NATIONAL QUALITY FORUM

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ATTRIBUTION: PRINCIPLES AND APPROACHES COMMITTEE IN-PERSON MEETING

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WEDNESDAY
JUNE 15, 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 9:00 a.m., Ateev Mehrotra, Chair, presiding.

PRESENT:
ATEEV MEHROTRA, MD, MPH, Chair
MICHAEL BARR, MD, MBA, MACP, National Committee for Quality Assurance
JENNY BEAM, MSc, Humana
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.
IRA MOSCOVICE, PhD, University of Minnesota School of Public Health
JENNIFER NOWAK, RN, MSN, Blue Cross Blue Shield Association
JENNIFER PERLOFF, PhD, Heller School for Social Policy and Management, Brandeis University*
BRANDON POPE, PhD, Baylor Scott & White Health

LAUREL RADWIN, PhD, RN, VA Boston Healthcare System
MICHAEL SAMUHEL, PhD, Booz Allen Hamilton
ROBERT SCHMITT, FACHE, FHFMA, MBA, CPA, Gibson Area Hospital & Health Services

NATHAN SPELL, Emory University School of Medicine
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ERIN O'ROURKE, Senior Director
ASHLIE WILBON, RN, MPH, Senior Director

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
ANDREW RYAN, PhD, University of Michigan School of Public Health

*** present by teleconference**

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Adjourn

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

9:07 a.m.

DR. AMIN: All right. Well, welcome everybody to day 2 of the Attribution meeting. Thank you for all of your contributions yesterday. We look forward to another exciting day of discussion on attribution.

Before we get started I just wanted to introduce Jennifer Perloff. Are you on the phone?

MEMBER PERLOFF: Yes, I'm here.

CHAIR MEHROTRA: Great. Would you mind introducing yourself to the Committee and if you have any disclosures to make.

MEMBER PERLOFF: Okay. Sure. So I'm a health physicist researcher at Brandeis, and the vast majority of my work in the last four years has been on episodes of care. And in that context, we are doing a lot of active work right now on attribution. And so, I think that would probably be my only disclosure is that we're actively funded to be developing attribution

methodology.

CHAIR MEHROTRA: Great. Thank you, Jennifer.

So with that, I think I'll turn it over to Ateev to walk through yesterday, some of the key guiding principles that we have in draft form, and then we will get started with -- oh, Ashlie, I apologize. And we have our commissioned author with us today.

Andy Ryan, if you wouldn't mind just doing a quick introduction?

DR. RYAN: Sure. Hi, everyone. It's a pleasure to have the chance to meet with all of you today. I am a health economist/health services researcher. I work at the University of Michigan, although here I'm here as an individual. And so, I'll talk about our approach to our report and what we did and what we found, but I'm just looking forward to engaging with you on these topics.

MS. WILBON: Thanks, Andy.

So before we get started on the review

of the draft principles, I thought it might be a helpful foundation for today as we kind of wrap up some of the discussions for over the two days on this issue to kind of give everyone a sense of what we're expecting or what our plan is at the end of the two-day meeting, the product that will come out, that will go out for public comment, and then ultimately the product that we're looking to have at the end of the project, which might help frame some of our discussions and kind of where it's going.

Because you guys have great discussion, and it's not just going into the air; we're capturing it all. We are still actively figuring out how to frame it all and put it into a product, but just basically the principles that we've come up with today or over the last couple of days, we've identified that some of these may fit better as recommendations. We're going to be parsing them out as we have more discussion to figure out what may fit better as a recommendation versus as a principle.

So the product that Andy has produced, which is the environmental scan, which will also include some elements of the discussion of the Committee to build on some of the work that he's done in the scan and the results and summary of that and evaluation of those methods.

We'll also be producing -- I won't say a separate report, but a supplemental report that summarizes some of the other discussions that we've had, particularly on day one about how to frame this issue, the elements to be thinking about when you're just thinking about the issue of attribution, that will go out as one product with the environmental scan as an appendix.

So the structure of that, exactly what it looks like we're still working through, but just wanted to give you guys a sense of the product that will come out, and that will go out for comment after this meeting.

When we reconvene in August, that meeting we hope to be more focused on specific recommendations to measure developers, to NQF, to

measure implementers. And that will again build on the report that we put out for comment after this meeting and ultimately will be one big, one large report that includes all of it.

We also discussed this morning the idea of having some kind of smaller, shorter, like maybe a one or two-page summary that would be put out for public consumption to kind of summarize some of the key ideas that have come out of this group, because it is a lot of information. It's a very dense topic. There's a lot of complexity to it. So figuring out how we can distill that down for broader public consumption to be put out as well in some mode.

So do you have any other --

CHAIR MEHROTRA: Yes, if I could just clarify actually. So what's going to go out for public comment, just to repeat, is going to be: this is why attribution is important.

MS. WILBON: Yes.

CHAIR MEHROTRA: Here is how attribution is being used out there. That's

Andy's work, or his team's work. And that's all, or the principles also?

MS. WILBON: The principles will also go out for comment.

CHAIR MEHROTRA: Okay.

MS. WILBON: And at the end of the next meeting we will add the recommendations, and that will also go out for comment after the second. So we'll have kind of two separate comment periods that the public and members will get to reflect on after the Committee's discussion after both meetings, but ultimately the report kind of builds on itself as we go through the project.

CHAIR MEHROTRA: Sounds good. Okay.

MS. WILBON: Does that make sense?

CHAIR MEHROTRA: Any questions on that? Okay. Go ahead, Elizabeth.

MEMBER DRYE: Just a question about like the level that you're thinking about having the principles at. Are they going to be like a sentence or two like we were -- as we first threw

them up there, or would we be doing any refinement to that --

MS. WILBON: We will definitely be --

MEMBER DRYE: -- before public comment?

MS. WILBON: Yes, we will definitely be doing more refinement. This is all kind of between the end of the meeting last night and this morning, so we've digested as much as we could, but there will definitely be more refinement. And I suspect as we put together a report, it will be probably one sentence and then maybe like a couple of sentences explaining where that came from and why we think it's an important principle. But we anticipate them being rather brief.

CHAIR MEHROTRA: And this level, too?

MS. WILBON: Yes.

CHAIR MEHROTRA: This is kind of what you were -- okay.

MEMBER SAMUHEL: Yes, thanks. I think this is all good as a starting point with the

environmental scan and the principles and so on, but I don't know if it's a concern, but I'm having a hard time getting my head around maybe what the final report is going to look like. And specifically I guess what I'm wondering about is there's work going on in developing methods for attribution in various scenarios. Some in terms of clinical attribution. The colleague from Brandeis mentioned the work that they're doing. There's work going on for CMS in terms of program attribution. And I'm wondering how we're going to -- or if we want to reflect the current status of these things in the report.

MS.WILBON: So that is actually what the environmental scan is intended to capture. So any additional -- so we'll go over what Andy and his team have been able to capture so far, but if there's any additional things that we think are missing or that some additional work or approaches that we think should be captured, I think that this is prime time to discuss that and figure out how to get that captured in an

environmental scan so that it is part of our catalog of what is going on in terms of current state.

CHAIR MEHROTRA: And just to clarify, so there will be that front section where it will be sort of the state of the literature, what we know so far, and what it's --

MS.WILBON: Yes.

CHAIR MEHROTRA: Okay.

DR. AMIN: And also just to add to that, Mike, I mean, part of today's discussion is to actually get the current state discussion, but then also just to orient folks. The purpose of our meeting, which we started to do even yesterday in terms of the table that we discussed and whether that is an approach or not, but essentially the purpose of the next meeting is to really get concrete in terms of recommendations in particular applications.

And so, we're not going to get to the level of this is the attribution approach you should select for X program, but rather an

approach that one might want to consider for each of these different use cases. And I would welcome input here as well from CMS and others in terms of what they would find particularly helpful as we get to that point.

Our approach is going to be very consistent. Now how detailed we get I think will be based on how comfortable we feel about making what level recommendation and given where other users may want input from this group as well.

So, Dan, I don't know if you have anything else to add to that.

MR. MULDOON: No, I think that sounds right. And what we'd be looking for is not -- like you said, we wouldn't be looking for this is the approach to use in this situation, but sort of, I think when we were talking about the table, it would be helpful if you sort of, for those examples, went through what some serious considerations were for each of the -- as you move down the rows sort of, oh, do you want to do this on an episodic basis versus a patient basis?

And sort of rather than being prescriptive just sort of going through the sort of serious considerations and things to think through as you work through whatever specific program or measure or other scenario you are in fact designing the attribution rule for.

DR. AMIN: Right. And so, sorry, to just to keep going on this, I think it's a really important point. Where we want to end today so we can feel comfortable leaving today that we've done our work is to have just generally our approach for how we're going to do that, which is we could put this table together to get a sense of how well this is going to work. If not, how we're going to start working on that. But then really the deep dive is going to be next time we meet in August to really do basically just want Dan just described.

CHAIR MEHROTRA: And just to be clear, at least two -- well, first a question just so I understand the process. We're going to have these principles, we're going to have this

environmental scan. I think the NQF staff is going to put it all together. And then are you going to send it out to all of us for input before it goes out for public comment? And how does that process work usually?

MS. WILBON: Yes, we can do that. And I have to look to Kim to see. I don't know the timeline in that much detail, but we can certainly build in time for after staff has had time to write for the Committee.

CHAIR MEHROTRA: So what's the norm, though? So I mean, I'm sure everyone in the room is like, oh, of course they want to look at it, but then everyone's busy.

MS.WILBON: Yes.

CHAIR MEHROTRA: So, I mean, what's the -- I mean, I don't want to like foist work upon the Committee members here.

MS.WILBON: No, we could certainly -- we have the SharePoint website, so that's probably the best way to communicate. Everyone's looking at the same draft at the same time.

People can add comments to that. We would give you guys probably about a week. We can plan and let you know in advance when that week would be so that you can try to build in time if you need to to review it. And then we would take everyone's comments.

We do also have a conference call that we put on the schedule, although I'm not sure of the timing. Oh, yes, the timing's not going to work. We wouldn't have it written by next week. But we can certainly figure out how best to do that, whether it's a call that some folks might be able to hop on to give input or whether we do it online. It would be a SharePoint or email.

MS. IBARRA: And just to add to that, if for some reason you're unable to make a comment before we put it out for public comment, you're still able to make comments throughout and to view the rest of the public comments, add anything at that point. So it's not just the right before it gets published. There's going to be continuous opportunities for you to review and

help us refine these products.

CHAIR MEHROTRA: Great. And then the last point is that, and this is a preview of a conversation we'll have later, just to reflect where we were yesterday, I think there's a desire, I think an appropriate desire for us to be a little bit more concrete. We discussed this table as a potential way. And Danielle, Srinivas and others had put some time into that yesterday and this morning. And we'll have to see how we feel about it, because I do want to go in that direction, because I do think it would be useful, but we'll have to -- I think responding to the table and getting your input will be very important in terms of whether that's something that will go into the final report.

I think there were some questions. Troy, you had a point?

MEMBER FIESINGER: Quick housekeeping question. I love that you guys have put together this list. At what point will the draft principles be sent out? Meaning, will we get a

chance to look over it, think about it on the flight home, respond back?

CHAIR MEHROTRA: Right. So I think we're hoping today to have real-time input on these principles and provide input, but I do think that after we leave you can also provide input. And we'd I think be happy to share.

DR. AMIN: Absolutely.

MS.WILBON: Yes, we can actually print -- once we have some discussion about them, we'll do kind of like a working session I guess, if you will, on them, and then we can have them printed out and hand them out before you --

DR. BURSTIN: I think hand them out before we have the discussion.

MS.WILBON: Oh, before?

DR. BURSTIN: I think it's really hard for people to look at things on a screen without -- it's just for a lot of people you have to see visual -- I think we'll just do it before. Then you could mark it up, and it's just easier, yes.

MEMBER FIESINGER: I'm old-fashioned.

I need a piece of paper and a pencil.

DR. BURSTIN: Yes, we can do pen and paper and electronic.

MEMBER FIESINGER: But I have a lot of friends who I'm thinking asking them, in this scenario, how would this play out for you in your job situation? And I want to get some more feedback to help me formulate my thoughts.

CHAIR MEHROTRA: Nate, you had a point?

MEMBER SPELL: Yes, I'm struggling, too, with this tension between how concrete to be versus the limitations of the evidence in some sense. And there are some paradigms out there that we might think about using. So for instance, the Preventive Services Task Force will grade the evidence. And we're about to hear what the collection of evidence is as we look at the draft of the paper, but thinking ahead a little bit we might want to, as we create something like a table, be able to also give a sense of our level of confidence in these particular

approaches, or at least a guidance of the rigor we would expect in testing as people try to apply it.

CHAIR MEHROTRA: That's interesting, right, because -- has NQF ever done that? So are you familiar with the U.S. Preventive -- they'll say something, right? Yes, so how --

DR. BURSTIN: Yes. Of course.

CHAIR MEHROTRA: Oh. So Helen knows it well.

(Laughter.)

CHAIR MEHROTRA: Is that something you've ever done in the NQF process? Would that be -- I mean, I don't know if we have to copy the A, Bs and so on and so forth, but --

DR. BURSTIN: Yes, I mean, so I used to oversee the U.S. Preventive Services Task Force, so this is something I know well from my AHRQ days. I still shudder sometimes at the thought.

(Laughter.)

DR. BURSTIN: But I am not sure

whatever we're going to talk about today is at that level of evidence, and I think that's going to be a question here. But I think a lot of this is more this is what's out there.

I'm not sure how much the recommendations are tied to evidence, so I think that is one particular question. I mean, certainly on the measure evaluation side, we have a very strict evaluation of the quality, quantity and consistency of evidence for all of our measures, but I think we need to think through with Andy in particular, since that's the part that's likely going to be the one that's most driven by evidence, how we want to assess maybe at least some categorization of personal information, evidence-based information for the literature just to provide some of that guidance.

But I think this is going to be a blend of consensus opinion, which is not very high evidence as many of you know, but important, along with some evidence from the literature of what Andy can provide.

MEMBER SPELL: And I think that's fine. We just ought to be clear about what evidence we reviewed, the state of the literature, what is our consensus based on? And then I think we can provide some guidance going forward about the degree of testing that should be expected for measures coming forward.

CHAIR MEHROTRA: Troy?

MEMBER FIESINGER: Sort of a follow-on to Nate's point. It's exciting, the last few years there's actually finally research on a lot of these ideas on this P4P work, which incentives drive which behaviors. One area, if you want to be aspirational, would be, can we draw that process a little farther forward, that there should be some evidence to support what people do? Because I just have this disquieted feeling that people are out there just trying all kinds of stuff to see what works, or even just trying stuff. It would be nice to do it a little more scientifically.

DR. BURSTIN: I do think it's

important to stay in scope about attribution. I mean, that could go pretty far afield in terms of the full evidence of P4P, et cetera. I think keeping it within scope of attribution, that would be fine.

CHAIR MEHROTRA: So let me just review where we are now. So we're going to go over these principles just to kind of set, kind of refresh where we are. We will have lots of time to discuss these, but just right now I'm just going to plant the seed, and then we'll go right to Andy, and then we'll come back to these principles later on, but just as a recap of where we were.

So the first idea was, we kind of switched a little with this first principle, which is really the goal of attribution is to drive the system, the healthcare system towards shared accountability and to advance the goals of the National Quality Strategy. And this is trying to incorporate some of the discussion we had about this tension between attribution and

accountability, and what's the goal of this? And we can discuss this, obviously. I think this will raise some controversy within the Committee.

The second point we want to do is really emphasize the point here. Attribution is an essential part of measure specification and policy and program design, and measures and programs should be tested with more than one attribution approach to ensure accuracy and fairness. We made the point that when we do that process -- I can't remember, I think it was Jenny who said make sure we get provider and patient input on attribution rules to make sure they have face validity. Consider alignment of the attributed and measure population so we didn't have some of the issues that folks were frustrated with about attribution in the past. And consider alignment of the purpose of attribution, the attribution approach and measure concept.

And I think that really builds into the third principle here, which is that you've

got to be transparent about the goals of your attribution rule and why you chose the method you did. And you also have to really consider the unintended consequences that might arise as providers respond to the attribution method. And I think this was articulated well by Elizabeth yesterday when we were discussing the smoking rate in the county. Why the heck would you attribute that to hospitals? Articulate why you might consider that.

Attribution can be a big deal. It can impact reliability, validity, score results of an individual provider overall.

The other point that we wanted to make is this is not a static issue, that as time goes on, new data sources come on board, health system itself changes, that we have to think about how attribution rules will evolve.

We really emphasize that attribution rules, at least algorithms that are used using claims-based, could be considered -- is not the only way to do things, and provider and patient

self-selection of the responsible provider may be preferable in some cases. And we discuss some of the limitations of self-selection.

To drive the system forward is necessary to challenge current norms of attribution including desire to identify a single clinician or provider versus assigning to multiple providers.

And this last point is that simplicity and consistency of attribution rules are the ideal, however, flexibility is necessary to align the attribution method and the use case. And the idea here was is that we needed a lot -- there's no one single attribution rule out there that can be used across everything.

And then I think this is a preview of some of the conversation in the rows of the table, if we want to call it this, which is when we think about the attribution approach we should take, here are some different elements that you should be thinking about: the environmental context that was important. Emphasize the time

frame, how far back you look, the services included, the geographic context, the measure use, the focus of the measure, the payment model, the care delivery model, provider eligibility criteria, patient eligibility criteria and locus of control.

Those are all some elements, and we're probably going to play with some of these and refine, but it at least gives you a sense of at least some of the thoughts were, reflecting on the conversation yesterday.

So, I was now going to turn to Andy, but any, I'm going to say, burning thoughts on this as we -- go ahead, Brandon.

MEMBER POPE: I was going to ask do we feel like we captured enough this concept that -- we talked about a lot of different terms not being accountability or the varying level of stakes, but I thought we sort of consistently hit on the fact that, look, initially it might be for the purpose of aspiration, and then it's for performance, and then it's for payment, and then

it's for even participation and that there's these increasing levels of stakes, and just being thoughtful about -- I think we talked a little bit the intent of what we're going to do with this attribution, but being clear and transparent about that. I just didn't know if people felt like that was --

CHAIR MEHROTRA: Maybe we can add that. My own reaction to what you said, Brandon, is, it's important, and I would say that going back up to that one where it's No. 3 now, I guess, about you want -- like why are you doing this? And maybe the couple sentences that Ashlie described that would go into that segment. But I think it's an important point.

Does that reflect what you were thinking?

MEMBER POPE: I think so. You could sort of roll it up into several of those, so I think if we call it out there, it will be great.

CHAIR MEHROTRA: Okay. I think, so, Bob, you had your -- oh, I'm sorry. Oh, you're

-- oh, look at --

MS.WILBON: Mike, Bob and Troy.

CHAIR MEHROTRA: Mike? Oh, Mike. Yes.

MEMBER SAMUHEL: Hiding me again today.

(Laughter.)

MEMBER SAMUHEL: Actually, it's kind of the same point I raised yesterday. I keep reacting to the term provider. And maybe we need some definitions here. I think we all understand what we mean by provider, but it has a pretty broad definition in the current state of healthcare, public health that I'd like to see us leave in here. It still feels to me like attending physician when I read this. Could be just me. I don't know.

CHAIR MEHROTRA: No, I think it's a good point. Often reports like this have a glossary, but maybe in this particular case we need to be a little bit more -- for a couple of the key terms really say when we're talking about

attribution, these are the kind of terms we're talking about. Accountability might be another term. So those are a couple key areas. Because I think you're right, we're very loose sometimes in the terminology.

MEMBER RADWIN: So just a point of information. On page 2 of the draft report there is a glossary, and providers is defined there. Now, I don't know if that's the kind of definition that's clarifying, but that is set out as -- I can read it, if you want, but --

MEMBER SAMUHEL: I didn't quite catch where the reference was.

MEMBER RADWIN: It's on page 2 of the draft report. I don't know if it needs to be -- if people feel it needs to be fine-tuned, but it has been defined.

CHAIR MEHROTRA: And I think there's something to be said for maybe even in this report avoiding the word provider, because -- maybe just being more clear. Clinician versus health system or practice. Because I think

sometimes we use a term broadly and that adds confusion. But that's a -- we can discuss that later.

I think Troy?

MEMBER FIESINGER: One thing I thought of adding to the components to consider for these attribution rules would be vulnerability to manipulation, meaning -- you can call it gaming, cherry picking, whatever word you want to use. We can't design the perfect system --

CHAIR MEHROTRA: So right now it is unintended consequences, but, yes, I think you're saying maybe it would be more forceful with that term.

(Laughter.)

MEMBER FIESINGER: There may be people out there who are trying to create consequences. I'm thinking even seeing ACO formation, you think about how you formulate an ACO and which patients you want to attribute because you're thinking about your benchmark and potential for savings. That's part of the calculation people make as

they predict what profits they think they can make. If we assume everyone's a rational economic actor, people are going to either consciously or unconsciously attempt to manipulate the system. There may also be people who intentionally manipulate the system. Anything we can do to make that a little more difficult or make it sort of more resilient would help.

CHAIR MEHROTRA: Great. No, I think it's a great point. We'll have to be careful with what we say there, but I do think your point is well taken. I'm with you 100 percent that if you don't consider the gaming, then you're in big trouble, because almost in every system it's going to have that.

Bob, were you set? You put your card -- oh.

MEMBER KROPP: Yes. Yes, thank. First of all, great job paraphrasing these -- or actually editing these principles. I think that this is clear progress since we left yesterday

evening, so thank you to you and staff for that.

My question is on page 6 of the draft report, and this is maybe for Andy, Andy's gone ahead, between lines 15 and 31, listed some ways in which the existing attribution methods have been arrayed. And I'm thinking that that integrates in some way, shape or form with our principles.

So my question is to what extent will the paper reflect the deliberations of the Committee upon which we're arraying some of the cardinal aspects of these principles -- methods?

CHAIR MEHROTRA: Yes, I think it's a great point, and I think hopefully as we hear from Andy, that will feed into how we refine this. But I do want to really emphasize this is just an iterative process to try to get to something. And I think we should have -- it should be consistent.

I think was Elizabeth.

MEMBER DRYE: A couple of the principles -- I think 7 was we should challenge

norms, like maybe a single provider, and then the general principle of supporting shared accountability in the National Quality Strategy are -- they feel like they're on conflict with Group 1's proposed progression from shared accountability down to a single provider over time. So I raised that yesterday, but I don't know if this is a good to under -- I don't know if anyone -- if that conflicts or I'm just misjudging that.

CHAIR MEHROTRA: No, no. And let me -- so I feel we're already -- let me ask a favor, if this seems reasonable to you, that maybe -- this is exactly the conversation we want to have, but I think there was a thought that -- get Andy's thoughts out there first. So could I hold -- I know Srinivas, Ari and Michael had some thoughts, and Ira, and then maybe come back to you guys? Would that be okay? Okay. So can I on that note --

(Laughter.)

DR. RYAN: Yes, right. So thanks. I

certainly hope that my comments about what we did -- I reviewed the principles, and hearing this discussion I think it very much will be an input to this process. It's certainly not meant to be external or something that is trying to put a form on these discussions that isn't already there.

So with that, I'll just kind of try to talk about what we did, why we did it, what we found and kind of my own view about some of the tensions and issues going forward with attribution. Again, we talked a little bit this morning. I think it's pretty consistent with where the group was yesterday.

So just as some background, I think this discussion is reflected in the principles, but attribution is really essential to drive value-based accountability in healthcare. We have an uncoordinated fragmented system, and there's -- first order problems associated with this are bad care for patients, but a kind of second order of problem with these uncoordinated

systems is kind of not knowing which provider is responsible for which patients, particularly from a measurement perspective. And this is really where attribution comes in. And so we really view this as the process through which providers, and using the word that might be in question --

(Laughter.)

DR. RYAN: -- but nonetheless providers are made responsible from a measurement perspective for some aspect of care they provide. So this is clearly necessary to drive value-based accountability.

But I think the reason why we're doing this project, the reason why we're all here is there isn't really clear guidance for how this should be done. Even some of the basic parameters of attribution haven't really been well-defined or considered or thought about how they should apply under different circumstances.

So that's really what we were trying to do with this report is think about what are the relevant dimensions of attribution? Why

might these dimensions -- how could they be thought of applying differentially to different types of care settings? And I think in a broad kind of way, what's good attribution? How can we think about criteria that -- attribution approaches that have desirable outcomes at a program level and also at a provider level? And so, these are some of the issues I think that we try to bring out a little bit in our scan.

So what we did is we performed an environmental scan to identify the attribution methods that have been proposed or are currently in use. So this is done with our team, which is Kristin Maurer, Ariel Linden, Rachel Werner and Brahmajee Nallamothu.

So our strategy for the search was we started with kind of a typical lit review search with MeSH headings and key words, but we found that this was really leading to too many false positives. We were getting way too many articles that were not sufficiently relevant. So instead what we did was we took some -- a number of what

we found to be key articles about attribution that were in the literature, and kind of saw what articles were citing the key articles and what articles were cited by the key articles, and then used that to kind of snowball and bring in additional approaches for attribution.

So we're currently supplementing this with a more traditional search method, key words to bring in additional approaches that we may have missed with our search strategy. But nonetheless, the bottom line is that today, our strategy identified 70 different sources, so either reports or published articles that describe 163 different attribution models that have currently been used or are currently being used in accountability programs.

And so, I'll just tell you that a model is not a discrete thing. It's really just a combination of different elements. And what we did is we defined the attribution models based on these eight dimensions. So one of them was clinical circumstances, the type of provider that

was attributed, the programmatic circumstances, the timing of the attributions. So this is a retrospective versus prospective issue.

The exclusivity of attribution. So this gets at the single versus multiple provider attribution issue. The period of over time -- of time over which the attribution, the provider was responsible for care for a given patient. The minimum requirements that were the minimum requirement to make an attribution. And this gets into the issue of kind of pluralities versus majorities.

And then the measure that was used in attribution. So an example here is whether attribution was best based on kind of spending or whether it was based on visits, for instance.

CHAIR MEHROTRA: But I think I'm still having difficultly wrapping my head around the difference between a model and a rule, so could you go through that one more time? We started using the word attribution model. I'm trying to get a sense still. If you could do it one more

time, what does it mean to you, a model?

DR. RYAN: What I would say a model is an integrated approach. So it's a way that you can -- it's a combination of different elements that are put together and that the resulting product of that is an algorithm that is used to attribute patients to a provider.

CHAIR MEHROTRA: Okay. Got it. So just to be very concrete, I know there are many elements, but let's just say one element is you used visits, and you used a 30 percent cutoff, and it had to be the plurality. Those would be the different elements. And then those together would make an algorithm or model that you were using. Is that --

DR. RYAN: That's exactly right. So we haven't further condensed the idea of a model and say, okay, we found five models. Basically, we haven't gotten beyond just identifying what we call the 70 separate ways that these elements were brought together to identify a specific algorithm for attribution.

CHAIR MEHROTRA: Okay.

DR. RYAN: All right. So we had to make some assumptions. Not all the relevant elements were defined in each of the approaches that we reviewed, but for instance, if someone's using a claims-based approach for attribution, we presumed that that's retrospective as opposed to prospective attribution.

So this boils down to 163 separate approaches or models. Again, some language slippage here. I'll just talk about -- try to stick with the word model. And of these 70, 83 percent have been proposed, and 17 percent have been implemented in some fashion. So the vast majority of these models have used retrospective attribution, 89 percent, compared to 6 percent using prospective attribution. One of our readings from the Dartmouth team talked about some of the, I think, advantages of retrospective attribution that might be good to talk about as a group.

Attribution approaches tend to require

attribution to only one provider, so that was about 77 percent of approaches compared to those that required -- multiple providers could be attributed for a given patient.

So visits and spending were the two most common measures used to attribute patients to providers, so visits were somewhat more likely, 42 percent, and 31 percent of models used spending as a way -- as the kind of measure for attribution. And I think interestingly, and hopefully this is something we can discuss as a group, there's really quite a bit of variation with respect to the minimum criteria required for attribution. For instance, a plurality was required in -- that was most common in 30 percent of cases. Specific thresholds were used in about 30 percent of other cases. So I think deciding whether -- what's the minimum determination used for a match is really crucial.

And our team tried to say, okay, we see all these different elements together. Are there common groupings of elements that we can

see in the data? And we tried to do some kind of cluster analysis to identify these, but so far we really haven't coalesced on saying there's 5 approaches or 10. This is still preliminary. But to us the difficulty identifying kind of common clusters speaks to the high variability of the different elements that have been applied in the extant models.

So that's kind of a high-level perspective about what we did. And so I just want to kind of comment on what I see as some of the important issues moving forward. I think that it sounds like the discussion yesterday was great, and I really agree with a lot of the principles that were talked about or established yesterday.

I think one of the things that we found is that there are some common features of existing attribution approaches like the use of retrospective attribution, but many other features really vary considerably. And I think having the group discuss even just conceptually

about why -- when different attribution methods, for instance, thresholds for attribution, how they should be thought of and enforced under different circumstances I think will be really important.

To me the key issue is really about how attribution approaches affect reliability and validity of, I'll just say profiling at both the program and provider level. So I'd say at the program level -- when I say that, I mean just say ACO program or say the MIPS or some kind of PCMH program. It seems to me that we need, for instance, some minimum number of patients to be attributed to providers for the approach to have tractability. If we developed -- if there's an attribution algorithm in which only five percent of patients are being attributed, we just think this isn't good enough; this doesn't work for program purposes.

At the same time if only 20 percent of providers are being attributed under a given programmatic -- under attribution rules, it just

seems like the whole program itself is not going to be able to meet the goals of accountability. So I think reflecting on how attribution -- how the individual provider attribution rules kind of roll up at a program level and affect the ability to the program for the program to do -- achieve its purpose is something that's important.

And I think Ateev's paper that was circulated among the Committee really highlights some of this, that if you apply different thresholds, you can have vastly different numbers of patients and providers that end up being attributed. And this is really crucial.

I mean, one way to think about solving a problem like this, and I don't want to get too deep in the weeds here, is kind of extending the window over which attribution can occur, to extending a time frame, to saying instead of looking at say 12 months, we could look at a longer period. That's really what CMS has done with other performance measures whether readmission or mortality, to get to greater

signal. That's often what's done.

So at the provider level, I think there's the real -- where the rubber meets the road here has to do with sensitivity and specificity. So if attributions are too sensitive and not specific enough, I think validity could be undermined. So if an algorithm can assign a patient to a physician just based on a single visit, and it's very sensitive, all patients end up getting attributed, for instance, but you have some poor matches. Physicians that have very little in common with certain patients that are attributed to them. I think that's a problem.

At the same time, if a measure is too -- if an attribution model is too specific, we could have this -- and attribution is only made when -- to say all the care of a patient is provided by a certain provider and otherwise attribution wouldn't be made. Then we'll have too few attributed patients to too few providers and that will kind of undermine the attribution

at program level.

So I just really think that that's a central contrast that I see. A central issue is sensitivity and specificity of attribution and how it relates to reliability and validity.

I think something that I've also been reflecting on is the importance of these different attribution rules to -- and we'll talk about use cases later today, but I see that what makes sense for ACOs and what might make sense for PCMHs or even PCPs really might not make sense for specialists.

And so, if we just think about for instance the one patient/one provider rule, so the exclusivity of attribution, I think this can make sense in the context of trying to drive accountability in a system where it hasn't been there. So an ACO, a patient gets attributed to a single ACO and then is responsible for all that patient's care, I think that really does make sense. But that really to me doesn't make sense for lots of specialists. Specialists should

probably just not ever really be responsible for all a patient's care.

And so as a result, that one patient to one provider rule could really make sense in an outpatient, primary care setting. But for I think specialist-based attribution considering multiple providers being responsible for multiple patients, getting rid of that exclusivity I think is probably more practical.

So I think that's just more kind of an example, and a lot follows from that. So if it's exclusivity, one-to-one attribution, then that's typically what follows is that that provider is responsible for all the patient's care, whereas if a physician might not have exclusive attribution, but it might be multiple providers are responsible for different patients under different circumstances, that makes more sense for kind of episodic care. So an orthopedist might be responsible for cost and quality outcomes within some defined window of an index event. So again, I think those are issues that

really map onto some of the key policy and accountability programs that are underway.

So I think just to kind of summarize our literature scan, we really saw a large variation in the approaches that were being used, the models/approaches for attribution. We see these in both the proposed and the implemented models. I think there's a tension about sensitivity and specificity and the trade-offs there with attribution and how that effects reliability and validity. I agree with the Committee's call for flexibility, and I see a key dimension of this really being related to kind of specialty care versus kind of more population-based accountability.

And then finally, I think some issues that really deserve attention in thinking about recommendations or even principles have to do with the exclusive versus non-exclusive attribution and kind of the resulting responsibility for episode-based cost and quality versus kind of program year cost and quality.

So and then I think finally this isn't an issue that's really going to be solved, but how to say whether an attribution approach is good, what are the criteria to say this model is moving us to where we want to be better than this other model, I think remains critical and important to discuss, and I just look forward to further discussion about these issues with the group. So thank you.

CHAIR MEHROTRA: Thanks, Andy. This is great. I think just seeing these different models laid out in this format and so forth, I think this would be really helpful, is also helpful. Encourage you to publish these results in the peer-reviewed literature. That would be really helpful, because I think a lot of people are looking for these kind of different models also. So a lot of rich stuff here.

Let me open up to the Committee for discussion and input. And we had some comments about the principles. Maybe if I could -- I have that list here, I do promise, but maybe we could

just focus right now on Andy's comments. So if you -- so starting there?

(Laughter.)

CHAIR MEHROTRA: Okay. There you go. But I will get back to folks.

Jenny, you had some thoughts?

MEMBER BEAM: Yes. Thanks, Andy, for your summary. I guess one of the things that keeps coming back is in talking about attributing to a single provider versus multiple providers, and one of the things I think when looking at -- it goes back to the intent of why we're attributing. If you're attributing for the purpose of an incented program or some type of payment program, I guess from what I've heard, you don't want patients in multiple provider buckets because then therefore you are rewarding for the patient more than once. So that was the intent in trying to do a single provider attribution, whereas if you're doing a performance evaluation to attribute patients to multiple providers, then that becomes much more

relevant at that point.

I guess I was wondering from Andy -- I don't know if those type of things have been looked at as far as in the literature review to look at the purpose, the intent of each of the studies. Like what was their goal? Was it on payment or an incentive versus performance evaluation; kind of more of that profiling, and then what method did they use from there?

DR. RYAN: Well, we did some work to define this, particularly in the -- for the implemented programs how the attribution, how the elements of that attribution varied across implemented programs. Because some of the proposed approaches like what Ateev did in his paper, it was just stuff that researchers came up with. So there wasn't so deep in there. There's probably very little thinking at all.

CHAIR MEHROTRA: It was very random, so --

(Laughter.)

DR. RYAN: And so, I'd be happy to

think about -- we can certainly discuss kind of what the approaches have been for those extant programs that have kind of -- and then into some practice.

But your first point about the goals and beyond what we can try to presume is the goal from the nature of the accountability program, I think that's something that we have a hard time discerning in the kind of literature review, right? We don't see the -- and what we're pulling from the papers is not -- in general there's very little detail about the like genesis of the program and kind of the thought process through which accountability did occur.

I think these can be gleaned a little bit by just seeing what's happened in practice and reflecting on why. And I think that probably would be --

CHAIR MEHROTRA: That's a good point. Nate?

MEMBER SPELL: Just first a housekeeping thing. I'm having trouble hearing

with the construction noise, so just a reminder to everyone to either speak close to your microphone or in a loud voice so I can follow it better. Thanks.

CHAIR MEHROTRA: That's a good point.

MEMBER SPELL: To the exclusivity question, I think it gets to the confusion we had coming out of Group 1 yesterday, and Elizabeth brought it up earlier. I have a colleague who likes to refer to his ideal state as the joint and several liability plan for accountability, which is that in fact if we are -- in looking at the future state for some measures, if you really want to drive a change in how people work together and form teams, you might intentionally want to share accountability across providers. Now, you don't want to pay more than once, so I think the payment is different, but the accountability might be shared.

So the example is again that diabetic patient who goes to the orthopedic surgeon let's say with something that is -- the patient ends up

given a prescription for steroids, which of course could drive the diabetes out of control. Well, if there's some accountability shared for diabetic control, it might for instance incentivize the orthopedist to communicate with the endocrinologist or primary care doctor around the care of the glucose management while on steroids.

So that's just that sort of example where we ought to be thinking about the implications of one versus another. And I'm not sure how much we can say what the downstream impact will be. We can simply describe the relative merits of one versus another.

CHAIR MEHROTRA: That's a really good point. I think it also builds on the conversation yesterday about how sometimes attribution -- I think just it's sometimes aspirational. We also discussed the case of the hospital and the 30 days follow-up. I think that right now it may be thought to be that the hospital doesn't have much to do with what

happens 28 days afterwards, but we're hoping through attribution to drive them to be. And so that whole locus of control issue, it's not today, it's the future.

Let's see. Danielle?

MEMBER LLOYD: So I was starting to go along Jenny's line, and I guess the 138 proposed kind of scared me, because that's a lot --

DR. RYAN: It's 163.

(Laughter.)

MEMBER LLOYD: Well, proposed. Sixty-three is within use though, right? So it doesn't matter. So I think part of what I was also trying to think is could we take some of the in-use ones -- because they're in use I give them a little more credibility. Sorry, Ateev. And maybe I had actually gotten some private payers to in a blinded fashion give their current attribution models. And then we also -- I don't think I see in here the LAN paper, attribution paper. And maybe that's because it's not officially published yet. Is it officially

published?

But there was such a huge appendix, maybe I missed it. But I think maybe if we took that because it was a broad effort that's recent and we took some of the payers and you took the 28 or whatever in use, maybe we would find some more commonalities. Or maybe if you only took -- I think to what Jenny was saying, let's look at the ones that are specific to ACOs or let's look at the ones that are specific to episodic or something. That might help us make a little bit more sense of this, because I was having trouble.

And I'm glad you're confirming because I couldn't really find a pattern. So I'm glad you're sort of saying the same thing. But I think maybe we need to take a couple more passes to try to glean some more specifics out of this.

You'd specifically asked about --

CHAIR MEHROTRA: Danielle, just if I could clarify. So what I'm sensing from you is that what you're asking for is almost like some analyses for specific real world applications;

ACOs would be an example, PCMHs, and to see if you go down to that level there's more consistency about the rules that are currently in use.

MEMBER LLOYD: So I would even say how they have the percent table, do that for only the 28 implemented plus the ones that you didn't find in literature review because they weren't actually published, the ones that are actually in use, and rerun these numbers and see if you see something.

CHAIR MEHROTRA: So this is like table 3?

MEMBER LLOYD: But that's not the ones that aren't published, right?

CHAIR MEHROTRA: Oh, I see.

MEMBER LLOYD: So implemented, but the things that aren't published is the problem, right, because --

CHAIR MEHROTRA: So it's a combination of table 2 and table 3 that focus only on those --

MEMBER LLOYD: Everything seemed to be cited, so it didn't seem like the collected private payers or the LAN papers was in that. Or no? Everybody's flipping.

DR. RYAN: Well --

MEMBER LLOYD: We don't have to answer this right now. Just let's think about it. And then --

CHAIR MEHROTRA: Can I just -- on that point?

MEMBER LLOYD: Yes.

CHAIR MEHROTRA: So, Danielle, I will come right back to you. But do you -- Danielle is proposing the idea of going to certain private payers and specifically getting --

MEMBER LLOYD: No, I already did it.

CHAIR MEHROTRA: Oh, okay.

MEMBER LLOYD: I already did it and gave it to them.

CHAIR MEHROTRA: Oh, you already have those? Okay. You incorporated them?

MEMBER LLOYD: At least four of them. I didn't get Aetna because I think they weren't -- somebody was previously on the panel from there.

MEMBER KROPP: Yes, I used to work for them, but --

MEMBER LLOYD: So I assumed you'd get it, Bob.

(Laughter.)

MEMBER KROPP: I said used to.

MEMBER LLOYD: You've got some phone numbers.

MEMBER KROPP: I'd give it a shot.

MEMBER LLOYD: Yes.

MEMBER KROPP: They're pretty sensitive about --

DR. RYAN: Well, Danielle, I think that's a great idea. So apologies if we didn't integrate stuff that we could have or should have, but we can certainly do that on the next round. We didn't limit to published. We looked in the gray literature, too, so it didn't have to

be peer reviewed approaches.

MEMBER LLOYD: Yes.

DR. RYAN: But surely there are some that we left out and we would love to supplement with existing -- other programs that we didn't include there. So again, I apologize if --

MEMBER LLOYD: No, no apologies necessary. I think it's always good to start specifically with peer reviewed and stuff, but since we've kind of got 165 or whatever you're saying --

DR. RYAN: Yes, yes.

MEMBER LLOYD: -- and we don't have a lot of semblance of cohesion around certain things, it might be another option.

DR. RYAN: Yes.

MEMBER LLOYD: But you had specifically asked about retrospective and prospective, and I guess this is part of why I think we -- at least I've been leaning towards here's the specific things you need to think about and steps you need to take and the things

that you need to make transparent to us, but you don't necessarily have to do one model or another, and that you need to test multiple models is because -- for instance, our members have always been, at least for ACO purposes, supportive of retrospective because we knew from our claims analysis it was more accurate, but the problem is it is not as easily implementable by the provider.

And the other thing here is that some payers will only give you legal waivers and such if you know who the beneficiaries are in advance. So there are other policy considerations that are then tied to that attribution choice, but I wouldn't want us to say retrospective is more accurate and that's the way we're going, right?

DR. RYAN: Great. Great point.

CHAIR MEHROTRA: Mike?

MEMBER SAMUHEL: Yes, I had a reaction to Andy's point about sensitivity and specificity, and it got me thinking, because my background is a statistician. And I think we

need to remember that attribution -- what we're talking about are estimates. We're not talking about exact engineered numbers. And so, since we have estimates, estimates have errors. And I think we need to recognize that fact. And it is possible to measure error in probably most of the underlying statistical methods that are at play in these models or algorithms. And I think it would be important to do so, and maybe even a principle here. And it might avoid some controversy down the road as we try to give some guidelines about -- especially when we try to attribute cost and quality to individuals or enterprises, or whatever.

DR. RYAN: I really like that point, and that gets me thinking that applying different models would change the individual providers estimates of kind of their cost and quality. And the different models would then -- there would be some variation derived from the application of different models and that could perhaps provide some balance or some notion of the error or

variation in different approaches.

I mean, imagine if we had like 10 ways of 10 models and that they varied with respect to sensitivity and specificity, but they all would generate estimates for the same provider. But then there would also -- there might be a one-point estimate or some way to combine those, but then there could be bounds around that and that could perhaps be information that's part of the profile and part of the description of performance. So anyway, I think I find that intriguing.

CHAIR MEHROTRA: Just one quick point, which I think it's an interesting idea, which is here's the truth who's responsible and here's a measure method to try to find that responsible provider.

But I think I forwarded you that paper that was done by some folks at Mass General where they tried to use an algorithm to try to figure out who was in a physician's panel and then they went to the physicians and said Sally Jones, in

your panel or not in your panel? And one of the things I came away with was like, oh, the truth is kind of fuzzy, right? Because you would go to the doc and you'd say is he or she in your panel? Some two years ago, I don't know, sort of. I think she's sort of still coming to me.

I mean, there were some that were very clear-cut, but there was a huge amount of gray area also in who is your patient, because they just haven't been seen. So I just want to reflect that the truth isn't so clear-cut either if you actually go to the providers themselves.

DR. RYAN: Can I ask you --

(Simultaneous speaking.)

MEMBER PERLOFF: This is Jen on the phone. Can I jump in on that point?

CHAIR MEHROTRA: Yes, of course.

MEMBER PERLOFF: I think I picked up on the sensitivity and specificity part as well being more methodological, but you could think about attribution as a negotiated relationship to some extent. So you might when you're setting up

a model -- we negotiate the bundle that providers are going to go at risk for. We might also negotiate the attribution methodology that someone's willing to enter into. So in that way you define the T, the truth against which you estimate the error, but it's just one dimension to the conversation.

I just wanted to throw in this idea that it is a design dimension that you could negotiate and have. There are different truths at play and different interpretations. So the MGH example is excellent. That's all.

CHAIR MEHROTRA: Yes. No, that's great. Truthiness, right?

(Laughter.)

CHAIR MEHROTRA: Bharat, you had a comment?

MEMBER SUTARIYA: So I think my comments are two comments, one related to the just conversation going on right now, which is it's one thing to find commonality or prevalence of types of models being used right now, but I

would think that since this experimentation or shift has been going on for now three to five years, there would be expectation that if we were to come up with a new model, it should be based on what do we know scientifically on whether things worked or not, not just here's what's in place, but did it produce intended results or not?

And in that regard I wonder if the author of this paper found any event -- just a high-level conclusion on what methods worked in producing the intended result, which is kind of what we're talking about, the sensitivity, specificity, not just theoretically but did it actually produce, which is a hard question. So one related to that.

Second, there's a second obligation I think we have as a committee, which is whatever we produce has to be implementable. That means the data to drive the logic has to be at least readily available in some form or fashion because each one of us are smart enough to probably

design a perfect algorithm, then to just go into the real world and not being implementable.

For example, right now; I'll share my own experience, across 50-plus clients that we're trying to implement attribution algorithm today for various different ACO efforts and private payer efforts, my team now has reached up to nine layers of logic. We're inching toward artificial intelligence, honestly, in trying to get the algorithms implementable for all scenarios for which the client is taking risk on today because the doctors don't want to be told on here's for your MSSP, here's for your bundle. They just want to know who is my panel and how does it work?

So sum it all up to a simple question out of that, one, any conclusion on what do you think actually worked in producing the result; and two, any challenges you saw in the literature or in anecdotal discussion about what is implementable and not implementable.

DR. RYAN: Well, if we say what has

worked from the perspective of improving system-based accountability -- so I'd be open to other people's interpretation of the evidence, but there's two papers that say that the Pioneer ACO program resulted in reductions in cost growth. And I actually don't recall the quality results, but I think improvements in quality as well. And there's also positive evidence of the alternative quality contract ACO model that Blue Cross Blue Shield implemented with respect to both cost growth and quality. So those are --

CHAIR MEHROTRA: But, Andy, is that worked for the program or worked for the attribution rule, or model? Because I feel like those are different.

DR. RYAN: Well, I think that the question was -- wasn't the question about when has this been applied, and then there's been a good system outcome?

MEMBER SUTARIYA: Yes, I'm not so much on the result generated from a cost savings. I think the charge really is did we attribute the

right patient to the right doctor?

DR. RYAN: Oh, okay.

MEMBER SUTARIYA: Or right team, right, because that's the first step. And then there's a complex mix of how do you measure quality and how do you attribute quality and how do you weight quality and so on to change behavior, right?

DR. RYAN: Yes.

MEMBER SUTARIYA: So I'm more interested in the first part, probably.

DR. RYAN: Okay. Well, then I think probably the evidence there is, to the extent that we have any, would come from attribution rules that are established and then patient and physician reports of how consistent those are.

I mean, as Ateev mentioned, there's I think potential sources of error on kind of what both -- there's really no gold standard there. And so, I mean, my read of the evidence is that we don't have a whole lot to tell us what's really -- what has worked, when has attribution

given the right patient to the right provider? And I think some of the discussions we've talked about it depends on a lot of other contextual factors, too. So that sounds like a total dodge, but I don't see existing evidence saying too much when as this model resulted in the kind of correct or best attribution.

CHAIR MEHROTRA: So, Andy, I think I'm with you just to be in -- when we were writing this paper, we had this sea of metrics and we were like which one's the best? And there was no single metric by which we could judge that. And it's very difficult.

And so, but I do think you made a point earlier in your presentation and, Bharat, your comment really emphasized for me, is that we have a -- currently; and we could discuss whether we want to include this principle, a principle that you got to test a couple. And as I think about that a little bit, that's a little bit -- we -- it's a bit bogus what we're saying, right, because then, okay, I tested two or three or

four, but how do I know which one seems to be better?

And so, we might think about I think for August meeting, at least from my sense, would be to think about what are the criteria by which you might judge that? So you've made one, which I thought was well-said, which was how much of the care/money/patients were attributed to any provider? And a program that only attributes only five percent probably isn't sufficient. We probably don't want 100 percent because that has some issues. But somewhere in the middle. That's one metric.

But what are the other metrics by which you judge how well an attribution rule is working? And we can probably at least start to get there, at least put something in the report about what those criteria might be. I don't know if we're going to get an exact answer because the gold standard, who is responsible? We often don't know the answer, so we're using proxies or other metrics to look at that.

DR. RYAN: Just the one thing I would add to that is that different -- say we're using a spending metric and all Medicare spending is our measure that we're trying to profile and different ways of attributing patients to providers could result in different reliability and validity of a metric. So in theory you could test the reliability and validity of the same performance measure that uses different attribution approaches. And that might be one way then to back out what it means how good the difference attribution --

(Simultaneous speaking.)

CHAIR MEHROTRA: That's a fair point. Yes, you could test at least some of those metrics. That's a good point. I'm talking too much.

Ira?

MEMBER MOSCOVICE: I had one comment, but you just convinced me that this testing thing raises the amount of work to do testing to an incredible level. And we really need -- it's not

going to be easy unless we make simple rules that really don't apply. If we're really going to test, we'll see what principles or criteria we come up with, but it's -- that raises the scope of what testing in my mind really means.

But the question -- comment I had was I'm not sure what the scope of Andy's work is with NQF, but given Danielle's and everybody else's comments there's not doubt to me that a real contribution would be to come up with a taxonomy for attribution systems. And it may well be that of your 168, well, only 100 fit into -- and you still have 68 sort of wild cowboys out there --

(Laughter.)

MEMBER MOSCOVICE: -- but it still seems to be -- I mean, a real value would be to say, at least for the guts of the ones we have, here are the five or six or seven that seem to be used a lot. And then we get at Bharat's comments and other comments in terms of, well, okay, what's the impact of those systems? Is it really

working? And so, it's sort of like what Shortell did with the ACO and Elliott Fisher. That would be a tremendous contribution, rather than saying here's all the different attributes. And I don't know if it's within the scope of what you have.

CHAIR MEHROTRA: Is this -- Ira, if I could push, I had thought that this table or the table before was that taxonomy that you were looking for. So if you could make the distinction between the two, like what beyond these elements, which all these rule are classified, what other elements would you put --

(Simultaneous speaking.)

MEMBER MOSCOVICE: Well, he said they did some cluster -- I mean, I want to take these elements -- let's assume these are the right elements. I want to take the ones that seem to be used a lot and then say how frequently are they being -- what are the five -- the combinations of these elements and really come up with a taxonomy saying here's the prevalent sets of these elements that are out there.

CHAIR MEHROTRA: So if I could frame that just slightly differently just to make sure I understood, which was here are the different elements, but what you're looking for is at the end put them all together and give me the most common models which are a combination of these elements.

MEMBER MOSCOVICE: And that's --

CHAIR MEHROTRA: Is that kind of --

MEMBER MOSCOVICE: That's in essence what cluster analysis tries to do. If it comes out by the way you can't do it, that's an important piece of information that says the report will even be more important if it can provide us to lead towards that in terms of the work we're doing. Because if there really is 168 different systems, so be it, but let's know that, because we need to put some structure around this I think if it's going to be meaningful.

CHAIR MEHROTRA: But I would make one point that -- and I think Bharat said this also, which is that I want to be careful. Let's say --

I don't remember what it was, let's say ACOs, and 86 percent of them use this model. The implication could be, well, that's a good model because 86 percent of them are using it. And do I want to question that assumption, because that might be just because they all kind of copied each other. But it was a bad model to start with.

So I think we should -- I agree with your point that it's useful to make that point if there are some clusters. I also just do want to question the assumption that that's a good model because it's used frequently.

MEMBER MOSCOVICE: Yes. No, I'm not saying it's -- we can test whether it's a good model if you have this taxonomy. Without the taxonomy we're working on individual cases one by one by one. It may well be that a very prevalent model might well work and accomplish the things that Bharat was talking about half the time and half the time it doesn't. And that's important also to understand as Danielle is saying in what

environments is it working and what it isn't. But without the taxonomy we're looking at individual cases, and that's not -- I don't know what to do with that if I'm a person out there trying to say how do I do this?

CHAIR MEHROTRA: So, Srinivas?

MEMBER SRIDHARA: So one, I would support that completely and then sort of dovetail back to sort of a conversation we started with the principles and the table or whatever and sort of align this with sort of use case scenarios. I mean, you brought up the primary care versus specialty care, but I really think that we need some way to assess that in certain types of use cases that certain models are prevalent and are they effective? I think that's the part two that I think you were asking is, well, is this a good way to do it? And I think we need to be able to answer that.

And so, if we are indeed then -- if I were to envision how that would lay out is we would say here are the common models as they

align to common use cases and our commentary on were these effective or not. And then the end result from all of this are our considerations in how to build an appropriate model. Some may be the individual factors that were listed at the end of this sheet that we talked about today, and with maybe some more, or maybe combinations that work and we can say these sets are the things you should consider as they align to certain use cases. So that to me seems like a logical flow of what your presentation might be, and our recommendations would then make sense as to why we landed on certain considerations or combinations of them aligned to use cases.

CHAIR MEHROTRA: I'm just going to keep on going. Jen, you had a comment, but then you jumped in earlier. Was that the point you wanted to make or was there something else? We're happy to have anything else.

MEMBER PERLOFF: Sure. The one other thing I wanted to mention, in our work we're looking a lot at MACRA and MIPS and beginning to

think about role-based attributions. So when you do a lot of the single, multiple attribution techniques that we're talking about, you focus on specific kinds of services that providers bill for. So evaluation and management services. But we're beginning to think more about patient relationships such as ancillary services, supporting services, surgical services.

And so, I just wanted to mention that because it's a kind of emerging aspect of attribution that probably isn't in the literature yet, but really important as we look at the future policy environmental and horizon. So that was the thing I wanted to throw into the mix.

CHAIR MEHROTRA: It's a good point, especially with MIPS coming on board and different providers.

MEMBER PERLOFF: Yes. And the MACRA five patient relationship categories, the supporting, ancillary, episodic, primary and principal.

CHAIR MEHROTRA: So I have a number of

folks on the list here, but I also wanted to do a quick time check because we can go on for a long time and I don't -- do we have public comment or something coming up?

DR. AMIN: So we're breaking at 11:00.

CHAIR MEHROTRA: 10:30 or 11:00?

MS.WILBON: I have 10:30 on my schedule.

CHAIR MEHROTRA: All right. So I think what I would say as we now move forward, let's continue this conversation. We have about 35 minutes and then we'll have a break at 11:00. Does that work for folks? Okay. So let's keep on going. This is great.

Brandon, you were next on the list.

MEMBER POPE: Yes, some unpublished data from the trenches, if you will, to the concern about attributing all the patients or attributing patients on the basis of one single visit.

So we recently sort of completed our complaint process where we told the providers

their performance, how it impacted their pay, complaints about patients you feel shouldn't have been attributed to you, etcetera. Probably 90 percent of those patients were providers complained. This was where the attribution was on the basis of something reported to us by the payer where it was either an HMO where the patient had to select a payer or it was essentially the patient and payer went off and figured out who the provider was, right? And it wasn't based on claims or the EMR or anything like that.

So just some sort of anecdotal evidence. That may just be one data point.

CHAIR MEHROTRA: So your point really kind of emphasizes the caveats we were making yesterday about the self-selection bias, because to the degree that those were the patients choosing their provider it sounds like 90 percent of the -- well, at least 90 percent of your complaints were providers going that was wrong.

MEMBER POPE: Yes, especially when you

say who's your PCP? Well, I don't have one. Well, choose one anyways, right? I mean, some of the -- literally work off that --

DR. BURSTIN: And some plans assign principles.

MEMBER POPE: Yes, absolutely.

DR. BURSTIN: That's actually a big issue here. I think a lot of those complaints are probably plan assignation --

(Simultaneous speaking.)

MEMBER POPE: Absolutely. Plan assignment. And when you ask the plan can you tell us specifically how that came to be, even if it was randomly -- and literally you cannot get an answer.

Anyways, another observation about sample size there was a comment, well, if you don't have enough sample size, you can look farther back. An alternative to that that we've taken is to say, well, if you don't have a sufficient number of patients, what we'll do is we'll give you a community-based performance,

right? We won't give you your 8 out of 10 because we don't think 10 patients is enough. Instead we'll give you 850 out of 1,000, which is the sort of ACO performance or something like that. So just a different approach dealing with sample size.

But I did want to comment on this idea that, well, we should judge them versus the gold standard or what's the right attribution, and wanted to make sure we're clear that that's really only an interesting thing to do when you consider the temporal nature of attribution, right? Because, yes, at any one point in time, sure, we can go figure out, okay, this was good versus that, but it's really that when healthcare is delivered over the course of a year, then -- and things happen where I change doctor, I change insurance plan. Different things happen where it's the temporal nature of it that really makes it more challenging than just if we could pause time and figure it all out and then we've got it right. So just to comment on when we test

things, you have to test them is sort of a temporal aspect, not just at a point in time.

CHAIR MEHROTRA: It's an important point.

Ari?

MEMBER HOUSER: So I wanted to respond to a couple of things recently, the idea of the measuring error and of developing a taxonomy. And I think both of those are great ideas.

I think the error is probably not quite as easy to measure as you think because why does the sensitivity of attribution matter? It matters because people are worried about being assigned somebody who has a bad outcome who perhaps shouldn't be assigned to them.

Alternately, from a system perspective we could also -- we don't want to assign people who have good outcomes to people who didn't have responsibility for those good outcomes, but no provider is going to complain about that going the other way.

But so, the uncertainty in attribution

is really an issue based on the uncertainty of the measure itself. If you have a highly variable measure, a little bit of sensitivity in the attribution could lead to very big differences in -- or a lot of uncertainty in the provider level score, whereas if the measure's -- there's not a lot of uncertainty in the measure, then you can tolerate quite a bit of uncertainty in the attribution because the scores are all going to be about the same. So it's really the -- the uncertainty that matters is not just the uncertainty in attribution. It's the whole uncertainty of measurement.

And then for taxonomy I think if you're not making any headway with a cluster analysis, which is really a data-driven approach to figuring out what the patterns are, is inject some theory and say let's create a hierarchy of characteristics. And it seems to me perhaps the top level could be the type of provider, like a model that attributes to an individual physician is a different type of model than one that would

attribute to an ACO. And so, you can create that -- maybe that's the first step in the hierarchy. You pick a second, pick a third and then see what your buckets look like after that.

So instead of making the data do the work, develop empirically or -- not empirically, conceptually that hierarchy. And then you'll probably have to do it a couple different ways, but see what makes the most sense.

DR. AMIN: I totally agree with your point about the interaction between measure uncertainty and attribution uncertainty, and the attribution uncertainty could just magnify inherent uncertainty in spending or other measures we look at.

I also think you're right about thinking about classification approaches conceptually to try to not just do the data work, but actually think a little bit, too, is probably a good idea. So thanks.

CHAIR MEHROTRA: Jenny?

MEMBER BEAM: Yes. No, I just want to

-- and again, I kind of expand on Brandon as far as what he was saying as far as the look-back period. And when we increase the length of time for that, that can also increase the error. Because again, if somebody had a bad year in the prior year and they saw certain physicians a lot and then maybe they were relatively healthy in the most recent year -- so again, if you expand that period to -- if claims are available or whatever method to look at the most recent year first. And then if nothing is available, then to go back another year to make sure we don't increase our margin for error there.

And also, in listening -- I mean, and I know we have to look at what's available to us, which is published, but we know a lot of work has been done that is not published. And so, I guess -- and in looking at places I've worked before, probably team members 5 to 10 people working on this year 'round for over 5 years.

So is there any thought to this Committee to reach out to them to have some

conversations about what they're findings have been? Because they're not published, but yet again thinking you have teams of people that have been doing this and working on reliability and validity and they know all of these pitfalls, maybe things that we haven't even thought of yet. Is there any thought to reaching out to having a meeting with them? And I could help facilitate one.

CHAIR MEHROTRA: So that's an interesting point because I do -- I'm getting the -- I think reasonable is that Andy and his team were limited by you've got to find some gray literature, published peer reviewed literature. You can only get so much. And I see the appeal of talking to other folks who have done this, both in describing their rule as well as what they've learned. I'm also trying to be protective of Andy and his team and scope creep. And so, I'm a little bit -- I think it's important.

DR. RYAN: Well, one thing I'll say is

part of what is part of -- is part of our scope of work is to do some key informant interviews. And so, it sounds like I should talk to you.

(Laughter.)

DR. RYAN: Because that was part of what helped when we've done this work in the past is that can provide a deeper perspective that doesn't just kind of come out with what's out there in the world. So what we have done in the past is this -- the kind of -- the group meeting can provide some kind of leads as to who can -- where that good information could come from.

CHAIR MEHROTRA: So could I -- would this be fair to -- for -- I mean, it was a very impressive amount of work that all of you have done regarding attribution in the roles that you all played. Would it be fair just to have -- if you have an idea on a lead, potentially send it to Kim and then Kim can kind of collect all those and send them off to Andy? And then you can choose -- I know with the resources that you have which informants, key informants that you might

speak with? Would that sound reasonable?

PARTICIPANT: That sounds good.

CHAIR MEHROTRA: Okay. That is a great idea. That's a good point, because there is a lot of knowledge out there. It's just how do you get to that knowledge in a quick way?

Elizabeth, I think you're next. Did you want -- your card was down and then up.

MEMBER DRYE: Yes, I was trying to look something up before I put my card up. So I did want to say something.

CHAIR MEHROTRA: Your mic. Hit it.

MEMBER DRYE: Actually I just wanted to go back to a comment you made awhile ago about potentially having not just principles, but criteria is the word that you used. And I don't think that's super defined, but I agree with that direction, because I think if we got to the point where we could list somewhat evaluative criteria that were still pretty high level, that would allow people to think through, well, does my attribution approach meet these criteria?

And I was just pulling a precedent which I'll just send around. In the early stages of using outcomes to profile quality the American Hospital Association and American College of Cardiology put together a consensus paper on the preferred attributes of models essentially for -- basically models used for publically reported outcomes. And to this day we use this paper. This is from 2006, and it's incorporated into the NQF -- the principles stayed -- run true to the NQF guidance and CMS' Blueprint and other documents.

And they're very simple. Things like clear and explicit definition of the appropriate patient sample. There's only seven. Use of an appropriate outcome in a standardized period of assessment, application of an analytic approach that it takes into the count the data structure. I mean, they're short, and then expanded on in the paper.

But so, I think there is a kind of middle ground that we could shoot for between

just principles to get a little bit more towards criteria that people could run their approach through.

CHAIR MEHROTRA: Right, and it's actually a good point. So first, if you could share that, because I do find that -- at least my own experience is that if you have an example of something that has had traction and success before and has actually been used by many people in the future, that's at least what I want here, because we want to have something that's as useful to anyone who's in this space moving forward here. So a concrete example in another space would be very useful.

And then I also think it's -- I'm not sure exactly what you're saying, bit at least one thing I took away is that when I had mentioned the word "criteria," I said that you have two different rules. And now we've got the two different rules and you run them. How do you know the criteria by which you compare?

But I think what you're making -- at

least what I'm taking away from one of your points is that you can also have criteria that go beyond just comparing the empirics about it, but more of a series of questions you need to ask yourself as you compare these two different rules. And they may be not a number answer, but more just a process by which you're going through to make sure that you're choosing the right rule.

MEMBER DRYE: Right, and the setting for this was people didn't think it was fair to evaluate quality using outcomes. And so, this was about how could you make sure the -- this isn't that long ago, right, but how can you make sure that the approach is fair? And I think underlying this attribution discussion is this notion that we're trying to set up a system that's fair and is driving towards things we agree on. So anyway, I can just send it around as a model.

CHAIR MEHROTRA: So I'm getting a sense; maybe it's just me, but the energy -- like we've been here for awhile here, so why don't, if

I do this, take two more -- one more comment and then take a break, refresh, and then maybe we can then decide how we want to take the rest of the time that we have together today in terms of energy.

So, Troy?

MEMBER FIESINGER: Elizabeth, actually you gave me great setup. In September after I have to get up in front of about 300 family docs two different times and talk about attribution as part of a Medicare education project. So there's the disclosure. And trying to decide what do I say, as I'm thinking one would approach would be, well, here are the rules, deal with it. You can imagine how that will go over.

(Laughter.)

MEMBER FIESINGER: But the question; this is more to Andy, is have we already or can we within your scope, within your time and funding look at end user impact? And I'm thinking on multiple levels as I try to get at the unintended consequences issue. Do we know

enough about any of these, I'll call them models to know how they're impacting clinician behavior, organization behavior, patient behavior? Because I'm thinking we're all in the middle of this grand decade-long experiment and none of us have any idea how it's going to come out. But in 20 years what am I going to wish I'd said differently today? And I don't know.

And that's a big level question, but is there any way to tease out even just one quality measure, walk it all the way through and compare three or four models was there any difference? And I'm thinking of some of the P4P studies where they said, okay, we'll apply it in a 30 rule. Here's how things change or here's how it's going to performance change. But can we do a step further? Did behavior change? Because ultimately what I want to do in an ACO in a clinic is guide team behavior to improve patient health.

DR. RYAN: Well, my own comment on that is as has been coming up with these

programs, we say, okay, did an ACO program -- like did it work? And there's how many different factors go into it working? All kinds of things, right? And one of them is the attribution. The other thing is the measures. The other thing is the incentives. The other thing is the existing structure before they even start it.

And so, I think we could say something about the application of different attribution models to successful enterprises, but of course you know the caveat always needs to be there that, who knows, at least that attribution approach didn't make everything go wrong. Maybe that's the best that could be said for it.

But on your other point, I think the end user impact could be a good -- that could really be a good thing to go after in the key informant interviews and to try to understand how to approach just, I'll say qualitatively how different approaches have been used and what was the response from physicians or patients there, or whoever. I think that might be a good way to

pursue that question to at least get some suggestive evidence that we can draw on from the expertise here.

MEMBER FIESINGER: And I think clearly that would answer my question is when I think of this potential audience, what are they going to think and feel? And if your conclusion on the first issue is that attribution doesn't really affect the measures, I'm okay with that. Then I know I don't sweat that as much. Let's worry about other stuff.

CHAIR MEHROTRA: And so, I mean, one of the things I took away from the HealthPartners paper or report that we looked at was that was one of the conclusions for that at least specific application, which was it didn't seem to make that much of a difference, the different attribution rules. So that might be a key point.

Another thing I might wonder as we think about -- so we've got challenges, principles and recommendations. And one of the recommendations that at least is coming to my

mind is that for some certain really key programs and/or situations where attribution is really thorny that there is a -- to make a call for if there is this idea that it's all about the responsible provider, that there could be research studies that would evaluate -- and maybe this has been done; I don't think it has been done, where they actually go and talk to the providers and the patients and say, okay, here's what the algorithm says is who your -- Troy's of doc. What do you think? Or who is your doc and say how often it's Troy and they match up. And that kind of work would -- at least for certain key programs, has some -- try to capture that gold standard and that potential bias there.

I recognize it's not perfect and I understand why, but as we think about that it does appear to me that kind of research is really critical. That's at least my thought. Do others like that recommendation or not?

MEMBER LLOYD: I actually thought that Atrius and some other folks who'd done a joint

workgroup in Massachusetts to try to get some commonalities across their attribution methods did a study like that, and I'm emailing people as we're talking- trying to get copies

CHAIR MEHROTRA: But, it's a good point.

I apologize for interrupting you. It's a good point that I did see. What they did is they took some of the commercial ACO algorithms and actually looked at to see whether, if I remember right -- and then they went back. And my memory is that they went into their health system records and their EHRs and said, hey, Ms. Jones was assigned to Troy based on the algorithm. Let's look at what we have, which is a little bit richer data, and does that make sense? And so, that's one of evaluating.

The other one would be to go to the doc itself or the patient itself, because the one other person going -- if I could speak for Carol, the patient's voice was not included in that. But that kind of work. I'm sorry for cutting you

off, Danielle.

Others like that idea? Bad idea? Good -- oh, Helen?

DR. BURSTIN: I think it's an intriguing idea. I think it all depends on how you define "research." We don't really have a -- prospective research is not something we could do here, however, one of the advantages of doing this work in the context at NQF is we do have 435 members of NQF representing every single stripe of what we're talking about the healthcare system, and we might have capacity to go to them and at least do something qualitative to build on this to bring to the process.

CHAIR MEHROTRA: Right, and I wasn't implying that NQF should do that work, but maybe a general statement that this literature, the knowledge base is relatively weak and therefore in general this kind of work needs to be done to better understand --

DR. BURSTIN: Yes, I agree.

CHAIR MEHROTRA: -- whether these

algorithms or models are working to capture what this underlying truth or truthiness is.

(Laughter.)

MEMBER RADWIN: Actually, I just wanted to note that some really good recommendations came out before the break, and I made a list of them because I think they're worth pursuing and documenting. And we really want to develop a glossary or taxonomy that there are criteria, as Elizabeth mentioned, for inclusion of models like what criteria do we choose on? And you can use both of those above to cluster models that are out there and analyze each cluster for strengths, weaknesses, opportunities and threats and then think about aspirational models like MIPS and MACRA, what effect they'll have on the models that are described. And I think that kind of organizational framework could be really useful moving forward, and all those ideas came out this morning.

CHAIR MEHROTRA: Great. Thank you for that summary. That's really helpful. I

appreciate that.

All right. So let me propose a break. Why don't we come back just after -- make it easier, 11:00. Would that be okay?

PARTICIPANT: Yes.

CHAIR MEHROTRA: All right. We'll see you back then.

(Whereupon, the above-entitled matter went off the record at 10:47 a.m. and resumed at 11:05 a.m.)

MS. WILBON: So we're going to go ahead and get started, and I think I'll go ahead and just give the group an overview of what we talked about.

CHAIR MEHROTRA: So we just what -- so we have till 2:30, so three-and-a-half hours, going non-stop, no breaks, no lunch. I'm just joking.

The thought is to for the next 45 minutes, an hour just try to think. We had talked a lot about this table has become, you know, legendary now, so we're going to talk a

little bit about the table and the idea of how does this work in terms of trying to take our principles, our recommendations, these criteria, a lot of different ideas and try to make it a little bit more concrete because we do want something that's helpful to the larger audience.

So we'll go over that, respond, react to that.

Then what I'd like to do, then we'll have lunch, and then after that our next step is to really go over the principles, go back to where we were before, and to try to hammer those out and to semi-finalize or finalize them to the point where we'd put them out for public comment and getting people's reaction. And then we'll wrap up from there.

That's at least the current plan, subject to change as we get your input from the end reaction Does that sound reasonable? Thoughts, concerns?

Shaking of heads or at least no negative.

So let's get started. What do you think, Kim, should I keep on talking?

MS. IBARRA: Well, yes, keep talking. We're trying to project the table for everyone but we're having some difficulties.

CHAIR MEHROTRA: Yes, so why don't we do that. That sounds like a great idea. So we have some comments that were left over regarding the principles, so let's at least start that conversation now while we deal with the sort of technical issues.

So this is a little hard, so I know I'm going to like pick on people like Srinivas right now, who might have had a comment for two hours. What were you thinking about two hours ago, Srinivas? Do you remember? Or I can skip around a little, too.

MEMBER SRIDHARA: Well, yeah, I mean I think, I thought the summary was great, sort of paring down the longer list and subsetting them.

I think, you know, one of the comments that was really related to these considerations

and -- sorry, I'm trying to pull up my earlier list -- but there might be some other considerations that we should think about. For example, one that's missing here was our question about unitive analysis of, you know, single provider versus organizations of ACOs or otherwise. That wasn't in this list of considerations. I think that's something we should probably --

CHAIR MEHROTRA: And that probably would go under -- I don't know if this is a good principle, because it doesn't sound very principally, but challenging some of the ideas of like always attribute to one provider. Maybe it also could be right there a challenge to assign to more than one.

MEMBER SRIDHARA: Yeah, yeah. No, so I don't think it's necessarily a principle. It was sort of a list that followed that said considerations --

CHAIR MEHROTRA: No, but I appreciate you bringing that back up. Yes.

MEMBER SRIDHARA: You know, so I think that was one that I thought should be added here.

And then in terms of principles, otherwise I actually thought this was a pretty good list. I mean I think we've talked about some of the other comments that we've had today about sort of, you know, how we frame our testing or, you know, the appropriateness for a use case. I think those you can roll into some of these others.

So I don't think I have any other principle comments for now. But probably as we dive in deeper on the considerations and how to tune them to use cases though.

CHAIR MEHROTRA: All right. I know this is a little awkward but let's stop the conversation now and let's go to the table which has emerged on our screens here.

Do we have that hand mike?

MEMBER LLOYD: Okay, the infamous table. The only problem is I can't move it on the screen. So will you guys move it down a

tiny, tiny bit? You're missing a row. No, no, other way. I want to see the top.

There we go. You were missing a row.

Okay, so as we discussed yesterday, this is by no means a baked product. This was as we were talking to try to classify or narrow down some of the discussions we were having. Not to say that if somebody -- you know, that this is a must. Right? Not that if you want to do ACO attribution you must use these criteria, this was if you're doing -- if you're doing attribution, what are some of the things you need to think through and you need to be transparent about, per our conversations yesterday.

So we started over here with a lot of these you can see, because it was off the top of our heads, right. A lot of these were things that were in the paper we discussed this morning. It's not perfectly one for one. But these are sort of the steps, we think.

And then up on the top we've got four different use cases just as examples, okay. Straw

man. So the idea was to make them somewhat different from each other to also highlight that you might make a different choice, depending what the use case is. Right? Because we stumbled a couple times yesterday saying, well yeah, that's true, but only in this case. Or that's true in these two out of four cases, or whatever.

So the first one is more primary care oriented. The second one is more specialty oriented. The third one is more about the quality improvement aspects, not necessarily tied to a payment program. But maybe it could be some sort of value-based payment, but basically not an alternative payment model.

And then the last one is institutional because, as we discussed there also, you know, if it's something like a hospital readmissions measure it's a little bit easy -- easier, right? Either they were at that hospital or they weren't. You're not trying to split it up or weight things or anything like that, right?

So there's a case study line here that

gives an example within.

CHAIR MEHROTRA: Danielle, this is a very minor point, but what's ACO Track 2?

MEMBER LLOYD: So that's what I'm getting to. So this box right here -- so the case study line is different scenarios that could fall under any of those categories: the primary, specialty, et cetera.

So primary care, a lot of the attributions, whether it's a primary care medical home, an accountable care organization, or even maybe just a primary care group, it could be similar. The issue though is that the attribution places an emphasis on primary care.

So the example here is an ACO Track 2. The reason it got so specific on Track 2 is because that's one of the risk-bearing tracks. Really the only reason. And it has -- we actually probably should have put Track 3 now that I think about it. Right, that -- because I should have picked it to put to show prospective alignment here. No, but the point is to show

differences, right?

So the only reason Track 2 is there is because you'll see in one of the later columns it's risk bearing. Okay? So think ACO.

The example for joint replacement -- I mean for specialty was joint replacement. The example for quality improvement was an endocrinologist and profiling, right? An endocrinologist profiling. And then institutional was skilled nursing facility readmission.

Now, there was some thought that it would be great if you could pick one measure and so you could see the differences with one measure across all of these. But to be honest, we ran out of time. So this is what you're going to get. Okay?

So if we -- if we just, for instance, picked complications and showed you how complication attribution would differ under each of these models, that would be great. We just didn't have time to do that.

So one of the first steps is what's the pool that you have established, like who's eligible for attribution. Who is it that is within the pool. You may or may not have inclusions and exclusions for a beneficiary population. It just depends. Not required.

So when you guys were talking about -- when Elizabeth was presenting on the smoking measures, it had to be within a certain county, so there was a geographic limitation. Right? So the inclusion is only for the county, and it's only Medicare beneficiaries.

But there are some cases where there could be exclusions. So if you're under the specialty column and you're looking at joint replacement, you may have inclusions for joint replacement bundle that's Medicare only, but you might have exclusions to say we don't want to deal with fractures in that population, so we're going to take them out and we're not going to attribute for those patients. Right?

So I'm not going to go through the

whole table. But you can see sort of examples of we're just trying to show that you might make a different decision in one of these boxes or another based on the model. Okay?

So a couple -- let me give just a couple other examples. So the accountable unit, we talked about that a lot yesterday. So if you're looking at an accountable care organization the idea might be that you're doing the measurement and the attribution across all of the TINs. So it's a collective tax I.D. number, so it's collectively at the model level, the whole ACO that you're doing this attribution, right? You're not splitting them and doing a spending target for one, and a spending target for one, and a spending target for one, you're doing it as an ACO, right? At that level.

But when you get quality improvement, this is where we might do the over-tagging, right? Where you can have multiple different positions who are tagged with attribution. You have to make a choice depending on where you are.

When you get to the institutional level for that one it's pretty easy because you're either you were at the SNF or you weren't. Right.

Okay. Let me give you one more example and then we'll stop and see if this is making any sense to anybody. And if not, we'll go back and try it with complications only.

We put a line in for stakes because a lot of people wanted to know, that's why we put Track 2, that it's a risk model. So if it's a risk model you might want some -- I'm looking over there because I'm struggling with I'm not going to use the right scientific term -- precision accuracy, validity, stability, I don't know. All of the above. You might want all of the above if it's a risk model instead of just the quality. Like that's where some of that -- the scientific perspective might play more of a role in that line, right?

We don't have beneficiary attestation really yet, but we put it in there as that

marker, the three- to five-year marker that we talked about in group one yesterday of showing, well, we want people to consider that and see if you go there.

So let me skip down to a couple other ones. So data on which the attribution is based. This is, you know, is it -- you want to get in here is it prospective, is it retrospective, is it one year of data, is it two year of data? You know, what are -- what are the differences that might be about the time period or the data you're using.

And then some other examples here is that this concept of is it services, number of services, is it costs, right, is it expanded E&Ms? You might do the expanded E&Ms in that -- I think it was C-1 in that paper, right? Because it's in the primary care you want to use primary care codes in this one. But you're not going to use primary care codes in the specialty column, you're going to want to use something that's specific to joints, right? And that's where the

exclusions and the services are going to match for a specialty because you want to make sure you pull in the specialists.

And, you know, we've got an eligible provider line but it's -- that's where you would decide, is it the orthopedist, is it the hospitalist, is it more than one of them? You know, and it just depends on which scenario you're doing.

And then one of the other factors is the -- down here on determination is it plurality of services, do you have to have at least X many percent services, is it to a single doc, you know, multiple docs, et cetera? So it's trying to start getting some examples in one place by case.

CHAIR MEHROTRA: Danielle, this is -- first, thank you to yourself and others who worked on this. It's, I think, really useful for us to put something concrete on the table. And I really do like that we went really concrete with the case studies. And that's helpful. And I

thought the choices that you made were good illustrations of this.

My quick reaction is, is that the framework for me -- there's a lot of benefits. But I think the part that I was wondering -- as I look at this and I react to your comments and your input, is that what I'm looking for to expand this is the logic.

And so what I almost might start with -- and it may not -- so as I think it through it may not even look like a table. But let's say we take the ACO Track 2 or the joint replacement bundle. We start with that first, which is our principle 3 I think now, which is the transparency, what was the goal of the joint replacement bundle, for example? Like why -- what are we trying to capture with attribution?

And then for each of the boxes -- and again maybe this is why it's text as opposed to a set, because you can only put so much in a little Excel spreadsheet -- for example when you have here services related to conditions with

exclusions, that makes sense to me. But I almost wonder whether it's useful to add the logic process.

So one could in this case focus on only the CPT codes or E&M services with an orthopedic surgeon. Or one could look at the actual CPT codes related to the procedure, or some combination of the two. Given the goal of this is to capture the -- let's say it's the hospital that's most attributable, we chose to -- we thought you might want to focus on X. But basically for each of these cells you lay out a couple of options and then think through, for the reader who might be going through this for another application, how we thought about it as a committee and then provide that input.

So it's kind of a -- it's the logic model by which we got to it. And in each of these cells we'd lay out a couple of options.

Another example would be for the ACO Track 2, ACO collection of TINs. The whole goal of this is to try to decrease smoking in the

county. You could either attribute this to an ACO, an individual physician, a hospital. Why would you choose the following? Well, we thought the ACO was most applicable because we thought here's where you could put resources into it and actually do the smoking cessation services, while maybe the hospital makes less sense because they don't have -- they're not touching a lot of these patients in encounters.

So that was kind of my quick reaction to the table. I'm curious what others thought of that.

MEMBER LLOYD: Can I just respond to that for a second?

CHAIR MEHROTRA: Yes.

MEMBER LLOYD: I think part of it is right, we didn't -- we kind of had to cut off yesterday. But this is why there's sort of this challenges column now, too, where at least I noted the -- you know, this is risk taking entity, you know, choose the -- you know, so there are some notes that you could put. I

agree. We couldn't really fit it into the table. But I think the table was to try to start showing those cells where there might be some overt choice you need to make or, you know, reason that it might be different.

Or I mean it could be that we -- if we find out that there is starting to be some major models, you could say these are the most prevalent. Like if they're clustering remarks, these are the most prevalent. But here's a note in each of these of why you're going to have to make a decision, the advantages or disadvantages of prospective versus retrospective and cite the study, or something like that.

But you're absolutely correct, we couldn't really fit it in a table.

CHAIR MEHROTRA: So first, again thank you very much for doing this.

So I'd love other people to react on is this the right direction, is it not. Because, again, the whole goal is to try to provide something concrete to the audience.

So let me start with Srinivas and then Ira and then a bunch of other people put their tags up. Yes.

MEMBER SRIDHARA: So before -- so just to step back a little bit because I think we do want to get to the specificity and the logic that you described, but I would use this sort of activity as not to get to the final how do we present everything, but rather think of a framework to understand the environmental scan or the literature or anything else out there.

I think it is -- there are sort of the combination of say goals and use cases that -- that you have that drive what attribution approach you might take. And based on that, how you choose the combination of considerations vary. And so I guess I would just keep that in the back of the mind that I think if you start going down and saying specifically for a CJR, for an ACO, for a specific measure, I think there's a lot of nuance to each of these.

And I guess what I would hope is that

we agree on a framework for understanding this and then get to exactly what you're saying, which is, okay, in the scenario that I'm an ACO trying to implement my smoking cessation program, or what is the difference between, say, you are looking at a CJR-type joint replacement episode, but it's an employed hospital model and physicians versus an ACO, how does that defer and how you might do attribution.

I mean I think there are questions that you can then disentangle, so why you might choose different considerations. So that's at least to me this should be an activity of how do you understand the framework and parse the information.

CHAIR MEHROTRA: And then on that note -- and I think this is an open question for others so I just want to prompt it here as I go to other people in the room -- are these the right criteria? What do you think?

MEMBER SRIDHARA: No I mean, I think you're going to have more, for the folks here.

CHAIR MEHROTRA: All right. Good.

MEMBER SRIDHARA: I think there's a lot more. And I think this is just sort of a quick list of examples. And I think you have some others on this list here that was presented this morning, and I bet others will have more to pull on. And I think to Ira's point, it may be that we say that there is a combination of considerations that generally bundle together that one should think about, or whatever.

So I think there's thinking to be done but this may be a framework to think about it.

CHAIR MEHROTRA: Okay.

MEMBER MOSCOVICE: Yes, I found this really useful. And I could see it being used in two ways in the report. One way which would be -- in the previous reports I've been involved with you had some concrete examples and really in very micro-level detail went through just sort of what Srinivas said in terms of how decisions were made and so forth.

And they would be, I don't know, sort

of dark boxes on the right-hand side that would point out here's a case study, so forth, so forth.

But to me this is the beginning of we could think about what Ari was saying, if they don't want to be data driven for a taxonomy let's think about this conceptually. And it seems to me the first level is really the purpose. Then underneath that is the accountable unit. And then beneath that then -- you know, I wrote down the three things that seemed to be important were the termination rule, the data source, the time frame. But there's a whole host, as have been pointed out, of other characteristics.

And the details are below that. But I think there's a couple levels on top that really drive this. And then the details get you into the nuances of people.

So I think this kind of approach could be real helpful in both ways, both in terms of conceptually thinking about what is the right framework but also then drilling down and giving

some specific examples in the report.

CHAIR MEHROTRA: That's interesting. So even right from the beginning of the report you'd have like almost a little sidebar, MedPAC style, where you'd say here's -- let me give you some context so then we can refer it back to it and try to make it more concrete. That's interesting. As well as I appreciate the other point.

Brandon.

MEMBER POPE: So applaud your all's bravery in that, you know, fitting a multi-dimensional taxonomy into a two-dimensional table is -- you know, it's always going to be a tough thing. And, frankly, getting this volume and variety of people to converge on a mental model of a taxonomy is in itself going to be really challenging. Maybe we want to figure out how much time we want to devote to that.

But would echo I think Ira and Srinivas' comments that this is a really useful direction. And -- but I think we ought to -- you

know, here we've got a lot going on. I would probably try and condense it a little bit.

I think, again, the five things that I wrote down are -- you know, and to use the term attribution model to refer to some of the details about what data, what time period, frequency, all those sorts of things. I think if we can group that into sort of calling that the attribution model, and that becomes one along with the measure, the unit of analysis, the unit of receiving attribution, and the stakes which we talked about these different levels of aspiration, reporting, payment -- you know, there's some different stakes.

I mean I would maybe even propose that as you could use that taxonomy to characterize both all of these use cases as well as, you know, talk through sort of like you said, like if you're thinking overall I want to decrease smoking, right? So let's start thinking about, okay, well you know you can go these directions of some of these aspects of this taxonomy, so.

CHAIR MEHROTRA: That's great. Thank you.

Troy is next.

MEMBER FIESINGER: Sorry. Thank you for taking this on. I definitely believe in jumping in and working through it. So thanks for putting this together. I'll throw a couple questions out there, and if I missed that part of the explanation, I apologize.

One of the exclusions, should that be handled at the attribution level or can that reside in the quality measure level, for example, since for those we always have denominators, numerators, the inclusion/exclusion criteria. I didn't quite specifically see cost measures versus quality measures. But we talked a lot in our group a clinical case about cost measures might have different attribution needs than quality measures.

And the other thought is we can discuss more ways to handle it, there's different good approaches. We thought maybe tell a story,

so pick a patient or a scenario and walk them through all of these situations. Because the two things that affect me that I don't quite see explicitly here would be the chronic disease patient with multiple doctors, sites of care, et cetera. How does he or she play into this? Add in transitions of care to that, SNFs, LTACs, hospitals, readmissions. I know you're trying to get at that from the measure perspective. An alternative might be do we tell that story and then wave it in from that direction.

CHAIR MEHROTRA: Great. Thank you.

Laurie, I think I skipped you. But my apologies.

MEMBER RADWIN: Actually Troy made my point which is that I think we need to bring the patient perspective back into this graphic. And I really appreciate being able to categorize things.

But exactly as Troy said, I think the cases that we use to apply this schemata should be a patient trajectory. And I'm thinking of

case 2 that we talked about where the gentleman began in primary care, ended up a couple times in specialty care. Who's accountable, responsible? To whom should you attribute the dropping the ball in terms of preventive care? Who picks up the responsibility? To whom is attributed the safety of the heart attack care?

And without marching a patient through this, it becomes a schemata, taxonomy for how we deliver care, not how we attribute patients.

MEMBER LLOYD: Can I just say on that I think -- and we did talk about this a little bit. I think Jenny might have brought it up. A single patient could be in any and all of these at the same time, yeah.

And to your point, Dan, yesterday, there's overlapping attribution in all of these.

MEMBER RADWIN: I think that's the --

MEMBER LLOYD: Then you get into like four-dimensional.

MEMBER RADWIN: No, but you -- we're agreeing vehemently that you need to address that

overlap because otherwise it becomes about the organizational unit and not about the person who's being attributed to whatever. And so we are -- I think we're agreeing.

CHAIR MEHROTRA: These are both good points.

Michael.

MEMBER BARR: First of all, I agree with everybody's comments that this is a great start. I can't help but think that with all the comments, building on Brandon and Ira's, implied by our conversation is sort of a flow diagram with branching logic and stuff.

And I wonder in the final report if there's an opportunity for this to be an interactive type of web-based toolkit where you could take a use case and build all the different sort of the logic model behind what the choices were referenced -- linked to references.

I mean just think if it becomes another PDF report it's going to be in the stack right here, whereas if it's online some of the

sort of challenges we're facing can be presented and have people make choices, see where they wind up, starting with the purpose and how do we drill down further and further. I think that would be really interesting.

I don't know if it's in the scope in terms of NQF, but I think it would be a really interesting exercise and could be very useful for people kind of dealing with similar issues.

CHAIR MEHROTRA: You guys want to comment back?

Helen, we want a video with you and like interactive and an interpretative dance of attribute.

(Laughter.)

DR. BURSTIN: We don't want the dance part. But I'm glad that this conversation is happening. And, you know, Sophia in addition to being an expert on, you know, what she was able to present yesterday from CMMI is also the person who leads our contracts. So we're delighted she heard this conversation. And we'll certainly

follow up and see what we can do within scope.

CHAIR MEHROTRA: But I think your point's well taken because we want to make this useful.

Ari was next.

MEMBER HOUSER: So I like the idea of having this table. And I like -- especially with a narrative that explains the thought process.

Looking at the table, however, I'm getting very distracted by the particulars of the case study. And I think the suggestion is we have to do a -- be very careful in our selection of what the case study is.

I look at the first case study with the smoking measures and I can't get past the fact that that's -- it seems like totally like you can't -- I grew up in California. My county that I was born in has two million people. Los Angeles County has eight million people. It's just -- it's like pissing in the ocean to attribute smoking rates to any group of providers.

If the providers could even make a difference in a small area I don't know. But I, you know, I can't get -- I can't get past that. And so what we have to do is we have to select cases where there aren't those kind of hang-ups.

MEMBER LLOYD: Yeah. And we did -- we did discuss that. And that's part -- one reason why we were trying to think like could we do complications, like something straightforward that's across all of them. But I think you could also easily just do primary versus specialty or something because it's just illustrative. You don't need the whole kit and caboodle, you don't need every single line.

MEMBER HOUSER: Right.

MEMBER LLOYD: So two columns and, you know, six lines like Ira's six or something like that. Just pare it down.

MEMBER HOUSER: It reminds me of, you know, when I started -- when I've written a book chapter with like an explanatory data example. Like, oh, this is easy. But then I have to run

like 200 models to get one that actually has the -- you know, where everything that I'm showing has to show up in the data and not, well, I know. So, you know, that doesn't fit well, but whatever.

So it's --

CHAIR MEHROTRA: So I think the point's well taken about which example do we want to choose. Is this a good example because it's particularly thorny and has some issues? Or is it so far afield that it probably distracts the reader?

So let me just see if I can summarize and then I'll turn to both Mike and Elizabeth.

If I'm hearing correctly, so the first is thank you to those who worked on this table. What I'm getting a sense of is that this is a useful framework. And at least where my thinking is -- and now I want to get people's reaction -- is as we look at this report what I'm envisioning is we have a set of principles, and then we have a set of recommendations. And part of those

recommendations -- or are they separate, is it almost a set of a checklist or criteria list where we say here's when you -- whoever is out there, state, health plan, federal level, is considering the next program or quality measure. Here is a checklist that you should go through in thought process.

And we lay out that checklist. And then we say to help anybody who is going through this we're going to give you some examples of going through that checklist with some case studies. And we'll go through that process for -- and whether it's these four or not, and then we'll go through some of that logic model for each of those.

And then what I'm also hearing from the group is as we look at these criteria here, right now we have, I don't know, 11 rows, maybe if we can try to simplify those -- not simplify but at least consolidate those a little bit so that the checklist doesn't become too long. But at least -- and again give that logic -- that

process by which we hope others will go through for other quality measures or programs.

Is that -- am I capturing the vibe of the group or not is a question I would love to know. So let me turn to both Mike and Elizabeth and then others if they want to jump in.

MEMBER SAMUHEL: Actually that was kind of the lines of a comment that I was going to make is what you're saying. It's a useful framework. And, you know, there are some missing parts, like you mentioned logic models that describe each of these programs.

But I also want to emphasize in the choice of the examples what Ira's point was to get clarity around the purpose of the case study, its goals, data sources and so on. We can't model the entire healthcare system. So the choice of the columns I think is important.

Well, I think what we're trying to do is lay out some guiding principles, bring -- you know, make people aware of some methods, checklists as you described it. And I think

that's a good contribution to the state of the knowledge.

CHAIR MEHROTRA: Elizabeth.

MEMBER DRYE: Yeah, I think that your summary is a good one. And I agree with what Mike said also. And I really like -- thank you so much for putting this table down because I know it wasn't easy, because I was working over here while you guys were doing it.

But I had a -- I had a thought that I think is consistent with an interactive sort of set of flows, and it's modeled off of this AHA scientific statement I just sent around, of making those -- that first column more normative. So instead of, you know, saying eligible bennies or stakes or whatever, we just have a series of -- like you were saying, a series of questions.

And I'm going to try to articulate it, and it's only like seven things so I will go pretty fast. But the first one could be the goal of the use trace is clearly articulated. So it's quality reporting, you know, pay for performance,

QI or whatever. I would -- that one column, the QI column I think is probably that, I think that's a goal of an intended use versus, you know, the other three which are good examples of a type of care that you're trying to assess.

So the goal to use case is clearly articulated. The goal reflects patient and provider input. That would be number two. You'd say, okay, yeah I got that, or not. The level of attribution is a line with the goal by level, I mean ACO or hospital or whatever.

The goal -- the eligible beneficiaries are clearly identified. And the eligible providers are clearly identified. I really like how you stated that. And then you could also have like a sub thing, inappropriate exclusions are well defined.

So this is number five, would be the determination rule reflects the goals of -- the goals of the program. And alternative attribution strategies that are consistent with the goals were also evaluated, so that captures -- the time

frame is clearly articulated. Because I totally agree with Brandon on that. The data source supports the approach.

That was basically my list. And that's more normative as opposed to, you know, element based. We're saying, you know, not just do you have a time frame, but the time frame reflects -- you know, is clearly articulated, so.

CHAIR MEHROTRA: That's interesting. I like that.

I mean so I'll make one quick point and reaction. So I like that. I think I respond to -- it's building on that, but I do like the way you do it in a normative way.

And it's also kind of an interesting idea. I was going back to a study that we did last week -- sorry, yesterday, of the smoking cessation -- smoking rates in the county, should they be attributed to the hospital? And as we go through that framework, based on the conversation that we had we would say probably no. Because really the group that's most likely to act upon

this is the outpatient providers.

And so that -- I don't remember which number it was, but it's an interesting question to go through as you go -- as you think that through, which is it could change the way we -- who you attribute to and a criteria.

MEMBER DRYE: Right. I would -- I just want to articulate that slightly differently which is, you know, was your goal to get the -- you know, the goal was, was the goal to get the hospital to act? We said that could be a goal but it would be a very like -- you know, I want easier words. That would be a real reach.

(Laughter.)

So anyway, yeah, that's what I meant by goals, not would you attribute to the hospital but is the goal to get the hospital to act? Because whoever you're attributing to I think you're doing it to get them to do -- to act in a certain way.

CHAIR MEHROTRA: Troy.

MEMBER FIESINGER: I think it's a good

idea. I think your approach you recently laid out, you modified, I think makes sense as far as how to describe this.

I was talking to a gentleman down the road from Illinois with the issues in my profession in my state is what do rural physicians and rural critical access hospitals do. So I think with an end user we could get a bunch of rural physicians together who say, hey, we want to make an ACO. They need to consider attributions. They're not experts. They don't live and breathe this stuff and read it for fun at night like we do. How can then -- how could this help them walk through it?

And Planned Parenthood has a great little app on their website where you can choose your birth control. They'll walk you through it. Do you smoke? How old are you? Are you going to remember to take a pill? Yada, yada, yada, you end up with here's your choice.

We don't have to go as far as an app. But if a group of healthcare providers,

hospitals, et cetera, could access this document, start at a very superficial level, read it and understand it, that would help. And if you think of who they're going to have to go talk to, chambers of commerce, business leaders in the community, politicians. I guarantee you I lost the politicians as soon as this file went up there. They started texting their offices.

So we would need a really simple way to tell the story but we have to interact with them to get permission, legal waivers, et cetera. So to really push for at least the top level of simplicity, but narrative that can be communicated, then people can dive down in deeper levels of usability.

CHAIR MEHROTRA: So I like where the conversation is going here. I might reflect upon one concern or one thing that is on my mind is that when we've looked at, Andy, your paper and some of the -- as well as some of the other stuff that was shared, much of the places where at least people could empirically evaluate things,

which was like do you use 30 percent or 50 percent. Or is it based on visits, and so forth. It's interesting, like there's almost this interesting disconnect between our criteria here and some of those criteria.

So it sounds like that would be almost like the third or fourth order issue that you might address. And I'm curious what your reaction is because it's almost as -- again, to see if I can articulate this well, there's a disconnect between what the literature has looked at and what we're arguing you should be looking at for attribution.

DR. RYAN: Well, I love Elizabeth's idea. And the way I see it is this is like the, you know, maybe necessary but not sufficient conditions for an attribution model that -- well, your kind of concept. It should do all these things. But -- and we were talking about this -- if it does all these things it doesn't mean that that's it and that's the only way to do it. But it should -- it should certainly do these things.

And the list should make you reflect on what some of the tradeoffs should be about the specific ways that the attribution is formulated.

But even within meeting these criteria, there's other ways -- there's alternative ways to specify, you know, an attribution method, which has been kind of the more kind of maybe technical in the way we -- ways that the literature has looked at this. And I still think, you know, we need to think about those -- those kind of second order criteria as well. That these things need to be met when you implement an attribution method, but we could still test alternative approaches that meet all these -- these criteria using, you know, these measures, these metrics.

So that's how I -- I don't see it as being inconsistent but just maybe kind of a order -- kind of an order thing about criteria.

CHAIR MEHROTRA: Then one of the things I had raised before was a set of empirical evaluations. So now you've gone through the

first four steps and now you're to, okay, now I've got to get down to some of these relatively weedy issues. What are the numbers I should generate for the two attribution rules? And that would -- do you have a sense of what those -- what would you measure to see -- you said how many people are attributed or what fraction of care, and how does the reliability of the metric change under the two rules. Are there others?

DR. RYAN: So I think what we've talked about today and what our group has thought about is kind of the share of eligible patients that get attributed, the share of eligible providers that get attributed. And then the -- so those are two, you know, basic ideas.

And then the other issues we discussed are the holding the measure constant, the effects of alternative attribution approaches on reliability and validity of given performance measurements.

Now, you know validity is always something that we struggle with. You know,

that's always when we do the NQF and evaluate measures that's the one where it's most controversial, and testing validity is more challenging. But reliability at least is something that we're more comfortable with. There's common measures to do that.

And, you know, in theory if we can do -- you know, we know how to do reliability tests, and if we did the same tests but apply different attribution algorithms to the data and redo those tests, I think that's honestly pretty straightforward. So I see no like major technical challenges to at least doing reliability.

CHAIR MEHROTRA: Another one might be really just -- I think what I hear from providers that has been most compelling is to show the correlation or just a comparison of people's performance under two attribution rules. We know that they're going to be different. But then to look at those and see which one just on face validity reasons you like better. But just

comparing the two I think is a useful exercise to go to which would go then into reliability.

I'm just trying to think of concretely what would a person do under that step in our criteria is what I wanted to explore.

Some cards are up. So Nate and then maybe Elizabeth.

MEMBER SPELL: Yeah, I was just thinking -- thinking this through as you framed it. Maybe if we're having someone have a guide that is in a way a model, attribution model builder. So you've got your -- you're designing through this table might be designing a candidate model, but you're then going to put it through the performance testing phase. And maybe as you do some performance testing within that test criteria by which, you know, you should be judging that.

And maybe you come up with several candidates you want to test. Or maybe you test one and, boy, it fails on one or more measures, you're going to go back and tweak the model.

CHAIR MEHROTRA: So just let me summarize where we are from 45 minutes ago when we started this. Sounds like there's enthusiasm for this idea. We've refined it. We've discussed changing it into a more normative framework and trying to at least decrease the number of criteria or steps you might go through by either consolidation or addressing this.

Let me --

DR. AMIN: Sorry.

CHAIR MEHROTRA: Oh, no, no. Go ahead.

DR. AMIN: Sorry, were you done? I --

CHAIR MEHROTRA: No, no, I think --

DR. AMIN: I think in terms of summary as well, I'm just sort of -- yeah, I'm sort of thinking through, you know, as we talked about these first order of criteria, I think we can refine these in the time between this meeting and August and maybe do some surveys to just confirm that we're good.

What Andy's got in his paper will help us define sort of the second level criteria that,

you know, once you have the, you know, candidate models as Nate described them. We talked a little bit about empirical analysis that you might do to sort of test the different models.

I guess the one question I'm still trying to understand is as we try to make this concrete for our audience, what are some suggestions about the columns here that make this as concrete as possible in terms of the use cases?

And Dan again, not to pick on you again, but I guess I'm sort of thinking through, you know, are there some, you know, concrete examples that we can provide that are particularly -- you know, some that are more straightforward but some that are particularly thorny or irrelevant to the discourse or the policy discourse right now that might be helpful to walk through to provide, you know, some level of guidance, you know, as we look at the potential case studies that we might consider for discussion during our next meeting.

MR. MULDOON: Yes, so I think I'd probably want to confer with Sophia before making specific recommendations. In terms of thinking about the broadest would be like the use cases that might be most helpful to CMS but also trying to be mindful of that if we want this to be more broadly applicable it might not just -- we wouldn't want to solicit only our, you know, CMS or other payers' feedback.

I think one thing that sort of occurred to me as we're talking about doing the empirical analysis and criteria, one thing I think would be helpful to reflect in here is that I think, depending on the goals of whatever the specific use case is, sometimes how you -- like what you might be looking for in that empirical analysis, comparing the different attribution methodologies could -- could differ.

And so like, again, it makes me wonder how -- again how -- like as we move to make this concrete do we also then lose -- maybe it's if we're trying to walk through the logic cases you

don't lose some of the sort of breadth of issues that you might want to consider, but sort of thinking about if depending on -- I guess I'm having trouble articulating it exactly, but if you have two different programs, you know, with an ACO attributing maybe for the entire year to -- if you're attributing a beneficiary's care for a whole year to an ACO you want to make sure that you're getting the beneficiary attributed to the provider, group of providers that are responsible for that beneficiary's care.

But, you know, for like the joint replacement -- the joint replacement bundle we talked about here, you know, there's more of a balance there between do we want to attribute it to maybe the hospitalist or someone who's attending and managing that care versus the orthopedist who performed that surgery.

Like trying to think about, right, either -- if you can attribute to either of those physicians I think, you know, if they're -- if there's a difference there. But there's like

different -- depending on what the goal of sort of assigning that episode to a provider is you might have, you know, even though you could attribute it in either scenario and you have an empirical analysis that shows, oh, if we attribute to the attending physician when it's different, we attribute to the attending physician versus the orthopedist, depending on the goals like which one -- which way does -- what of those empirical results do you want to put more weight on based on what the program is trying to achieve.

So I'm not sure if that's clear. I'm having trouble articulating it. But that was sort of occurring to me.

CHAIR MEHROTRA: But, yeah, so I appreciate that point. And -- but I do think that I do want to -- while we certainly don't want all four cases to be CMS, I think having one or two that are the most thorny for you probably is going to both be compelling for the audience of this report because that's going to seem that

much more relevant to them because what you do impacts so many providers, as well as we do want to make this helpful.

So given these kind of bins that I thought Danielle had created, I think, you know, if you and Sophia want to tweak or so forth we'd be I think very open to that.

Yes, so Brandon and then Ira.

MEMBER POPE: I just want to -- Taroon, you're asking about what's a good thought process on how we choose the columns of this, which are really examples of how our sort of taxonomy plays out. Yeah. I mean my thought was it's obviously a pretty big space. And the best way to explore a big space in my mind is choose, you know, one of the most salient characteristics.

I think you can go a different -- couple of different directions. Whether you're talking about the unit of analysis being an event, an episode, a patient year or a population year, you know, you could try and really tie -- we chose these different columns as, you know,

four examples of different units of analysis or different, you know, stakes or attribution models, measures, purposes.

I think when it can get confusing is if we choose different columns, like this column is an example of a quality measure. This column is an example of a PCP attribution. This column is an example of when we're only reporting, we're not actually doing pay for performance. I think it becomes a little more jumbled if you do that.

So my recommendation would be pick one of your dimensions of your taxonomy, and try to sort of stratify across them to give a sense of the breadth of the tree.

DR. AMIN: Do you have a recommendation of what that -- I mean you listed -- you listed a few of them but do you have -- I mean --

MEMBER POPE: I think either the -- to me the unit of analysis and the unit receiving the attribution those are going to end up being somewhat related, right? But if it's an acute event versus an episode, versus a patient year,

versus a population year, right, you're going to again -- similarly you're going to attribute those to things like a surgeon, a hospital, a PCP or an ACO. Right? You could go either one of those directions and I think you'd have a pretty good sense of the breadth of considerations.

CHAIR MEHROTRA: Ira.

MEMBER MOSCOVICE: Yeah, I guess I would resonate with what Laurie said earlier. I think what's on the top of each of these columns are different kinds of patients where one would be an acute care episode, and that could be in a bundled payment. Another could be the chronically ill patient. And the third would be the thorny one, population based, whether it's smoking, you can call it whatever you want. That's what should be driving the columns I think rather than the structures.

Then you can choose how this is going to play out in an ACO or how this is going to play out in whatever structure. But --

CHAIR MEHROTRA: Ira, I hear the point.

And I wonder whether there would be -- you know, as we have these little boxes we might have there was Ms. Jones who had this thing, and so when we talk about our logic we might refer back to a concrete case. But I do worry about making -- at least my own thought is because at the end of the day who's going to use this? Is it a interactive or is it a PDF? It's someone who's going to have I'm developing an ACO program or I'm developing the new outcome measure for SNF readmission.

And I think starting where the audience is, as opposed to the audience is not where a patient doing this. That's at least -- or maybe I misheard you a little bit about that, but that's at least -- that's why I thought the logic going through it from a use case, if we're okay using that term still.

MEMBER MOSCOVICE: Yeah, I understand where you're going from but I don't think they preclude each other. But I think the comment that was made before, which is this can't be just provider driven I think is really important.

In the end, you're right, the users may well be certain types of providers. But I think what drives this -- and to me that means what drives the columns are how are different kinds of patients being attributed, rather than what organizations are taking -- starting with the organizational level.

CHAIR MEHROTRA: What if we were to do a way to address what I think is an important point, and I'm trying to make this feasible and not take on too much. But what I'm envisioning in the report is we have four case studies, use cases or whatever else we want to call it, we'll decide what those are. And we'll describe those in a sidebar explaining a little bit of the context so someone who's not familiar can understand it.

But we also have potentially a couple of sidebars of patients who've received a hip replacement, smoke, went to a SNF. And then when we discuss, for example, the accountable unit we -- beyond just going in generalities we could

say, hey, you know, Sally would have been attributed to the SNF but, you know, we gave you the example of Bill because Bill adds a nuance and, you know, an issue of it gets a little confusing because he also had a hip -- you know, I mean we can think about that.

But the idea would be is that if we provided those cases, it may make it even more concrete as we discuss these different criteria that we're going through. Isn't that -- do you think that would help or does that address your comment?

MEMBER MOSCOVICE: I think we're not that far apart. But I would go where Brandon was before which is we want to keep this as simple as possible but yet we want to cover a broad range of issues. And that -- where that -- those two spaces interact is sort of -- sort of the key I think.

CHAIR MEHROTRA: Quick time check just before I forget. So I think we'll have -- I'd love to discuss this for about ten more minutes

or so and then I think lunch.

MS. O'ROURKE: Lunch is going to be ready in about ten, if you want.

CHAIR MEHROTRA: Okay. So we'll talk for ten minutes about this and then we'll have lunch. And then I think we'll go back to the principles after that.

So let me -- Danielle.

MEMBER LLOYD: Of course I'm headed back to your specific question and the specifics.

So just as examples, if you decide to do it, because I'm struggling with how to do it from the patient perspective. It's almost you go patient to the payer, payer to the patient, either way I think you're discussing the same thing. You just need to make sure there is a vignette about the patient somewhere in there.

But if you wanted to sort of mix things up you could have a Medicare Track 3 ACO, because that has some distinctions in terms of risk and perspective and such, depending on what's in that, you could have a Medicaid bundle

like Arkansas or Tennessee or one of those, whichever you guys have in your paper, and then you could have a private payer tiering system or something like that.

And then it would sort of be different payers and so -- but it's still concepts that would apply to you guys. And it would draw different distinctions between the three.

But you could use -- instead of us making up these answers, you could just take three of the ones that you've already put in Dr. Ryan's paper and sidebar those and say let's call out three examples that we looked at and evaluate them against our criteria.

CHAIR MEHROTRA: Interesting. That's good.

So other -- so, Laurie, comments on any of those?

MEMBER RADWIN: Yeah. Just a remark on the dialog between you and Ira. And that is that people don't -- clinicians, providers don't set up structures and then say how am I going to

populate the structure with patients so that I can apply the attribution rule. You're taking care of a bunch of patients. And you're choosing the structure and then figuring out what attribution rule makes sense.

You know, so if I'm running a well woman clinic, you know, those are what my patients look like. Sometimes they have to go to the hospital. Sometimes they go to specialty care for an OB. But I've already populated my structure with patients.

And the question becomes the column headers, which type of structure and attribution rules make sense for me. You know, when you work the other way with let's talk about ACOs, you're applying ACOs to a group of people that you're taking care of, right? And so that tension, you know, it's impossible to ignore the patients when you designate structure and attribution rules because the patients are already populating your structure.

And that's why, you know, I would

advocate very strongly for having the case studies be about the typical kind of patients that muck you up, like the guy in case 2, or you know, like the person who disappears and doesn't come back for chronic care.

And so that was the point of having a prototypical patient populate, you know, the rows or not just be a sidebar.

CHAIR MEHROTRA: I hear a lot of people, this idea resonates with them. So I want to take that and see how we can incorporate that. And I don't want to be anti this approach because I do think it has a lot of merit, but I -- one of the things I'm also thinking about, which is that to really illustrate this you almost need a couple cases for each one. You know, you want your classic person who has a joint replacement, and then the person who has 20 comorbidities, and then the person who disappears for care.

And so maybe I'm being too reactionary but I'm trying to think of how can we really illustrate some of the nuances of attribution.

So I think the point's well taken. And then I'm just trying to think through how it would actually look like.

MEMBER RADWIN: I mean just to respond, I mean there's some pretty high level characteristics that patients have. And there's also the problems for -- there are the problem, you know, patients that are just plain hard to take care of, hard to pay for, hard to attach to a clinician. And I think, you know, your worst nightmares should be the case studies because then it would help.

CHAIR MEHROTRA: But I mean we do also want to be careful. We don't want the uncommon or the exception to undermine something right. Because if 90 percent are typical and ten percent are atypical, we don't want the case to only focus on the atypical. So that would be important.

So let me -- I'm talking too much, so Srinivas and then Helen.

MEMBER SRIDHARA: Sorry. I just wanted

to comment again on this patient organization sort of thing. And I think we want to use case scenarios to help people get a sense or understand. But I would argue that the notion of attribution performance measurement payment is a sort of population statistics idea. It's not an individual patient care idea, if you will, if you were to take that approach.

So I think people are going to find exceptions based on individual scenarios that don't work with the attribution model. So I'd go back to the notion that I think Mike mentioned some time ago which was there is error in this process and things are going to fall outside of it. And I think -- that's why I think if you think of who is trying to do this, it is usually a payer or an organization like an ACO, or a provider group, or someone else who's trying to do this activity. And they are looking across a broad spectrum of patients who are, you know, who have varying ranges of complexity and everything else.

1 And so I think our guidance is
2 probably to the people trying to implement the
3 attribution and probably not to the doc who is
4 doing the services, though they probably need to
5 understand eventually how their behavior falls
6 into attribution models and how they get paid.
7 And I think we use specific case scenarios to
8 help a doc or anyone else sort of be able to
9 understand how it might fall into a logic as a
10 whole, but agree that we're focusing on the 80
11 percent and not the 20 percent and think of it
12 that way. I think we're trying to provide a
13 framework.
14 CHAIR MEHROTRA: That's a good point.
15 Helen.
16 DR. BURSTIN: Yeah, this is a great
17 discussion. I'm not sure it's an either/or. And
18 I guess I'm in Ira's camp and the other camp. I
19 actually think what Ira's proposing is being less
20 focused on the specific programs and being more
21 patient centered.
22 And, you know, as employers look at

this, as patients look at this, there has to be something that logically makes sense. So I don't see it as an either/or, maybe it's that elusive third dimension you can't put on this chart, or maybe it is a way to just then describe this in ways that is more relatable. This is what happens to patients with acute illness. Not to get into the exceptions or the 20 percent that doesn't fit, but literally illustrate an acute patient going through a process, a patient with multiple chronic conditions going through a process. I think that's an -- or even a patient who goes in and out of settings of care. Maybe just a couple as illustrative examples.

And then, interestingly, see how well they tie or don't tie to the ways we're looking at it currently. I think it's good stuff to explore. I don't think you're going to fix it today but I think it's an intriguing idea.

CHAIR MEHROTRA: A lot of people have cards up. I want to make sure if -- I have Elizabeth and then Jenny I think are the people.

And, Elizabeth -- oh yes, so go ahead.

MEMBER DRYE: Since I'm sitting between Brandon and Ira, I actually think they're kind of rounding out, I mean your thing -- anyway, I was having a side conversation because I like -- I really like this idea of an event, acute event and episode, a patient year and a population year. And you could just make it a little more concrete.

This is still not down to the individual patient level but you could -- the generic could be something like an acute illness or admission, say for appendicitis or whatever, a heart attack. An episode would be like treatment of low back pain or treatment of chronic knee pain.

A patient year would -- you could make it for all ambulatory patients with multiple chronic conditions or whatever. You could choose your -- the generic would be, you know, a patient year. So you're looking at quality and cost.

And then the final population year

would be, you know, smoking cessation programs or whatever effort. And that would be quality and cost. And there you could figure out where you attribute it. Because I think we want one to keep on both quality and cost. And we want to be -- this is one area where we basically want to be generic enough. Then you could have specific patients.

And the other thing I wanted to say was you could for those extreme cases -- and it's already on Danielle's chart -- think about either adjustments or exclusions when you got into the second level of, you know, here's how you would handle some of the problematic pieces that undermine fairness potentially.

MEMBER BEAM: Yes. And I think I was just, if I was hearing Helen correctly and talking about Ira's model, I almost see, like I said, the model, when you're thinking about implementing the model from a system perspective, and again whether you're providers or groups or whatever, you're implementing that to a large

body of patients.

But then Ira's is where I see is almost setting up with those particular and typical patient, like I said, the healthy, the chronically ill, the one that's gone to the ER, the one that's inpatient. And those are almost the things you want to go back and look at in your model to say how do they fall out in this model? So it's almost like a cross-section, like cross-sectional view of the model itself. You're going to come at it from this angle and from that angle, and then does it make sense.

I don't know, I think that's what Helen was saying, too. I'm not for sure but that's just it.

DR. RYAN: Comment because, okay, I really agree with Jenny. And I think that the problem is if we do, if the columns are based on kind of clinical circumstances is that some of the attribution models, you know, cover these different, apply to these different clinical circumstances. Like ACOs will apply to all these

things.

And presumably, unless we're talking about having multiple attribution approaches within ACO models, which I don't think we're talking about, then it does seem like we should -- the central organization should be based on that application, like the program application. But we should bring out the detail of how specific clinical events or patients, whatever, are captured within that, that programmatic context is how I see it.

CHAIR MEHROTRA: So let me wrap up here.

So first I thought we could wrap up some of the -- kind of summarize what I'm hearing right now. But before I do that, I know there are a couple people who haven't had a chance to weigh in. Jen, on the phone or others?

MEMBER PERLOFF: Oh, again this is I really appreciate the struggle of trying to get the grid correct. And anyway, I emailed in some comments on validation that might be interesting.

And I just wanted to highlight the patient perspective is a really interesting dimension to this.

When we talked about validation in terms of, you know, can the patient name their primary care provider, but you could think about this in a more extended way that providers have an obligation or a commitment to inform patients that they're in an ACO or what model or program they're in. And that may be another way to validate is to find out the extent to which patients understand, you know, the assignments they've been put into.

So I just wanted to throw that into the mix. It's a little bit in left field, but --

CHAIR MEHROTRA: No, not in left field at all.

MEMBER PERLOFF: All right, thank you.

CHAIR MEHROTRA: So, all right, well let me summarize quickly.

So it sounds like from where we were this morning. We had yesterday and through this

morning we had a desire to try to make this more concrete. And it sounds like the framework that we're discussing here, people are generally enthusiastic about it.

What we need to do is, building off Brandon's comments and Elizabeth's comments and others, about what are those case studies to try to -- huge landscape, which are the ones that we think are most illustrative, and building off also Ari's comments that maybe these aren't the right ones.

And we'll have some conversations with Dan, Sophia and others. We'll maybe put out after some discussion maybe in the next couple weeks we might distribute here are the four that we accumulate.

And then also building on the comments here of what are the criteria, we can maybe put those out at the same time as here's consolidating all these comments and then maybe have the group react to that and say, oh, I think this works; I don't; and tweet. And then maybe

for our August meeting we can then try to put those in together in terms of actually fleshing those out.

So does that seem to summarize where we are?

DR. AMIN: Absolutely, Ateev.

Just on that last point around the criteria, it seems, just to be a little bit more nuanced, what I'm here is that there is this sort of first order of criteria which we'll try to develop and sort of summarize. Some of the second area of criteria, second order criteria is in Andy's paper.

And then there's also this what are the elements of the empirical analysis that we'll try to bring together and maybe test with the group in the next several weeks, and we'll have a discussion about that in August as well.

CHAIR MEHROTRA: Right. And then also I don't want to use the thread of the patient's voice and trying to see how we might, as Helen articulated, not either/or but how we might try

to play that out.

And so I think my own reaction is I'm enthusiastic about the idea, but I want to see an example to see if it kind of works on the page or in a video.

So let me stop here. So we're going to have lunch for how long?

MS. O'ROURKE: Do you want to give them 30 minutes, or do you want to do a working lunch?

CHAIR MEHROTRA: I think people would -- I'm always famished from actually talking. So how about a 30-minute break; would that be okay? I don't know. Sorry. Okay.

MS. O'ROURKE: Should we do the public comment first before we break?

CHAIR MEHROTRA: Oh yes. I apologize. How do I do that?

MS. O'ROURKE: Are there any public comments in the room?

OPERATOR: To ask a public comment please press star one.

CHAIR MEHROTRA: Come one. One public

comment.

OPERATOR: And we have no public comment.

CHAIR MEHROTRA: All right. Darn.

So 30 minutes break. We'll come back at 12:45. And for the rest of our time together we'll be going back to the principles and make sure we hammer those out and the language and so forth. So we'll talk about it.

(Whereupon, the above-entitled matter went off the record at 12:14 p.m. and resumed at 12:54 p.m.)

CHAIR MEHROTRA: All right. We are all gathered. So the key thing is we want public comment, so I have put the gauntlet down for our folks to see if we will have any public comment during our time period here. So we'll see.

So in the last block we have together, you know, I feel like overall we have made great progress in terms of moving forward and a lot of, you know, really great input here.

I think where we want to end today is

what is going to go out to the public and get input, which are these draft principles and then what I reviewed earlier. My thought is -- my own inclination as I reflect upon the conversation today and sort of thinking what this report would look like, my thought is that some of these should potentially be removed as a principle and be more as a recommendation.

I know I was struggling with that little distinction there, but a principle is like a sort of guiding idea of what we want, and then a recommendation is -- maybe I'll just pick on Elizabeth. Like, Elizabeth, next time you have a measure, here is what we think you should do, and that is sort of part of that recommendation/checklist kind of idea.

So that is at least one thought I had, but maybe we can just kind of go one by one through these and get people's reaction about drop it, change the language, et cetera.

So the first one is the goal -- a goal of attribution is to drive the system towards

shared accountability and advance the goals of the National Quality Strategy. I am going to start with the first clarification, which I should have asked, what is the National Quality Strategy like? Just to make sure like -- you know, like what element of this is on there or -- Kim, as the author of the National Quality Strategy, give us a sense of --

(Laughter.)

CHAIR MEHROTRA: It is one of those things, you laughed, so --

(Laughter.)

CHAIR MEHROTRA: -- what you have chosen. I know, it's a terrible thing.

MS. IBARRA: Well, I will start. I am not the author of the National Quality Strategy, for the record. So this is in response to some early -- early committee discussions that we have had around capturing the importance of attribution and bringing in the Triple Aim.

And so the National Quality Strategy builds on the Triple Aim, and it is better care,

healthier people, and affordable care. And so it just tries to take it a little bit further. It is work that we are using at NQF, we are supporting at NQF. It is at CMS, and it tries to encompass not only the Triple Aim but kind of bring it a little bit further down the road.

So does that help?

CHAIR MEHROTRA: That does help me, yes.

Reactions from the group for this first one? Changes you would make? Go ahead, Michael.

MEMBER BARR: Sorry to be picky, but "the system," do we want to be a little bit more specific or -- that could be interpreted very broadly or narrowly or -- it's just a generic word, "the system." Some people might even say we don't have a system.

CHAIR MEHROTRA: So I think that's a really good point. I agree with Taroon that just adding "healthcare" would help a little bit, but I don't think it fully captures what you're

looking for, Michael. Do you have any proposed language there?

MEMBER BARR: I mean, in theory, you could handle it in a series of definitions potentially. I think "healthcare" helps, but then I think there has to be some sort of expanded language within the document that references everything that you might be including at the different levels, practices, you know, clinically integrated networks, and so on, whatever the target of the measurement might be or the attribution might be.

CHAIR MEHROTRA: Other thoughts? One thought I had was basically the goal of attribution, is there also -- we have talked about this aspirational aspect of attribution, which is the shared responsibility. But at its heart, should we also add the point that attribution is to identify who the responsible provider is, so it would be two goals? Or is that already taken for granted and that's not necessary, or that's -- do you disagree? Go

ahead, Michael.

MEMBER BARR: That was the other question I had was I -- we all talked about shared accountability. But in the context of a principle, should we leave it at accountability? Because that could be shared or not shared. And to be driving towards accountability -- shared accountability may not work in all circumstances. So if you make it a principle, that elevates it to across everything.

I mean, there are some cases I think people made where there is one person who is accountable, and so sharing doesn't apply to all circumstances, and principle should apply across the board.

CHAIR MEHROTRA: I didn't see when the cards came up, so maybe Ari first.

MEMBER HOUSER: Just to get to the point you had said about whether it goes without saying, too, that attribution is to identify the responsible party, I think that's not quite right. It's not "the." It could be "a"

responsible party, and I might even say a potentially responsible party, because you could have multiple parties and they may or may not be responsible. But there could theoretically --

CHAIR MEHROTRA: I hear you. That sounds sort of like potentially responsible.

(Laughter.)

MEMBER HOUSER: I don't know.

MEMBER BEAM: And that's the same. I was going to even say you're really identifying relationships. That's what you're -- you're identifying the relationships in the care delivery system, so that it can facilitate, you know, but those relationships are --

CHAIR MEHROTRA: Right. But, you know, just to push on that, so, you know, if we look in the claims pattern and we're looking at PCP, you know, ENM visits, and we see that Ms. Jones had a visit with the orthopedic surgeon, and there's an ACO thing, they have a relationship, but what we're really trying to do, the reason we focus on PCPs in that context is we

think that PCP has that responsibility or care coordination or overseen aspect.

For example, Keith in the ED, not -- you know, you're not thinking, oh, I'm taking care of Mrs. Jones, all her care. You're thinking of -- so that is the reason I didn't -- but they did have a relationship, because they had an encounter. I don't know. Just pushing on that a little.

CHAIR MEHROTRA: Go ahead, Ira.

MEMBER MOSCOVICE: I thought this was going to be easy. We're never going to get through these.

CHAIR MEHROTRA: I know. We've got to like hurry up.

(Laughter.)

MEMBER MOSCOVICE: If we're going to deal with wordsmithing, we're not -- but it's not -- the healthcare system doesn't fit in there. It means nothing to say we're driving the healthcare system towards accountability. And we don't want to use the word "providers," and I

don't know what the right words are, but I think we need to get a little bit more specific.

And what we're really trying to do is to clarify, define, call it what you want, but it -- I just wish we would use a different term than "healthcare system," which is sort of a generic Pablum.

CHAIR MEHROTRA: And then, do you think that if we said "clinicians," or what would be -- I hear your point, but then I'm like, oh, I don't know. Oh, Nate has got an idea.

MEMBER SPELL: I was going to suggest that we just say "to drive accountability and advance the goals of the National Quality Strategy," and leave it at that.

CHAIR MEHROTRA: I like that. Others agree? Jenny, did that -- okay. Oh, Jen, go ahead.

MEMBER NOWAK: I wanted to support the concept that attribution is identifying relationships, because it depends on how you use attribution. You may be using it to identify

accountability, but it may be used in measurement to identify some other aspect of healthcare. So in an ACO situation, it is to identify accountability.

MEMBER BEAM: And I think that was my -- I wrote this down. I was saying earlier -- and I think this is still something we are keeping with as -- we said earlier that attribution was our -- accountability -- one equals one, but one does not equal the other. So are we contradicting that by the statement? Because we said accountability always equals attribution, but attribution does not always equal accountability. That was an earlier statement we had made, and we wrote that up.

So if we say it like this, I feel like we're almost contradicting. So that's where the relationships come into play.

MEMBER POPE: Yes. I don't read it like that. I read it as accountability is going to be -- I don't think anyone would debate that accountability is going to be necessary at some -

- to some extent in some places to achieve the goals of the National Quality Strategy.

So I think we're saying attribution is to do that, and to more broadly advance the goals of the National -- it's not necessary that someone being accountable for every single outcome is going to be necessary to achieve a strategy. It is sort of this and this, not this or this, if you -- if I can start using arm gestures.

CHAIR MEHROTRA: I think some people have their mics on. I think, Ira, if -- Danielle?

MEMBER LLOYD: I guess because this is -- I recognize that what you're saying, Jenny, doesn't go both ways, right? But I think we are in a goal statement, right? So I think part of the goal that I heard out of those three groups is to use the attribution to drive providers toward accountability for the National Quality Strategy goals, right?

So, ultimately, attribution is to a

provider. So I don't think we can get around that. And you can't -- I don't think we can just put in health system, right, because it's too amorphous. The attribution is linking the patient and the provider, and part of the point of this is we want to use it to try to get more people to take accountability.

CHAIR MEHROTRA: So we are measuring relationships but driving towards accountability?

MEMBER LLOYD: Yes. So, I mean, a goal of attribution is to drive providers toward accountability for the goals of the National Quality Strategy, right? Is that -- you're trying to tag people, so that they have the accountability?

CHAIR MEHROTRA: Okay. Well, I'm -- these are great. I'm also -- I think Ira's point is also well taken, which is we do have a lot more. So why don't we keep on going and iterate here a little bit, because otherwise we'll be on number one until 2:30 here.

So the second one here, if that's okay

-- I don't want to cut off conversation too early, but attribution is a central part of measure specification and policy and program design. Measures and programs should be tested with more than one attribution approach to ensure accuracy and fairness.

Provider and patient input on attribution of approaches may help to obtain face validity for selected approaches, and we should consider both alignment of the attributed and measure populations as well as consider alignment of purpose of attribution, attribution approach, and measure concept.

So I think the first point I heard, which I think is a very valid one, which is, what does number 2B mean? And I think I -- as I said it, I wasn't sure exactly either, so maybe we could kind of -- my memory is what we are trying to do is address the ideas that were presented earlier yesterday, which was like you've got your cost measure, you know, your population by which you are -- I think -- let me see if I have this

right.

You are -- let's say you're measuring cost and quality. On one measure you have one population; on another metric you have another population. To the degree that we can align the two, that would be correct. Is that what this is trying to capture? Oh, Erin, you're going to say -- you didn't put your tag up.

(Laughter.)

CHAIR MEHROTRA: Just joking. Go ahead, Erin.

MS. O'ROURKE: Yes. We were trying to get to, Danielle, you made the point a little more in real-world examples yesterday. So we were trying to take that up to the principle level about aligning the people assessed in the measure as well as the attributed in a various program, if you will.

So it seems like we did not get that language right, so, Danielle, if you wouldn't mind reiterating your position.

MEMBER LLOYD: I was going to say I

didn't know that was mine, so I think that means it didn't work. I think you are trying to align the measurement -- well, we are -- I'm not going to be able to write it right now. You know what I mean? We're going to have to wordsmith that later, but you're trying to align the measure -- the population you're measuring, which is the attributed population -- with those for whom you have the accountability, right?

You don't want there to be a mismatch between who do you have accountability for and who you are measuring in the measure. That's ultimately -- as we have said, it's not always the same thing, right? So if you have a quality measure that's on 10 people, and you're applying it to a payment ramification that is on 100 people, like that doesn't work. You want the same people who -- the 100 people you have payment responsibility for are the 100 people who are in your quality measure. You want those to be the same.

CHAIR MEHROTRA: And so what I'm

hearing from you is in that -- that's a case of payment and quality. It could be cost and quality or two quality metrics, but when you have a program that --

MEMBER LLOYD: It could be patient experience also.

CHAIR MEHROTRA: -- combines the two --

MEMBER LLOYD: It could be patient experience. It is whatever -- whatever is relevant to the program, the attribution should be the same across them. You pick one method per program, and that's it.

CHAIR MEHROTRA: Okay.

MEMBER LLOYD: But I think the piece of this that is troubling me, I continue to worry about the testing, you must test piece. Can we say novel models need to be -- if you have a novel model, it needs to be tested, because to the point of driving up costs, it might be that some model ends up being tested ad nauseam. Everybody doesn't have to test it.

If you pick up something that is already tested, that should be fine. You shouldn't have to test just to test, but only if you are taking a new approach, I think.

CHAIR MEHROTRA: This is helpful; I think we can continue to refine this. I did hear something on -- and just because it was hard on the phone -- Jen, did you say something on the phone? I heard something.

MEMBER PERLOFF: Yes. I just want -- yes, I'm sorry. I just wanted to jump in that that's an excellent criteria or goal, but a lot of work fails to meet that right now. And I think MIPS might not even meet it in its first iteration because, you know, attribution and quality measures are not aligned at this point.

So I just wanted to point out that we might be setting a bar that for a long time people can't meet.

CHAIR MEHROTRA: Would it be because we did -- the part of the conversation yesterday was really trying to say we're trying to see

where we want to push attribution in the future. Could we frame this to both capture reality but also be aspirational, to say in the ideal this is what we want, and so there were -- at least, you know, acknowledging what you're saying right now, Jen, but also to say in the ideal world we would have that.

MEMBER LLOYD: But that's why I started with saying these are goals. I don't want to hamstring myself on goals as to what we can or can't do today, and so it is a goal that it drives accountability. It is a goal that there is matching. It doesn't have to be in every scenario you are only going to approve the things that meet -- these are not the criteria; they're the goals.

MEMBER RADWIN: Could it be something like as new measures are developed, or as new models are developed, so that you become that cutting edge instead of having to carry the burden of history on your back to get everything right again?

CHAIR MEHROTRA: That's a good point. But some sort of language in that I think makes a lot of sense.

So let me see, Troy, Ari, and Srinivas are next. So, Troy?

MEMBER FIESINGER: So I'll give you an alternate take. I agree with the point and the goal. To me, thinking it is somewhat on the ground level, I would like attribution to be accurate, equitable, and fair, and we can wordsmith the nuances, the terminology. But I want to feel like it's right. I want to feel like I'm being treated fairly. I want to feel like the allocation of responsibility is equitable and balanced.

So when I think of aligning populations, different measure types, processes, that is the lens that I think through. Does it feel -- I may not love it, but it's okay.

CHAIR MEHROTRA: Reactions to that, as well as others? Let me go with Ari next.

MEMBER HOUSER: So I wanted to speak

up in terms of keeping that you should test more than one attribution approach in the goal. And I -- it doesn't say that you -- every time you want to create a measure, you have to test multiple attribution approaches and then pick the one that is best in the testing.

You may have, for other reasons, an attribution approach in mind, but you still need to test to make sure that the approach that you want to use isn't bad. You know, there can be lots of good approaches that are not exactly the same, and so you can test to see whether the approach that you want to use, because it aligns with some other -- with some other purposes, is valid here, and give you some evidence that that is the decent way to do it.

You don't have to choose the result of your testing, but you should still test. Does that make sense?

CHAIR MEHROTRA: Right. So you are really pushing to keep that as really a principle in terms of what we're --

MEMBER HOUSER: Yes. I mean, otherwise, I worry if you can -- again, just because someone else has done it doesn't mean that it was good when they did it. So --

CHAIR MEHROTRA: Okay. We'll keep -- Srinivas?

MEMBER SRIDHARA: So a comment on the test, and I think that we may be getting tripped up over the word "test." At least that's how I am seeing it right now, and I think the way I heard Danielle describe it, that to me sounds like a research question or an empirical analysis of an approach and whether it is good or bad, as opposed to how I think about it is more -- it's more like a sensitivity analysis.

Like if I did it this way, or a what-if sort of analysis, and I think that's really what we're after is try out a couple of different approaches and figure out how that impacts the -- you know, sort of the question you are asking and how that might inform the answer. So that's -- so I think, again, some wordsmithing on that, but

I think that's what we're trying to communicate.

And, two, in terms of the, you know, sort of ABC or, you know, if we are worried about this alignment question, and it's not currently possible, to me some of this is like, what's in two is our either principle or goal, and maybe these are recommendations, you know, to align with that particular principle.

So maybe not all of this needs to be a principle as opposed to a recommendation, especially for things that are aspirational.

DR. RYAN: On the tested part, maybe we could say evaluated and compared?

MEMBER SRIDHARA: Sure.

DR. RYAN: Because I was thinking the same thing. Testing seems to imply like a certain -- like a regimented process that has already been specified. And it seems like we are not quite there yet.

CHAIR MEHROTRA: Done. Michael, you put your card down.

MEMBER BARR: I took it down because

Srinivas -- I had a question on 2B. I'm not sure my understanding is the same as the prevailing one. I was thinking about the overlapping of the denominators of the population that meets a measure and how -- what percentage of those you can actually attribute. So that's how I read that.

CHAIR MEHROTRA: Oh, okay. And I also thought that was almost a criteria that would go into the recommendation. So that -- so I think, clearly, we need to clarify that. Do you think that that should be a principle?

MEMBER BARR: I think it should be the aspirational goal for -- as many of the folks who meet the measure definition. Right?

CHAIR MEHROTRA: Well, I was thinking about -- the health partners folks made the point in theirs about -- in their report where they were talking about how many people were attributed, and they made this point that -- but the goal is not to get to 100 percent, because they felt that this might be going a little bit

to what Andy was saying, which was, if you have a measure -- an attribution approach that attributes everybody, then you probably have something that is a little bit too sensitive and, therefore, is adding noise.

So that's why I didn't -- that's the only part that gave me pause. Well, five percent ain't going to cut it for me, but what should that right number be?

MEMBER BARR: So maybe that's what we need to come up with, so the parameters -- they need the metric to judge the adequacy of the model. I think that was a comment we made during the earlier conversation. I haven't heard anybody suggest it, so I'll go ahead and suggest that we put something along those lines in number 2.

CHAIR MEHROTRA: Okay. Do you want to play with this?

Let me -- Jenny, Brandon, and Elizabeth are next.

MEMBER BEAM: And I just have a

comment on the -- aligning the population you're measuring with those for whom you have accountability. And I guess I'm still -- because I can think of a couple of cases like where you may not want to do that, and you don't want them to be aligned, and one is.

You know, again, you have a panel of patients. You know you are accountable for a period, and that maybe is based on retrospective. But then, also, there are times that people say, "But you're likely to be -- these will show up on your panel next year," and so you want to know ahead of time who those people are likely to be, because you have a claim that has been triggered, or two.

So they may not always be aligned, but as a provider I would want to know that I'm likely that these patients are liable to end up on my panel next year, so I can go ahead and start managing their care and talk to the patient and say, you know, "Am I your primary care provider? Are you seeing someone else? What's"

-- you know, so to try to establish that relationship.

And also, you know, thinking about where you may have a panel for -- and I know Danielle's example was a payment. So it was saying, you know, for the patients that you are going to be paid for, but then also there is a larger -- if I'm a provider and I've got a larger panel that I'm responsible for, maybe from a population health perspective I'm only going to get paid for these, because we talked before about in a payment model you only pay -- want to pay for one patient on one physician panel, but yet there are -- sometimes multiple providers are involved in the care.

So if I know that I'm partially responsible for your care, I may not be getting paid for you, but I still want to make sure that you've had your whatever, your colonoscopy or whatever screenings that you need, so there's two different things. One is payment, and one is who am I trying to influence their care and their

outcomes.

CHAIR MEHROTRA: That's a great example. So I think this really builds on what Danielle was saying, that -- do you think it's -- so, first, add this as a point. There are clearly examples out there right now, just take myself in your patient panel, where you are not responsible -- you are not being paid for my care, but you're responsible for my quality.

And what Danielle was I think articulating -- tell me if I have paraphrased this right -- which is that in the ideal world, the two of those are aligned and that should be an aspirational goal or a principle of attribution to whatever degree.

And so I guess, do you think -- am I hearing you say that that's not the reality right now and that's okay, or do you think that should be where we're trying to go?

MEMBER BEAM: I don't think patient behavior and care-seeking patterns are going to allow that. I live an hour away from where I

work. I see two providers; I'm not going to see one ever. So, you know, you're ending up in situations where that people don't always -- they are not always loyal to one given PCP. So unless you are willing to take away patient choice, I don't know how we can do that.

MEMBER LLOYD: I think this -- I think the problem is that this is sort of how we ended up circling yesterday and why we ended up with the four case studies is I think to some extent it fits certain case studies better than it fits others. But I think ultimately what Troy said is the crux of it, is you want -- the providers want to believe that there is some fairness involved here, and that you're -- the measure for which you are measured -- the population for which you are measured in terms of quality is not entirely different from the population for which you are measured for payment, right?

That there is some alignment between the two, that there is some idea that if you are going to take a quality measure score and apply

it -- direct that the two -- when the two are used together, when the quality score reduces or increases your payment, that they have something to do with each other.

MEMBER BEAM: And I think that works when you have a panel that you are entirely getting paid for.

MEMBER LLOYD: When one is applied for the other, together.

MEMBER BEAM: But for markets where payment models and incentive models are not implemented on a large scale -- so I can give you an example of providers, provider groups, maybe where only 10 percent of their patients they are getting paid on. So do we just say that -- don't worry about the other 90 percent? You don't have to worry about their quality, because you're not getting paid for them.

MEMBER LLOYD: So let me take one more stab, because I don't think I made it clear here.

MEMBER BEAM: Sure. Okay.

MEMBER LLOYD: It's not to say you're

not responsible for the quality. It's not to say that you're not getting paid for them. But if you take a measure and say on this shared savings check, you're going to have your shared savings check reduced by 10 percentage points because you had a fault on the following quality, that is when they need to be together.

You're still getting paid your fee for service for all of the patients. You're still, you know, going to be -- you know, you're still responsible for their quality. But when the quality measure actually affects that particular shared savings check, or that bundled payment, or that, you know, whatever, that they are at least reasonably the same populations. That doesn't have to be perfect, but that there -- I mean, I think the part of it is it doesn't have to match; it just has to be aligned.

MEMBER BEAM: And I think we just need to -- and maybe that's in the paper to be addressed, as far as the audience and who is developing, because if you're developing a

measure, I agree. But, again, when you're dealing with multiple measures, multiple programs, you've got physician groups or you've got collaboratives or other third party entities trying to roll multiple programs and panels together, so that providers don't have -- I have -- here is my Medicare shared savings patients, here is my these patients, here is my Aetna patients, here is my -- that doesn't work for providers. You know, they want one consolidated panel to work from, you know, regardless of who the payer is. So I just --

CHAIR MEHROTRA: So let me make two proposals. First, I want to put on the table if you would consider that that was something that I realize did get lost, which was that in the ideal, if you have four different ACO programs, you would have four -- one attribution rule.

And so I think the consider -- in the ideal -- and I don't know what the right term is, but in the ideal there should be -- for similar programs there should be alignment of the

attribution rules. And maybe that's C or item D or whatever, but I think that might be an interesting idea.

And then, specifically about the alignment of those where you have financial and quality accountability, I would love for others to weigh in as they go with comments, because I hear both sides of this and I'm trying to decide what is the right language to use.

And so let me -- but I also want to keep on going, too. So maybe, Brandon, if you want to weigh in on this.

MEMBER POPE: Yes. I guess I favor keeping this list of principles somewhat short and not starting to go A, B, C, D, and then I, double, I, triple I. So I actually favor this concept you all are talking about being a normative principle that could be applied.

I phrase it simply as, look, when you're considering a program, does the attribution align with other existing attributions, both quality and cost, that are

being imposed on the entity, right? So, in other words, and here we said align the population, right? It's not population as much as I'm thinking in this context the attribution, right? So, in other words, for readmission are we attributing to the attending provider, but for mortality are we attributing to the discharging provider? Or, you know, it's -- there's attribution differences that are not just population differences.

So I guess that's my thought. I like number 2, that, you know, a principle is that this is an important part of the program design. You've got to evaluate it. You can't just sort of go willy-nilly. And that we maybe would have a list of these normative principles being a separate list, because otherwise I think it will sort of just become a little big.

CHAIR MEHROTRA: So I hear you, and I am a little worried about A, B, C, D, and all the way to I. Are you -- but just to be very concrete, are you saying take the A, B, C, D, and

move them out for now?

MEMBER POPE: I am. I think -- I am looking at these. I think these are all good -- like I think Elizabeth had the suggestion of a list of normative tests that could be like -- this could be further elaborated on in a different list, right? So, for example, these are some of the considerations you might want to explicitly address. Have you considered both the patient and the provider's perspective? Have you considered what other attributions are being cast upon this provider or this hospital? Have you considered, you know, if you can actually implement this for the data they have available to them? Things like that. And that would be a normative list, but maybe not a principle. I don't --

CHAIR MEHROTRA: That is a fair point. I'm going to vote for not removing these concepts entirely but removing them from the principles here. Those -- so I'm seeing some shaking heads up and down. Are there those who disagree with

that idea? So maybe if you can move those, that would be awesome.

So let me -- I'm also conscious of the time, so maybe we can have Dan, Keith, and Bharat speak about these -- this -- number 2, and then we could then maybe go to the next one?

MEMBER SUTARIYA: If you don't mind, since I've got to run, I'll just make a very quick comment. I'm in favor of keeping this short as well. But at the same time, there is probably a right balance to strike somewhere. It can't just be five bullet points.

Second, I think the other concept I want to make sure the committee keeps in mind is the concept of aggregation. Andy put in his paper the definition of aggregation, and most all attribution models are applied at the aggregation level when it comes to CMS payment, meaning at the risk-taking entity level.

So that affords this level of forgiveness from getting an individual attribution perhaps slightly wrong, but at the

same time we also need to think about most federal programs today are paid based on an aggregated attribution and not based on an individual, one single physician provider.

CHAIR MEHROTRA: If you don't mind, we can just build on that point a little bit, because that's really -- it was in number 7 before. It was -- that was, to drive the system forward, it is necessary to challenge current norms of attribution, including desire to identify a single clinician or provider. And I think that was trying to address this issue, both do you assign it to multiple people as well as do you assign it to a single physician or other entity? And is that a principle or -- I don't know.

I'm curious what people's reaction is because I was struggling with number 7, to be honest with you. Like I get the idea, I like the idea, but I don't know if it's a principle because in some cases, as somebody said, it sometimes does make sense to go to an individual

doc.

Well, so I did a bad thing here, so I should -- didn't go in the order. So maybe I'll stick with the order, and if you could comment on something else as well as that point, that would be great. I don't know if that's too much. Everybody is putting their cards down now.

Elizabeth? I don't know. Were you going to comment on that point or any other point?

MEMBER DRYE: I think you just spied something I would -- a lack of -- something I wasn't clear about. When we were talking before about not an individual provider, I literally was thinking about an individual like doctor or nurse, not about, you know, an individual ACO or an individual hospital.

So I think that we were thinking this is a team sport, and also, I mean, as a measure developer and doing outcomes, I am always thinking there is just no technical way to evaluate individual providers almost ever unless

it's like, you know, a cataract surgeon who does hundreds and hundreds and hundreds of cases.

So I didn't know, though, is that something we are trying to say? Like because delivering care is a team sport or because we're worried about technical issues, or is it -- am I just interpreting that wrong?

CHAIR MEHROTRA: So, yes, let me -- I might have made a mistake by skipping ahead, but let me explain -- at least what I heard yesterday from Troy and others was, should there be a principle that the idea of attributing care to an individual clinician is generally not a good idea, and should that be almost a principle that should be put out there?

And we saw so many rules put in that -- so many attribution models currently do do that. And so the question at hand is: is that a principle we should put out there or not? Maybe that's where -- I don't know if that's where Bharat was heading, but that's one thing I heard from his comment. So that's why I brought it up.

Let's see --

MEMBER LLOYD: Can I actually just make a technical comment on that? There is one thing about the paper that I think was a little bit confusing. So it's my understanding, for instance, in the Medicare Shared Savings Program you are not actually attributing to an individual physician. You are actually attributing to the tax ID number. You have to start with looking at, did they have at least one physician ENM visit?

But at the end of the day, you take the PA, NP, CNS, various -- et cetera, and it is still at the TIN level. And I actually thought that was a little bit confusing and misleading in the paper, that it's not a doc exactly, for at least that model. Some of them do, and maybe quality improvement, et cetera, but I think -- I found that confusing in the paper, and that might have contributed to leading us astray on that individual --

CHAIR MEHROTRA: So, first, it's a

good point. The tax ID is -- as we I think discussed yesterday -- is a very difficult thing to use because it can represent so many things from an individual physician all the way to a very, very large physician group under -- all under one tax ID.

I think, given we are at the principle and aspirational role goal here, I think why was tax ID used, because the tax ID is available, and that's the only thing -- you know, you can't go more granular often, though with NPIs you can start to do so.

But I guess the question is, going back to the point, maybe people -- I have an order here, but maybe just to finish up this point -- is it a good principle to have that idea of we should not be attributing to a single clinician?

And I don't know, Troy, did you have a comment on that specifically? I'll --

MEMBER FIESINGER: Yes. I'll address that. So I'm trying to think of like a buzz word

or phrase. So when I think of accurate, equitable, and fair, that's what I want it to be. As I wrestled with this this morning, I was thinking about earlier when I was on a walk, can we -- to me, there is a way to separate attribution, meaning what bucket does each patient go in?

A population of 5,000 or 10,000, this ACO versus accountability, like -- or the Scott & White Baylor, you're talking about for audit purposes we might want to know very specifically who goes where, who does what. But for attribution, you may just know that it's Baylor Scott & White ACO.

And I don't think I can specifically say we should never attribute to single clinicians. There might be times when that's necessary, but in the big picture attribution really -- what group of people and team is responsible for it, and that team can decide internally through governance policies, et cetera, how to handle what part of the process is

-- needs to be dealt with, what team members' actions or inactions need to be modified or changed. So, to me, I would like to separate them, but I don't know if I can exactly say it should never ever be attributed to one person. That might be necessary in terms of assigning a patient to a bucket, but totally different is how we use that information to improve health care.

CHAIR MEHROTRA: So if I was to write the principle, "In general, we believe that it is better to attribute to a team of provider -- not to attribute to a single clinician," is generally the right way to go, is that -- I mean, so I'm not -- we're not saying absolute.

MEMBER FIESINGER: Yes. I would be okay with that.

CHAIR MEHROTRA: Others on that? So are you -- I know I'm going a little bit out of order here. Sorry. Go ahead.

MEMBER HOUSER: I was going to say that I think the issue is not attribution to a single physician, but holding a single physician,

or even a group of physicians, accountable for activity that is outside of their levels of control to bring in another terminology from yesterday.

That the problem is not with attribution to an individual physician, which could be desirable in the case of quality improvement, or it could be a necessary step in terms of holding that physician's ACO accountable.

It could be -- attribution to the ACO may go through the physician as a mechanism to get there. And that's not -- that is probably not problematic. What is potentially problematic is holding individual physicians accountable for the entirety of that attributed patient over which they may have only a small level of control.

CHAIR MEHROTRA: Others want to weigh in? Okay.

MS. O'ROURKE: So Ira has been wanting to weigh in on this point.

CHAIR MEHROTRA: Okay. So Ira, and then Brandon maybe?

MEMBER MOSCOVICE: Just two things. When we use the words "it is necessary," it sounds to me like it's a recommendation rather than a principle. Most of the other statements were more normative statements. "Necessary" sounds like it's a requirement; it's something we are really recommending.

But the other part is, given the last conversation, once again, I think we may have our urban values influencing ourselves. It depends on the supplier providers, by the way, and it may well be in a smaller, underserved rural area where there is not a lot of bypass, maybe it is okay to attribute --

CHAIR MEHROTRA: To an individual?

Brandon, do you want to --

MEMBER POPE: I would say at a high level I'm actually in favor of attributing at the most granular -- yes, the most granular level possible when we have sufficient sample sizes,

reliable measures, and data to support it.

So if we were to -- I would not, in general, be in favor of saying a principle is we don't want to attribute to the physician level sort of higher -- I am more of that I actually want to do that. In a lot of cases, it's not possible.

CHAIR MEHROTRA: So why don't we just summarize this. It sounds like there is little enthusiasm for this idea, so I'm going to propose cutting number 7 fully and moving that to when we talk about the recommendations and we go through that checklist that, you know, this is something you should think about, building on Brandon's point is, is that when you are doing this attribution rule, don't always go to the individual physician level, especially when you have sample size issues, et cetera, or it might even make more sense to do it at the group level.

But that would be more a thing you should think about as opposed to this is some sort of principle. Does anyone disagree with

that idea? So, Jenny, do you want to --

MEMBER BEAM: Not necessarily disagreement, but, you know, a lot of times provider groups want to know at the physician level because when they are taking -- when you have a large physician group and they have to distribute the payment to their physicians, they want to know -- you have 100 patients, you only have 10. You're going to get more of the money when they distribute.

So I still think the attribution is fine to occur at that level, at that group level, but to have the more -- the reporting and saying you are the most likely responsible, or you are responsible for the majority of care within your group. So however you want to --

CHAIR MEHROTRA: Okay. Thank you.

Bob, were you saying --

MR. MULDOON: Can I say something about the --

CHAIR MEHROTRA: Oh, go ahead, Daniel.

MR. MULDOON: -- in response to Jenny

and say I think that's something, though, that we could do by, you know, really, the consideration is find the level at which you sort of can balance the accuracy, equity, and the fairness of your attribution.

But in terms of figuring out which providers -- and by "providers" now I'm meaning individual clinicians are sort of touching the patient and furnishing services, seeing them. That sort of also seems like it could come into types of data that -- like CMS or other payers provide in terms of providing whatever level we do attribute a beneficiary or a patient to, that that then allows for sort of a more granular distribution of any potential payments that are tied to those -- the quality measures or as part of the payment model that we are attributing a beneficiary to.

I think sort of it's a balance between what is the right level of attribution, but then still making it available for the entity to which you are doing the attribution to figure out which

providers within the entity are sort of responsible for the majority of the care the beneficiary is receiving.

MEMBER BEAM: Right. And as far as, you know, even looking at -- I would say individual physicians within a group, they don't always have the control to change certain things, whether -- especially if you are talking cost, because it's a lot of times purchasing and contracts are negotiated at a group level.

So when you are attributing to the physician instead of the group, you know, it's not always -- I guess it goes back to that locus of control, you know, issue. So I just thought that as well. I don't know.

CHAIR MEHROTRA: Right. These are things we should be thinking about.

Bob, you got cut off, so I just wanted to --

MEMBER KROPP: Yes. I'm in favor of keeping it as a principle for a couple of reasons. The first is that I think there is a

strong tendency to go to the individual provider too quickly, and most -- and a lot of the injustices I have seen in the name of attribution have occurred in this domain.

So I would suggest keeping it as a principle because I think it deserves that kind of attention. And I would suggest perhaps to make it more acceptable, that the language might say, "To drive the system forward, it is necessary to" -- oops, where am I? Yes. "It is necessary to change current -- current" -- this is all messed up now. "Current norms of attributions, including a desire to always identify only a single clinician." And does that -- you know, does that -- do those clarifying adverbs help?

DR. RYAN: It would be a tendency.

MEMBER KROPP: A tendency. Okay.

CHAIR MEHROTRA: I don't think I have a good finger on the pulse of what the -- where the group is. So maybe I could even have like a vote here a little bit. So, Bob, what you're

saying makes a lot of sense to me. It's consistent with others. On the other hand, I hear the voice of maybe this isn't a principle that we want to articulate, so I'm kind of on the fence.

So maybe I could put it back to you, that recognizing the language is not perfect here but just -- I think Bob articulated well the idea that he is putting out there and that others have articulated, who thinks this should be a principle? If you would just raise your hand. Well, that was not helpful. We are split.

So go ahead, Srinivas.

MEMBER SRIDHARA: So I think what -- again, so, to me, this comes back to what you are trying to do. Again, and sort of, if you take the look at an ACO, the comment was made that they and, say, CMS are attributing to the level of an ACO, and that's appropriate because that's the level of accountability.

But the ACO, in reacting to that, wants to attribute to the single clinician level

when they build their network. So I think it's dependent on what you're trying to do that informs what you do here. And so I actually would say I think Troy's comment before, or otherwise, that this is really about not saying -- think about this notion of locus of control or, you know, and the notion of equity and fairness, and maybe we need to package a principle around that that says you should be considering who has the ability to change whatever it is that you're trying to change, tied back to your goal. I mean, this is not certainly the wording that you should use, but, you know, I think that's the principle we are after.

And what the recommendation will come that follows that is going to center around certain scenarios where you would attribute to a group versus an individual, and how that is fair or not fair. But the principle rises to a higher level for me.

CHAIR MEHROTRA: So what about this -- yes, I'm going to throw a proposal out, which is

number 3 here is about transparency about the goals. It was also articulated the idea here is that you want to -- when you are transparent about the goals, you try to figure out who is going to act upon those goals. And we went back -- I at least keep on coming back to that hospital versus ACO in the smoking example. And maybe that kind of captures what you are saying, Srinivas, which is that as, you know, we have, A, B, C, D for two, maybe there is an A, B, C, D here that captures what Bob is saying, which is when you're transparent about the goals, and you know exactly what you're aiming for, part of that process is don't always go to what is easy for you, which is the individual clinician.

Similarly, and then also think about the locus of control, who is most likely going to act, react? Given your goals, who is the level of the organization that has the resources and wherewithal to actually act upon this and improve whatever the goal is? That was very inarticulate, but sort of -- does that sort of

get to where you are thinking?

MEMBER SRIDHARA: Yes. I think so.

CHAIR MEHROTRA: So, others? So I have cut off Keith for like ever, so, Keith, do you want to weigh in here?

MEMBER KOCHER: Sure. So I think part of the challenge here is we have sort of been muddying the waters because we don't -- we haven't really coalesced around a principle around how we assess measurement yet, sort of back up, but sort of when we were on point 2. And I think we are probably all on the same page about it. It is just getting the language right. So I want to toss out sort of some language to consider.

I wonder if we start with something like there is no gold standard for determining methodology for attribution. Therefore, when assessing any one methodology, it's important to understand the goals of the methodology or the attribution and balance that with things like equity, fairness, those other considerations.

I don't think we've -- I think it is important to settle the fact that there is no gold standard out there to rely on, and making sure that we state that up front before we start diving into how we do methodology. And I think even -- you know, we haven't even gotten beyond whatever -- a few of these, but like six point -- you know, principle 6 I think is probably something that has fallen by the wayside, that basically we are also beginning to address already in these conversations, and we could probably even almost take that off the table, I feel like.

CHAIR MEHROTRA: So I think your -- so if I could unpackage some of the things, I think first you said is it would be useful just to emphasize there is no gold standard right now for attribution. I also might add a caveat, which is that also the attribution rules or method will likely be different for different purposes. There is no one single rule that is going to be out there.

And so I think both of those I am 110 percent with you, and then I'm -- then, just to think out loud, now I'm trying to think, is that a principle, or is that an explanation, as we described that?

So let me go to a couple of others to weigh in on that point as well as others. Elizabeth, I think you were next.

MEMBER DRYE: Well, first of all, this conversation really turned me around on the one provider thing. I think sometimes it's okay, sometimes it's not, and that's either, you know, locus of control goal-related, but, you know, it also has to be technically possible. And I don't think those might -- they may not end up in the same principle. So, anyway, that was super helpful to hear that, because I am -- I have always been biased against one, but I don't think that's right.

But I just wanted to let you know what I'm doing, which hopefully it will be helpful, is I am just taking the normative criteria we talked

about earlier, and the things that are kind of coming out of the principle level and -- might be the rows of that table that you would just -- you know, is the goal of attribution clearly articulated? Does the goal reflect patient input? Is the level aligned with -- of attribution aligned with the goal?

I am just putting some of those sub-bullets in my thing here, so we can keep track of them, because some of them fall under those more technical decisions. And then I will just send it to you guys. So while you are shortening this, I am just trying to -- because I think there is a tension between the principles, because if you really want to keep these short and very high level, they are not going to be the normative criteria that we can -- people can go through, boom, boom, boom, boom for their, you know, ACO level or whatever, their chronic disease management patient, their acute management.

So I'm just going to stay quiet and

keep typing.

CHAIR MEHROTRA: So, let's see, I have Ira, Danielle, Brandon, Ari, and Troy. Yes?

MEMBER LLOYD: So I think we kind of led Elizabeth astray in that comment of the group to the one thing, because I think really what we were trying to convey yesterday. If you remember, in our report out my example was, you know, if the A1c is not done, and they saw a cardiologist, endocrinologist, and a primary care, they all should be responsible for the fact that that wasn't done.

You start with this overtagging notion of providing attribution to multiple, multiple -- to try to -- because we are still in this, you know, dispersed state where there is not sort of everybody grouped up into ACOs or whatever, you start with the overtagging, and then you narrow down into an accountable unit that -- you know, so instead of tagging medical group 1 that had the endocrinologist, medical group 2 that had the cardiologist, medical group 3 that had the

primary care, right, they could be three different groups, and you're overtagging them.

And at some point, one group is going to be responsible because they will have taken on the accountability step, and they will say this patient is mine, and they are working with all of the others.

I think that was what we were trying to say yesterday. It's not necessarily a physician. It could be a physician, but the point is at some point there will be an accountable unit, not just we're going to overtag everybody. Is that at all clear?

MEMBER DRYE: Yes. I mean, I think -- I guess what I'm realizing is I don't totally agree with that. I think we are all seeing that sentence about a single physician a little bit differently, and I'll give an example.

So, for example, I was part of a team consulting to Blue Cross/Blue Shield in Hawaii where they were moving to a per member per month through their primary care providers, and they

wanted to -- they have gone to attributing or they're piloting attributing, you know, hemoglobin A1c to the primary care provider.

And I actually think that's aspirational, right? It's like you're in charge of making sure this person gets their hemoglobin A1c. And maybe the person is really being cared for by a specialist, so they are piloting it, and all those things are going to come up.

But I just -- so I feel like in that context that might be okay, if they have enough patients and technically we can manage -- you know, we can measure their -- what's their hemoglobin A1c, you know, average or whatever on their patients, and how many people are getting it, what proportion.

So I actually feel myself conflicted. In the end, for me it's, is it aligned with the goal? And I think in that context you're saying you may not be so pushy. You know, you may be like let's start by allocating across or by holding everybody. Let's try to drive towards

single accountability, but I'm kind of more -- as you guys know, I'm more aspirational on these things. I'm like, okay, just set up the primary care. If you want the primary care doctor to be responsible, let's just give that person or his or her practice 100 percent responsibility. That is a piece.

The other piece is technical. Can we technically do it? And that's something you can test, so that's --

MEMBER LLOYD: It's almost like, you know, if you're starting in a MIPS world but you're going to an advanced APM world at some point, right? If you've got this disarray, you know, then just do the weighting concept across many. But eventually you want an accountable unit.

But I don't know that that needs to be a goal. I think this can be discussed later in the document. So I'm changing my vote.

MEMBER PERLOFF: This is Jen from the phone. Can I jump in at some point?

CHAIR MEHROTRA: Sure, Jen. Go ahead. It's hard for you to put your tag up, so why don't you just go ahead.

MEMBER PERLOFF: This is a great discussion. I just want to point out one error that we haven't talked about. One of the problems -- we talked about the small sample size. When you drill down to the provider, a single provider might only touch 10 patients.

But the concern I have is sometimes when we do that, we attribute the effect of the group, the delivery system, variation, you know, is all around the provider to that provider. We can't always tease apart what that provider's unique contribution is. But in single attribution, we kind of nail it all on that one person.

And I know we have been talking about these ideas, but it's that bias that worries me about the single attribution. That's the crime we have committed against, you know, providers. So, anyway, I just -- this is a fascinating

debate. So, thanks.

CHAIR MEHROTRA: Thank you, Jen.

Let me go with Ari, Troy, and Mike, and then we will -- I do think we should probably move on to the other principles here, just to make sure we don't drop -- miss those completely.

MEMBER HOUSER: So I just recognize that we are in about the place where I wanted to make a comment back in the first session, and then we tabled it. And that is, in this point 3 where it -- and Troy had mentioned something about the idea of that -- gaming the attribution rules, either intentionally or unintentionally.

And it was suggested that that could fall sort of into three unintended consequences. And I don't like the use of unintended consequences here. I would probably say "in consideration of the consequences that might arise." And if they're foreseeable, I don't think they're unintended. They may be unwanted but unavoidable, but not unintended if you're declaring them up front.

CHAIR MEHROTRA: But you think about -- I think the unintended consequences was trying to be polite about gaming. So do you -- would it be better just to be clear-cut and say "and consideration of potential gaming that might arise"?

MEMBER HOUSER: Well, I want to separate gaming from other consequences, because there are consequences that result from the fact that you are -- when you attribute to a single physician or a couple of physicians, you are grossly oversimplifying what is actually going on, and there is consequences that result from that simplification. And that is really I would call more like a measure imperfection type consequence.

And then there is susceptibility to gaming, which is another type of consequence that is -- and I -- I'm not sure they should be mixed, and certainly they should -- they shouldn't be -- they both are important, and we shouldn't have language that suggests one to the exclusion of

the other.

CHAIR MEHROTRA: Yes. So my quick reaction was is that I had seen the transparency about the goals as being the -- what we hope will happen or what we think is going to happen, and then just make sure that you think about the things that you -- like make sure you put your evil hat on and say, "What would you do in terms of response?" But that's at least what I -- where I was thinking, but I do think that the unintended consequences -- maybe that choice of language is a poor one, and I appreciate that point.

So let me go to Troy and then Mike and then Brandon.

MEMBER FIESINGER: I just want to make a couple of points. I'll take back my comment that I'm okay with attributing the teams, because I think I'm like Elizabeth; there's a lot of different options and possibilities we have to think about.

In terms of the comments, there is no

gold standard, et cetera. Why don't we call it a preamble? Not to be too much of a history buff, but they put the preamble to the Constitution for a reason. Here is the basic stuff we want to put out there that we think is important. And then we go through all these rules. I think that would be a nice place to say there is no gold standard, there is no road map, there is not a lot of research or data, all these issues we are covering, and we can wordsmith it.

In terms of the consequences of --

CHAIR MEHROTRA: This is in the Bill of Rights.

(Laughter.)

We're aspirational here. We're going change this from principles to --

MEMBER FIESINGER: I was a history major, so it all comes back to that.

CHAIR MEHROTRA: -- bill of attribution rights.

MEMBER FIESINGER: I mean, they locked 200 people in a room and let them argue for a

year. The notes are actually very revealing -- three kings, one president, whatever. They finally came up with a document that worked pretty well. We're going through a similar kind of process while trying to get to the same place. So preamble might be a home for these principles we agree on, but I won't call them principles.

In terms of the consequences, I think we have to balance getting at what we're talking about with being sensitive and diplomatic. When I have -- like we had to create legislation in our state for supervision of mid-level providers, is it supervision, is it regulation, so on and so forth. You don't want to put words in the law that you wish you hadn't put in.

So I'm okay with "consequences," knowing that I'm going to mean manipulation, gaming, and unintended consequences. And, to me, a great unintended consequence would be when ACOG set up new rules about vaginal birth after C-section criteria, I did OB as a family doc for 15 years, what happened is, once you had to have a

C-section-capable OB/GYN or a family doctor in house, VBAC rates went to nothing.

And timed antibiotic in the ER, similar issue. I remember in the ER I was in them saying, you know, that wasn't a great quality measure to say timed antibiotics, because we pushed inappropriate antibiotic use. We didn't realize that would happen. So those are two good examples of they didn't want those things to occur, but they did.

But if we say gaming, and we say manipulation, even though I'm thinking that, I'm not sure I want to read that on the NQF website, so we need to be a little diplomatic.

CHAIR MEHROTRA: And we also recognize that we will have language under each of these principles that kind of explains and provides context. So let me keep on going with Mike and then Brandon and then I'll move on, if that's okay with folks.

MEMBER SAMUHEL: I just want to come back to this notion that attribution is not an

exact science, that there is error in attribution, and there are several sources of error. And I don't think we've got a principle that really covers that. It feels like it's connected with not having the gold standard in fairness, and so on.

I might be getting a little bit ahead of myself. What we're talking about in terms of error may come out as we work through some of these case studies or whatever we're calling them. But I do think it's important in some solutions down the road, instead of like percentages of payments and, you know, you get three percent, you get six percent, is a banding, you know, this group will all get five percent in terms of payment. But I think it is an issue that is going to come up, and we need to address it.

CHAIR MEHROTRA: I think that's a good point, and it might also come up with number 4 when we turn to it in a second. So --

MEMBER SAMUHEL: Yes. I looked at

number 4, but I think 4 is really talking about quality measures, the impact of the attribution on quality measures, if I'm reading it right. So it doesn't quite fit with what I'm talking about.

CHAIR MEHROTRA: Yes. I know that's a good point.

Let me -- Mike? I'm sorry, Brandon?

MEMBER POPE: I would agree with both Ari and Troy on -- I like the language shift away from unintended consequences to something more about, you know, the direct and indirect impacts taking into, you know, effect how people will change their behavior according to the sort of mechanisms you'd put in place.

I also like Troy's idea. I think we have hit on this a lot, that maybe it is both appropriate in the preamble and the afterword to, you know, express our humility in this matter, that it's difficult and, you know, but I was just going to say, with regards to the overtagging, I don't see this being a huge issue in the near future that we've -- you know, we've decided that

we need to hold accountable, you know, both the PCP and the endocrinologist and the hospitalist and the diabetes educator and the care manager all for the A1c test.

And this has become sort of a tragedy of the commons A1c test situation where, look, I thought you guys were going to take care of it. I don't really see that being a near-term problem, so I just wanted to -- you know, I think we've talked about that a little bit, but I think we're more on the other side where we're trying to figure out what are the appropriate ways to hold somebody accountable for these things?

CHAIR MEHROTRA: So let me move on, if that's okay with you, just because I do -- we only have about half an hour left. We have a number of other principles here. And as I look at -- I'm just going to vote, just in -- to give you my own thoughts on number 4. I'm the one who I think pushed for this, which is basically, if I could simplify with two words. It was attribution matters.

And I am wondering whether that is not really a principle. It is more of a -- to use Troy's language, a preamble kind of point. So I'm going to argue that that moves away from a principle and moves to more just trying to say, why the heck are we spending all this time working on this issue?

That's my vote. Do -- I see some shaking heads yes. Is there anyone who disagrees with that idea? Okay. Well, that was easy.

All right. Well, let's move on. Number 5 is attribution rules are not static and likely will evolve over time with increased data availability, and as the health system changes, maybe as the -- belongs there, good principle, bad principle? Elizabeth?

MEMBER DRYE: I would just revise it to say "as the goals of health" -- I don't want to use the word "reform," but as our goals for our health system evolve, because --

DR. RYAN: That should say "should." If that's the idea, it should evolve over time.

I mean, otherwise, with the "will evolve over time," it sounds like maybe it's the preamble statement.

CHAIR MEHROTRA: No. I think that's a good point. We are trying to say what we think.

Go ahead, Charles.

MEMBER HAWLEY: This is just I think restating that there is no gold standard, so I don't know if they can be lumped together or --

CHAIR MEHROTRA: To put like almost a clause underneath it as we have done for some of the other ones, given that there is no gold standard, so as data availability becomes -- better data becomes available, you want another rule that captures that. Do you think that is -- did I capture what you were saying?

MEMBER HAWLEY: Yes. I mean, yes, I guess so. I guess the point of saying that there is no gold standard is -- you know, that there is no one way of doing it, this is basically saying not only is there no one way to doing it, but

there is -- these several ways are likely to change. I feel like those are kind of the same point, which is, yes, just that there is no one way of doing it.

CHAIR MEHROTRA: So I agree with that idea. I wouldn't put -- I'm just going to put my own personal thought that that -- the point you just made goes right underneath the principle but isn't part of the principle itself. Or maybe I misunderstood you. You could add the caveat, "Given there is no gold standard, attribution rules should evolve over time." Is that -- or which one of the two did you favor?

MEMBER HAWLEY: Yes. I think that -- I think that would -- I just kind of think --

CHAIR MEHROTRA: Love this real-time -- it is also intimidating, by the way. It can be. It's like, I didn't say that. Did I say that?

(Laughter.)

MEMBER HAWLEY: I just feel like they could be combined. I guess that's -- you know, I

don't know that it needs to stand -- I don't think that either one needs to stand alone, the gold standard -- I think they're related I guess. I'm not exactly sure how to capture that, but --

CHAIR MEHROTRA: Oh, go ahead, Jen. Sorry. You always have --

MEMBER PERLOFF: I'm so sorry. Is the principle that you should revisit or reconsider your attribution methodology on a regular basis? I'm not sure I understand the necessity to change if you nailed it, but we're saying that the dynamic is data is becoming available -- is the principle that you should always be aware of, you know, testing and abating your approach rather than being prescriptive that you shall change over time?

CHAIR MEHROTRA: That's a good point. So it's given there is no gold standard, and data systems and health systems are evolving over time, one should revisit your attribution rule over time.

MEMBER PERLOFF: Every six months.

MEMBER HAWLEY: So I think maybe that kind of highlights that maybe this isn't so much a principle as something that should go into whatever the preamble might be, because we are not necessarily prescribing that it should change. We are just sort of acknowledging that given the fact that there is not a single way of doing this at this time, that it is likely to change. That seems more of a preamble. Interesting conversation.

CHAIR MEHROTRA: Nate, you had your card up. Reaction to that or --

MEMBER SPELL: Yes. I think our original -- to respond to Elizabeth, our original intent with the word "health system changes" was the acknowledgment that it is structural change that is really happening toward more team-based and, you know, integrated networks and those sorts of things.

But to state that -- because it does kind of state the obvious. I do like the idea that maybe if we're putting it out there as a

principle, the principle is that attribution models will, by necessity, need to be reevaluated periodically because there are changes in the health system.

CHAIR MEHROTRA: I like the change in language there. Would you guys agree with that? So let me just make sure -- if Kim, in her amazing writing, can try to capture that again from what you heard from Nate. Any disagreements to that in principle, or does anyone feel like it should be struck?

So why don't you -- if you can try to capture that, why don't we keep on going here, because I think number 6 is going to garner some significant debate here. "Provider and patient self-selection of the responsible provider may be preferable to only use of claims-based attribution algorithms."

So I think in response to some of -- we had some nice debate about this issue about -- or examples of when patient providers' self-selection can be wrong, or auto assignment of a

PCP can be wrong, I think that's why the word "may be" -- it just has the word "may" there. But is that not far enough, and should this be -- to respond to question of "strike this," should it be struck? Go ahead, Jenny.

MEMBER BEAM: I was just going to say, because if it is a "may," then it's probably not a principle would be my --

MEMBER MOSCOVICE: Principles don't have the word "maybe."

(Laughter.)

CHAIR MEHROTRA: All right. So, on that note, maybe we will take a vote here. Should this be -- all in favor of striking this? Oh, I'm sorry. I don't know why I looked at you. I'm sorry, Laurel. My apologies. I'm getting -- I'm having a hard time here. I'm missing Carol.

MEMBER RADWIN: Before we throw the baby out with the bath water, are we trying to say something about claim-based attribution algorithms that can be stated alone as a principle without the prelude there of "provider

and patient may be." Is there something in principle -- and it's a real question. I'm not advocating either way that we want to say about claim-based attribution systems. I think they're weaker, they're less desirable, they're often flawed. I mean, is there something we want to say or not?

CHAIR MEHROTRA: So I guess if we were to go back to -- that's an interesting point, so let me reframe that slightly. So let's not take the reality of our crazy HMO assignment of a PCP, and let's say every day -- I'm taking it to the extreme -- I have checked in with our patients and said, "Who is your provider today?" And we have that every single day, and that was the -- and we used that -- I think that would be preferable to what were are currently doing maybe in terms of claims-based or no. Maybe not.

MEMBER HOUSER: It's hard to say that I think.

CHAIR MEHROTRA: So I guess my -- just to emphasize the point, I think what I'm trying

to raise is that is our concern about this particular principle because of the current self-selection and the biases in that? Or is it that principally we just don't agree with the general principle? So sorry for --

MEMBER HOUSER: I mean, the question whether it's better is, how do you define "better"? Is it more accurate for the people to whom it is applied? Probably. Is it -- but it may be worse in that it now creates inconsistency in the way that it -- that this is defined across your population. Is that, in aggregate, better or worse? I don't know. But that kind of suggests that this goes into the things-you-should-consider menu and not the principles menu.

MR. MULDOON: And it seems like maybe it's -- have you considered all of your available data sources that you could potentially use, and which combination of those best furthers the ultimate goal of why you're performing this attribution.

CHAIR MEHROTRA: Right. So it sounds

like there is -- first, built on the Ira "maybe," as well as just generally. So this sounds like this should be removed and down lower.

Srinivas?

MEMBER SRIDHARA: I just want to make one -- I actually -- I think what we -- that particular comment, you know, yes, probably is a recommendation. But I think along the lines of what -- actually what Dan was saying, I think there are several things here what -- including our level of -- do you attribute to the provider level or not?

All of these I think our principle, if you will, is that the available data and data quality are fundamental to deciding an attribution approach, or some wording like that. And I think because that's a theme that is going to come across like everything that we say is that, you know, you may have some ideals, but you're not able to do it today, and that sort of is what you were asking.

If I could ask someone every day,

would that be better? But maybe once EHRs and HIEs proliferate and you have better information, maybe that's another source. Maybe, you know, CAHPS has better sampling in, you know, certain places. Or, you know, I don't know. There are so many places where you could do things like this that you -- if your people are doing attribution.

So I would go for something like that, and then in the recommendations --

CHAIR MEHROTRA: Do you think that would go under number 3 where we were talking about when you think about from a conceptual perspective how you choose your attribution rule, or is that a separate principle? I agree with the idea fully, and I'm just trying to understand whether -- where it's --

MEMBER SRIDHARA: I think it is actually different than the goal, because you have a goal and then you have what are -- you know, I think the data quality and data availability is a fundamental problem, and I

think -- because when you think about later recommendations and perhaps even sort of, how does this committee look to the future and maybe make recommendations that aren't just attribution recommendations but sort of highlight the need for better quality data, and more availability of data broadly, that becomes something that we probably need to talk about in this, whether it's a preamble type of thing or a recommendation, that it's a fundamental problem. And so I think we can say something about that in a principle standing alone.

CHAIR MEHROTRA: Let me -- I have cut off a couple of people for a while, so let me just come back to them. Troy, and then Bob.

MEMBER FIESINGER: If I can comment directly on that. I'm okay with moving the specific language about patient designation and provider designation, claims data, but I want to give up on the principle because to me what matters is accuracy. We have already talked about how we can't be 100 percent accurate, and

that may be bad. But the principle I want is every attribution measure should have mechanisms by which it can be corrected.

You know, Jennifer told me all the work that goes into Blue Cross/Blue Shield's efforts to assign patients. Jenny has talked about this, too. If I perceive it as inaccurate, I need a mechanism and a way to adjudicate that, and I think that is going to -- to me, that needs to be enshrined in attribution measures going forward.

My memory of who my patients are isn't perfect. Their thought about who their doctor is isn't perfect. But claims data also has multiple problems we are probably already -- we are all painfully familiar with, yet we use it because it's available.

So the principle of accuracy I want to keep in here somewhere, even if we move mechanisms or tactics down.

CHAIR MEHROTRA: So I hear -- that's a great point, which is this -- how to address

the accuracy. And so to push the point, this is very similar to what I was thinking with in -- also saying that I'm with you, but is that a principle? And so just to make sure you're proposing that there should be -- I won't use the right words, but there should be some mechanism by which people can address perceived misattribution.

MEMBER FIESINGER: Yes. Like in the Next Generation ACO model, the patient can voluntarily attribute. So if someone is seeing me, and is a Medicare or fee for service patient, they could join the Next Generation ACO under me, even if they weren't originally attributed on their prospective model. I like that. That is just one example, but, you know, anyway --

MEMBER DRYE: May I just --

CHAIR MEHROTRA: Go ahead, Elizabeth.

MEMBER DRYE: I just want to suggest a way to solving that, because I'm putting back on my working in the executive branch and the Congress, the sort of policy-writing hat. That

goes pretty far. I mean, that's very prescriptive, so I think it's too prescriptive for principle.

But you could say something like opportunities, you know, or opportunities to review and correct attribution contribute to fairness, or something, contribute to greater fairness. As opposed to saying everybody has to do this, you could say something more general like, if you build that in, it contributes to greater fairness. Even that I am little -- I feel like it's a little granular for a principle, but it backs off of the requirement and gets -- hopefully it supports your point.

MEMBER FIESINGER: I guess to clarify, if accuracy is in there as a principle, I'm okay with everything else being somewhere farther down, so I don't mean to put the Next Gen ACO example in the principles at all. It's more let's be accurate. Later, okay, here's all the different ways we can make sure things are accurate.

CHAIR MEHROTRA: So what if we -- I'm going to propose combining a couple of things here. So what if we -- you see this 5A? What if it was, given that there is no gold standard and data systems and health systems -- well, are evolving over time, one should revisit your attribution rule and allow mechanisms for -- to consider mechanisms for misattribution?

So it sort of captures I think what Charles was saying. There is no gold standard here, so we need to be thinking about changing things over time, or so forth. Does that help, or is it --

MEMBER FIESINGER: That's pretty close

MEMBER BEAM: Or does that belong with transparency? Because if I'm being transparent, you know who is on your panel, and then I have to allow you a way to address what is on their panel.

CHAIR MEHROTRA: Okay.

MEMBER BEAM: I don't know. Just --

CHAIR MEHROTRA: Bob, you had

something you wanted to show that, or would that be -- I would be happy to look at that for a second. Is that something you could -- Bob, you shared a little bit of these RACI --

MEMBER KROPP: Yes. It's late in the day to introduce another concept, but I'd like -- I sent you that just to consider after the meeting and after an adult beverage or two.

CHAIR MEHROTRA: RACI --

(Laughter.)

CHAIR MEHROTRA: Do you want to walk us through --

MEMBER KROPP: We are struggling with the concept of who really is -- attribution, I am sensing from the group, is a process by which we determine who is accountable, and we have taken that to mean who is ultimately responsible for getting something done. And then, further, who might contribute to that activity and who might get paid for it. And I just -- I have given Ateev some additional terms to consider that might help us distinguish between these groups.

MEMBER KROPP: Yes. What is the context behind this? Like where does the RACI thing come from?

CHAIR MEHROTRA: Oh. Well, there it is. I didn't mean for it to come out.

(Laughter.)

CHAIR MEHROTRA: This is a business model that large organizations use to allocate work.

MEMBER KROPP: I see.

CHAIR MEHROTRA: So in large -- in project management, this is something that is routinely done to identify who is on first, and it overlaps with some of the concepts that we have been talking about the last two days. It is also --

MEMBER KROPP: I don't know whether --

CHAIR MEHROTRA: -- like what I was thinking with Danielle, or somebody made the whole point about the hemoglobin A1c, and all of these different people.

MEMBER KROPP: Correct.

CHAIR MEHROTRA: Who is in charge of getting the hemoglobin A1c to less than 7-1/2, but then who should be consulted, who should be --

MEMBER KROPP: Yes.

CHAIR MEHROTRA: That's interesting. I'm -- I appreciate you bringing this up, but I'm still not sure how to incorporate it.

MEMBER KROPP: No, no. And I -- and that's why I was trying to sort of not have it come out publicly, because --

(Laughter.)

CHAIR MEHROTRA: No. I appreciate it. I think it's good to bring this up.

MEMBER KROPP: No, it's late -- it's late in the day, and I think it's a concept that is best, as I suggested, after a meeting and adult beverage, you know, see if this helps inform the discussion between now and next time.

CHAIR MEHROTRA: So we'll make sure this is after dinner -- on the August dinners that we have red wine any other adult beverage

that is --

MEMBER KROPP: But thank you both for bringing it forward.

CHAIR MEHROTRA: All right. So let me do a time check. We've got 15 minutes. We have, how many, five minutes?

DR. AMIN: Yes, five minutes because we need to wrap up and talk about next steps. So if we can --

CHAIR MEHROTRA: Okay. So, Charles, why don't I have you weigh in and then I'd love to -- and then I'll probably propose some changes here to sort of get closer to final here.

MEMBER HAWLEY: Okay. I'll just say quickly that the one -- the one concept that I think should be captured when talking about self-selection is consistency -- and this came up yesterday -- and understanding that the method may change over time is one thing, but in any given moment being consistent is important; otherwise, I think what you have measured is not necessarily comparable.

So if you're going to have provider and patient self-selection, everyone needs to have self-selection. Or if you are going to rely on claims data, you should rely on claims data. But I'm not sure that a mix-and-match approach is consistent, and I think that that's problematic or at least potentially problematic. So --

CHAIR MEHROTRA: Something that Ari brought up -- and I wasn't sure if I -- I can kind of see -- I'll say that, in general, we have this idea what we're trying to capture, and you try to use all the data, available sources, to do it. And, in some cases, you have that patient self-selection; in other cases you have to do something else and fill in the gaps. And we -- I feel like we do that in policy interventions all the time.

But why don't -- but I take your point also. I see why you could have -- want to have a consistent approach across all. So given the time here, I feel like this -- it sounds like we're going in circles a little bit, but I do

think, to build on the example of locking people in for 100 days and trying to get the declaration of -- we are only locking you in until 2:30, and -- but it's something slightly less important, but I think this kind of wordsmithing has been helpful.

I am going to expect that, based on these caveats, you can adjust some of this language. Let me make a couple of points that I think I heard. I think we decided to get rid of six fully. And all who disagree, okay. And then, if you go back up, six was the self-selection thing that we thought that was a principle.

Oh, no. I'm just joking with you, Danielle. Please weigh in.

MEMBER LLOYD: So I think the reason I'm struggling with losing it from the principles is because fundamentally, from my perspective, and I think others, including the health care transformation task force, and I think even some of the land papers, is that to me attribution is

a proxy, right? What is the true answer is, what is the compact between the patient and the provider, right?

So we are trying to capture that in an automated fashion by harnessing data and -- but it is a secondary process. The ideal first process is to actually identify it between those two parties who essentially entered into that agreement with each other. And that's why I think it needs to stay as -- at some point at a principle level.

CHAIR MEHROTRA: Jenny, can I have you -- do you mind weighing in? Because you have articulated the --

MEMBER BEAM: Right. I just -- you know, looking at the data and what I have seen, you know, the patients don't always -- again, who is your patient? Dr. Smith. Well, which Dr. Smith? Because you're in a large city, so there's five Dr. Smiths. Oh, I don't know, you know. Or even if you get to Tom Smith, you know, then you go, well, is it Jr. or Sr.? Oh, I don't

know, who's 40 or 50.

So then people are not accurately really selecting. The data often shows that whoever the patient selects really is not who they are seeking for care. Or I have said I am going to come see you, but, then again, I go see -- you're on vacation. I go see someone else in your group, and I really like them better and I stay with them.

So what the data has actually shown is that oftentimes there is not good overlap. So, again, I would hate to replace actual data, where we know a patient is seeing a provider, with a less accurate measure. I think in the ideal world, if you could capture that, and it would be accurate, I don't think anybody would argue. But I just don't think it's clean today.

MEMBER LLOYD: Yes. We've got to go, but I think part of it is also there are other mechanisms that people are starting to test to get around this.

In fact, we were just talking about

putting it in something like the current -- you know, the Medicare beneficiary survey is if you -- if you put in, you know, here is three people you commonly see, who do you believe is the person that is ultimately responsible for your -- so you are not just having them fill out a blank form where the 85-year-old blind diabetic was like, what was his name?

You know, like there can be combinations of these things, but ultimately part of the goal here is to make sure that we have a new day and age where people are making an overt decision. So it is on the aspirational side, not the in today's -- is it --

MEMBER POPE: Ateev, I think part of the reason we started to strike it was, you know, we had this language from May, and so I think everybody agrees we -- you know, we can't leave it as a principle where we say you may do this or that.

I really favor, you know, having some discussion around that in the section where we

talk about as new data sources become available, and ways of more discretely and concretely capturing that relationship come onto the scene, you can incorporate that, the reality is those things don't exist today. So I don't know how -- you know, how useful that is in some sense.

CHAIR MEHROTRA: So what if we were to say basically attribution rules or attribution methods have often been equated with claims-based mechanisms. And given what we are trying to capture here, we recognize that attribution can come from many other sources, including self-selection, EHR data, et cetera. But that would not be a principle, but that would, rather, be in the language we describe and is really an important part of this document.

MEMBER BEAM: I would just say that many other sources are not available, and EHR is not available today. I mean --

CHAIR MEHROTRA: No, no, no. I'm saying that, as time evolves, these --

MEMBER BEAM: Yes.

CHAIR MEHROTRA: Exactly.

MEMBER BEAM: Yes.

CHAIR MEHROTRA: Okay. So very conscious of time, and so I am going to just quickly -- we never really addressed six, seven, and eight. So what I would like to do is propose just having some quick votes, just to get a sense for the NQF staff to do -- what to do with these, and then I think there should be -- I think there is a necessary next step, which is to clean up the language, for us to reflect a little bit, and then to have us have another opportunity to weigh in on these principles. Does that make sense? In the future.

So let me just get a sense of -- number 6 I thought was a great idea, but I wasn't sure that it was a debate about principle. Available data and data quality are fundamental to deciding on attribution approach. There's a thought that should be a principle.

We have about four or so but -- okay, a little bit more than half, maybe two-thirds.

To drive the system forward, it's necessary to challenge current norms of attribution, including a tendency to identify a single -- only identify a single clinician or provider. Who thought that was a good principle? Okay. Maybe a little bit less support for that idea, though there are certainly key -- those who agree think it is --

(Simultaneous speaking.)

CHAIR MEHROTRA: Okay.

MEMBER FIESINGER: I like the concept, but the wording doesn't quite say what in my head I'm trying to articulate.

CHAIR MEHROTRA: Okay. But that's exactly what kind of feedback we needed.

And, lastly, simplicity and consistency of attribution rules are the ideal state. However, flexibility is necessary to align the attribution method and the use case.

(Laughter.)

CHAIR MEHROTRA: And you should love your mother and baseball.

(Laughter.)

MEMBER BARR: Shouldn't that be in the preamble?

CHAIR MEHROTRA: So those who thought this was something really critical -- important for us to put as a principle? I'd just remind you, put your mic on.

MEMBER KROPP: I'm sorry. Two days and I'm challenged with technology. Sad.

I think it needs to stay as a principle, because this is where a lot of providers will just immediately reject attribution out of hand. So I think that some acknowledgment up front that this is -- that simplicity and consistency is what we're looking for. Troy said it several times.

However, the system is complex, and the rules need to reflect the complexity of the system in order to ensure fairness and equity and things like that. So I think it is a principle.

CHAIR MEHROTRA: Right. So that's helpful. I know we haven't come to full conclusion. Let me -- Jen, you had -- you

just --

MEMBER NOWAK: Just a real quick statement. We use attribution rules, attribution method, attribution model, attribution algorithms. There is logic. I think we just need to land on something. There is rules, and then there is the logic and algorithm around those rules. That's --

CHAIR MEHROTRA: So I think we'll --

MEMBER NOWAK: It's consistent in our wording.

CHAIR MEHROTRA: That's a very fair point. I think attribution model, based on Dr. Ryan's recommendation, is what we -- at least where I am. You good with that?

All right. So I'm going to now turn it over to the capable NQF staff to wrap up.

DR. AMIN: I have some wrap up elements, but, Donna, do you have some that you want to walk through as well?

MS. HERRING: Just quickly. Operator, could you open the line for public comment?

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

And there are no public comments at this time.

MS. HERRING: Okay. So I'm just going to go over some next steps for the project. So next we will be posting the summary of this meeting to our project page. That will happen next week. The authors will continue to refine the paper based on the discussion that we have had today and yesterday.

Our next meeting is in person at NQF in this same room again in August, and we will discuss the public comments that have occurred on the paper, and we will refine the principles and make recommendations.

And then, on the next slide, we will just quickly review where we have been and where we are going. So, as you can see, we did convene the committee and the commission's authors. We

had a web meeting to review the environment scan outline. The authors conducted their environmental scan, drafted the commission paper, and here we are today at our in-person meeting number one.

So next we will post the report for public comment, and then we will have our second in-person meeting before drafting the report, and then having our final report.

That's all I have.

DR. AMIN: So, Donna, a few things for the committee. There is a number of elements of pre-work that is going to really be helpful in order to get our August meeting to where we want it to be. We really want to start looking at this -- at the criteria, the second order criteria as we referred to.

Sorry. Let me just look at my notes here. The criteria, the second order criteria, and the elements that we want to -- as part of the checklist.

So I know, Elizabeth, you mentioned

that there are some things that you are working on, so it would be helpful if others would send it along. We are going to -- we are sort of going to ask a few of you to work on sort of small groups with us, so we'll be reaching out to you individually to help us sort of refine the various criteria.

And then, as we identify the use cases from the input from CMS, and then others in the room, we are going to ask -- again, convene a small workgroup of this group to help, you know, put together kind of what we did between day one and day two here, just run those case studies through the criteria and have that as a starting point for our discussion in August, so that we are sort of working, you know, from a more robust product and to keep the work going in the interim period.

So please look out for that. We're just going to sort of reach out to folks that have been really actively participating in those elements. I'm sure you guys know who you are.

And then we'll convene a small call to do that.

Now, the other question is that, clearly, what we're going to public comment on is, in addition to Andy's paper, is going to be these principles. You know, we still need some refinement, clearly, in terms of where we are. There are two different ways that we have done this in the past. The first is to -- you know, staff will take the list and sort of pass it around, ask for track changes, and have that all sent back to us, and we'll do the second set of iteration.

The other option is that we do have a call that is currently on the books, next Tuesday, which would be another opportunity for us to refine it, send it back to you, and for you all to jump on a call and talk it out. We can do either approach, and so I think I'm actually asking for recommendations about how we want to do it. Ashlie?

MS. WILBON: Yes. If we could vote, I'm -- we could go either way, but I think I'm

with Ateev on this. I think it's helpful to have people talk, because my sense is that track changes will get conflicting recommendations, and then staff is left to try to reconcile those, which may or may not be -- you know, we can only go back and forth so many times before we have to put things out for comment.

So I think my leaning would probably be towards the call, just so we have an opportunity to verbally hash it out and kind of either get strawman vote on the phone or whatever about which way to go, so that we are not left to reconcile conflicting recommendations.

But I did also want to put -- put that out to the group. If we could just see a show of hands of people who are willing to hop on a call on Tuesday. We would take another stab at what we were left with today, try clean it up again, send it out to you guys, and then use the call to just make sure we get the final okay before it goes out for comment, or just kind of get the temperature of where you guys -- you know, if

that's -- just let us know what you're thinking based on where we left off today, and that plan of us going back and doing some editing and then what's the step after that in terms of committee checkoff.

CHAIR MEHROTRA: So maybe we'll just have a vote?

MS. WILBON: Yes.

CHAIR MEHROTRA: So those in favor of having a phone call next Tuesday?

(Simultaneous speaking.)

MEMBER SRIDHARA: I just have a question about that. Is it -- how realistic is it that from now 'til Tuesday, given you have all been here for two full days, and so has everyone else, and a number of other things you have probably left behind for the two days, how much further will this move forward before our Tuesday call if you have to get something back to us in like a day or something, two days, for us to have time to review?

I mean, I think a call, good idea.

I'm asking a "when" question, of actually having time to process this, and especially if you wanted to reach out to anyone else or do whatever else to sort of refine -- there are some pretty, you know, substantial questions or elements left open right now. And so if you want the most out of that feedback, is it better to push it out a little bit and have time to do that?

CHAIR MEHROTRA: When do you have to send this out for public comment?

MEMBER SRIDHARA: Yes, right. I don't know what the logistics are, but, yes.

MS. HERRING: Yes. So the report goes out for public comment in mid-July, July 15th. We had the June 21st meeting on everyone's books as follow-on from this meeting. That's why it held. We have an option of finding -- the challenge is is that we want everyone to participate in the discussion, and so that's why we send the dates out so far in advance.

So I think it's an open question, but logistically whether or not that's possible at

this time is potentially going to be the monkey wrench in there.

CHAIR MEHROTRA: Srinivas, I was going to say that, given those issues, and this is fresh in our minds, and so forth, and the capabilities of this NQF staff and how quickly they move, that we keep with the next Tuesday call, just because I think we will be all fresh with it and we will be thinking about it, because I think in two or three weeks we might be like, what is attribution? And so --

(Laughter.)

CHAIR MEHROTRA: So if that's -- so recognizing it may not be perfect timing, but just the logistics. That seems reasonable.

MS. WILBON: So it sounds like the consensus is that we're going to use the call on Tuesday. Okay. So we will be sending something out to you guys -- today is Wednesday -- by the end of the week maybe. We'll have it to you guys by the end of the week, so you have the weekend plus Monday and the call will be on Tuesday.

CHAIR MEHROTRA: It's only half a page or so, so --

MS. WILBON: Yes. It's not -- yes, we can call that out. So does that sound like a plan? Okay. Good.

CHAIR MEHROTRA: Is that it?

DR. AMIN: All right. So, in summary, we will send this out, and then there is going to be small workgroups on the criteria, and the case studies, and then that will feed our discussion for next time. And, again, just for everyone's sort of orientation, the real content for next meeting is to then take these case studies and look at the criteria, work it through, and then really extract sort of the logic that we have talked about in terms of, you know, the logic that we've talked about. I'm not even going to try to summarize what that is.

And, you know, and then we will use that as -- and then take that and apply it to what we -- the NQF process, meaning the consensus development process for measure endorsement and

measure selection and make specific recommendations on how that affects our internal processes, and then that will basically be the structure of the second meeting that we have in October.

So thank you all for your time and your mental energy that you have all contributed to this over the last two days. Ateev, for your excellent leadership of the team. And it has been a great two days.

Are there any additional questions about what we are trying to get done, where we are in the process? Any questions from the group?

All right. Thank you all. Thank you very much.

(Whereupon, the above-entitled matter went off the record at 2:35 p.m.)

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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