PBGH Response to CMMI Request for Information on Advanced Primary Care Model Concepts

1. Please comment on the above description of PBPs in terms of (a) the impact on the delivery of advanced primary care and (b) primary care practices' readiness to take on such arrangements.

In order for new models of care to achieve the full potential of better and more affordable care, they need to move away from fee-for-service payments. This includes making a transition to payments that involve the assumption of greater financial risk – two-sided risk, partial capitation, or full capitation.   CMS should make risk-bearing contracts attractive to spur innovations and improvements with greater speed. CMS can do this by providing additional safeguards for smaller providers and offering flexibility in assignment options.

4. To what extent are primary care practices willing to be accountable for total cost of care?

Care delivery systems respond to financial incentives, whether volume-based or value-based. PBGH supports payment reforms that create accountability for the quality of patient care.   To move away from payment based on volume and toward value, accountability and incentives are necessary, including full or partial capitation or shared savings

In a fee-for-service or PPO environment, it is important to address attribution and benefit design. PBGH members have used benefit enhancements including lower share of premiums, lower or no co-pays for preventive services or for chronic condition management services delivered by providers within a network, and digital access to medical information and communication with providers. These benefit enhancements help direct patients to utilize care within the network where care can be most effectively managed.

The size of the primary care practice as well as its structure are factors in assessing the feasibility of accepting risk. Practices with a larger patient base, medical groups, and IPAs (such as those in California) are likely to be more willing to be accountable for total cost of care. However, In the case of medical groups and IPAs, understanding the financial arrangements/incentives they have with the practices/providers in their network would help shed light on what are more successful strategies for engaging primary care practices in accountability for total cost of care. For example, Hill Physicians Medical Group in California uses a model of passing through financial rewards to primary care physicians. Their physician compensation is comprised of over 15% value-based compensation, and in some instances as high as 30-40%. Notably, Hill Physicians are consistently rated in the top tier of performance in California's IHA Pay-for-Performance program.

Also in California, IHA's Pay for Performance (P4P) Program has developed a measure of Total Cost of Care (TCC) that captures the costs of care delivered to all commercial HMO/POS enrollees in each participating physician organization. The TCC measure includes all covered professional, pharmacy, hospital, and ancillary care, as well as administrative payments, and is risk-adjusted to capture differences in patient population characteristics across physician organizations. Three plans have implemented the TCC in the P4P incentive program.

6. What key challenges do primary care practices face in assuming financial accountability?

Please refer to California financial solvency regulations as a model to address organizational capacity to manage/accept downside risk.

8. Practices caring for patients with complex needs–either the practice's full population or a subpopulation of its patients–could receive additional incentives and resources to deliver enhanced services to these patients, including better integration with social and community-based services, behavioral health, and other health care providers and facilities. What are the best methodologies to identify patients with complex needs?

PBGH was awarded a Health Care Innovation Award in 2012 to implement the Intensive Outpatient Care Program (IOCP). IOCP addresses medical, behavioral and psychosocial needs for patients with chronic illness and co-morbid conditions. IOCP emphasizes:

- Longitudinal 1:1 relationship between the care coordinator and patient,
- Use of multidisciplinary care teams that include licensed and unlicensed staff,
- Patient engagement to support effective self-management and development of a shared action plan,
- Connection to primary, specialty and ancillary services, and
- "Warm handoff" to behavioral, psychosocial and community services.

Current enrollment is 12,000 and many best practices have been identified in its three years of operation.

IOCP's 23 care delivery system partners have developed multiple approaches to identify patients. All include a review of emergency department and inpatient admissions within the prior 12 months, combined with (a) number of chronic, ambulatory sensitive conditions, (b) number of medications (c) number of specialists, (d) physician consultation to confirm patients' appropriateness, as well as direct referral from physicians, and (e) various types of predictive risk scores. IOCP's clinical advisors and partner medical directors caution against using risk scores alone. As needed, IOCP provides specific guidance to partners to augment or replace predictive risk scores is as follows:

1. Number of hospital admissions in the last [6] months:
    - Threshold 1 or more
2. Number of ER visits in the last [6] months:
    - Threshold 1 or more
3. Number of [active specialists] that the IOCP participant is seeing:
    - Threshold 3 or more
    - "Active" refers to a scheduled follow-up visit (e.g., the patient has a scheduled visit with a rheumatologist in 1 year)
4. Number of active conditions] that are monitored by the participant's physician(s).
    - Threshold 3 or more
    - The participant may have a single major condition that makes him/her a good candidate for IOCP
5. Number of current medications (Rx) the participant is taking
    - Threshold is 5 or more

8.d What performance metrics are most appropriate and meaningful to assess the quality of care for these patients?

The health system often fails to adequately coordinate care across a fragmented system of providers. With half of Medicare beneficiaries being treated for five-or-more conditions and chronically ill patients seeing a median of seven different physicians per year, the benefit of improved care coordination is obvious. Measuring and rewarding activities that are enabled by information exchange—such as care coordination—will drive the adoption and use of HIT. Health IT and health information exchange also elevate the capacity of measures to assess the quality of care in general (i.e., not just for activities enabled by information

exchange) by making data collection and distribution more agile. For example, using HIT to collect data across time (longitudinal measurement) and space (the spectrum of providers) creates a more complete picture of patient outcomes than the pinhole picture derived from a singular event.

CMS should implement a limited set of high-value measures that leverage functionalities that support Advanced Primary Care and other new models, with a focus on measures that are only possible in an electronic environment. The measure set should focus on outcomes, both clinical and patient-reported, as well as measures that address care coordination.   We strongly advise against an over reliance on process measures, particularly "check-the-box" measures that document steps a provider has taken, but tell us little about the quality of care provided or its outcomes. Evidence indicates there is a poor relationship between such measures and patient outcomes. We, however, suggest the inclusion of process measures in composites, particularly if they are based on a patient-centered approach (i.e., the patient has received all indicated tests and treatments known to provide significant positive health effects for their condition). The measure set should be parsimonious and integrated with other federal programs, when appropriate. CMS should also support the widespread alignment of measures by incenting states and collaborating with private payers to use these measures.

While using existing measures is a good way to start, there are significant measurement gaps. Thus, new measure development is necessary to the successful use of measures in evaluating the success of new models of care. Resources must go to the development of high-value measures, while low-value measures become obsolete. For more information on designing measures, please refer to *Ten Criteria for Meaningful and Usable Measures of Performance*.

Below, we describe two areas of measurement we believe are particularly important to Advanced Primary Care Models —care coordination and patient reported outcomes measures—that are also activities enabled by information exchange.

Care Coordination

There are two consistent complaint areas for patients interacting with the health care sector: lack of communication and lack of coordination. The idea behind *care coordination* is simple: the care patients receive should be coordinated between each of their health care providers and across the settings where they receive care. Health information exchange is an important vehicle for improving care coordination, and the overall effectiveness and efficiency of care provided to the patient.

An important element to assessing care coordination is the patient's experience; patients can provide valuable insight on whether or not care was coordinated. A recent study showed 45% of patients reported having to act as communicator between doctors who are not talking to each other. There are currently available patient experience surveys that assess aspects of care coordination. For example, the Patient-Centered Medical Homes Consumer Assessment of Healthcare Providers and Systems (PCMH CAHPS) survey focuses on: access, information, communication, coordination of care, comprehensiveness, self-management support and shared decision making. Questions that address care coordination include care from other providers and care from others on the care team. It is used by NCQA in its PCMH Recognition Program and can also be used by practices for internal quality improvement.

The CAHPS products also include a supplemental HIT Item Set focusing on patients' experiences with the use of HIT in physicians' offices. It contains 21 items across three content areas: provider use of computer or handheld devices, email access and helpfulness, and helpfulness of HIT. It was developed with an eye towards which HIT functions were important to patients, patients' views of HIT's role facilitating those functions, and how patients viewed the roles for HIT in a physician practice. Although this survey looks at whether patients have *access* to online personal health information (i.e. laboratory or other test results, listing of their prescription medicines, physician's notes from prior office visits), the survey must evolve to ask about patients' experience with these functions and how valuable they find them; this additional testing work can be supported by CMS.

Another example of a patient-centered measure is the NQF-endorsed Care Transitions Measure (CTM-3). Administered at the time of hospital discharge, this three-question survey measures three areas that patients

identified as critically important to their experience with coordination out of the hospital: self-care in the post-hospital setting, medication management, and adherence to patient preferences in the care plan. In contrast to other measures that focus on hospital discharge, the CTM-3 inspects *whether* and *how* hospital staff prepared the patient for discharge and includes reference to family caregivers, an important partner in care coordination. Notably, the CTM-3 has been found to predict re-hospitalization and return to the emergency department, underscoring the fact that care coordination is essential for both patient outcomes and cost containment.

Patient Reported Outcomes Measures

Patient-reported outcomes measures include information collected from patients to elucidate on aspects of their care in which they are the expert (e.g., pain management, activities of daily living, functional status). This information supports a collaborative care management model and shared decision-making when results are shared with both patient and provider. Some examples of EHR-enabled quality measures that use data directly entered by patients are as follows.

- The Dartmouth Institute (TDI) is tracking PROMs over time to determine the impact of treatments on outcomes and the experience with care. The PROMs they are tracking include four clinical populations: (1) annual wellness visit, (2) heart failure, (3) hip replacement, and (4) knee replacement. They believe PROMs will improve patient engagement and the quality of patients' decisions about health and health care. To promote widespread use of PROMs, TDI has made available a data collection platform and benchmarking capability, and facilitated training and sharing of best practices.

- Partners Healthcare conducted a two-phase PROMs pilot for CABG procedures and diabetes care. During the pilot, they are collecting PRO data through a multi-modal approach, reporting PRO measures to providers and patients, and using PRO data as quality metrics on a physician, clinic, hospital, and system level.

- Consultants at Royal Cornwall used PRO measures data to monitor via a website post-surgical patient health following hip and knee replacements. The intent of the initiative was to improve patient health, encourage better adherence with post-surgical therapy, and reduce the need for face-to-face post-op outpatient appointments. This model of having patients report health outcomes via website could be adopted by other providers to collect information in a streamlined way that is straightforward and accessible to most patients.

- California Joint Replacement Registry also incorporates PROMs on hip and knee replacements in its Level 3 registry and plans to publicly report results at the hospital-level by May 2015. It pushes online data collection, with other methods as back up to increase representativeness and response rates.

Although not always collected via health information technology, we believe these PROMs can provide valuable information for an advanced primary care population: depression remission at 6 and 12 months, optimal asthma control, functional health improvement following back surgery, and VR-12 or VR-36. While not a performance measure, The Patient Activation Measure is a PRO used in IOCP that is a useful tool in patient engagement, and ultimately improving outcomes. The PAM, developed by Dr. Judith Hibbard, helps categorize how activated a patient is in their care by assessing skills, knowledge, beliefs, and behaviors. By knowing a patient's stage of activation, providers can tailor care plans that better meet their patient's needs.

We strongly support the use of the Patient-Reported Outcomes Measurement Information System (PROMIS). PROMIS measures patient-reported functional status. Patients deserve to know whether treatments that are intended to improve their functional status actually make a positive difference. Measuring functional status is also important to assessing appropriateness of care and whether a treatment was effectively administered. PROMIS promotes parsimony because it is cross cutting. It provides a stable of "general" surveys that can be used to measure patient functioning in various clinical areas. We recognize PROMIS may not be ready for "prime time" use but emphatically encourage CMS to lay groundwork for its use.

Finally, there are specific functionalities that can only be leveraged in an electronic environment that support HIT-enabled measures. CMS should add these functionalities to program requirements to improve the availability of high-value measures. These include:

- Capturing patient information such as patient identifiers, contact information, caregiver information, primary language, and social and behavioral determinants of health.
- Encouraging the transmittal of data between providers, such as offering provider directories mapped to Direct addresses and standard identifiers;
- Ability for patients to contribute information to their medical records that is related to their care; and
- Ability to interface to claims/administrative data using common identifiers (e.g. plan member ID) to permit construction of longitudinal measures.

9. What data do practices need from payers to perform well and manage population health in a model that includes PBPs, financial accountability, and specified requirements for primary care delivery? Please be specific in describing helpful feedback or utilization reports in terms of timing, content (e.g., patient characteristics, services used, providers of services), and format.

Senior populations often receive care in hospitals, skilled nursing facilities and home health settings. Managing population health, as well as total cost of care, thus requires access to hospital (ED use, inpatient admissions and readmissions, and length of stay), home health and skilled nursing data. The Triple Aims cannot be achieved without consistent access to payer data.

Care delivery systems would benefit from access to full claims and encounter data from payers on their entire senior population, while adhering to patient privacy law and maintaining security of the data. This would allow delivery systems to conduct internal administrative analytics, assess risk, and better manage population health for their patients. These data are often shared intermittently, as determined by contract terms and risk-sharing arrangements between the care delivery system and payers.

10. What transformative changes to HIT – including electronic health records and other tools – would allow primary care practices to use data for quality measurement and quality improvement, effectively manage the volume and priority of clinical data, coordinate care across the medical neighborhood, engage patients, and manage population health through team-based care (e.g., transitioning from an encounter-based to a patient-based framework for organizing data; using interoperable electronic care plans; having robust care management tools)?

A well-designed and implemented HIT infrastructure is essential to realizing the triple aim of better care, better population health, and lower costs. As a cornerstone for delivery system and payment reforms, HIT will enable new models of care to share data and integrate it across sources (including non-EHR) and types of data (i.e., clinical, claims, and patient-generated data). To realize the promise of HIT, *all* providers must adopt HIT that is capable of coordinating with other providers, measuring the quality of care, and giving patients and family caregivers the information they need to be active partners in health care.

The "Meaningful Use" of Electronic Health Records (EHR) Incentive Program is propelling a redesign of the health care system around patient- and family-centered health care—with HIT as its backbone—and serving as a catalyst for progress. Among its accomplishments, Meaningful Use spurred the standardization of data elements and transmission methods, which are critical for uniform collection and sharing of health information. For example, the policymaking and parallel certification process has produced standardized data elements regarding critical records and processes of care, including:

- Summary of Care Record: The eligible hospital delivers a summary care record for 50% of transitions of care or referrals.
- After Visit Summary: Clinical summaries for patients following each office visit.

- View, Download, Transmit (V/D/T): Provides patients the ability to view online, download and transmit their health information, and specifies the types of information that must be made available.

We believe the advances made through Meaningful Use, like those above, should be extended broadly across *all* providers, not just those that are Meaningful Use eligible and would be an important criteria for Advanced Primary Care Models. And we need more robust information standards than what is in the Meaningful Use program to fully realize the potential of information exchange. The Meaningful Use program's impact can be extended by advancing requirements that create standardization for a range of data and functions. In particular, CMS should advance the method used to transport data elements between systems. The process should be simple, secure, scalable, and standards-based. Although the Consolidated CDA standard for the electronic transfer of a Care Summary and the Direct standard provide a framework, the task of enabling EHR systems to incorporate standardized data elements directly into the medical record is not complete. Something as straightforward as improving emailing capabilities would go a long way towards improving communication.

Registries, particularly those that capitalize on HIT, are also important tool for care management and quality measurement. Electronic clinical registries are typically used by clinicians to manage patients with chronic conditions or, in surgical specialties, to benchmark performance against their peers. For registries to take advantage of health information exchange, however, they need to meet certain criteria. For example, registries should electronically interface with other data sources, including both EHRs and other sources of data that might not be included in the EHR (e.g., imaging, product bar code, other settings). For instance, a surgeon's private practice EHR may not be integrated with the EHR at the hospital where she practices, but both the surgeon's and hospital's EHRs can supply data to the registry. They should also be able to transmit data electronically to third parties (e.g., vendors, CMS). Additionally, registries should use standards for common data elements, such as LOINC codes for laboratory data and NCPDP standards for pharmacy data. A critical element to sharing registry data via health information exchange is for HHS to develop data and interoperability standards and find ways to encourage EHR vendors to adopt those standards.

See question 8b. for other recommendations on HIT recommendations to support quality measurement and quality improvement.