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

9:34 a.m.

MS. WILBON: Good morning, everyone. I want to welcome everyone and thank you all for coming to join us today. We're really excited about today's meeting.

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

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

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

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

Your name tent cards are a way for us

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

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

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

There are a couple of breaks

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

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

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

Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

also readmissions and cost and resource use.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, we'll start with Ateev.

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

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

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

cost utilization measures, our physician cost profiling.

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

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

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

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

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

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

and quality as well.

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

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

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

I don't have any particular disclosures.

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

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

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

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

Thanks.

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

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

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

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

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

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

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

Very happy to be here.

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

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

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

perspective.

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

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

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

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

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

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

Improvement Program.

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

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

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

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

I'm here representing the American

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

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

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

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

So, happy to be a part of the group.

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

Before I was with IBM, I was with

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

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

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

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

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

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

can physicians and patients navigate this.

Thank you.

MEMBER NOWAK: Hi, I'm Jennifer Nowak. I am from Blue Cross Blue Shield Association. It's the association -- the national association for our 36 Blue Plans across the country.

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

MEMBER HAWLEY: Hi, I'm Charles Hawley. I'm with the Utah Department of Health. I'm the analytics lead working with the all-payer claims database to develop total cost of care and quality performance reporting.

MEMBER HOUSER: Hi, I'm Ari Houser. I work at the AARP Public Policy Institute mostly working on long-term care policy. But my background as a statistician so when numbers are involved I work on just about any issue area that we get involved in.

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

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

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

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

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

Pleasure to be here.

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

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

I was nominated by the ANA and I'm a

nurse by training.

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

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

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

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

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

and clinical analytics and served over the attribution team there.

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

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

I'm here representing the National Rural Healthcare Association.

Thank you.

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

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

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

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

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

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

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

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

strategic perspective.

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

DR. BURSTIN: All right, excellent.

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

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

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

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

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

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

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

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

any staff or the chairs.

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

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

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

Thanks a lot.

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

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

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

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

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

So, next slide?

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

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

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

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

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

spend most of our meeting in August doing.

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

So, next slide? Okay.

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

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

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

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

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

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

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

MS. O'ROURKE: Thanks, Ashlie.

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

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

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

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

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

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

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

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

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

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

Next slide.

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

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

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

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

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

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

And, finally, we will ask the

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

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

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

MS. WILBON: Thanks, Erin.

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

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

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

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

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

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

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

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

Next slide.

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

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

Each committee is tasked with

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

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

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

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

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

meeting.

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

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

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

For various reasons, you know, system

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

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

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

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

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

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

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

measure results.

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

Next slide.

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

MS. O'ROURKE: Thanks, Ashlie.

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

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

performance measures for public reporting and payment purposes.

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

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

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

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

the implementation of that measure in the various programs.

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

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

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

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

Next slide.

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

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

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

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

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

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

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

Next slide.

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

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

This is an attempt to diagram out the

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

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

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

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

efficiency and cost reduction and safety.

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

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

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

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

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

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

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

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

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

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

MS. O'ROURKE: Sure.

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

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

But, I think the fundamentally -- MAP

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

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

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

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

CO-CHAIR RAPHAEL: Okay, Troy?

MEMBER FIESINGER: It's a valiant

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

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

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Taroon?

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

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

of the programs.

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

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

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

CO-CHAIR RAPHAEL: Okay. Ateev?

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

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

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

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

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

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

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

I would just say, from our

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

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

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

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

CO-CHAIR RAPHAEL: Nate?

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

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

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

CO-CHAIR RAPHAEL: Danielle?

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Troy?

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

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

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

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

But also, how much of this is just

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

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

Thank you.

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

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

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

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

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

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

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

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

I think that Eddie, you are next.

MEMBER MACHADO: Thank you.

I think this may be a bit obvious, but

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

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

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

CO-CHAIR RAPHAEL: Thank you.

Ari?

MEMBER HOUSER: So, I think the main

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Elizabeth?

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

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

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

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Okay, Ira?

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

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

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

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

CO-CHAIR RAPHAEL: Okay, thank you.

Jenny?

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

we do this, this and this.

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

That's my only question.

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

CO-CHAIR MEHROTRA: Just two things on that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER SUTARIYA: Sure.

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Brandon?

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

And to me, it seems like we're talking

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

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

CO-CHAIR RAPHAEL: Charles?

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

responsible. It's always the provider, singular.

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

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

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

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

a hospital provider and a post-acute care provider.

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

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

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

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

Do others --

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

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

MR. MULDOON: Yes.

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

CO-CHAIR RAPHAEL: Yes, Michael?

MEMBER BARR: Yes, thanks.

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

talking about.

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

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

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

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

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

CO-CHAIR RAPHAEL: Bob?

MEMBER KROPP: Just a question for Dan.

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

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

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Danielle?

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. MULDOON: No, thanks for that feedback.

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

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

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

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

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

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

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

Okay, let's take it away.

Brandon?

MEMBER POPE: Thanks, Carol.

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

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

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

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

integrated.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Two thoughts I had is, one, I know we

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

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

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

Thank you.

CO-CHAIR RAPHAEL: Okay, Jenny.

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

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

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

historically.

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Okay, Ari?

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

double attribute and not partially attribute?

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

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

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

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

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

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

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

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

I just -- if you have two different

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

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

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

So see you in 11 minutes.

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

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

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

CO-CHAIR RAPHAEL: Sophia, take it

away.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We talked about the potential role of

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

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

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

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

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

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

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

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

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

result from methodological artifact?

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

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

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

(Laughter.)

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

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

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

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

Okay. Ira, you get first dibs.

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

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

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

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Okay. Ateev?

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

CO-CHAIR RAPHAEL: I have to have

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

(Laughter.)

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

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

CO-CHAIR RAPHAEL: 12:45.

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

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

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

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

(Laughter.)

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

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

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

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

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

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

as a quality metric on MI mortality.

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

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

(Laughter.)

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

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

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

So those are just four principles. Let me repeat them again. Attribution makes a big difference, no single rule is going to work, challenge some common expectations of how we build these rules, and make sure you test more than one rule.

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

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

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

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

MEMBER LLOYD: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER SRIDHARA: Thanks. So a quick

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Thank you.

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

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

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

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

CO-CHAIR RAPHAEL: Okay. Laurie?

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

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

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

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

being the attributable unit of outcome assessment and measurement.

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

CO-CHAIR RAPHAEL: Okay. Nate?

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

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

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

CO-CHAIR RAPHAEL: Troy?

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

it?

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

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

CO-CHAIR RAPHAEL: Okay. Elizabeth?

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

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

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

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

that's transparent.

And I'm struggling a little bit with how that relates to the quality measure. I'm not 100 percent sure if the programmatic use of some of these measures is the same or different than a quality measure. I think it's actually both. Sometimes, like I built an admission measure for ACO that contains an attribution strategy, right? And it's implemented in CMS's ACO, CMS, CMMI's ACO programs with that strategy, but sometimes, many times this drives Helen crazy sometimes. People are just taking measures and applying them and then building an algorithm to attribute say process of care or outcome measures.

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

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

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

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

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

CO-CHAIR RAPHAEL: Okay. Ari?

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

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

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

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

PARTICIPANT: No. Not so easy.

MEMBER HOUSER: Relatively.

(Laughter.)

MEMBER HOUSER: But you could

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

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

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

MEMBER BEAM: -- blocks the podium

CO-CHAIR RAPHAEL: Thank you.

MEMBER BEAM: Sorry to interrupt, but --

CO-CHAIR RAPHAEL: It's all right.

That's important to know. Can we --

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

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

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

CO-CHAIR RAPHAEL: Okay. Jenny?

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

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

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

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

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

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

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

MEMBER BEAM: Yes, I definitely agree

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

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

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

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

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

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

(Laughter.)

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

actually look like.

MS. WILBON: Yes.

CO-CHAIR RAPHAEL: All right, Ashlie.

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

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

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

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

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

So just again, this is just additional

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

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

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

DR. BURSTIN: Maybe just a --

MS. WILBON: Yes.

DR. BURSTIN: -- little more context.

Maybe just a tiny bit of context.

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

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

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

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

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

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

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

DR. BURSTIN: Yes, and maybe one way

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

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

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

Brandon?

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

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Thank you. Bharat?

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

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

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

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

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

of the ecosystem by optimizing one side of it. So those are the two questions or comments I have.

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

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

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

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

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

of measure scores.

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

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

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

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

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Okay. Taroon?

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

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

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

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

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

circumstances.

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

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

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

CO-CHAIR RAPHAEL: Okay. Ira?

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

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

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

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

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

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

Okay. Eddie, take it away.

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

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

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

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

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

CO-CHAIR RAPHAEL: Thank you. Eddie?

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Okay. Charles?

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

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

CO-CHAIR RAPHAEL: Okay. Jenny?

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

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

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

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

way.

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

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

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

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

speak before we conclude this.

Anne?

MEMBER DEUTSCH: Great. Thank you. So first of all, I wanted to support the four principles Ateev mentioned and the transparency that Nate mentioned. Also wanted to build on Elizabeth's comment in terms of the measure developers indeed do address attribution in some way when they're developing the measures.

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

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

CO-CHAIR RAPHAEL: Jennifer?

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

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

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

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

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

plead guilty to being a fanatic baseball fan, but --

(Simultaneous speaking.)

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

(Laughter.)

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

(Laughter.)

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

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

(Laughter.)

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

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

And there are no public comments at this time.

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

DR. BURSTIN: Jennifer or Jack.

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

OPERATOR: They are not.

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

Ashlie, are there instructions?

MS. WILBON: Kim, go ahead.

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

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

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

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

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

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

MS. IBARRA: Yes, 1:15.

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

CO-CHAIR MEHROTRA: No, this is great.

CO-CHAIR RAPHAEL: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

you're testing these different rules.

Is there another slide?

MS. WILBON: Yes, from --

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

(Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR RAPHAEL: So let me --

MS. WILBON: -- may be helpful.

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

MEMBER SAMUHEL: I thought I was hiding.

(Laughter.)

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

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

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

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

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

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

(Laughter.)

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

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

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

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

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

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

being measured.

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

CO-CHAIR RAPHAEL: Okay, Bob?

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

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

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

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

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

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

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

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

CO-CHAIR RAPHAEL: Thank you. Jenny?

(Laughter.)

MEMBER BEAM: I'll learn by tomorrow.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

year out?

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

MEMBER LLOYD: But --

CO-CHAIR MEHROTRA: -- there --

MEMBER LLOYD: -- you do --

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

MEMBER LLOYD: -- that metric --

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

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

CO-CHAIR MEHROTRA: I see --

MEMBER LLOYD: -- further out --

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

MEMBER LLOYD: Right.

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

MEMBER LLOYD: Yeah.

CO-CHAIR MEHROTRA: -- echo that --

MEMBER LLOYD: Yeah.

CO-CHAIR MEHROTRA: -- but I guess what I wanted just to say is that I'm not -- the attribution rule from my perspective may not always have to be -- I can see cases where you might want a different attribution rule even though you might have the same patient population.

MEMBER LLOYD: So to give another example where I think it's a little bit closer, in the Medicare Shared Savings Program, you

finish up the year, you see who is attributed for payment purposes, and then you measure on those same patients. So your quality metrics are on the same patient population as your spending metrics because they do it all retrospectively, so there is alignment between those.

You are not using quality metrics on patients that have nothing to do with the ACO and then applying it to their payment, right? It is the same group of patients regardless of which measure it is.

CO-CHAIR RAPHAEL: All right. We're going to take two more comments before we wrap and go into our breakout groups. So it's Elizabeth and then Brandon.

MEMBER DRYE: Yes, just real quick because I wanted to -- I am with Danielle on this, as I told her over the break.

I mean, just to use that word that gets thrown around by leadership in both parties and in Congress and in, you know, the administration and everywhere, private sector,

public, we're trying to move from pay-for-volume to pay-for-value, and so I think, you know -- and that -- those clarifications are really helpful.

We are really just trying to -- if we want to look at value, we have to say what did this care cost? So in the case of total joint replacement, you know, what did this care cost, and what was the outcome? And things like the time frame, they just totally echo that. They don't have to be aligned, but the patient got the service, we're attributing to a patient, and we're also attributing to some physician or group or, you know, hospital or something, right, and we want to just parallel that so we can evaluate the value that that -- say, for example, our measures are being used in bundle payments and also in a hospital level, but you want to be able to compare across providers who is providing better value, so to do that, you've got to have an attribution strategy that aligns the cost and the quality on a clearly defined cohort of patients.

CO-CHAIR RAPHAEL: Brandon, last word.

MEMBER POPE: My thought is on the same line. It is not that we're saying there is always going to be quality measures and cost measures with a given attribution, and it is not that this guiding principle does not break down in some specific examples, but it is more from the general thought process of, you know, healthcare is a good which people value for both the cost and quality, and when you start to separate the attribution of those things, then you sort of get some -- you know, I think the unintended consequences become a little less clear what we're doing, whereas when it's clear that this is the cohort or the set of events, whatever may be, and I'm aligned on both the cost and quality of care, I think there is -- it's sort of a general principle.

And there's going to be some specific examples where you can say, well, but this. But high level, that's what I think I'd commented on this earlier, so -- .

CO-CHAIR RAPHAEL: So Ashlie.

MS. WILBON: Yes. I'm going to actually hand it over to Erin to just give a quick overview of, again, remind people where they're going, the goals for the sessions, and hopefully everyone knows where they're going, and we can probably have a meeting place for -- by staff person. So Taroon has the measurement group. I have the clinical case group. And Erin and Helen --

MS. O'ROURKE: Helen and I have the program case group.

MS. WILBON: So we'll line up, and you can follow us to where you go. But Erin will give you a little bit more information in just a second. Did you have a question?

MS. WILBON: Sure, so just -- oh, go ahead, Eddie.

MEMBER MACHADO: Going to ask, we can leave our stuff here, is that right?

MS. WILBON: Yes.

MEMBER MACHADO: Okay.

MS. O'ROURKE: So just a quick reminder about the goal of this next session. Again, we took attribution issues from three different perspectives: from an individual measure perspective, from the perspective of a patient, and from the perspective of a measure use case, if you will, to get to a programmatic issue.

So we're breaking into three groups. If you are in the measurement group with Taroon, you will be staying up here. If you are with the clinical group with Ashlie or the programmatic group with Helen, we'll be going downstairs. We will guide you down. And again, the goal is to try to test the principles we've already identified as well as think of some more that we might want to put on the list to then come back together as a large group and start to expand or winnow our principles.

CO-CHAIR MEHROTRA: And I'm -- when you say programmatic, which one is that? Is that number three, two, or one?

(Laughter.)

MS. O'ROURKE: That is number three, I believe, the smoking measure.

CO-CHAIR MEHROTRA: All right.

MS. O'ROURKE: Measure use.

CO-CHAIR MEHROTRA: Measure use, all right.

MS. WILBON: Also, I would encourage you guys, the discussion questions that we put on there are, you know, to help drive discussion, but there's a lot of things discussed today at the table that we hadn't all included as considerations, so feel free to bring those to your discussions as well and expand as needed, so we're looking forward to hearing what you guys come back with. Thanks.

MS. O'ROURKE: So for those on the phone, we will be reconvening at 3:15. Members of the public, if you're interested in listening in to a group, please feel free to join us.

MS. WILBON: Yes, so we'll be in breakout groups until 3 o'clock, and then we'll

break immediately after the breakout groups and then come back to do report outs about 3:15, okay? All right. All right.

(Whereupon, the meeting went off the record at 1:45 p.m. and resumed at 3:20 p.m.)

MS. WILBON: Good afternoon, everyone. We are getting towards the end of day one. So hopefully everyone had a good discussion in their breakout groups and we're going to reconvene to hear what happened in the different breakout groups and see what we might be able to add to the list of principles that we started earlier.

So we're still not fully back I don't think maybe. I know that Kim has the slides from one of the groups, but why don't we go ahead and get started.

Did the measurement group, do you guys want to go first? Do you have slides?

MEMBER LLOYD: Yes.

MS. WILBON: Can you sit at a microphone? Oh, hand mike. Okay, hold on one second.

He's got one for you.

MEMBER LLOYD: Thank you.

Okay, so we're measure group one. And that was attribution challenges associated with measurement, which probably sounds like most of the other names. So specifically it was -- now that I read it, it's not very informative -- total cost of care, total cost of care was one of the measures, as an example; hospital level risk standardized payment associated with 30-day episodes of care; and then standardized readmissions ratio for dialysis facilities were the three that we had to start off our conversation.

So I think some of our challenges though, as you can already see up here, re somewhat universal to many of the case studies I'm assuming, and are also things that we started to talk about earlier.

So the first issue was around the selection bias. And I forgot to say, please jump in, guys, fellow group members. Selection bias.

So, part of the issues around like let's say you're an ESRD facility and with this readmissions to the ESRD, readmissions measures, you know, what if your main feeder is the safety, the local safety net hospital? And so you're getting a lot more acute patients or patients that don't have access to other related services, et cetera, could be a challenge.

The second, we were talking about disease state. So, again using that ESRD concept, you know, is there someone who just became end stage renal disease or someone who has been living with it for awhile? Do they have other complications and comorbidities, other things that would affect it?

Then we have the temporal -- I'm going out of order, aren't I -- temporal issues, which is somewhere in here. Did we get out of order? Where is timing? Locus of control disease. Well, I don't know where temporal issues fell off our list here so I'm going to say it anyway.

There are issues with the attribution

in terms of some of these measures. You could end up with certain services attributed to you before you even saw the patient. So there are some issues where you may have had no idea that that patient was going to be yours, and yet they were yours and it's associated with you. And that can be a big challenge.

The locus of control issue obviously we've discussed quite a bit today, but we had a little bit of back and forth on some of these issues about whether or not there are exclusions or segmentations or other ways in which you can deal with some of the locus of control issues to make people more comfortable.

So if you're giving them a 30-day measure and they don't feel like they have control over 30-day measures, well, can you make it smaller by saying, you know, there are certain patients we're going to exclude and because it sort of gives you some comfort that you'll have a little bit more control over the patients who are going to be attributed to you. So there was sort

of a back and forth of is that risk adjustment or not and, you know, how do we, how do we deal with this?

The other issue here with the fit for purpose was the, you know, what are we exactly using it for? Jenny, this is some of your things you were saying before as what's the program context? You know, why, why are we doing this attribution? And that that can make a difference.

So you're going to have more, you're going to put a little more -- you're going to have a different level of willingness if something is lower stakes and quality improvement, you're going to have, you know, a little bit more tolerance for the attribution not being perfect than if it's high stakes and it's for payment or, you know, extensive payment. Right?

So if it's higher stakes you're going to sort of care more about the level of precision and validity and all of those good things.

And then we have the volume issues. You know, is there a point at which certain providers should just not be part of the attribution if the numbers are getting too low and there's too much variation. We had some discussions about that.

Availability of services: you know, if you have hospitals that tags with readmissions and but there is no availability of home health agencies in the area, you know, how much of it can they, you know, it gets a little bit back to the control issue, but the availability can be a challenge.

The unintended consequences feature on the challenge list, we discussed an example of if you use a total cost of care measure and you use something like evaluation of management services, you sometimes might have an ophthalmologist who gets tagged with a diabetic because they've seen them for a number of retinopathy visits. Right? And so sometimes you're going to have those sort of idiosyncrasies that we'll have to figure out a

way to get around. Right?

So in terms of the -- and, sorry, the last one is evolution of the care team is if you only have one physician who ever treats a patient then attribution is pretty easy. But to the extent that we're practicing team-based care more, it's just making the charge of this group a little bit more difficult. And so that evolution of changing care team and sites of care and other aspects made me think of new technology and where we're getting care. That's going to be -- basically make this more challenging.

So, in terms of the guiding principles, we were saying that we do want to try to build into the principles somewhere that we are trying to really derive accountability and be aspirational in these attribution methodologies. But in the same respect, there will have to be some sort of phase-in if you do that.

So the examples of, you know, MSSP, how you sometimes do pay for reporting and then you do pay for performance. Or maybe using an

episode measure before you use a total cost of care measure, or something that there are step-wise fashions.

Somebody else had a good example and now I'm forgetting what it was. I can't, you'll have to jump in if there was another, another one there.

And then we want to make, we want to put a marker out there for three to five years of what do we -- where do we want to go? So as people are developing measures right now and they're thinking about their attribution models, what signal do we want to give them now so that their measures when they come up in front of NQF in three to five years are adequate and meet some of the expectations.

And we also want to err on the side of over-tagging at first. So we talked about if you have a cardiologist, an endocrinologist and a primary care physician and none of them did an A1C, perhaps you start with them all being responsible, multiple responsibilities, and

eventually you can narrow in over time onto more specific accountability. And perhaps, as the organizations coalesce around payment programs or something, or become ACOs, et cetera, when it's sort of less diffused then you might narrow the accountability.

Testing: the testing these models is key. We talked about the earlier. Resources have to match. So if, you know, if you have expectations for an area that, you know, certain providers, providers or clinicians or whatever that don't necessarily have the resources to make good on what you're asking them do, do they have to find other programmatic ways to make it match? Which I don't, I think we kind of strayed out of attribution by the time we got to that one, but nevertheless.

And then lastly, the transparency of the models and their impact and how, you know, if you tag someone with an attribution, you know, there could be financial impacts or public reporting impacts or other things that, you know,

impact those clinicians and that, but that should be very transparent and clear.

Did of that make sense or does the group want to add anything? No?

Okay, questions?

CO-CHAIR MEHROTRA: Go ahead. Did you want to -- you had a question, Bob?

MEMBER KROPP: Yeah. On the concept of over-tagging, if I could paraphrase, you just test it. But is the concept that a measure might be applicable to a, a certain group of specialists and primary care physicians or providers but not necessarily should be? In other words, in certain contexts one of the group of eligible providers would be tagged, you know, with that measure?

Is that the concept that you were getting to?

MEMBER LLOYD: So I think what we're struggling with right now is that is there any individual person that truly has accountability?

MEMBER KROPP: Right.

MEMBER LLOYD: And right now, not really. And part of it is because the delivery system is so diffused, et cetera.

But if you are trying to be aspirational and you're trying to get people to make change, you're trying to drive change --

MEMBER KROPP: Right.

MEMBER LLOYD: -- then if you, if you give sort of everybody a slice of the accountability it's going to help them move forward. And it may not be perfectly fair and accurate. I mean you want to be careful about who you choose because you're not going to pull in that ophthalmologist, right, for the AIC, but you are going to pull in the relevant physicians treating the case.

Is that clearer?

MEMBER KROPP: Yes. I think so, yeah.

MEMBER LLOYD: You don't want to just give blanket to one.

MEMBER KROPP: So the hemoglobin A1C, for example, might wind up in some circumstances

attributed to the endocrinologist and the primary care provider group. In some cases it would be one or the other.

CO-CHAIR MEHROTRA: Michael, did you want to jump in?

MEMBER BARR: If I might. I think Danielle did a great job, and other team members, if I off base too. So I think there is a general sense that for quality, quality-level metrics that you want to be more sensitive, less specific, so hence the over-tagging on the quality measures. There's less sensitivity about doing that as opposed to a costly "we really want to get it right because people are going to react."

So the issue was sort of a shared accountability on the quality side to start. And then as Danielle said, over time that gets focused as we learn how this works and adjust the measures over time.

I believe that's what you said; correct?

MEMBER LLOYD: So that was my question, just to clarify, was on the phased approach. Is that sort of the same concept here? Because I was trying to understand exactly, I was trying to think how the attribution rule -- like pay for reporting, public reporting, accountability, I see that as a general Medicare principle or other payer principle that we want to move towards this.

What I was having a struggle with, and maybe you can just re-articulate this, is how does that link to the attribution rule that you might use or the attribution approach?

MEMBER LLOYD: Yeah. So I think part of this is it's a principle that we wanted to think about through all of these. Right? And I don't think we really went through every single option, but that's one reason why I gave the one I gave this morning of is it, you know, maybe you give, maybe you give them an attribution model that's based on episodes first before you give them, you know, a one-year total cost of care

measure attribution.

I mean, so some of it I think could be you only select certain providers or you alter which beneficiaries are eligible for the attribution. Or I think within each of these steps we can probably come up with ways that kind of minimize who and how they're impacted in the first generation of it.

But, Michael, yeah.

MEMBER BARR: If I may also add, I think there was a general sense that we shouldn't design measures and attribution methodologies for the availability of the kind of metadata data we have now. And that over time that will get more sophisticated in that the kind of attribution rules as well as the relationship codes we talked about earlier become more prevalent and available, so that we start with where Danielle was referring to, then over time progress.

So I understand the challenges that brings, but we didn't want to say this is fine for now, and that's good enough. We want to

design and then move in the direction that is aspirational.

MEMBER LLOYD: I think we messed that up on the guiding principles. We might actually want to actually add that somewhere then.

CO-CHAIR MEHROTRA: Do you think it would be fair to -- I don't want to oversimplify what your discussion was, but the general concept that we, when we think about attribution rules that they are not static. And both as the healthcare system changes as well as the availability of data changes, it is really critical that just as we would revisit a quality metric or a payment model, the attribution rules should also be readdressed.

And we would expect as a committee that those would evolve over time. It would just be a guiding principle there.

Or if that goes too amorphous, I completely get it. But I don't know, I wonder how -- does that resonate with you?

MEMBER BARR: I'll speak for the group

but let them agree to disagree. I think that was the general sense looking around at the members of the group, that we didn't articulate it as clearly but I think that was sort of understood.

MEMBER LLOYD: Yes. We touched upon it in different areas. Right? So we talked about data is changing, where you're providing the care is changing, who's providing the care is changing, and all of these are involved in the assess of attribution.

Yes?

MEMBER HOUSER: I think that's correct. I think there's a little bit more in that we want to get ahead of the curve, that we want to get ahead of the curve instead of chasing the curve. And that's one of the reasons for the phased approach; that way you can get a little bit of buy-in for being ahead of the curve if you're not putting the full consequences in on day one.

MEMBER POPE: One more. I was going to say there's a glide path both in terms of the stakes but also in terms of the attribution

itself; right? You could glide from, look, we're holding our physicians accountable to the group performance, then to the performance of everyone you saw. And then eventually we want to get to the point where everyone has one person that's accountable for their AIC testing, for example.

So there can be both gliding in terms of the stakes and the sort of the specificity of the relationship, if you will.

MEMBER LLOYD: Multiple groups. Right, the example with the endocrinologist, primary care, cardiologist, those could each be in three different medical groups; right? And then over time maybe it's one group and then one person.

CO-CHAIR MEHROTRA: Well, maybe we should move to the second group and then I think we're going to continue to have this conversation.

It's interesting though, we're hearing, I'm hearing some things that were consistent with in our third group also.

Who's the spokesperson for group

number two?

MEMBER FIESINGER: In our group we had robust discussion and then realized we had 15 minutes left and had to come up with something.

(Laughter.)

MEMBER FIESINGER: Call it Zen and the Art of Motorcycle Maintenance, everything was quality. So everything is attribution. But we tried to distill things down to this, it may be a little bit oversimplified, but we tried hard to distill it down to some relatively straightforward principles as we got off onto the details of payments, risk pool, et cetera.

So first, why, why are we treating the purposes for purposes of attribution? So is it improving the patient's health? Is it lowering cost? Is it improving quality? Does it relate to a payment model, a quality measurement type? So thinking about that as we went through everything this morning, going into developing an attribution model.

We did agree that the primary care

provider should be the core in the attribution model, even for patients with chronic, complex conditions. We didn't get into percentages of care; that's another discussion for another day I think.

We thought about exceptions. And these we thought of as areas where the majority of the care is provided not by the primary care provider but by a certain specialty provider or team of providers: renal disease, transplant, HIV/AIDS. There might be other exceptions where we want to carve that out from this.

The case we have was very classic: diabetes, heart disease, hypertension, high cholesterol type of patient.

This was in terms of attributing measures to entities, to whom you attribute the measures to be based on the nature of the measure. What can be accurately, fairly and appropriately attributed to the individual provider or to the team, the patient-aligned care team the VA uses, to this clinic, to this system,

or, as one of our members said, if it's an ACO with a big risk pool, maybe that measure only goes to the ACO and not to anyone below that level.

And, finally, in terms of how specific you make the attribution, you should definitely try to make that proportional to the local risk pool. My way to think would be probably has to affect something, I want my responsibility to be roughly proportional to that so that people perceive fairness.

CO-CHAIR MEHROTRA: Do you think it's safer to ask, because I didn't, I don't know what was your case study?

MEMBER FIESINGER: Oh.

CO-CHAIR MEHROTRA: Can you just give a quick overview of that just so that I think --

MEMBER FIESINGER: Sorry.

CO-CHAIR MEHROTRA: -- we can ground some of these comments.

MEMBER FIESINGER: I'd be glad to. Sorry.

Okay, so we had the clinical perspectives in changes in attribution. So I totally skipped that. Hope you ask me back tomorrow.

Do you want clinical details or?

CO-CHAIR MEHROTRA: Just general idea. I apologize, I was trying to -- it was useful to have the care examples so, Yes.

MEMBER FIESINGER: Okay. So 72-year-old male, retired truck driver with obesity, uncontrolled diabetes with neuropathy, hypertension, high cholesterol, glaucoma, bilateral osteoarthritis of the knees, Medicare Parts A, B and D, with an AARP supplement, who's seeing his PCP. Can't afford a specialist in the last year, including endocrinology, ophthalmology, orthopedic surgery and neurology. None of them share EMRs.

He takes ten medicines. He's missed multiple appointments. He's had a couple heart caths.

CO-CHAIR MEHROTRA: And so what, and

the goal is to attribute for what purpose?

MEMBER BERGER: So many conditions and doctors. And I think our, our charge was to say, okay, what do we do in this case? Here is a train wreck with many doctors. How do we do attribution?

And so that's where we started with we have to answer the question why are we doing the attribution and what's the reason?

MEMBER FIESINGER: So to -- Sorry.

CO-CHAIR MEHROTRA: No. Just super helpful. Thank you.

MEMBER FIESINGER: So to answer that we found as we got into the details of this case we very quickly got very down into the payment models or who's responsible for what and who's getting paid what and where are resources being aligned and shared, and how -- do the employers know what they're getting for their money? And we got so detailed we weren't really answer the question of attribution.

So we tried to pull back to, given

this very common patient scenario, how should we start deciding how to attribute the patient, him or herself, which bucket does he go in? Then, how do you attribute the different episodes of care within that?

So I hope that makes a little more sense.

CO-CHAIR MEHROTRA: Any questions for group two, just to clarify some of the principles? Go ahead, Ed.

MEMBER MACHADO: You know, I was part of group one. And we also touched upon number four, this whole idea of proportionality with locus of control. And I was just curious how far your group went with that because I think we struggled a bit with the fact that in some cases, you know, it may not be straightforward on how to determine that and that, you know, there's that concern about really defaulting to an arbitrary distribution. You know, 10 percent, 20 percent, whatever it may be. So I'm just curious what you had on that.

MEMBER FIESINGER: We didn't have an answer either. Various ideas for that were just everyone who's involved gets tagged to the one that we're using. Some of us had worked in development teams that looked at trying to attribute specific percentages. But how do we do that in a fair manner?

And as one of our members who works mostly on the commercial side said, how do you create something that works across all pairs and all payment models? And we didn't have a great answer in our time slot of how we do that so it works in everything from the payment side. So the answer, I don't know.

MEMBER RADWIN: I didn't bring it up in the group but part of it I think came down to scope of practice as well. When you describe --

MEMBER FIESINGER: Thank you.

MEMBER RADWIN: -- where you hand off as a family physician, family practice frame, where you have to hand off what you don't treat. It really boiled down to scope of practice.

And I think that may help define specificity in one way.

MEMBER FIESINGER: So to elaborate, we thought of, okay, I'm a family physician. If you're a nurse practitioner, if you're an endocrinologist what would you normally cover within the scope of your specialty or license, et cetera? And that should set the rough boundaries of the part of the care for which you're responsible.

CO-CHAIR MEHROTRA: I'm curious what to respond to this. I envision that this is likely going to a level of detail that we don't want to go as a committee. But I'm curious just to know because it's that it, you know, there's an idea that, say, this patient Mr. Jones had ten visits during the year. And to count up really quick, he was six to a PCP and once to a bunch of other, you could put a weight on those other P -- so the total cost of care, the ophthalmologist where Mr. Jones gets whatever his costs are, so the total costs of the year is weighted much less because

he only saw the patient once.

But a PCP would be weighted more. So the total costs of care are there, but in terms of the weighting of that it would be that weight would be assigned to the dot.

That's a, it's a pure -- from a mathematical perspective we do this all the time. We weight people in regression analysis, et cetera. On the other hand, I could see a number of doctors in the community going, their heads explode going, oh, way too complicated.

And so I'm curious like but because you did the proportional with the locus of control, I was curious whether is that kind of the idea that where you were headed or is that too far?

MEMBER FIESINGER: I'll give my opinion because I know it's the group time. We were trying to I think get beyond counting visits. You know, there are definitely models that do that. A lot of us have worked those kind of models or seen those models.

Simple number of visits to me doesn't necessarily reflect the quality of care. When I've been in capacitated systems I could do an awesome job. I had great numbers seeing patients once a year. But may have also had phone contact and others way of contact.

I got a message during this visit. A friend of mine does urgent care. She says, well I'm getting tagged for their colonoscopies I saw once for taking a splinter out of the foot.

So for my percent you could be 10 percent.

So we didn't flesh it out beyond this locus of control and scope of practice idea, but we were trying to go down the path I believe of how we not simply count visits. That's an easy thing to do. You can use claims-based data. But how to be a little smarter about it.

But I wish I had a better answer for exactly how to do it perfectly. But I think the group thought that scenario worth exploring more.

MEMBER BEAM: And I think too, I think

it goes back to what your purpose is for, and again are you trying to measure their performance or are you trying to find like responsibility for care going forward because if you tell a provider that you're responsible for 20 percent of the care for a patient, and am I going to focus my effort and my time on that knowing that you're responsible for 80 percent and I'm responsible for 20 percent?

So, again, what's your purpose and what's the intent? If it's, again, to evaluate overall performance so that you can award some incentives, then that may be something that would be very good to do. But if you're just trying to give them a panel to work from as far as to say you're accountable going forward, that may not be good.

MEMBER RADWIN: One of the challenges of our case was that some of the care that the patient ended up getting was preventable. And so when you look at visits, number of visits, and weighting visits, some weight has to go to the

fact that the ball may have been dropped in primary care when it came to a follow-up phone call or something like that.

And that's what made this case I think particularly challenging, like real people. Because there should be some attribution of preventive care, that when it doesn't come through that gets -- that provider is accountable as well.

CO-CHAIR MEHROTRA: So, Yes, a couple other people had their tags lit. You want to -- I don't know who was up first. Do you want to go, Nate, first here?

MEMBER SPELL: Just say our group struggled with this a bit, too. And how do -- you know, do you model an attribution based on how current care is fragmented and divided amongst these different providers? Or do you intentionally make it aspirational and say, okay, all of you get to own this one and you're in a way incentivizing future collaboration, coordination of care, perhaps interoperability,

those sorts of things.

But you can't get too far ahead of the ability to implement. And that's where we were talking about the resources. So if you get too far, if your attribution model assumes a future state that is not readily achievable, you're perhaps undermining credibility of that.

So we kind of struggled with how do you build the right measure? And it gets back to what's your purpose? Is your purpose to reward current performance or is your purpose to partially incentivize future performance?

CO-CHAIR MEHROTRA: That's really interesting. So a apropos of some of this stuff we were having.

So why don't I propose we have group three discuss. Elizabeth had some comments there. And then maybe we'll just circle back to all of us.

Is there any way that we could have the draft principles or notes from all the groups so we could kind of react to them? I know that's

a tall task; sorry about that, Kim.

MEMBER DRYE: I don't think we -- I have pictures on my phone. I should have forwarded them.

So I'll just describe the case study and then I'm going to -- I would say we focused on trying to apply the first couple of the principles that we developed this morning and summarized after lunch. And that process led us to some ideas about the next steps, some of the next steps for this group.

So the case was that I'm going to, I'll just briefly talk about, the case was -- it's really interesting, so NQF in the MAP process got a proposal from CMS to apply a smoking rate, a population-based smoking rate measure to use it in the Inpatient Quality Reporting Program, which is a hospital pay-for-reporting program. And measures still would go up on hospital compare.

So each hospital, in this case in a county, because the county score was calculated

county level of the proportion of patients -- I think it's smoking cessation, not smoking, actual smoking -- so smoking cessation rate. Each hospital in that county would get that score of accounting smoking cessation rate. If you were in a different county you would get that county's score.

And the push-back from the inpatient, the MAP inpatient quality reporting really fell kind of low. Hospitals can't be accountable for, you know, with their county smoking cessation rate.

So and we would start with our own concept which was what are we conceptually trying to do with this measure? And we laid out, you know, how are we expecting this measure to change the world?

And we just threw out, well, some patients are going to the hospital. Okay, hospitals can account for those patients. Some patients, so they're touched. You know, some patients won't be touched but they'll be right

there nearby the hospital in the county. They're not that far out of the hospital's reach. And some are even further away.

Is it reasonable to attribute that quality measure, that outcome of smoking cessation to the hospital? And at first blush it didn't seem very reasonable to us because they're not really touching most of these patients. But actually if we took the devil's advocate position and really gave a lot of reasons why you might want to do that. I mean maybe the hospital, we want the hospital to be driving smoking cessation.

It might be especially reasonable, for example, in a state like Maryland where there's a global hospital budget that is incentivizing financially hospitals to address population health. Maybe it's the most effective mover in the community and the hospital could push for what we know are really effective policies like tax cigarettes or education campaigns.

Maybe they can lobby their

politicians. They're very forceful, well funded organizations within a community,. And, you know, we, and as the group pointed out, very little portion of health funding goes to public health. It's almost all going to clinical care.

So if our goal is to change behavior, so that just segues from what you were saying in group two, if our goal is to really change, change -- use this level of quality measurement and the attribution strategy to drive change, hey, it could be a reasonable way to get it done.

And so that just, I think it reinforces the importance of transparency and really stating your goal. And you could take it to the map and say, okay, we realize, you know, you only touch maybe 10 percent of these physicians and you already have a smoking cessation, you know, counseling measure by the way, but this is our best shot at improving the population health.

So once we, once we went through that we said, well, let's see if we can apply the rest

of our principles. And I would say where we, you know, we, considering attribution that's important. Because that was our principle number one, we've got to consider it.

Number two was be clear about your goals. And it's okay to be aspirational but you have to be clear that you're being aspirational and make that, you know, something that's explicitly discussed.

And then the third one was, okay, one size fits all probably doesn't work. And here's where we shifted our focus and Srinivas gave us some thoughts about how we might try to go back to a more practical task as a committee of giving some specific cases and breaking down -- and here we, just as a note, we noted that our nomenclature is not, we still need to work on our nomenclature.

So someone like me who's a measure development -- developer primarily, the word use case is a little hard to, I need that defined for me. You know, when I use risk adjustment I use

it in a way that makes Srinivas uncomfortable. But I have a certain way of thinking about that. So we probably need some work on our terms.

But we thought it would be useful going forward, and I think we're willing to do some work to try to make this happen, to create some tables, so I'll just try to describe them to you, that would give us more narrow cases that are exemplary cases that we could apply our principles to. Because applying the principles broadly is just too hard.

But as you, as you guys were talking about, you were just talking about a chronic disease patient, you know, one principle should be that the locus of control is primary care; right? So this table would have, or set of tables, would have across for the columns what my colleagues are calling use cases. But I'm just suspending my lack of -- but what we mean is, okay, types of programs; right?

So episodes, episode type programs like for a procedure or chronic disease

management.

A next column would be total population programs, so a patient center in a medical home, or a zero based, hospital based program, post-acute care, physician profiling. And then those would be columns.

Then we'd create rows that are the kinds of choices we have for our attribution strategy. So, for example, just going back like the Beth McGlynn article, but do we want to use a patient-based or an episode-based approach? Do we want to use dollars or visits for responsibility? Those kind of attribution choices could go in rows.

And if we can get a series of cases that fit into those cells we're willing to do more than four, which I think is what we talked about from our last phone call. We could do a series of cases.

And just to make this hopefully not -- well, let me just stop there and see if anybody has a question. Because probably we want, we

might want to do not just one table but a second table. You know, one table might be focused on chronic disease, okay, another on procedures, and another on public health. And we could build a couple of these columns for each one and then try to fill in what we think the implications of those choices might be.

So that's where we ended up, thinking we should do some more work based on the learning we did from our case. If that made any sense.

CO-CHAIR MEHROTRA: Do folks have questions, clarifications? Go ahead, Danielle.

MEMBER LLOYD: I was just going to say I should have been in your group because I have that table on my laptop right here.

MEMBER DRYE: We talked about you. We credited you with the kernel of the idea.

MEMBER LLOYD: So, you can come and just help me fill it out here --

MEMBER DRYE: Yes.

MEMBER LLOYD: -- and we'll be good.

CO-CHAIR MEHROTRA: Well, let me take

that as a starting place. So, you know, just I'm trying to think of the charge of this group, trying to think -- and please our NQF colleagues please jump in if you wish -- but what are we trying to do and how are we trying to help folks out? Because attribution is an issue that a lot of folks are struggling with.

We decided that we're going to address the challenges. And we feel like we got that covered in terms of the problems.

We have these principles, but I think there's been some concerns, I think appropriate concerns that they're a little pie in the sky. And the idea was with these use cases that Danielle and Elizabeth are proposing -- use? Could use some other word. -- examples, that we would go through them and try to illustrate some of our thinking so that we could guide others who might not have that same exact idea but at least would have a sense of a very illustrious group of people from a lot of different perspectives, at least how they're thinking about this and might

come to what is the attribution rule.

Does that sound like a both useful, feasible goal for our group over now this session, two days, as well into August? Folks want to jump in?

I'm trying to remember. Carol left. I have to do my hard job now.

So maybe I'll just go around, if that's okay, just so I can keep track. You want to go first?

MEMBER FIESINGER: We like the idea of the grid. I think that helps describe what we were trying to get to in our group. Because we kept thinking, okay, different models of attribution to work for different scenarios, different needs, et cetera, et cetera. And I can think of different cases that have nuances based on our own clinical case.

We had the example brought up in our group, okay, what about the 30, 40-year-olds who don't have a regular source of care; where do they fit?

So I think having that grid, having the scenarios would definitely help us clarify our way of thinking, like they could be useful.

MEMBER SUTARIYA: So I think I'll add one plus to that. And I share some experience from the successful examples of what large ACOs have done in terms of how they have internally attributed responsibility among themselves. And, you know, as to grid-like responsibility of knowing the purpose for which you're attributing makes a lot of sense to me as well.

CO-CHAIR MEHROTRA: Ari.

MEMBER HOUSER: I may be a little bit offbase since I don't have the provider perspective. But I like the idea but it seems to me a little bit at odds with our principle of we need to try out a lot of different attribution models to get a sensitivity analysis and to see what the implications are for each choice.

CO-CHAIR MEHROTRA: That's a really good point. I guess it matters how far this goes. And so let's just take the example that

Elizabeth just presented of smoking cessation within -- no, I think it was smoking rates within the county. We could at least go through and say, here are some things, here are some different rules that you could test and see whether they make a difference.

But I guess my thought was it's most important to explain the thought process as opposed to here's the rule thou shalt use at the end.

But that's just an idea. I don't know if that's too like plain, a little too loose.

MEMBER HOUSER: My experience would be is if we come up with a table that has a attribution in a cell, someone will use that table. And I think people will use that table to figure out what cell they're in and pull that model with no further thought. And in a rush, that's what I would do.

MEMBER LLOYD: If you require them to pass multiple ones they can't do that though; right? I mean that was part of the --

MEMBER HOUSER: Are we going to like be the police and tell them --

CO-CHAIR MEHROTRA: That's what NQF is, they have a whole police force out there really.

(Laughter.)

MEMBER LLOYD: You just don't have specifics, you just don't get approved if you don't. But that, I mean that was the point I made this morning of I think these are a little bit at odds.

But the way I'm rethinking this is you have these steps that you have to look at. And you don't have to end at this answer. And we're going to tell you in some, in some cells you may say here's a couple options that might make sense. Or, you know, it doesn't, it doesn't have to be just one answer per cell; right?

CO-CHAIR MEHROTRA: Let me just --

MEMBER LLOYD: Therefore just explain the challenges.

CO-CHAIR MEHROTRA: I think, Eddie, you had your --

MEMBER MACHADO: Yes. No, I think everyone's really hit upon the same thing. I think it's a good idea because it's very -- it will give folks very practical, you know, something concrete, you know, to at least react to, to go along with the principles.

But I do agree with Ari that we have to be very careful in constructing this if we proceed to do this that we don't necessarily recommend a specific, you know, attribution rule. I think we can go as far as saying, you know, these are the things to consider or to talk about. But I think you have to be very careful that you don't end up like with that one comment in a box. And then because folks will run with it. Because it's just the natural way of, I think, reports.

CO-CHAIR MEHROTRA: Jenny.

MEMBER BEAM: I just have a question. I guess hearing Danielle saying the next measure doesn't get approved, am I -- so for all the measures that are out there are we going to be

doing attribution along with those measures? Like is that part of -- did I miss something or is that --

MEMBER DRYE: Are you saying is it separate from the measures themselves or is it --

MEMBER BEAM: Yes. So I guess --

MEMBER DRYE: Well, I would just say, I mean, okay --

MEMBER BEAM: -- saying if someone, because I mean the questions, the comments were saying I think we should be careful, and then who's going to be the police. And saying, well, then the measure just won't get approved.

MEMBER DRYE: Oh, Yes.

MEMBER BEAM: So I guess I'm asking so for all the like quality metrics that are out there are we envisioning that, that they will now have an attribution component with this?

MEMBER DRYE: I can try to speak to that.

CO-CHAIR MEHROTRA: Yes, go ahead.

MEMBER DRYE: But having put so many

measures, outcome measures through NQF.

So they always go through with a clear attribution design. So, you know, you built this measure, we built the measure for ACOs, to profile ACOs because --

MEMBER BEAM: Right.

MEMBER DRYE: -- the quality measures we're using going back bigger picture are to compare provider performance. And I think when we're talking about attributing cost and quality, again we want to be able to compare value so that payers or consumers can figure out where to get the best value care.

So that's explicit when you put a measure through the NQF process and you test it at that level. And if you move it to some other level, for example moving to the smoking cessation measure, which is a population-based measure, into profiling hospitals, it's not really, it's not approved in that context.

So but measures, as you know, more and more just get used all the time at lots of

different levels. So I don't think -- and I'm looking at Taroon, and I mean Erin, and any of you guys from NQF could elaborate -- I don't think you're going to change your guidelines that like once approved you can use it any which way you want. It's approved for a specific provider level, provider -- and now and I can't use any of my words.

CO-CHAIR MEHROTRA: It's a use case, don't worry.

MEMBER DRYE: It's a use case. It's approved for, you know, profiling a specific type of entity. And that's it. And if you're going to extend it in some other program, or some other provider level, it's not NQF approved for that.

And so I think what we're saying is forget the NQF approval. For example, CMI doesn't need any of its measures to be NQF approved, and they roll them out, you know, whenever they want, wherever they want. We're just saying like, here, let's figure out what's advisable versus what, you know, what would make

sense.

MEMBER BEAM: Thanks.

MEMBER DRYE: Sure.

And I just, sorry, I just want to say to Jennifer and Anne and others in our group, if you guys have anything else to add.

CO-CHAIR MEHROTRA: Going to Srinivas and then Rob.

MEMBER SRIDHARA: Yes. So just to, just to clarify. I think -- I don't think the goal of the table was to be prescriptive, rather to say so the question was level of, let's say unit of analysis was something that we've talked about here. It's a different discussion if you're say, discussing ACO models and how do you attribute? And, you know, what is the unit? It's probably the ACO and you might need some multiple attributions that will work into an ACO or something like that.

That, so that will be a list of considerations for level of, you know, unit of analysis for the scenario, use case, what have

you that is ACO models. Medicare wants to consider that. Versus, say, a CPC program or something like that. There's the unit of analysis, how you attribute what you do becomes different.

And I think our guidance would be around that, like that you should be taking a different approach or consideration based on this. You would still have whatever choice you wanted to make. And we would just provide some guiding guidance around how you might make such a decision. But which of the options is left to the user, if you will.

CO-CHAIR MEHROTRA: Thanks.

Rob.

MEMBER SCHMITT: My comment's really just an echo of something Ira mentioned this morning. As we go through this entire process and come up with all these attributions and things I think we need to be conscious to not develop something that leaves rural behind. 25 percent of Americans live in rural America. And

so we can have all these aspirations and think of all these great things. And if rural is excluded from them, then that's a problem.

CO-CHAIR MEHROTRA: No, I think that's a really good point. And you gave a great example of -- you want to tell the story about smoking cessation within your county? I thought that was very illustrative.

MEMBER SCHMITT: Sure. We're a single hospital county, small county, 14,000 people. We are currently trying to do smoking cessation programs within our county. And actually we're going to -- not merge but take over our health department in our county.

And the health department was for that. You know, the whole community's together. But then regulation gets in the way. The state doesn't allow a hospital and a public health department to work together. And the grants that the health department can get, the hospital can't get.

And so the health department, because

the county is broke and they can't even afford to have a health department, so we said we will take that on. We have the resources, let us help you. But we can't regulatorily. And state law prohibits us from helping them.

So we're doing, trying to do the population health. We're part of a rural ACO with 25 other rural hospitals. I mean we're trying to do all the right things. But in a lot of cases we're presented from doing it. Like HCAHPS. We're not required to be in HCAHPS but we are. We want to do a lot of, we want to do value-based purchasing but we can't. We're not permitted to be in that yet.

So there's a lot of things that rural wants to participate in but, for whatever reason, we're left outside. So I just, I don't want this group to leave rural out.

CO-CHAIR MEHROTRA: Can I make a couple comments. Folks who have their cards up, do you -- oh, I wasn't sure, okay. What I'm sensing from the group is that there's some -- you guys

are going to push back -- there's some enthusiasm for this idea but it's not clear in people's head exactly what this will look like. And they're like, I think this sounds good in theory but is this being reality.

And I wonder, and this is going to be, I'm going to be asking for volunteers, but -- everyone's card is down. Everyone is looking. Everyone check your iPhone really quickly -- would be is that would someone be willing to try this out, like just one set of, one column and some ideas to -- and then put them up in front of the group tomorrow so we could at least have something concrete to react to and immediately go, Oh, this is not helpful to anybody or Oh my gosh, this is exactly what folks need, or somewhere in the middle and we can tweak?

My sense is that would be helpful. I'm having head shakes. So that sounds like it would be helpful. Are there any volunteers that would be willing to do that? Just it can be rough.

MEMBER LLOYD: I mean I've got like some already, but maybe I could have another volunteer coming over and help.

MS. WILBON: Use your microphone. We want to make sure that's recorded.

(Laughter.)

CO-CHAIR MEHROTRA: We want it on record.

MS. WILBON: For perpetuity. Okay, thanks.

MEMBER SRIDHARA: I'll help you, Danielle.

MEMBER LLOYD: This is Danielle Lloyd. Yes, I have quite of bit of this fleshed out already just as a straw man example. But I think --

MEMBER SRIDHARA: Sure, I'll help you with that.

MEMBER LLOYD: -- my friend here has agreed to --

MEMBER SRIDHARA: Sure.

MEMBER LLOYD: -- help flesh it.

CO-CHAIR MEHROTRA: Thank you both, Danielle and Srinivas.

MEMBER SUTARIYA: I'll help out as well.

CO-CHAIR MEHROTRA: All right, so we have three volunteers. First, thank you. Four. Four. Jenny, all right, great. I was expecting zero. This is great.

So thank you all for helping out with this. And so I think that would be -- I would find that really helpful. So maybe we can try that out if we could re-jigger our agenda tomorrow because and we'll see if this is something we should kind of flesh out, change or drop like a hot potato. So we'll see.

MEMBER DRYE: Actually, can I just --

CO-CHAIR MEHROTRA: Go ahead.

MEMBER DRYE: Danielle, I don't know if, I think it might be helpful to just do maybe two different types of care that we're trying to --

CO-CHAIR MEHROTRA: Use cases. Use the

words.

MEMBER DRYE: I know. But I'm thinking like maybe you can -- because when we did the columns and rows we felt like -- maybe. Well, I just think when you do your grid, you know, are you thinking, it might be good to just think about like a chronic disease case or an acute case. And we were thinking in our group about a public health case.

I wouldn't mind doing a public health one just because we already thought it through so it wouldn't be extra work. But those were like categories we thought the table actually might look a little different. Like you're talking about chronic disease management versus an acute intervention or surgery. Maybe not.

CO-CHAIR MEHROTRA: I see a lot of cards up. But I'm also conscious of the time here. So there is this public comment period coming up.

Is it possible to do the public comment now and then have more conversation? I

think there's a lot of good comments here but this might be a good break pause. And so can you do that magic with the --

OPPORTUNITY FOR PUBLIC COMMENT

MS. WILBON: Oh, well actually anyone in the room that would like to comment? I don't think so.

So, Operator, can you -- is there anyone on the line from the public?

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

(Pause.)

OPERATOR: And there are no public comments at this time.

MS. WILBON: Okay. Are there any committee members, I think that Jennifer Perloff and Dr. Resneck were going to be dialing in at some point, as well as Ariel who is on the Commission Authors Team. Is anyone on the line that would like to either make a comment from

this morning or this afternoon's discussion, from the breakout groups?

OPERATOR: There is no one dialed in.

MS. WILBON: Oh, okay. That's easy.

So in that case we can continue. We have until 4:30.

CO-CHAIR MEHROTRA: Okay. So we have, great, so we have about 20 minutes for I think -- and I would love conversations about any of the principles that were provided by the groups. These principles were all, they're all kind of melded together, as well as it's a great idea.

So let me just open it up and then we'll wrap up at 4:30. So, Jenny, do you have -- all the cards went down.

All right, so who's down there? Troy. Troy, go ahead.

MEMBER FIESINGER: Just a comment I guess sort of bridging up what Ari said, that we don't want to be prescriptive. The NQF plays to me a very critical role in that I know the process. I know the huge amount of work,

research, vetting goes into this. If I want to find a reliable source of a measure for attributable principles I know I can go to NQF to find it.

So on a ground level definitely in policy issues and discussions with payers to be able to say here's best practices vetted on a national level. We don't agree with what you're doing, but here's a model that can be used that's helpful. So versus picking something on a grid and going with it, it helps to have those models out there.

That said, sometimes people are in situations where you just need something that's already been developed that you can plug and play because you don't have the time, the staff, the finances to develop it. Like the AMA's PCPI measures can be our case in point. I know I can grab those. I know they're good.

So I would look to the NQF to have here's the best practice, here's the way it ought to be done. We're not telling you how to do it

but this is good advice and good framework.

CO-CHAIR MEHROTRA: Would it be, just to jump in and then think about it, is we can talk about this tomorrow after the group presents the principles, but if the -- what we're providing for this group is just some guidance. But then I'm curious what the group reacts to is that if the NQF wants to in the future for certain select measures, let's say ACOs for example -- maybe that's a bad example because there's been a lot of work done there -- but ACOs that if there is an attribution rule that wants to be used across all the different commercial, Medicaid, et cetera, and they're attribution rules, then there really needs to be a specific committee set up for that case.

That we can't as an attribution committee just say for every single example, but there might be select cases where a committee just goes directly on one specific attribution rule and votes on it and says this is what we believe is the right attribution rule that can be

used, plug and play across a lot of areas.

And that might be above and beyond what we're doing here. I don't know. Do folks want to react to that now or tomorrow?

MEMBER FIESINGER: So, I'm in a Next Gen ACO. We're using prospective, not retrospective, assignment. I thought that was great. I read the paper from the Dartmouth Group saying prospective assignment is terrible, we think retrospective is better. I'm thinking, no, that's not the way I see it.

My NVVAP has its own views, its own position papers on this. So there's already debate going on on what's the best way to do it. I'm glad there's research data we can look at.

Now, I'm less certain than I was two days ago about what is the best method. Let's keep discussing this.

So I, personally, as an individual think that would be useful.

MEMBER SUTARIYA: So perhaps this is because of my late arrival this morning, is the

charge of this committee to develop attribution models that are specific to federal programs or to solve attribution models nationally, irrespective of federal or non-federal? Because this, this comes up in various different conversation today. And I think it's important to specify what is the mission of this committee.

MS. WILBON: So I would say that also and particularly in August we were definitely looking for the committee to make recommendations in general to the field which would, all of our work generally crosses public and private sector. However, because our work is funded by CMS and they have some specific needs, they are asking for specific feedback from the committee on the applicability of certain models within CMS, some CMS applications.

Not that we necessarily have to go through every program, but I think having some discussions specifically about some of the CMS applications and where there might be some, you know, threats to validity or some issues in how

certain models are applied would be useful as well.

So I think we probably -- hearing the committee's discussion, I think as staff would probably have some more thinking to do about how to frame that for you guys and how to -- and maybe talking with our CMS colleagues as well and what might be the most useful approach to getting them the specificity and the type of guidance that would be really helpful for them.

But in general, we do try to provide feedback to the field that is broadly applicable and where it might apply to the public, you know, to the public sector that we can make --

MEMBER SUTARIYA: Yes. And perhaps in the charter from the CMS to NQF there are some expectations laid out as to what they are. And it would be important for us to know as a committee.

MS. WILBON: Yes.

CO-CHAIR MEHROTRA: Eddie, you had a comment?

MEMBER MACHADO: Yes. I was just wondering whether or not that fine line of how far we go with trying to flesh out the principles really begins to cross over to the charge of the MAP Committee to really potentially take what we've done to a certain extent and take it that next step forward. Because in many ways they're already doing that on behalf of CMS, really taking it to that next step and saying, well, you should use Measure X for this particular purpose and so forth.

So just a thought. I don't know if that's the way to go.

MS. WILBON: I think, and I'll turf this to Taroon and Erin at some point because they work much more closely with MAP than I do, but I think initially going into this we are definitely looking for guidance for MAP, particularly because right now attribution, from what I understand, is not a focus specifically of the specifications that they look at when they're making decisions or recommendations for programs.

And so I think that any guidance that we have, which again was one of the items we had laid out for the meeting in August, once we kind of have some foundational principles to think about what specific recommendations would we have for the selection process of the Measure Applications Partnership on what they should be considering when they're selecting measures for programs and in terms of attribution.

So I think definitely there are some connections there and some lessons to glean from this group and what can be passed on and picked up by MAP in their work.

So I don't know if Taroon or Erin would like to add anything to that. Okay.

CO-CHAIR MEHROTRA: So just again to comments here about anything related to these principles, the grid, the challenges, anything else came up in the groups. Go ahead, Nate.

MEMBER SPELL: I was going to ask in line with who our audience is. Seems like some of our discussion really seems like it would be

relevant for measure developers in that we're asking them to do some -- be thoughtful about the attribution model and even potentially to test it. So it feels like we're aimed at them.

Because by the time a measure comes to, you know, to NQF it's there's been some work done, a lot of work done on it; right?

CO-CHAIR MEHROTRA: Yes. No, I think that it's a fair point. It might be a little bit broader than measure developers. For example, if I'm a -- someone was working with Aetna. I apologize, I lost track. But if you're working with Aetna Health Plan I don't know if you'd label the person who's running their, you know, patient-centered medical home initiative, but that person might really benefit from this when they're applying that program.

So I might be a little bit broader than measure developers. But that's the kind of group at least I believe are target audiences.

MEMBER SPELL: Yes. And I didn't mean specific only to measure developers. But we

certainly are aiming a lot of our stuff at people who are developing measures.

CO-CHAIR MEHROTRA: I think that's a fair point. I think maybe biased by Elizabeth being in our group here, you know, that's a real, that's a key focus right from the start of a measure to think about attribution.

Laurie.

MEMBER RADWIN: Yes. I just had a question about the grid.

So I'm having trouble visualizing it. So what would the row headers and column headers look like on your grid? I understand it would be applied to a case but what would be a typical element that you'd be cost matching on?

MEMBER LLOYD: So I'm making stuff up based on the fact that you guys said pick four and this is up to the group. Right? So I was trying to make some diversity of options here; right?

Under the sort of primary care-ish column I had a Track 2 ACO, so you pick somebody

who's prospective attribution and has risk, you know, comparative rate.

And then for the next row I have episode heart failure bundle as a case study example.

And then for the quality improvement bucket I had, I just picked an endocrinologist under MIPs. But, again, I'm making stuff up.

And then for institutional I picked SNF readmissions because I think that's first, I think that's first up in the SNF VBP.

And it's different for, as an institutional level attribution. So the attribution, you know, it's a lot easier to if you're at the SNF, you're at the SNF; right? As opposed to quality improvement where I have multiple clinicians tagged or err on the side of over-tagged; right? Versus the accountable care organization, it's that collection of TINs that's tagged; right?

So each one of these is going to be a little bit different based on the different types

of things in the McGlynn paper plus others I think that I've heard today at least.

MEMBER SUTARIYA: Putting Medicaid Advantage into accountable care or that's a different category you're not dealing with?

MEMBER LLOYD: Well, because it's an ACO Track 2 they are statutorily prohibited. So that makes the answer easy. They are not in this particular example.

But we could have a different case study. Doesn't matter.

CO-CHAIR MEHROTRA: Right. And so I think the issue here is that we just want some really concrete examples that we can start to trigger conversation, recognizing that those are just four examples out of hundreds and hundreds of different things out there. But with at least the idea of going from what I would view as relatively amorphous -- not amorphous, more kind of aspirational principles to something relatively concrete is what I'm hearing.

And then, Danielle, sorry to pick on

you but you just have this awesome spreadsheet. I'm very jealous. Can you just give us some examples of the rows?

MEMBER LLOYD: So on the rows I have so my high level buckets, right, are primary care specialty, quality improvement, institutional. But then within that, the case studies I just read.

And then below that I have eligible beneficiaries and geography. So that's not going to be applicable under every situation. And it's the smoking measure under ACO, too, by the way.

So where'd she go? She went back. She was down there when she said it.

And for county, right, so it has to be within the county.

So there may or may not be a geographic or beneficiary narrowing; right?

For the heart failure bundle it's only heart failure patients; right? So it depends on which row.

Then I have accountable unit. So for

the ACO's it's the collection of TINs. For the bundlers this is an open question. Is it the bundle applicant? Depends on the model. Or do you want to tag the procedural list? This is heart failure, so maybe I shouldn't have picked heart failure. Maybe I should have picked an orthopedic one. But you can have a debate over that; right?

Quality improvement, I have the multiple clinicians. And then, obviously, SNF is institutional.

But eligible clinicians, is there a step of only who can be attributed on; right? So in MSSP you've got like six primary cares and then certain specialists. Heart failure you might only say -- I'm making stuff up. I'm the finance person here. So some clinician tell me, cardiologists, anybody else? No. Whatever else you would put for cardiologists. Whatever else you'd put for heart failure. You know, that's an example.

Then for the level, is it an episode

or a patient level.

Service cost, is it E&M or expanded E&M or is it service, you know, visits? Is it -- right?

Determination. So is it plurality? Is it a majority? Is it percent of services.

CO-CHAIR MEHROTRA: This is helpful. No, this is perfect.

MEMBER LLOYD: Right.

CO-CHAIR MEHROTRA: So you've already kind of started to give us a preview for tomorrow. But does that help? Okay.

So I think there's -- I see a lot of shaking of heads in the right direction, which is up and down. So it sound like we're enthusiastic, Danielle. Thank you very much for this. And I think it will be great to react to this more tomorrow. Sorry for changing the agenda.

So I wonder if, so I'm going to throw out just a couple ideas, just one new idea, in terms of what this report might look like. And

it occurred to me as we're having some of these conversations that I almost see this section -- maybe I write too many papers -- future directions. And so future directions of attribution or future needs.

And I'm curious what your reactions. So what was on my mind in that area, the first was in terms of attribution, things that we hadn't worried about too much previously need to be addressed. And one of the examples is their specialty of the physician.

You know, in Medicare claims data we've always had the specialty of the physician and it was, I don't know, it was okay. But I can tell you from clinical experience, a lot of cardiologists were really doing primary care. And there was sub-specialists who were only doing cath. But no big deal, it was just, you know, a couple of codes.

Now when we start doing these attribution rules and you're trying to figure out it can only be done a primary care physician,

then you all of a sudden really care, well, who is a primary care physician?

And so one area of future need that I see is that if to the degree that specialty of the physician is important, and I'll also say for the nurse practitioners this is also key because nurse practitioners aren't one big, amorphous group. There are a lot of different kinds of nurse practitioners, but I have no clue from claims data what they're doing. And so there's a real need for a future need for CMS or others to really how is it, what is a mechanism by which providers can now fix their specialty or address their specialty and have more sub- specialties? Because those kind of needs really wasn't important before but now are really important.

MEMBER MOSCOVICE: You let providers decide that or do you use claims data to decide it?

CO-CHAIR MEHROTRA: Well, it's really interesting -- all right, now I'm going to go into really weedy stuff -- but you know, we have

done some work in the past where we've tried to use claims to figure out someone's specialty. And that's kind of an interesting exercise. You start putting there's the heart failure doc who's a cardiologist who's in a different bin than the preventive cardiologist, who's different from the interventional cardiologist.

You know, so you can start getting to some pretty -- those categories. And whether that's done via claims or whether you have the physician decide or some combination of the two. I don't know what the answer is. All I'm saying is that the real future direction is we need better labeling of provide -- any, all these different kinds of clinicians.

The other place where I see a real need is that there was a lot of enthusiasm for not attributing to individual clinicians but larger groups of providers. In the ACO environment where ACOs contribute their TINs, it's a little easier to figure out who's in an ACO or not an ACO.

But a real future direction that I see is better clarifications on who, which, all these clinicians out there which practice are they in, which group are they in if they are in a group. Because we need that better data if we think that's the better level to attribute.

And then the third future direction -- this is one that I don't think is specific at all to attribution -- but the timing of the data. Sophia's comments a little bit about 2- to 3-year lags really became, struck me as saying that when we're talking about trying to change behavior, quick turnaround and getting those data out is such a critical thing for attribution but for a lot of other purposes, too. But just making that point in our report might be helpful.

So I just had three of those future directions. I don't know, reactions?

Michael, go ahead.

MEMBER BARR: Just real quick on the second one. I believe the MACRA NPRM includes the promulgation of some codes, new attribution

codes for the ACOs and clinicians and qualified clinicians. So that might be helpful to that.

No, no, no, I think it includes sort of taking the TINs, NPIs and account for entity codes and kind of making some sort of associations to these middle, middle layer of association for future directions. Is that correct or not?

CO-CHAIR MEHROTRA: And it's also complicated, right, because the TINs can be one doc versus ten docs versus 100. I mean it's like what a TIN is can be kind of confusing sometimes.

MEMBER BARR: Well, this covers the TIN, MPI, the clinician also.

CO-CHAIR MEHROTRA: Yes, it's complicated. I guess if we feel we're going to only contribute to practices it sounds great in theory, but in reality it might be pretty difficult in 2016, so.

Go ahead, Troy.

MEMBER FIESINGER: To me a concern is that a definition of primary care might become

like the definition of the patients in a medical home. So we had a discussion in our group, What is a provider and the D.O., nurse practitioner, physician assistant? What is a primary care physician? Is it the National Health Service Corps definition: family medicine, pediatrics, internal medicine, OB/GYN? Depends on what the OB/GYN does; depends what the internist does; depends on what the family doctor does.

Certainly there would be heartburn within my organization if those, that was defined certain ways. One way to look at it is What do you do? Roll-based, what services do you provide, what codes do you bill? So in our group we'll have the counterpoint, well, how do I measure that via claims? Okay, good question.

We have to look at a lot of those issues. If we sidestep it all by contributing to specific group level, you avoid the issue. But if we're going to define primary care, I know what I think it is, but what does everyone else think it is?

And when you task money, as we all, now, it gets very contentious.

CO-CHAIR MEHROTRA: Well, no, it's a fair point. You made the point earlier which I think resonated with a bunch of folks which was is it ever right to profile an individual clinician? Though I think I heard the second group also describe that it was important to include focus on primary care, too.

So I feel like you didn't -- No, no, not at all, I don't mean to say that. But I mean I do think at its heart right now, right now, a lot of attribution rules are focused on who are primary care physicians.

So while I totally agree that myself, a bunch of other people might really have a lot of heartburn about whether they are primary care or not, but it seems to be critical that we try to answer that question because right now it's still too amorphous, so.

Are we at recap time? Or are there any other comments before we end? Oh, sorry,

Elizabeth, I missed that.

MEMBER DRYE: I had a -- we can talk about it tomorrow. But the group two was talking about moving from a, you know, a broad accountability towards a more narrow individual provider or medical home accountability over time which I just wasn't sure what was behind that. Because we didn't talk about that per se but I think that, you know, if we're going to join accountability in well functioning systems, driving towards the individual over time, I would just love to hear more about the thinking of that.

Oh, that was group one? I'm sorry. Group one. Bad, bad.

MEMBER FIESINGER: I have no recollection of making that comment. Thank you.

MEMBER DRYE: It was -- yes, I did not look at my notes. But I looked at the, I looked at the concept but not the group attribution.

And then my second, just to, I mean MACRA there's a couple things about it. It has

those, I don't know what they're called, relationship codes of responsibility fields or whatever, it's going to pretty much points that we've talked already. But we might want to comment on those, which I think goes to the definitional issues. I don't think we can really tackle that fully in this group, but I think we want to keep it in view.

And I, I just -- and really as a measure developer I'm worried. I feel like this is where we're moving. We're moving towards the need for outcome measures and accountability for outcomes in the group level. But when I look at MACRA, you know, it has -- I'm thinking what's feasible to measure? Where am I going to get enough sample size and comparability across groups that I could do a outcome measure that's going to meet all of NQF scientific acceptability criteria.

And it feels like a very fluid definition in the statute and in the rule right now where it's saying, you know, not in the first

year out. But the statute requires it.

CMS allow these -- you can form your own virtual groups or whatever.

So I think that the fluidness of what physician groups are is a particular challenge. And I don't think we can solve it. But I think maybe we should just be thinking about. But if we're going to compare providers there has to be some way to think about, you know, to classify groups.

CO-CHAIR MEHROTRA: Those are great points.

Did group one or group two want to respond to Elizabeth's question?

(Laughter.)

CO-CHAIR MEHROTRA: Well, it's the end of the day. So we will have plenty of time over dinner and wine, maybe we'll address those tougher philosophical questions.

MS. WILBON: So Kim is going to recap.

MS. IBARRA: Okay. I'll start the recap and then I'll turn it over to my team if

they want to join in and add anything.

So the day started, and I'll remind us that we started with why we're all at the table, why we're discussing attribution, why is it important not only from all of your perspectives but also the NQF perspective? And we heard from our CMS colleagues as well about some of the challenges that they face in their work and where guidance would be needed.

We heard a lot from you about the different goals of attribution, why we're doing this, what kind of specificity we need, what are the specific areas that we need to consider when we're thinking about attribution rules and methods, how can we lay these methods out, what kind of guidance are we going to develop?

And we started to draft principles which our team is going to put together, revise, bring back to you tomorrow so that we can have a look at them again as a committee. And lots of great discussions using different case examples from a measurement lens, from a current case,

clinical case, from a programmatic lens.

I think all of this discussion is really helping us get to a set of principles that we'll be able to use to guide different stakeholders of NQF and different stakeholders of the healthcare system, so from measure developers to plans, to patients, to purchasers, to providers, to clinicians, to government policy makers.

So I will leave it at that and see if my team has anything that they wanted to add to that recap?

(No response.)

MS. IBARRA: Okay. So tomorrow we will be focusing on reviewing the environmental scan. Dr. Andrew Ryan will be here to lead us through that discussion.

This will be an opportunity for the committee, but also members of the public and NQF members to provide input for the authors, for us to revisit the draft principles and also consider if the grid that Danielle and others have so

kindly offered and volunteered to put together for us.

So that's the plan for tomorrow.

Tonight we, for those who have said that they are coming to dinner, we're meeting at 6:00 p.m. around -- Oh, okay. We will be sending out an email to the committee of -- with instructions. And you can come see me afterwards. Okay.

CO-CHAIR MEHROTRA: Thank you very much for all of your work. And we will see you -- for those going to dinner you will get an email about where to go very shortly.

(Whereupon, the above-entitled matter went off the record at 4:36 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

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was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter