of
16 attribution by the time we got to that one, but
17 nevertheless.

18 And then lastly, the transparency of
19 the models and their impact and how, you know, if
20 you tag someone with an attribution, you know,
21 there could be financial impacts or public
22 reporting impacts or other things that, you know,

1 impact those clinicians and that, but that should
2 be very transparent and clear.

3 Did of that make sense or does the
4 group want to add anything? No?

5 Okay, questions?

6 CO-CHAIR MEHROTRA: Go ahead. Did you
7 want to -- you had a question, Bob?

8 MEMBER KROPP: Yeah. On the concept of
9 over-tagging, if I could paraphrase, you just
10 test it. But is the concept that a measure might
11 be applicable to a, a certain group of
12 specialists and primary care physicians or
13 providers but not necessarily should be? In
14 other words, in certain contexts one of the group
15 of eligible providers would be tagged, you know,
16 with that measure?

17 Is that the concept that you were
18 getting to?

19 MEMBER LLOYD: So I think what we're
20 struggling with right now is that is there any
21 individual person that truly has accountability?

22 MEMBER KROPP: Right.

1 MEMBER LLOYD: And right now, not
2 really. And part of it is because the delivery
3 system is so diffused, et cetera.

4 But if you are trying to be
5 aspirational and you're trying to get people to
6 make change, you're trying to drive change --

7 MEMBER KROPP: Right.

8 MEMBER LLOYD: -- then if you, if you
9 give sort of everybody a slice of the
10 accountability it's going to help them move
11 forward. And it may not be perfectly fair and
12 accurate. I mean you want to be careful about
13 who you choose because you're not going to pull
14 in that ophthalmologist, right, for the AIC, but
15 you are going to pull in the relevant physicians
16 treating the case.

17 Is that clearer?

18 MEMBER KROPP: Yes. I think so, yeah.

19 MEMBER LLOYD: You don't want to just
20 give blanket to one.

21 MEMBER KROPP: So the hemoglobin A1C,
22 for example, might wind up in some circumstances

1 attributed to the endocrinologist and the primary
2 care provider group. In some cases it would be
3 one or the other.

4 CO-CHAIR MEHROTRA: Michael, did you
5 want to jump in?

6 MEMBER BARR: If I might. I
7 think Danielle did a great job, and other
8 team members, if I off base too. So I think
9 there is a general sense that for quality,
10 quality-level metrics that you want to be more
11 sensitive, less specific, so hence the over-
12 tagging on the quality measures. There's less
13 sensitivity about doing that as opposed to a
14 costly "we really want to get it right because
15 people are going to react."

16 So the issue was sort of a shared
17 accountability on the quality side to start. And
18 then as Danielle said, over time that gets
19 focused as we learn how this works and adjust the
20 measures over time.

21 I believe that's what you said;
22 correct?

1 MEMBER LLOYD: So that was my question,
2 just to clarify, was on the phased approach. Is
3 that sort of the same concept here? Because I
4 was trying to understand exactly, I was trying to
5 think how the attribution rule -- like pay for
6 reporting, public reporting, accountability, I
7 see that as a general Medicare principle or other
8 payer principle that we want to move towards
9 this.

10 What I was having a struggle with, and
11 maybe you can just re-articulate this, is how
12 does that link to the attribution rule that you
13 might use or the attribution approach?

14 MEMBER LLOYD: Yeah. So I think part
15 of this is it's a principle that we wanted to
16 think about through all of these. Right? And I
17 don't think we really went through every single
18 option, but that's one reason why I gave the one
19 I gave this morning of is it, you know, maybe you
20 give, maybe you give them an attribution model
21 that's based on episodes first before you give
22 them, you know, a one-year total cost of care

1 measure attribution.

2 I mean, so some of it I think could be
3 you only select certain providers or you alter
4 which beneficiaries are eligible for the
5 attribution. Or I think within each of these
6 steps we can probably come up with ways that kind
7 of minimize who and how they're impacted in the
8 first generation of it.

9 But, Michael, yeah.

10 MEMBER BARR: If I may also add, I
11 think there was a general sense that we shouldn't
12 design measures and attribution methodologies for
13 the availability of the kind of metadata data we
14 have now. And that over time that will get more
15 sophisticated in that the kind of attribution
16 rules as well as the relationship codes we talked
17 about earlier become more prevalent and
18 available, so that we start with where Danielle
19 was referring to, then over time progress.

20 So I understand the challenges that
21 brings, but we didn't want to say this is fine
22 for now, and that's good enough. We want to

1 design and then move in the direction that is
2 aspirational.

3 MEMBER LLOYD: I think we messed that
4 up on the guiding principles. We might actually
5 want to actually add that somewhere then.

6 CO-CHAIR MEHROTRA: Do you think it
7 would be fair to -- I don't want to oversimplify
8 what your discussion was, but the general concept
9 that we, when we think about attribution rules
10 that they are not static. And both as the
11 healthcare system changes as well as the
12 availability of data changes, it is really
13 critical that just as we would revisit a quality
14 metric or a payment model, the attribution rules
15 should also be readdressed.

16 And we would expect as a committee
17 that those would evolve over time. It would just
18 be a guiding principle there.

19 Or if that goes too amorphous, I
20 completely get it. But I don't know, I wonder
21 how -- does that resonate with you?

22 MEMBER BARR: I'll speak for the group

1 but let them agree to disagree. I think that was
2 the general sense looking around at the members
3 of the group, that we didn't articulate it as
4 clearly but I think that was sort of understood.

5 MEMBER LLOYD: Yes. We touched upon it
6 in different areas. Right? So we talked about
7 data is changing, where you're providing the care
8 is changing, who's providing the care is
9 changing, and all of these are involved in the
10 assess of attribution.

11 Yes?

12 MEMBER HOUSER: I think that's correct.
13 I think there's a little bit more in that we want
14 to get ahead of the curve, that we want to get
15 ahead of the curve instead of chasing the curve.
16 And that's one of the reasons for the phased
17 approach; that way you can get a little bit of
18 buy-in for being ahead of the curve if you're not
19 putting the full consequences in on day one.

20 MEMBER POPE: One more. I was going to
21 say there's a glide path both in terms of the
22 stakes but also in terms of the attribution

1 itself; right? You could glide from, look, we're
2 holding our physicians accountable to the group
3 performance, then to the performance of everyone
4 you saw. And then eventually we want to get to
5 the point where everyone has one person that's
6 accountable for their AIC testing, for example.

7 So there can be both gliding in terms
8 of the stakes and the sort of the specificity of
9 the relationship, if you will.

10 MEMBER LLOYD: Multiple groups. Right,
11 the example with the endocrinologist, primary
12 care, cardiologist, those could each be in three
13 different medical groups; right? And then over
14 time maybe it's one group and then one person.

15 CO-CHAIR MEHROTRA: Well, maybe we
16 should move to the second group and then I think
17 we're going to continue to have this
18 conversation.

19 It's interesting though, we're
20 hearing, I'm hearing some things that were
21 consistent with in our third group also.

22 Who's the spokesperson for group

1 number two?

2 MEMBER FIESINGER: In our group we had
3 robust discussion and then realized we had 15
4 minutes left and had to come up with something.

5 (Laughter.)

6 MEMBER FIESINGER: Call it Zen and the
7 Art of Motorcycle Maintenance, everything was
8 quality. So everything is attribution. But we
9 tried to distill things down to this, it may be a
10 little bit oversimplified, but we tried hard to
11 distill it down to some relatively
12 straightforward principles as we got off onto the
13 details of payments, risk pool, et cetera.

14 So first, why, why are we treating the
15 purposes for purposes of attribution? So is it
16 improving the patient's health? Is it lowering
17 cost? Is it improving quality? Does it relate
18 to a payment model, a quality measurement type?
19 So thinking about that as we went through
20 everything this morning, going into developing an
21 attribution model.

22 We did agree that the primary care

1 provider should be the core in the attribution
2 model, even for patients with chronic, complex
3 conditions. We didn't get into percentages of
4 care; that's another discussion for another day I
5 think.

6 We thought about exceptions. And
7 these we thought of as areas where the majority
8 of the care is provided not by the primary care
9 provider but by a certain specialty provider or
10 team of providers: renal disease, transplant,
11 HIV/AIDS. There might be other exceptions where
12 we want to carve that out from this.

13 The case we have was very classic:
14 diabetes, heart disease, hypertension, high
15 cholesterol type of patient.

16 This was in terms of attributing
17 measures to entities, to whom you attribute the
18 measures to be based on the nature of the
19 measure. What can be accurately, fairly and
20 appropriately attributed to the individual
21 provider or to the team, the patient-aligned care
22 team the VA uses, to this clinic, to this system,

1 or, as one of our members said, if it's an ACO
2 with a big risk pool, maybe that measure only
3 goes to the ACO and not to anyone below that
4 level.

5 And, finally, in terms of how specific
6 you make the attribution, you should definitely
7 try to make that proportional to the local risk
8 pool. My way to think would be probably has to
9 affect something, I want my responsibility to be
10 roughly proportional to that so that people
11 perceive fairness.

12 CO-CHAIR MEHROTRA: Do you think it's
13 safer to ask, because I didn't, I don't know what
14 was your case study?

15 MEMBER FIESINGER: Oh.

16 CO-CHAIR MEHROTRA: Can you just give
17 a quick overview of that just so that I think --

18 MEMBER FIESINGER: Sorry.

19 CO-CHAIR MEHROTRA: -- we can ground
20 some of these comments.

21 MEMBER FIESINGER: I'd be glad to.

22 Sorry.

1 Okay, so we had the clinical
2 perspectives in changes in attribution. So I
3 totally skipped that. Hope you ask me back
4 tomorrow.

5 Do you want clinical details or?

6 CO-CHAIR MEHROTRA: Just general idea.
7 I apologize, I was trying to -- it was useful to
8 have the care examples so, Yes.

9 MEMBER FIESINGER: Okay. So 72-year-
10 old male, retired truck driver with obesity,
11 uncontrolled diabetes with neuropathy,
12 hypertension, high cholesterol, glaucoma,
13 bilateral osteoarthritis of the knees, Medicare
14 Parts A, B and D, with an AARP supplement, who's
15 seeing his PCP. Can't afford a specialist in the
16 last year, including endocrinology,
17 ophthalmology, orthopedic surgery and neurology.
18 None of them share EMRs.

19 He takes ten medicines. He's missed
20 multiple appointments. He's had a couple heart
21 caths.

22 CO-CHAIR MEHROTRA: And so what, and

1 the goal is to attribute for what purpose?

2 MEMBER BERGER: So many conditions and
3 doctors. And I think our, our charge was to say,
4 okay, what do we do in this case? Here is a
5 train wreck with many doctors. How do we do
6 attribution?

7 And so that's where we started with we
8 have to answer the question why are we doing the
9 attribution and what's the reason?

10 MEMBER FIESINGER: So to -- Sorry.

11 CO-CHAIR MEHROTRA: No. Just super
12 helpful. Thank you.

13 MEMBER FIESINGER: So to answer that we
14 found as we got into the details of this case we
15 very quickly got very down into the payment
16 models or who's responsible for what and who's
17 getting paid what and where are resources being
18 aligned and shared, and how -- do the employers
19 know what they're getting for their money? And
20 we got so detailed we weren't really answer the
21 question of attribution.

22 So we tried to pull back to, given

1 this very common patient scenario, how should we
2 start deciding how to attribute the patient, him
3 or herself, which bucket does he go in? Then,
4 how do you attribute the different episodes of
5 care within that?

6 So I hope that makes a little more
7 sense.

8 CO-CHAIR MEHROTRA: Any questions for
9 group two, just to clarify some of the
10 principles? Go ahead, Ed.

11 MEMBER MACHADO: You know, I was part
12 of group one. And we also touched upon number
13 four, this whole idea of proportionality with
14 locus of control. And I was just curious how far
15 your group went with that because I think we
16 struggled a bit with the fact that in some cases,
17 you know, it may not be straightforward on how to
18 determine that and that, you know, there's that
19 concern about really defaulting to an arbitrary
20 distribution. You know, 10 percent, 20 percent,
21 whatever it may be. So I'm just curious what you
22 had on that.

1 MEMBER FIESINGER: We didn't have an
2 answer either. Various ideas for that were just
3 everyone who's involved gets tagged to the one
4 that we're using. Some of us had worked in
5 development teams that looked at trying to
6 attribute specific percentages. But how do we do
7 that in a fair manner?

8 And as one of our members who works
9 mostly on the commercial side said, how do you
10 create something that works across all pairs and
11 all payment models? And we didn't have a great
12 answer in our time slot of how we do that so it
13 works in everything from the payment side. So
14 the answer, I don't know.

15 MEMBER RADWIN: I didn't bring it up in
16 the group but part of it I think came down to
17 scope of practice as well. When you describe --

18 MEMBER FIESINGER: Thank you.

19 MEMBER RADWIN: -- where you hand off
20 as a family physician, family practice frame,
21 where you have to hand off what you don't treat.
22 It really boiled down to scope of practice.

1 And I think that may help define
2 specificity in one way.

3 MEMBER FIESINGER: So to elaborate, we
4 thought of, okay, I'm a family physician. If
5 you're a nurse practitioner, if you're an
6 endocrinologist what would you normally cover
7 within the scope of your specialty or license, et
8 cetera? And that should set the rough boundaries
9 of the part of the care for which you're
10 responsible.

11 CO-CHAIR MEHROTRA: I'm curious what to
12 respond to this. I envision that this is likely
13 going to a level of detail that we don't want to
14 go as a committee. But I'm curious just to know
15 because it's that it, you know, there's an idea
16 that, say, this patient Mr. Jones had ten visits
17 during the year. And to count up really quick,
18 he was six to a PCP and once to a bunch of other,
19 you could put a weight on those other P -- so the
20 total cost of care, the ophthalmologist where Mr.
21 Jones gets whatever his costs are, so the total
22 costs of the year is weighted much less because

1 he only saw the patient once.

2 But a PCP would be weighted more. So
3 the total costs of care are there, but in terms
4 of the weighting of that it would be that weight
5 would be assigned to the dot.

6 That's a, it's a pure -- from a
7 mathematical perspective we do this all the time.
8 We weight people in regression analysis, et
9 cetera. On the other hand, I could see a number
10 of doctors in the community going, their heads
11 explode going, oh, way too complicated.

12 And so I'm curious like but because
13 you did the proportional with the locus of
14 control, I was curious whether is that kind of
15 the idea that where you were headed or is that
16 too far?

17 MEMBER FIESINGER: I'll give my opinion
18 because I know it's the group time. We were
19 trying to I think get beyond counting visits.
20 You know, there are definitely models that do
21 that. A lot of us have worked those kind of
22 models or seen those models.

1 Simple number of visits to me doesn't
2 necessarily reflect the quality of care. When
3 I've been in capacitated systems I could do an
4 awesome job. I had great numbers seeing patients
5 once a year. But may have also had phone contact
6 and others way of contact.

7 I got a message during this visit. A
8 friend of mine does urgent care. She says, well
9 I'm getting tagged for their colonoscopies I saw
10 once for taking a splinter out of the foot.

11 So for my percent you could be 10
12 percent.

13 So we didn't flesh it out beyond this
14 locus of control and scope of practice idea, but
15 we were trying to go down the path I believe of
16 how we not simply count visits. That's an easy
17 thing to do. You can use claims-based data. But
18 how to be a little smarter about it.

19 But I wish I had a better answer for
20 exactly how to do it perfectly. But I think the
21 group thought that scenario worth exploring more.

22 MEMBER BEAM: And I think too, I think

1 it goes back to what your purpose is for, and
2 again are you trying to measure their performance
3 or are you trying to find like responsibility for
4 care going forward because if you tell a provider
5 that you're responsible for 20 percent of the
6 care for a patient, and am I going to focus my
7 effort and my time on that knowing that you're
8 responsible for 80 percent and I'm responsible
9 for 20 percent?

10 So, again, what's your purpose and
11 what's the intent? If it's, again, to evaluate
12 overall performance so that you can award some
13 incentives, then that may be something that would
14 be very good to do. But if you're just trying to
15 give them a panel to work from as far as to say
16 you're accountable going forward, that may not be
17 good.

18 MEMBER RADWIN: One of the challenges
19 of our case was that some of the care that the
20 patient ended up getting was preventable. And so
21 when you look at visits, number of visits, and
22 weighting visits, some weight has to go to the

1 fact that the ball may have been dropped in
2 primary care when it came to a follow-up phone
3 call or something like that.

4 And that's what made this case I think
5 particularly challenging, like real people.
6 Because there should be some attribution of
7 preventive care, that when it doesn't come
8 through that gets -- that provider is accountable
9 as well.

10 CO-CHAIR MEHROTRA: So, Yes, a couple
11 other people had their tags lit. You want to --
12 I don't know who was up first. Do you want to
13 go, Nate, first here?

14 MEMBER SPELL: Just say our group
15 struggled with this a bit, too. And how do --
16 you know, do you model an attribution based on
17 how current care is fragmented and divided
18 amongst these different providers? Or do you
19 intentionally make it aspirational and say, okay,
20 all of you get to own this one and you're in a
21 way incentivizing future collaboration,
22 coordination of care, perhaps interoperability,

1 those sorts of things.

2 But you can't get too far ahead of the
3 ability to implement. And that's where we were
4 talking about the resources. So if you get too
5 far, if your attribution model assumes a future
6 state that is not readily achievable, you're
7 perhaps undermining credibility of that.

8 So we kind of struggled with how do
9 you build the right measure? And it gets back to
10 what's your purpose? Is your purpose to reward
11 current performance or is your purpose to
12 partially incentivize future performance?

13 CO-CHAIR MEHROTRA: That's really
14 interesting. So a apropos of some of this stuff
15 we were having.

16 So why don't I propose we have group
17 three discuss. Elizabeth had some comments there.
18 And then maybe we'll just circle back to all of
19 us.

20 Is there any way that we could have
21 the draft principles or notes from all the groups
22 so we could kind of react to them? I know that's

1 a tall task; sorry about that, Kim.

2 MEMBER DRYE: I don't think we -- I
3 have pictures on my phone. I should have
4 forwarded them.

5 So I'll just describe the case study
6 and then I'm going to -- I would say we focused
7 on trying to apply the first couple of the
8 principles that we developed this morning and
9 summarized after lunch. And that process led us
10 to some ideas about the next steps, some of the
11 next steps for this group.

12 So the case was that I'm going to,
13 I'll just briefly talk about, the case was --
14 it's really interesting, so NQF in the MAP
15 process got a proposal from CMS to apply a
16 smoking rate, a population-based smoking rate
17 measure to use it in the Inpatient Quality
18 Reporting Program, which is a hospital pay-for-
19 reporting program. And measures still would go
20 up on hospital compare.

21 So each hospital, in this case in a
22 county, because the county score was calculated

1 county level of the proportion of patients -- I
2 think it's smoking cessation, not smoking, actual
3 smoking -- so smoking cessation rate. Each
4 hospital in that county would get that score of
5 accounting smoking cessation rate. If you were
6 in a different county you would get that county's
7 score.

8 And the push-back from the inpatient,
9 the MAP inpatient quality reporting really fell
10 kind of low. Hospitals can't be accountable for,
11 you know, with their county smoking cessation
12 rate.

13 So and we would start with our own
14 concept which was what are we conceptually trying
15 to do with this measure? And we laid out, you
16 know, how are we expecting this measure to change
17 the world?

18 And we just threw out, well, some
19 patients are going to the hospital. Okay,
20 hospitals can account for those patients. Some
21 patients, so they're touched. You know, some
22 patients won't be touched but they'll be right

1 there nearby the hospital in the county. They're
2 not that far out of the hospital's reach. And
3 some are even further away.

4 Is it reasonable to attribute that
5 quality measure, that outcome of smoking
6 cessation to the hospital? And at first blush it
7 didn't seem very reasonable to us because they're
8 not really touching most of these patients. But
9 actually if we took the devil's advocate position
10 and really gave a lot of reasons why you might
11 want to do that. I mean maybe the hospital, we
12 want the hospital to be driving smoking
13 cessation.

14 It might be especially reasonable, for
15 example, in a state like Maryland where there's a
16 global hospital budget that is incentivizing
17 financially hospitals to address population
18 health. Maybe it's the most effective mover in
19 the community and the hospital could push for
20 what we know are really effective policies like
21 tax cigarettes or education campaigns.

22 Maybe they can lobby their

1 politicians. They're very forceful, well funded
2 organizations within a community,. And, you
3 know, we, and as the group pointed out, very
4 little portion of health funding goes to public
5 health. It's almost all going to clinical care.

6 So if our goal is to change behavior,
7 so that just segues from what you were saying in
8 group two, if our goal is to really change,
9 change -- use this level of quality measurement
10 and the attribution strategy to drive change,
11 hey, it could be a reasonable way to get it done.

12 And so that just, I think it
13 reinforces the importance of transparency and
14 really stating your goal. And you could take it
15 to the map and say, okay, we realize, you know,
16 you only touch maybe 10 percent of these
17 physicians and you already have a smoking
18 cessation, you know, counseling measure by the
19 way, but this is our best shot at improving the
20 population health.

21 So once we, once we went through that
22 we said, well, let's see if we can apply the rest

1 of our principles. And I would say where we, you
2 know, we, considering attribution that's
3 important. Because that was our principle number
4 one, we've got to consider it.

5 Number two was be clear about your
6 goals. And it's okay to be aspirational but you
7 have to be clear that you're being aspirational
8 and make that, you know, something that's
9 explicitly discussed.

10 And then the third one was, okay, one
11 size fits all probably doesn't work. And here's
12 where we shifted our focus and Srinivas gave us
13 some thoughts about how we might try to go back
14 to a more practical task as a committee of giving
15 some specific cases and breaking down -- and here
16 we, just as a note, we noted that our
17 nomenclature is not, we still need to work on our
18 nomenclature.

19 So someone like me who's a measure
20 development -- developer primarily, the word use
21 case is a little hard to, I need that defined for
22 me. You know, when I use risk adjustment I use

1 it in a way that makes Srinivas uncomfortable.

2 But I have a certain way of thinking about that.

3 So we probably need some work on our terms.

4 But we thought it would be useful
5 going forward, and I think we're willing to do
6 some work to try to make this happen, to create
7 some tables, so I'll just try to describe them to
8 you, that would give us more narrow cases that
9 are exemplary cases that we could apply our
10 principles to. Because applying the principles
11 broadly is just too hard.

12 But as you, as you guys were talking
13 about, you were just talking about a chronic
14 disease patient, you know, one principle should
15 be that the locus of control is primary care;
16 right? So this table would have, or set of
17 tables, would have across for the columns what my
18 colleagues are calling use cases. But I'm just
19 suspending my lack of -- but what we mean is,
20 okay, types of programs; right?

21 So episodes, episode type programs
22 like for a procedure or chronic disease

1 management.

2 A next column would be total
3 population programs, so a patient center in a
4 medical home, or a zero based, hospital based
5 program, post-acute care, physician profiling.
6 And then those would be columns.

7 Then we'd create rows that are the
8 kinds of choices we have for our attribution
9 strategy. So, for example, just going back like
10 the Beth McGlynn article, but do we want to use a
11 patient-based or an episode-based approach? Do
12 we want to use dollars or visits for
13 responsibility? Those kind of attribution
14 choices could go in rows.

15 And if we can get a series of cases
16 that fit into those cells we're willing to do
17 more than four, which I think is what we talked
18 about from our last phone call. We could do a
19 series of cases.

20 And just to make this hopefully not --
21 well, let me just stop there and see if anybody
22 has a question. Because probably we want, we

1 might want to do not just one table but a second
2 table. You know, one table might be focused on
3 chronic disease, okay, another on procedures, and
4 another on public health. And we could build a
5 couple of these columns for each one and then try
6 to fill in what we think the implications of
7 those choices might be.

8 So that's where we ended up, thinking
9 we should do some more work based on the learning
10 we did from our case. If that made any sense.

11 CO-CHAIR MEHROTRA: Do folks have
12 questions, clarifications? Go ahead, Danielle.

13 MEMBER LLOYD: I was just going to say
14 I should have been in your group because I have
15 that table on my laptop right here.

16 MEMBER DRYE: We talked about you. We
17 credited you with the kernel of the idea.

18 MEMBER LLOYD: So, you can come and
19 just help me fill it out here --

20 MEMBER DRYE: Yes.

21 MEMBER LLOYD: -- and we'll be good.

22 CO-CHAIR MEHROTRA: Well, let me take

1 that as a starting place. So, you know, just I'm
2 trying to think of the charge of this group,
3 trying to think -- and please our NQF colleagues
4 please jump in if you wish -- but what are we
5 trying to do and how are we trying to help folks
6 out? Because attribution is an issue that a lot
7 of folks are struggling with.

8 We decided that we're going to address
9 the challenges. And we feel like we got that
10 covered in terms of the problems.

11 We have these principles, but I think
12 there's been some concerns, I think appropriate
13 concerns that they're a little pie in the sky.

14 And the idea was with these use cases that
15 Danielle and Elizabeth are proposing -- use?
16 Could use some other word. -- examples, that we
17 would go through them and try to illustrate some
18 of our thinking so that we could guide others who
19 might not have that same exact idea but at least
20 would have a sense of a very illustrious group of
21 people from a lot of different perspectives, at
22 least how they're thinking about this and might

1 come to what is the attribution rule.

2 Does that sound like a both useful,
3 feasible goal for our group over now this
4 session, two days, as well into August? Folks
5 want to jump in?

6 I'm trying to remember. Carol left.
7 I have to do my hard job now.

8 So maybe I'll just go around, if
9 that's okay, just so I can keep track. You want
10 to go first?

11 MEMBER FIESINGER: We like the idea of
12 the grid. I think that helps describe what we
13 were trying to get to in our group. Because we
14 kept thinking, okay, different models of
15 attribution to work for different scenarios,
16 different needs, et cetera, et cetera. And I can
17 think of different cases that have nuances based
18 on our own clinical case.

19 We had the example brought up in our
20 group, okay, what about the 30, 40-year-olds who
21 don't have a regular source of care; where do
22 they fit?

1 So I think having that grid, having
2 the scenarios would definitely help us clarify
3 our way of thinking, like they could be useful.

4 MEMBER SUTARIYA: So I think I'll add
5 one plus to that. And I share some experience
6 from the successful examples of what large ACOs
7 have done in terms of how they have internally
8 attributed responsibility among themselves. And,
9 you know, as to grid-like responsibility of
10 knowing the purpose for which you're attributing
11 makes a lot of sense to me as well.

12 CO-CHAIR MEHROTRA: Ari.

13 MEMBER HOUSER: I may be a little bit
14 offbase since I don't have the provider
15 perspective. But I like the idea but it seems to
16 me a little bit at odds with our principle of we
17 need to try out a lot of different attribution
18 models to get a sensitivity analysis and to see
19 what the implications are for each choice.

20 CO-CHAIR MEHROTRA: That's a really
21 good point. I guess it matters how far this
22 goes. And so let's just take the example that

1 Elizabeth just presented of smoking cessation
2 within -- no, I think it was smoking rates within
3 the county. We could at least go through and
4 say, here are some things, here are some
5 different rules that you could test and see
6 whether they make a difference.

7 But I guess my thought was it's most
8 important to explain the thought process as
9 opposed to here's the rule thou shalt use at the
10 end.

11 But that's just an idea. I don't know
12 if that's too like plain, a little too loose.

13 MEMBER HOUSER: My experience would be
14 is if we come up with a table that has a
15 attribution in a cell, someone will use that
16 table. And I think people will use that table to
17 figure out what cell they're in and pull that
18 model with no further thought. And in a rush,
19 that's what I would do.

20 MEMBER LLOYD: If you require them to
21 pass multiple ones they can't do that though;
22 right? I mean that was part of the --

1 MEMBER HOUSER: Are we going to like be
2 the police and tell them --

3 CO-CHAIR MEHROTRA: That's what NQF is,
4 they have a whole police force out there really.

5 (Laughter.)

6 MEMBER LLOYD: You just don't have
7 specifics, you just don't get approved if you
8 don't. But that, I mean that was the point I
9 made this morning of I think these are a little
10 bit at odds.

11 But the way I'm rethinking this is you
12 have these steps that you have to look at. And
13 you don't have to end at this answer. And we're
14 going to tell you in some, in some cells you may
15 say here's a couple options that might make
16 sense. Or, you know, it doesn't, it doesn't have
17 to be just one answer per cell; right?

18 CO-CHAIR MEHROTRA: Let me just --

19 MEMBER LLOYD: Therefore just explain
20 the challenges.

21 CO-CHAIR MEHROTRA: I think, Eddie, you
22 had your --

1 MEMBER MACHADO: Yes. No, I think
2 everyone's really hit upon the same thing. I
3 think it's a good idea because it's very -- it
4 will give folks very practical, you know,
5 something concrete, you know, to at least react
6 to, to go along with the principles.

7 But I do agree with Ari that we have
8 to be very careful in constructing this if we
9 proceed to do this that we don't necessarily
10 recommend a specific, you know, attribution rule.
11 I think we can go as far as saying, you know,
12 these are the things to consider or to talk
13 about. But I think you have to be very careful
14 that you don't end up like with that one comment
15 in a box. And then because folks will run with
16 it. Because it's just the natural way of, I
17 think, reports.

18 CO-CHAIR MEHROTRA: Jenny.

19 MEMBER BEAM: I just have a question.
20 I guess hearing Danielle saying the next measure
21 doesn't get approved, am I -- so for all the
22 measures that are out there are we going to be

1 doing attribution along with those measures?
2 Like is that part of -- did I miss something or
3 is that --

4 MEMBER DRYE: Are you saying is it
5 separate from the measures themselves or is it --

6 MEMBER BEAM: Yes. So I guess --

7 MEMBER DRYE: Well, I would just say, I
8 mean, okay --

9 MEMBER BEAM: -- saying if someone,
10 because I mean the questions, the comments were
11 saying I think we should be careful, and then
12 who's going to be the police. And saying, well,
13 then the measure just won't get approved.

14 MEMBER DRYE: Oh, Yes.

15 MEMBER BEAM: So I guess I'm asking so
16 for all the like quality metrics that are out
17 there are we envisioning that, that they will now
18 have an attribution component with this?

19 MEMBER DRYE: I can try to speak to
20 that.

21 CO-CHAIR MEHROTRA: Yes, go ahead.

22 MEMBER DRYE: But having put so many

1 measures, outcome measures through NQF.

2 So they always go through with a clear
3 attribution design. So, you know, you built this
4 measure, we built the measure for ACOs, to
5 profile ACOs because --

6 MEMBER BEAM: Right.

7 MEMBER DRYE: -- the quality measures
8 we're using going back bigger picture are to
9 compare provider performance. And I think when
10 we're talking about attributing cost and quality,
11 again we want to be able to compare value so that
12 payers or consumers can figure out where to get
13 the best value care.

14 So that's explicit when you put a
15 measure through the NQF process and you test it
16 at that level. And if you move it to some other
17 level, for example moving to the smoking
18 cessation measure, which is a population-based
19 measure, into profiling hospitals, it's not
20 really, it's not approved in that context.

21 So but measures, as you know, more and
22 more just get used all the time at lots of

1 different levels. So I don't think -- and I'm
2 looking at Taroon, and I mean Erin, and any of
3 you guys from NQF could elaborate -- I don't
4 think you're going to change your guidelines that
5 like once approved you can use it any which way
6 you want. It's approved for a specific provider
7 level, provider -- and now and I can't use any of
8 my words.

9 CO-CHAIR MEHROTRA: It's a use case,
10 don't worry.

11 MEMBER DRYE: It's a use case. It's
12 approved for, you know, profiling a specific type
13 of entity. And that's it. And if you're going
14 to extend it in some other program, or some other
15 provider level, it's not NQF approved for that.

16 And so I think what we're saying is
17 forget the NQF approval. For example, CMI
18 doesn't need any of its measures to be NQF
19 approved, and they roll them out, you know,
20 whenever they want, wherever they want. We're
21 just saying like, here, let's figure out what's
22 advisable versus what, you know, what would make

1 sense.

2 MEMBER BEAM: Thanks.

3 MEMBER DRYE: Sure.

4 And I just, sorry, I just want to say
5 to Jennifer and Anne and others in our group, if
6 you guys have anything else to add.

7 CO-CHAIR MEHROTRA: Going to Srinivas
8 and then Rob.

9 MEMBER SRIDHARA: Yes. So just to,
10 just to clarify. I think -- I don't think the
11 goal of the table was to be prescriptive, rather
12 to say so the question was level of, let's say
13 unit of analysis was something that we've talked
14 about here. It's a different discussion if
15 you're say, discussing ACO models and how do you
16 attribute? And, you know, what is the unit?
17 It's probably the ACO and you might need some
18 multiple attributions that will work into an ACO
19 or something like that.

20 That, so that will be a list of
21 considerations for level of, you know, unit of
22 analysis for the scenario, use case, what have

1 you that is ACO models. Medicare wants to
2 consider that. Versus, say, a CPC program or
3 something like that. There's the unit of
4 analysis, how you attribute what you do becomes
5 different.

6 And I think our guidance would be
7 around that, like that you should be taking a
8 different approach or consideration based on
9 this. You would still have whatever choice you
10 wanted to make. And we would just provide some
11 guiding guidance around how you might make such a
12 decision. But which of the options is left to
13 the user, if you will.

14 CO-CHAIR MEHROTRA: Thanks.

15 Rob.

16 MEMBER SCHMITT: My comment's really
17 just an echo of something Ira mentioned this
18 morning. As we go through this entire process
19 and come up with all these attributions and
20 things I think we need to be conscious to not
21 develop something that leaves rural behind. 25
22 percent of Americans live in rural America. And

1 so we can have all these aspirations and think of
2 all these great things. And if rural is excluded
3 from them, then that's a problem.

4 CO-CHAIR MEHROTRA: No, I think that's
5 a really good point. And you gave a great
6 example of -- you want to tell the story about
7 smoking cessation within your county? I thought
8 that was very illustrative.

9 MEMBER SCHMITT: Sure. We're a single
10 hospital county, small county, 14,000 people. We
11 are currently trying to do smoking cessation
12 programs within our county. And actually we're
13 going to -- not merge but take over our health
14 department in our county.

15 And the health department was for
16 that. You know, the whole community's together.
17 But then regulation gets in the way. The state
18 doesn't allow a hospital and a public health
19 department to work together. And the grants that
20 the health department can get, the hospital can't
21 get.

22 And so the health department, because

1 the county is broke and they can't even afford to
2 have a health department, so we said we will take
3 that on. We have the resources, let us help you.
4 But we can't regulatorily. And state law
5 prohibits us from helping them.

6 So we're doing, trying to do the
7 population health. We're part of a rural ACO
8 with 25 other rural hospitals. I mean we're
9 trying to do all the right things. But in a lot
10 of cases we're prevented from doing it. Like
11 HCAHPS. We're not required to be in HCAHPS but
12 we are. We want to do a lot of, we want to do
13 value-based purchasing but we can't. We're not
14 permitted to be in that yet.

15 So there's a lot of things that rural
16 wants to participate in but, for whatever reason,
17 we're left outside. So I just, I don't want this
18 group to leave rural out.

19 CO-CHAIR MEHROTRA: Can I make a couple
20 comments. Folks who have their cards up, do you
21 -- oh, I wasn't sure, okay. What I'm sensing
22 from the group is that there's some -- you guys

1 are going to push back -- there's some enthusiasm
2 for this idea but it's not clear in people's head
3 exactly what this will look like. And they're
4 like, I think this sounds good in theory but is
5 this being reality.

6 And I wonder, and this is going to be,
7 I'm going to be asking for volunteers, but --
8 everyone's card is down. Everyone is looking.
9 Everyone check your iPhone really quickly --
10 would be is that would someone be willing to try
11 this out, like just one set of, one column and
12 some ideas to -- and then put them up in front of
13 the group tomorrow so we could at least have
14 something concrete to react to and immediately
15 go, Oh, this is not helpful to anybody or Oh my
16 gosh, this is exactly what folks need, or
17 somewhere in the middle and we can tweak?

18 My sense is that would be helpful.
19 I'm having head shakes. So that sounds like it
20 would be helpful. Are there any volunteers that
21 would be willing to do that? Just it can be
22 rough.

1 MEMBER LLOYD: I mean I've got like
2 some already, but maybe I could have another
3 volunteer coming over and help.

4 MS. WILBON: Use your microphone. We
5 want to make sure that's recorded.

6 (Laughter.)

7 CO-CHAIR MEHROTRA: We want it on
8 record.

9 MS. WILBON: For perpetuity. Okay,
10 thanks.

11 MEMBER SRIDHARA: I'll help you,
12 Danielle.

13 MEMBER LLOYD: This is Danielle Lloyd.
14 Yes, I have quite of bit of this fleshed out
15 already just as a straw man example. But I think
16 --

17 MEMBER SRIDHARA: Sure, I'll help you
18 with that.

19 MEMBER LLOYD: -- my friend here has
20 agreed to --

21 MEMBER SRIDHARA: Sure.

22 MEMBER LLOYD: -- help flesh it.

1 CO-CHAIR MEHROTRA: Thank you both,
2 Danielle and Srinivas.

3 MEMBER SUTARIYA: I'll help out as
4 well.

5 CO-CHAIR MEHROTRA: All right, so we
6 have three volunteers. First, thank you. Four.
7 Four. Jenny, all right, great. I was expecting
8 zero. This is great.

9 So thank you all for helping out with
10 this. And so I think that would be -- I would
11 find that really helpful. So maybe we can try
12 that out if we could re-jigger our agenda
13 tomorrow because and we'll see if this is
14 something we should kind of flesh out, change or
15 drop like a hot potato. So we'll see.

16 MEMBER DRYE: Actually, can I just --

17 CO-CHAIR MEHROTRA: Go ahead.

18 MEMBER DRYE: Danielle, I don't know
19 if, I think it might be helpful to just do maybe
20 two different types of care that we're trying to
21 --

22 CO-CHAIR MEHROTRA: Use cases. Use the

1 words.

2 MEMBER DRYE: I know. But I'm thinking
3 like maybe you can -- because when we did the
4 columns and rows we felt like -- maybe. Well, I
5 just think when you do your grid, you know, are
6 you thinking, it might be good to just think
7 about like a chronic disease case or an acute
8 case. And we were thinking in our group about a
9 public health case.

10 I wouldn't mind doing a public health
11 one just because we already thought it through so
12 it wouldn't be extra work. But those were like
13 categories we thought the table actually might
14 look a little different. Like you're talking
15 about chronic disease management versus an acute
16 intervention or surgery. Maybe not.

17 CO-CHAIR MEHROTRA: I see a lot of
18 cards up. But I'm also conscious of the time
19 here. So there is this public comment period
20 coming up.

21 Is it possible to do the public
22 comment now and then have more conversation? I

1 think there's a lot of good comments here but
2 this might be a good break pause. And so can you
3 do that magic with the --

4 OPPORTUNITY FOR PUBLIC COMMENT

5 MS. WILBON: Oh, well actually anyone
6 in the room that would like to comment? I don't
7 think so.

8 So, Operator, can you -- is there
9 anyone on the line from the public?

10 OPERATOR: At this time if you'd like
11 to make a comment, please press star then the
12 number one on your telephone keypad. We'll pause
13 for just a moment.

14 (Pause.)

15 OPERATOR: And there are no public
16 comments at this time.

17 MS. WILBON: Okay. Are there any
18 committee members, I think that Jennifer Perloff
19 and Dr. Resneck were going to be dialing in at
20 some point, as well as Ariel who is on the
21 Commission Authors Team. Is anyone on the line
22 that would like to either make a comment from

1 this morning or this afternoon's discussion, from
2 the breakout groups?

3 OPERATOR: There is no one dialed in.

4 MS. WILBON: Oh, okay. That's easy.

5 So in that case we can continue. We
6 have until 4:30.

7 CO-CHAIR MEHROTRA: Okay. So we have,
8 great, so we have about 20 minutes for I think --
9 and I would love conversations about any of the
10 principles that were provided by the groups.
11 These principles were all, they're all kind of
12 melded together, as well as it's a great idea.

13 So let me just open it up and then
14 we'll wrap up at 4:30. So, Jenny, do you have --
15 all the cards went down.

16 All right, so who's down there? Troy.
17 Troy, go ahead.

18 MEMBER FIESINGER: Just a comment I
19 guess sort of bridging up what Ari said, that we
20 don't want to be prescriptive. The NQF plays to
21 me a very critical role in that I know the
22 process. I know the huge amount of work,

1 research, vetting goes into this. If I want to
2 find a reliable source of a measure for
3 attributable principles I know I can go to NQF to
4 find it.

5 So on a ground level definitely in
6 policy issues and discussions with payers to be
7 able to say here's best practices vetted on a
8 national level. We don't agree with what you're
9 doing, but here's a model that can be used that's
10 helpful. So versus picking something on a grid
11 and going with it, it helps to have those models
12 out there.

13 That said, sometimes people are in
14 situations where you just need something that's
15 already been developed that you can plug and play
16 because you don't have the time, the staff, the
17 finances to develop it. Like the AMA's PCPI
18 measures can be our case in point. I know I can
19 grab those. I know they're good.

20 So I would look to the NQF to have
21 here's the best practice, here's the way it ought
22 to be done. We're not telling you how to do it

1 but this is good advice and good framework.

2 CO-CHAIR MEHROTRA: Would it be, just
3 to jump in and then think about it, is we can
4 talk about this tomorrow after the group presents
5 the principles, but if the -- what we're
6 providing for this group is just some guidance.
7 But then I'm curious what the group reacts to is
8 that if the NQF wants to in the future for
9 certain select measures, let's say ACOs for
10 example -- maybe that's a bad example because
11 there's been a lot of work done there -- but ACOs
12 that if there is an attribution rule that wants
13 to be used across all the different commercial,
14 Medicaid, et cetera, and they're attribution
15 rules, then there really needs to be a specific
16 committee set up for that case.

17 That we can't as an attribution
18 committee just say for every single example, but
19 there might be select cases where a committee
20 just goes directly on one specific attribution
21 rule and votes on it and says this is what we
22 believe is the right attribution rule that can be

1 used, plug and play across a lot of areas.

2 And that might be above and beyond
3 what we're doing here. I don't know. Do folks
4 want to react to that now or tomorrow?

5 MEMBER FIESINGER: So, I'm in a Next
6 Gen ACO. We're using prospective, not
7 retrospective, assignment. I thought that was
8 great. I read the paper from the Dartmouth Group
9 saying prospective assignment is terrible, we
10 think retrospective is better. I'm thinking, no,
11 that's not the way I see it.

12 My NVVAP has its own views, its own
13 position papers on this. So there's already
14 debate going on on what's the best way to do it.
15 I'm glad there's research data we can look at.

16 Now, I'm less certain than I was two
17 days ago about what is the best method. Let's
18 keep discussing this.

19 So I, personally, as an individual
20 think that would be useful.

21 MEMBER SUTARIYA: So perhaps this is
22 because of my late arrival this morning, is the

1 charge of this committee to develop attribution
2 models that are specific to federal programs or
3 to solve attribution models nationally,
4 irrespective of federal or non-federal? Because
5 this, this comes up in various different
6 conversation today. And I think it's important
7 to specify what is the mission of this committee.

8 MS. WILBON: So I would say that also
9 and particularly in August we were definitely
10 looking for the committee to make recommendations
11 in general to the field which would, all of our
12 work generally crosses public and private sector.
13 However, because our work is funded by CMS and
14 they have some specific needs, they are asking
15 for specific feedback from the committee on the
16 applicability of certain models within CMS, some
17 CMS applications.

18 Not that we necessarily have to go
19 through every program, but I think having some
20 discussions specifically about some of the CMS
21 applications and where there might be some, you
22 know, threats to validity or some issues in how

1 certain models are applied would be useful as
2 well.

3 So I think we probably -- hearing the
4 committee's discussion, I think as staff would
5 probably have some more thinking to do about how
6 to frame that for you guys and how to -- and
7 maybe talking with our CMS colleagues as well and
8 what might be the most useful approach to getting
9 them the specificity and the type of guidance
10 that would be really helpful for them.

11 But in general, we do try to provide
12 feedback to the field that is broadly applicable
13 and where it might apply to the public, you know,
14 to the public sector that we can make --

15 MEMBER SUTARIYA: Yes. And perhaps in
16 the charter from the CMS to NQF there are some
17 expectations laid out as to what they are. And
18 it would be important for us to know as a
19 committee.

20 MS. WILBON: Yes.

21 CO-CHAIR MEHROTRA: Eddie, you had a
22 comment?

1 MEMBER MACHADO: Yes. I was just
2 wondering whether or not that fine line of how
3 far we go with trying to flesh out the principles
4 really begins to cross over to the charge of the
5 MAP Committee to really potentially take what
6 we've done to a certain extent and take it that
7 next step forward. Because in many ways they're
8 already doing that on behalf of CMS, really
9 taking it to that next step and saying, well, you
10 should use Measure X for this particular purpose
11 and so forth.

12 So just a thought. I don't know if
13 that's the way to go.

14 MS. WILBON: I think, and I'll turf
15 this to Taroon and Erin at some point because
16 they work much more closely with MAP than I do,
17 but I think initially going into this we are
18 definitely looking for guidance for MAP,
19 particularly because right now attribution, from
20 what I understand, is not a focus specifically of
21 the specifications that they look at when they're
22 making decisions or recommendations for programs.

1 And so I think that any guidance that
2 we have, which again was one of the items we had
3 laid out for the meeting in August, once we kind
4 of have some foundational principles to think
5 about what specific recommendations would we have
6 for the selection process of the Measure
7 Applications Partnership on what they should be
8 considering when they're selecting measures for
9 programs and in terms of attribution.

10 So I think definitely there are some
11 connections there and some lessons to glean from
12 this group and what can be passed on and picked
13 up by MAP in their work.

14 So I don't know if Taroon or Erin
15 would like to add anything to that. Okay.

16 CO-CHAIR MEHROTRA: So just again to
17 comments here about anything related to these
18 principles, the grid, the challenges, anything
19 else came up in the groups. Go ahead, Nate.

20 MEMBER SPELL: I was going to ask in
21 line with who our audience is. Seems like some
22 of our discussion really seems like it would be

1 relevant for measure developers in that we're
2 asking them to do some -- be thoughtful about the
3 attribution model and even potentially to test
4 it. So it feels like we're aimed at them.

5 Because by the time a measure comes
6 to, you know, to NQF it's there's been some work
7 done, a lot of work done on it; right?

8 CO-CHAIR MEHROTRA: Yes. No, I think
9 that it's a fair point. It might be a little bit
10 broader than measure developers. For example, if
11 I'm a -- someone was working with Aetna. I
12 apologize, I lost track. But if you're working
13 with Aetna Health Plan I don't know if you'd
14 label the person who's running their, you know,
15 patient-centered medical home initiative, but
16 that person might really benefit from this when
17 they're applying that program.

18 So I might be a little bit broader
19 than measure developers. But that's the kind of
20 group at least I believe are target audiences.

21 MEMBER SPELL: Yes. And I didn't mean
22 specific only to measure developers. But we

1 certainly are aiming a lot of our stuff at people
2 who are developing measures.

3 CO-CHAIR MEHROTRA: I think that's a
4 fair point. I think maybe biased by Elizabeth
5 being in our group here, you know, that's a real,
6 that's a key focus right from the start of a
7 measure to think about attribution.

8 Laurie.

9 MEMBER RADWIN: Yes. I just had a
10 question about the grid.

11 So I'm having trouble visualizing it.
12 So what would the row headers and column headers
13 look like on your grid? I understand it would be
14 applied to a case but what would be a typical
15 element that you'd be cost matching on?

16 MEMBER LLOYD: So I'm making stuff up
17 based on the fact that you guys said pick four
18 and this is up to the group. Right? So I was
19 trying to make some diversity of options here;
20 right?

21 Under the sort of primary care-ish
22 column I had a Track 2 ACO, so you pick somebody

1 who's prospective attribution and has risk, you
2 know, comparative rate.

3 And then for the next row I have
4 episode heart failure bundle as a case study
5 example.

6 And then for the quality improvement
7 bucket I had, I just picked an endocrinologist
8 under MIPS. But, again, I'm making stuff up.

9 And then for institutional I picked
10 SNF readmissions because I think that's first, I
11 think that's first up in the SNF VBP.

12 And it's different for, as an
13 institutional level attribution. So the
14 attribution, you know, it's a lot easier to if
15 you're at the SNF, you're at the SNF; right? As
16 opposed to quality improvement where I have
17 multiple clinicians tagged or err on the side of
18 over-tagged; right? Versus the accountable care
19 organization, it's that collection of TINs that's
20 tagged; right?

21 So each one of these is going to be a
22 little bit different based on the different types

1 of things in the McGlynn paper plus others I
2 think that I've heard today at least.

3 MEMBER SUTARIYA: Putting Medicaid
4 Advantage into accountable care or that's a
5 different category you're not dealing with?

6 MEMBER LLOYD: Well, because it's an
7 ACO Track 2 they are statutorily prohibited. So
8 that makes the answer easy. They are not in this
9 particular example.

10 But we could have a different case
11 study. Doesn't matter.

12 CO-CHAIR MEHROTRA: Right. And so I
13 think the issue here is that we just want some
14 really concrete examples that we can start to
15 trigger conversation, recognizing that those are
16 just four examples out of hundreds and hundreds
17 of different things out there. But with at least
18 the idea of going from what I would view as
19 relatively amorphous -- not amorphous, more kind
20 of aspirational principles to something
21 relatively concrete is what I'm hearing.

22 And then, Danielle, sorry to pick on

1 you but you just have this awesome spreadsheet.
2 I'm very jealous. Can you just give us some
3 examples of the rows?

4 MEMBER LLOYD: So on the rows I have so
5 my high level buckets, right, are primary care
6 specialty, quality improvement, institutional.
7 But then within that, the case studies I just
8 read.

9 And then below that I have eligible
10 beneficiaries and geography. So that's not going
11 to be applicable under every situation. And it's
12 the smoking measure under ACO, too, by the way.

13 So where'd she go? She went back.
14 She was down there when she said it.

15 And for county, right, so it has to be
16 within the county.

17 So there may or may not be a
18 geographic or beneficiary narrowing; right?

19 For the heart failure bundle it's only
20 heart failure patients; right? So it depends on
21 which row.

22 Then I have accountable unit. So for

1 the ACO's it's the collection of TINs. For the
2 bundlers this is an open question. Is it the
3 bundle applicant? Depends on the model. Or do
4 you want to tag the procedural list? This is
5 heart failure, so maybe I shouldn't have picked
6 heart failure. Maybe I should have picked an
7 orthopedic one. But you can have a debate over
8 that; right?

9 Quality improvement, I have the
10 multiple clinicians. And then, obviously, SNF is
11 institutional.

12 But eligible clinicians, is there a
13 step of only who can be attributed on; right? So
14 in MSSP you've got like six primary cares and
15 then certain specialists. Heart failure you
16 might only say -- I'm making stuff up. I'm the
17 finance person here. So some clinician tell me,
18 cardiologists, anybody else? No. Whatever else
19 you would put for cardiologists. Whatever else
20 you'd put for heart failure. You know, that's an
21 example.

22 Then for the level, is it an episode

1 or a patient level.

2 Service cost, is it E&M or expanded
3 E&M or is it service, you know, visits? Is it --
4 right?

5 Determination. So is it plurality?
6 Is it a majority? Is it percent of services.

7 CO-CHAIR MEHROTRA: This is helpful.
8 No, this is perfect.

9 MEMBER LLOYD: Right.

10 CO-CHAIR MEHROTRA: So you've already
11 kind of started to give us a preview for
12 tomorrow. But does that help? Okay.

13 So I think there's -- I see a lot of
14 shaking of heads in the right direction, which is
15 up and down. So it sound like we're
16 enthusiastic, Danielle. Thank you very much for
17 this. And I think it will be great to react to
18 this more tomorrow. Sorry for changing the
19 agenda.

20 So I wonder if, so I'm going to throw
21 out just a couple ideas, just one new idea, in
22 terms of what this report might look like. And

1 it occurred to me as we're having some of these
2 conversations that I almost see this section --
3 maybe I write too many papers -- future
4 directions. And so future directions of
5 attribution or future needs.

6 And I'm curious what your reactions.
7 So what was on my mind in that area, the first
8 was in terms of attribution, things that we
9 hadn't worried about too much previously need to
10 be addressed. And one of the examples is their
11 specialty of the physician.

12 You know, in Medicare claims data
13 we've always had the specialty of the physician
14 and it was, I don't know, it was okay. But I can
15 tell you from clinical experience, a lot of
16 cardiologists were really doing primary care.
17 And there was sub-specialists who were only doing
18 cath. But no big deal, it was just, you know, a
19 couple of codes.

20 Now when we start doing these
21 attribution rules and you're trying to figure out
22 it can only be done a primary care physician,

1 then you all of a sudden really care, well, who
2 is a primary care physician?

3 And so one area of future need that I
4 see is that if to the degree that specialty of
5 the physician is important, and I'll also say for
6 the nurse practitioners this is also key because
7 nurse practitioners aren't one big, amorphous
8 group. There are a lot of different kinds of
9 nurse practitioners, but I have no clue from
10 claims data what they're doing. And so there's a
11 real need for a future need for CMS or others to
12 really how is it, what is a mechanism by which
13 providers can now fix their specialty or address
14 their specialty and have more sub- specialties?
15 Because those kind of needs really wasn't
16 important before but now are really important.

17 MEMBER MOSCOVICE: You let providers
18 decide that or do you use claims data to decide
19 it?

20 CO-CHAIR MEHROTRA: Well, it's really
21 interesting -- all right, now I'm going to go
22 into really weedy stuff -- but you know, we have

1 done some work in the past where we've tried to
2 use claims to figure out someone's specialty.
3 And that's kind of an interesting exercise. You
4 start putting there's the heart failure doc who's
5 a cardiologist who's in a different bin than the
6 preventive cardiologist, who's different from the
7 interventional cardiologist.

8 You know, so you can start getting to
9 some pretty -- those categories. And whether
10 that's done via claims or whether you have the
11 physician decide or some combination of the two.
12 I don't know what the answer is. All I'm saying
13 is that the real future direction is we need
14 better labeling of provide -- any, all these
15 different kinds of clinicians.

16 The other place where I see a real
17 need is that there was a lot of enthusiasm for
18 not attributing to individual clinicians but
19 larger groups of providers. In the ACO
20 environment where ACOs contribute their TINs,
21 it's a little easier to figure out who's in an
22 ACO or not an ACO.

1 But a real future direction that I see
2 is better clarifications on who, which, all these
3 clinicians out there which practice are they in,
4 which group are they in if they are in a group.
5 Because we need that better data if we think
6 that's the better level to attribute.

7 And then the third future direction --
8 this is one that I don't think is specific at all
9 to attribution -- but the timing of the data.
10 Sophia's comments a little bit about 2- to 3-year
11 lags really became, struck me as saying that when
12 we're talking about trying to change behavior,
13 quick turnaround and getting those data out is
14 such a critical thing for attribution but for a
15 lot of other purposes, too. But just making that
16 point in our report might be helpful.

17 So I just had three of those future
18 directions. I don't know, reactions?

19 Michael, go ahead.

20 MEMBER BARR: Just real quick on the
21 second one. I believe the MACRA NPRM includes
22 the promulgation of some codes, new attribution

1 codes for the ACOs and clinicians and qualified
2 clinicians. So that might be helpful to that.

3 No, no, no, I think it includes sort
4 of taking the TINs, NPIs and account for entity
5 codes and kind of making some sort of
6 associations to these middle, middle layer of
7 association for future directions. Is that
8 correct or not?

9 CO-CHAIR MEHROTRA: And it's also
10 complicated, right, because the TINs can be one
11 doc versus ten docs versus 100. I mean it's like
12 what a TIN is can be kind of confusing sometimes.

13 MEMBER BARR: Well, this covers the
14 TIN, MPI, the clinician also.

15 CO-CHAIR MEHROTRA: Yes, it's
16 complicated. I guess if we feel we're going to
17 only contribute to practices it sounds great in
18 theory, but in reality it might be pretty
19 difficult in 2016, so.

20 Go ahead, Troy.

21 MEMBER FIESINGER: To me a concern is
22 that a definition of primary care might become

1 like the definition of the patients in a medical
2 home. So we had a discussion in our group, What
3 is a provider and the D.O., nurse practitioner,
4 physician assistant? What is a primary care
5 physician? Is it the National Health Service
6 Corps definition: family medicine, pediatrics,
7 internal medicine, OB/GYN? Depends on what the
8 OB/GYN does; depends what the internist does;
9 depends on what the family doctor does.

10 Certainly there would be heartburn
11 within my organization if those, that was defined
12 certain ways. One way to look at it is What do
13 you do? Roll-based, what services do you
14 provide, what codes do you bill? So in our group
15 we'll have the counterpoint, well, how do I
16 measure that via claims? Okay, good question.

17 We have to look at a lot of those
18 issues. If we sidestep it all by contributing to
19 specific group level, you avoid the issue. But
20 if we're going to define primary care, I know
21 what I think it is, but what does everyone else
22 think it is?

1 And when you task money, as we all,
2 now, it gets very contentious.

3 CO-CHAIR MEHROTRA: Well, no, it's a
4 fair point. You made the point earlier which I
5 think resonated with a bunch of folks which was
6 is it ever right to profile an individual
7 clinician? Though I think I heard the second
8 group also describe that it was important to
9 include focus on primary care, too.

10 So I feel like you didn't -- No, no,
11 not at all, I don't mean to say that. But I mean
12 I do think at its heart right now, right now, a
13 lot of attribution rules are focused on who are
14 primary care physicians.

15 So while I totally agree that myself,
16 a bunch of other people might really have a lot
17 of heartburn about whether they are primary care
18 or not, but it seems to be critical that we try
19 to answer that question because right now it's
20 still too amorphous, so.

21 Are we at recap time? Or are there
22 any other comments before we end? Oh, sorry,

1 Elizabeth, I missed that.

2 MEMBER DRYE: I had a -- we can talk
3 about it tomorrow. But the group two was talking
4 about moving from a, you know, a broad
5 accountability towards a more narrow individual
6 provider or medical home accountability over time
7 which I just wasn't sure what was behind that.
8 Because we didn't talk about that per se but I
9 think that, you know, if we're going to join
10 accountability in well functioning systems,
11 driving towards the individual over time, I would
12 just love to hear more about the thinking of
13 that.

14 Oh, that was group one? I'm sorry.
15 Group one. Bad, bad.

16 MEMBER FIESINGER: I have no
17 recollection of making that comment. Thank you.

18 MEMBER DRYE: It was -- yes, I did not
19 look at my notes. But I looked at the, I looked
20 at the concept but not the group attribution.

21 And then my second, just to, I mean
22 MACRA there's a couple things about it. It has

1 those, I don't know what they're called,
2 relationship codes of responsibility fields or
3 whatever, it's going to pretty much points that
4 we've talked already. But we might want to
5 comment on those, which I think goes to the
6 definitional issues. I don't think we can really
7 tackle that fully in this group, but I think we
8 want to keep it in view.

9 And I, I just -- and really as a
10 measure developer I'm worried. I feel like this
11 is where we're moving. We're moving towards the
12 need for outcome measures and accountability for
13 outcomes in the group level. But when I look at
14 MACRA, you know, it has -- I'm thinking what's
15 feasible to measure? Where am I going to get
16 enough sample size and comparability across
17 groups that I could do a outcome measure that's
18 going to meet all of NQF scientific acceptability
19 criteria.

20 And it feels like a very fluid
21 definition in the statute and in the rule right
22 now where it's saying, you know, not in the first

1 year out. But the statute requires it.

2 CMS allow these -- you can form your
3 own virtual groups or whatever.

4 So I think that the fluidness of what
5 physician groups are is a particular challenge.
6 And I don't think we can solve it. But I think
7 maybe we should just be thinking about. But if
8 we're going to compare providers there has to be
9 some way to think about, you know, to classify
10 groups.

11 CO-CHAIR MEHROTRA: Those are great
12 points.

13 Did group one or group two want to
14 respond to Elizabeth's question?

15 (Laughter.)

16 CO-CHAIR MEHROTRA: Well, it's the end
17 of the day. So we will have plenty of time over
18 dinner and wine, maybe we'll address those
19 tougher philosophical questions.

20 MS. WILBON: So Kim is going to recap.

21 MS. IBARRA: Okay. I'll start the
22 recap and then I'll turn it over to my team if

1 they want to join in and add anything.

2 So the day started, and I'll remind us
3 that we started with why we're all at the table,
4 why we're discussing attribution, why is it
5 important not only from all of your perspectives
6 but also the NQF perspective? And we heard from
7 our CMS colleagues as well about some of the
8 challenges that they face in their work and where
9 guidance would be needed.

10 We heard a lot from you about the
11 different goals of attribution, why we're doing
12 this, what kind of specificity we need, what are
13 the specific areas that we need to consider when
14 we're thinking about attribution rules and
15 methods, how can we lay these methods out, what
16 kind of guidance are we going to develop?

17 And we started to draft principles
18 which our team is going to put together, revise,
19 bring back to you tomorrow so that we can have a
20 look at them again as a committee. And lots of
21 great discussions using different case examples
22 from a measurement lens, from a current case,

1 clinical case, from a programmatic lens.

2 I think all of this discussion is
3 really helping us get to a set of principles that
4 we'll be able to use to guide different
5 stakeholders of NQF and different stakeholders of
6 the healthcare system, so from measure developers
7 to plans, to patients, to purchasers, to
8 providers, to clinicians, to government policy
9 makers.

10 So I will leave it at that and see if
11 my team has anything that they wanted to add to
12 that recap?

13 (No response.)

14 MS. IBARRA: Okay. So tomorrow we will
15 be focusing on reviewing the environmental scan.
16 Dr. Andrew Ryan will be here to lead us through
17 that discussion.

18 This will be an opportunity for the
19 committee, but also members of the public and NQF
20 members to provide input for the authors, for us
21 to revisit the draft principles and also consider
22 if the grid that Danielle and others have so

1 kindly offered and volunteered to put together
2 for us.

3 So that's the plan for tomorrow.

4 Tonight we, for those who have said
5 that they are coming to dinner, we're meeting at
6 6:00 p.m. around -- Oh, okay. We will be sending
7 out an email to the committee of -- with
8 instructions. And you can come see me
9 afterwards. Okay.

10 CO-CHAIR MEHROTRA: Thank you very much
11 for all of your work. And we will see you -- for
12 those going to dinner you will get an email about
13 where to go very shortly.

14 (Whereupon, the above-entitled matter
15 went off the record at 4:36 p.m.)
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