NATIONAL QUALITY FORUM

Memo

May 30, 2018

To: Improving Attribution Models Advisory Panel

From: NQF staff

Re: Post-comment call to discuss public and member comments received

Purpose of the Call

The Improving Attribution Models Advisory Panel will meet via conference call on Wednesday, May 30, 2018 from 12:00-2:00 pm ET. The purpose of this call is to:

- Review and discuss comments received during the public and member comment period
- Provide input on proposed responses to the comments
- Discuss potential revisions to the draft white paper

Advisory Panel Actions

1. Review this briefing memo and the draft white paper.
2. Review and consider the full text of all comments received and the proposed responses to the comments (see comment table).
3. Provide feedback and input on proposed comment responses. .

Conference Call Information

Please use the following information to access the conference call line:

Speaker dial-in #: 1-800-768-2983

Access code: 291-5367

Background

Value-based purchasing (VBP) programs aim to realign incentives to focus on quality of care while alternative payment models build on the VBP framework to enhance care coordination and promote responsibility for patient outcomes. However, successful implementation of value-based purchasing and alternative payment models requires an understanding of who is responsible for a patient's outcomes and healthcare costs. Attribution is a methodology to assign patients, encounters, or episodes of care to a healthcare provider or practitioner. An attribution methodology seeks to accurately determine the relationship between a patient and his or her team to ensure that the correct entity or entities are accountable for the patient's outcomes and cost.

In 2017, NQF issued its first guidance report on attribution models and defined the elements of an attribution model. While the contributions of the first effort were substantive, the Committee recognized the need for further guidance. This project builds on the first report and explores a set of key attribution challenges, contributes to the development and dissemination

of best practices, and spells out the key considerations for evaluating attribution models with the goal of developing a white paper that explores these issues.

Comments Received

The draft white paper went out for public and member comment from April 12, 2018 to May 14, 2018. In order to facilitate discussion, the majority of the comments have been categorized into major topic areas or themes. Although all comments are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics that arose from the comments. Note that the organization of the comments into major topic areas is not an attempt to limit Advisory Panel discussion.

We have included all of the comments that we received in the comment table. This comment table contains the commenter's name and organization, the comment and proposed response. Please refer to this comment table to view and consider the individual comments received and the proposed responses to each.

Additional comments not included in the comment table were submitted by The American Society for Radiation Oncology and can be found in Appendix A.

Comments and Their Disposition

Four major themes were identified in the comments, as follows:

1. Requirements for evidence
2. Clarifying testing for scientific acceptability
3. Additional guidance on preventing unintended consequences
4. Guidance on considering attribution in CDP and MAP

Theme 1 – Requirements for Evidence

Under Evaluation Consideration #1, the white paper currently suggests that a conceptual rationale supporting the linkage between the measured health outcome and an intervention that the accountable entity undertakes could be the basis of evidence for an attribution model, citing work by NQF's Evidence Task Force and the limits to current evidence to support attribution models. The Advisory Panel laid out potential ways to support the conceptual basis behind an attribution model: how the accountable entity can influence results, why a given set of rules was selected, and the consideration of consequences.

However, commenters note that NQF updated the evidence requirements for outcome measures as "Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service." In the absence of such evidence, empirical data that show a significant performance gap between providers may be submitted.

Action Item: Does the Panel support requiring empirical evidence for attribution models or is a conceptual rationale sufficient? Does the Panel have any additional guidance that should be included in the white paper?

Lead Discussants: Jack Resneck, Ateev Mehrotra

Theme 2 – Clarifying Testing for Scientific Acceptability

Commenters note that additional clarification is needed to specify acceptable parameters for testing attribution models for scientific acceptability. In additional to clarification, commenters suggested that the newly formed NQF Methods Panel, currently charged with evaluating the scientific acceptability of complex measures submitted to NQF for evaluation as part of the Consensus Development Process, should be consulted.

There are potential areas of clarification to the white paper's guidance on testing attribution models. First, the Panel may wish to discuss if the conceptual difference between evidence and testing of an attribution model is clear. The Panel generally agreed that the goal of reviewing evidence used to support an attribution model is to demonstrate that a provider can reasonably influence the outcomes. In contrast, the goal of testing is to determine the effectiveness of the attribution model to approximate the patient and provider relationship. Thus, for each measured outcome, testing should quantify the patient and provider interactions, and the evidence should conceptually evaluate whether those interactions can have a meaningful impact on the outcome being measured.

The Panel further clarified that testing the attribution model should be done through both the performance measure specifications used and the program. At the measure level, reliability and validity can be assessed once the measure is passed through the attribution model. The attribution model at the measure level identifies the individual patients who will be included in the denominator of the measure, the accountable unit, and the data used to determine the provider and patient relationship. Specifically, the source of the data used, the length of time, and the age of the data are critical to understanding the provider and patient relationship. At the program level, the attribution model depends on the time period selected, and the data or services used to identify patients and their associated providers.

Action Item: Does the Panel have any input on how its guidance on quantifying patient and provider interactions could be operationalized? Operationally, what does it mean to do this at a performance measure and program level?

Lead Discussants: Jennifer Perloff, Elizabeth Drye

Theme 3 – Additional Guidance on Preventing Unintended Consequences

Evaluation Consideration #5 asks if potential unintended consequences of the model have been explored and if negative consequences have been mitigated. The paper highlights a series of potential unintended consequences and suggests appropriate exclusion criteria and risk adjustment as potential safeguards. Commenters asked for additional guidance on how to minimize unintended consequences to patients and providers.

Action Item: Are there additional best practices that could be highlighted in the white paper?

Lead Discussants: Brandon Pope, Danielle Lloyd

Theme 4 – Guidance on Considering Attribution in CDP and MAP

Commenters strongly recommended that the Expert Panel include specifically recommend incorporating evaluation and consideration of attribution models into NQF's Consensus Development Process for evaluating performance measures, and the Measure Applications Partnership (MAP) that guides the selection of performance measures for federal health programs. Commenters sought specific guidance from the Panel on how findings from the Improving Attribution Models project should affect the measure selection criteria used in the CDP and MAP processes. Note: the ultimate responsibility for changes to the endorsement process rests with the Consensus Standards Approval Committee (CSAC), and for MAP with the Coordinating Committee. Therefore, the details of implementation are the domain of these bodies, and out of scope for this project.

Action Item: Does the Panel have any guidance for the CSAC or MAP Coordinating Committee on how to address attribution considerations in NQF's endorsement and selection work?

Lead Discussants: Srinivas Sridhara, Dan Muldoon

Appendix A: Additional Comments Received Via Email

May 10, 2018

Shantanu Agrawal, MD
President and CEO National Quality Forum
1030 15th Street, NW, Suite 800
Washington, DC 20005

Dear Dr. Agrawal:

The American Society for Radiation Oncology (ASTRO) appreciates the opportunity to provide written comments on the National Quality Forum (NQF): Improving Attribution Models draft report. ASTRO supports the NQF's efforts to develop an attribution methodology that recognizes the complexities of multi-disciplinary care particularly for cancer patients.

ASTRO members are medical professionals, practicing at hospitals and cancer treatment centers in the United States and around the globe, who make up the radiation therapy treatment teams that are critical in the fight against cancer. These teams include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, and other allied health professionals who treat more than one million cancer patients each year. We believe this multidisciplinary membership makes us uniquely qualified to provide input on the patient relationship categories and codes.

The NQF has asserted that attribution models be actionable, accurate, fair and transparent. In this most recent report the NQF expounds upon that assertion by identifying six key evaluation considerations:

- Use transparent, clearly articulated methods that produce consistent and reproducible results:
- Ensure that accountable units can meaningfully influence measured outcomes;
- Use adequate sample sizes, outlier exclusion and/or risk adjustment to fairly compare the performance of attributed units;
- Undergo sufficient testing with scientific rigor at the level of accountability being measures;
- Demonstrate that the data sources are sufficiently robust to support the model in fairly attributing patients/cases to entities; and
- Be implemented with an open and transparent adjudication process that allows for timely and meaningful appeals by measured entities.

We appreciate NQF's recognition of the complexities associated with developing accurate attribution methodologies, particularly for patients who see numerous providers in multiple settings. This challenge is acute for cancer patients, given that they frequently are treated with surgery, chemotherapy, and radiation therapy, either concurrently or consecutively.

The NQF draft report includes a reference to the Oncology Care Model as an example of an existing attribution model. According to the report, the OCM attributes each patient to a

practice based on the number of evaluation and management (E&M) visits with a cancer diagnosis during the episode of care. While we appreciate this simplified approach to patient attribution in the OCM, we also believe that it is important to point out that the OCM begins with the infusion of chemotherapy and includes all Part A and B services over the six-month period. The delivery of chemotherapy related services can easily be attributed to the medical oncologist, who orders the chemotherapy, but it is far more difficult to attribute all the Part A and B services that may also be delivered during that six-month period.

Radiation therapy is frequently delivered concurrently with chemotherapy, so in many cases patients attributed to a medical oncologist may also be receiving radiation therapy treatments from a radiation oncologist. This complicates the assertion that attribution is based on which practice provides the most E&M services. For example, radiation oncologists have a face-to-face visit with their patients after every 5 treatments to ensure that the treatment is going according to plan and to help manage any side effects or toxicities related to the treatment.

These visits are not, however, categorized as E&M services. This reality underscores the NQF statement that "inclusion of complex and/or vulnerable patients may hamper the ability of an attribution model to facilitate fair measurement."

The report goes on to state "these complexities could decrease the ability of value-based purchasing models and alternative payment models (APMs) to improve costs and outcomes for these patients." While ASTRO agrees that the complexities of cancer care make attribution a challenge, we disagree with the statement that such complexities could hamper the development of viable value-based purchasing models or APMs. In fact, ASTRO has developed a Radiation Oncology APM that is specific to the 90-day episode of care associated with radiation therapy. We believe that by identifying distinct services, such as the delivery of radiation therapy by a radiation oncologist, that attribution of patients to multiple physicians over a broader episode of care can be achieved. Attribution to multiple physicians is complex, but it has the potential to lead to better patient outcomes through better care collaboration.

The NQF draft report also discusses the use of patient relationship categories as a way to collect data that would assist in the development of attribution models. The patient relationship codes reported on claims will be used to attribute patients and episodes (in whole or in part) to one or more providers, and determine each provider's level of responsibility and the costs associated with providing care. Although these new patient relationship categories will allow for increased risk adjustments, the categories may need to be further adjusted once data collection starts. New care episode measures may also need to be adjusted over time to better reflect patient relationship categories and appropriate reimbursement for clinicians.

ASTRO believes that the patient relationship categories and codes capture the majority of patient relationships for clinicians furnishing care to Medicare beneficiaries. However, it is important to understand that the role of physicians may change during a course of care. As an example, radiation oncologists are involved in many complex diagnoses indicating a need for multidisciplinary and complex care; as a result, the physician may oscillate between categories over a period of time. Attribution for these patient categories may be difficult due to these changes, and NQF should consider the effects and complexity of attribution when categories may shift based on changes in clinical indications for individual patients.

The NQF should seek opportunities to collaborate with ASTRO, as well as other stakeholders in the cancer provider community, on the development of meaningful attribution models for cancer care. We believe that stakeholder engagement in this process is critical and will lead to attribution models that can be modified to appropriately account for the various components of cancer care that will lead to improved patient outcomes through better care coordination.

Thank you for the opportunity to comment on the NQF: Improving Attribution Models draft report. We look forward to working with NQF in order to strengthen the attribution model methodology. Any questions regarding our comments can be submitted to Anne Hubbard, Director of Health Policy, Anne.Hubbard@ASTRO.org or 703-839-7394.

Sincerely,

Laura Thevenot

Laura I. Thevenot
Chief Executive Officer