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November 20, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

**RE: Request for Information CMS Innovation Center New Direction**

Dear Administrator Verma:

Thank you for the opportunity to provide input on the future directions of the Center for Medicare & Medicaid Innovation (Innovation Center) and, more broadly, on CMS's work to promote value throughout the health care system. This direction closely aligns with the mission and goals that have driven our organization for more than 25 years. The Pacific Business Group on Health (PBGH) is a purchaser coalition representing 60 public and private organizations that collectively spend $40 billion each year purchasing health care services for more than 10 million Americans. Our members share a passionate belief in the possibility of transforming the health care system to be accountable for health outcomes, patient experience, and spending, and in which consumers are motivated to make the best choices for their individual health needs and providers are motivated to offer high quality, efficient and appropriate care. PBGH and our members design and test innovative models ranging in size and scope. Our programs and pilots have included:

- Designing and implementing a nationwide Centers of Excellence program that offers travel surgery and other care for joint replacements, bariatric surgery, and spine care;
- Operating the California Healthcare Performance Information System, a database that combines data on the health care experiences of more than 12 million people from commercial health plans and Medicare to evaluate the quality and efficiency of medical services in California;
- Translating a pilot program to improve health outcomes and cost of care for complex patients to support Medicare beneficiaries in five states;
- Engaging thousands of physicians in California to redesign care and improve measures of cost, quality, and patient experience as part of the CMS-led Practice Transformation Network; and
- Working with three hospitals to improve data, care delivery, and payment in a comprehensive approach to reducing the rate of unnecessary cesarean sections.[1]

[1] For more information about these programs, see:
- Employer Centers of Excellence Network, http://www.pbgh.org/ecen
- California Healthcare Performance Information System, http://www.chpis.org/

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PBGH and our members have decades of experience designing, implementing, and scaling these and many other innovations that aim to improve the quality, affordability, patient experience, and outcomes of health care. In addition to our work directly with employers, we have worked with CMS and other public sector stakeholders to support innovation and care redesign for diverse populations. These experiences have reinforced our understanding of the value of the Innovation Center as a key lever for CMS to improve care for Medicare beneficiaries and to drive system transformation more broadly. We applaud CMS for proactively seeking opportunities to improve health care value. We recommend that the Innovation Center's new direction include work to:

- Articulate a clear vision that shows how the Innovation Center's new direction will lead to robust system transformation toward value-based payment and care delivery. A clear and consistent signal from CMS will best enable providers, purchasers, payers, and other stakeholders to invest in and commit to the infrastructure and redesign needed for a high-value system.
- Evaluate models transparently using a consistent set of outcomes to enable comparison.
- Ensure models have a sufficiently large and representative sample of participants so evaluation results can inform the decision to scale a model.
- Further adopt rapid-cycle innovation and evaluation. When models prove to achieve better outcomes, better patient experience, and moderated costs, scale them quickly to maximize their reach and impact.
- Work with purchasers and other stakeholders to draw lessons from the private sector, and to design and test aligned or collaborative cross-sector models. A greater degree of alignment of payment models and incentives to improve care delivery offered by payers and purchasers is a critical step in supporting real system transformation and enabling successful models to take hold.
- Build innovative models on a foundation of robust, patient-centered information that includes the true outcomes important to patients, such as through condition-oriented measure sets centered on patient-reported outcomes, patient experience, and functional status.
- Rapidly develop or implement robust information systems and performance measures to support care redesign, consumer choice, and value-based payment.
- Ensure that consumer-directed models including value-based insurance design provide sufficient information about cost and quality, and effectively promote high-value care.

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- CMS-funded Intensive Outpatient Care Program, http://www.pbgh.org/storage/documents/IOCP_Program_Summary1214.pdf
- Practice Transformation Initiative, http://www.calquality.org/programs/practice-transformation/tcpi-pti
- Maternity Payment and Care Redesign pilot, http://www.pbgh.org/storage/documents/TMC_Case_Study_Oct_2015.pdf

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Below we offer more detail about these recommendations. In an Appendix that follows, we share results and lessons learned from our experience testing innovative health care models in specific markets with implications for the Innovation Center's new direction and for CMS more broadly.

**Achieving a High-Value Health Care System**

We strongly support the Innovation Center's continued goals of more patient-centered care, improved quality, reduced costs, and better outcomes. The Innovation Center has significant potential to accelerate the transformation of our health care system through the testing and spread of those payment and care delivery models that best improve care quality and population health, and that effectively reward providers based on value.

*Defining a Path to Value*
While we understand the Innovation Center's desire to take on a new direction and new priorities, the initial ideas laid out in the RFI leave many questions about the overall pace of system transformation and the role CMS anticipates taking in enabling and accelerating that transformation. We urge CMS to clearly articulate its vision for how best to promote and activate health care system transformation toward value-based payment and care delivery. As part of that vision, CMS should discuss how existing promising models can work in conjunction with the new areas that CMS may wish to test. The types of models identified in the RFI represent important new areas of exploration, and they remain component parts of a broader landscape and strategy. That landscape and strategy requires federal policymakers to offer a clear rationale for the individual models and direction in order to promote adoption and alignment of new models: payers and purchasers need to see a steady direction and opportunity to align with CMS; providers need to understand CMS's long-term direction so that their investments and leadership can be well-founded and stable; and all stakeholders need to feel confident that individual models will continue as long as they directionally support overall system transformation.

While exploring new models and pursuing opportunities to increase provider participation in Advanced APMs, we urge CMS to maintain the existing criteria for Advanced APMs. In particular, we caution CMS not to weaken or waive the current nominal risk standard, which is an important feature ensuring a model offers enough value to merit qualifying for the MACRA-established Advanced APM bonus. At the same time, effective system transformation requires accommodating providers at different levels of transformation readiness by setting a clear path, providing resources for support, and creating incentives for progress that encourage providers to move into the most high-impact payment and care delivery models.

*Selecting and Implementing Models*
In our experience, there are many challenges in ensuring a model supports the triple aim of better care, better experience, and lower costs. There are more challenges when trying to

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scale a pilot to be ready for broader provider participation and greater patient population impact. The incentives of an APM need to represent a significant portion of a provider's revenue and patient panel in order to result in practice transformation and care redesign that benefits all patients in a provider's care, and to avoid situations where success in an APM can be achieved through short-term add-ons or workarounds for small patient segments. Achieving critical mass is a challenge for most payment and care delivery reform initiatives. The Innovation Center should test strategies such as common financial incentives across models and sectors, significant financial risk thresholds, and patient incentives to participate in new models such as through discounted premiums. In addition, there is a lack of common data infrastructure and information exchange that impacts the quality, patient experience, and efficiency of care. Providers need real-time feedback to improve care delivery and rapid information from other providers to coordinate care. The Innovation Center should invest in and test strategies to improve information capture and availability within the models under its purview going forward.

*Evaluating Models*

The evaluation approach taken by the Innovation Center is a significant improvement over the previous CMS demonstration evaluation approach; still, we encourage the Innovation Center to further adopt rapid-cycle innovation and evaluation. We urge CMS to strategically design and invest in models in such a way that models' outcomes can be effectively compared and common themes found. That is, we must be able to evaluate models' relative performance in order to move from testing one model in one market at one time to spreading successful models more broadly to promote system transformation. We encourage the Innovation Center to consider a common set of metrics to evaluate the performance of all APMs. In particular, the Innovation Center should adopt a core set of uniform outcome measures for model evaluation. This would allow a variety of approaches to be tested and compared to each other, without CMS micromanaging the care process or payment methods.

In addition, we encourage the Innovation Center to implement quasi-experimental evaluation design to ensure the success of a model is not a byproduct of voluntary participation only by those providers best positioned to succeed at that model. An approach emphasizing small-scale testing and voluntary participation in models may best support new ideas and wide provider participation, but risk providing insufficient information about the potential for success those models may have outside the narrow scope of a small pilot. We urge the Innovation Center to ensure models have a large and representative sample of providers so evaluation results are useful in deciding whether models should be scaled.

Similarly, we urge the Innovation Center to be fully transparent in the design and evaluation of models to support wide participation. Providers and others need to understand exactly how a model will work for their practice and how a model's success will be assessed to make an informed decision about participation. Full transparency in all matters related to APMs, including details about the specific methodology for setting target prices and benchmarks for each participant, may lead to shorter cycle times to refine program designs while also

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promoting greater understanding and trust in the technical aspects of any new payment program.

**Promoting Private Sector Innovation through Collaboration with Purchasers**

PBGH and our members have been leaders in implementing innovations in transparency, care delivery, benefit design, and provider payment in California and nationally. Together we have piloted and implemented reference pricing, centers of excellence and bundled payments, medical homes and accountable care organizations, a statewide joint replacement registry, cesarean section reduction initiatives, and many others. We are eager to share the lessons learned from our experience with the Innovation Center as you further define your new direction and develop new models of innovation.

A significant challenge we have encountered in our previous experiences is in scaling successful models beyond the scope of an initial pilot program. Large employers with significant presence in a specific market have been able to work with the providers in that market to design and implement innovative models, but even when these models show success in improving patient health, experience of care, and moderating costs, it can be prohibitively difficult to spread the successful model to other markets or regions. This challenge exists in part because of the variety of payer and purchaser stakeholders that often compose a provider's business model. As such, a greater degree of alignment of payment models and incentives to improve care delivery offered by payers and purchasers is a critical step in supporting real system transformation and enabling successful models to take hold. We need the Innovation Center to collaborate with purchasers in the design, implementation, and evaluation of models. In particular, we urge the Innovation Center to work closely with purchasers to find alignment on the patient populations targeted, particularly to consider the health needs and cost drivers of a population broader than just those aged 65 and older; on performance measures used within models; and on criteria for upside and downside financial incentives.

We look forward to working closely with the Innovation Center in coming months to identify promising models and opportunities to expand private sector models to Medicaid and Medicare beneficiaries. We encourage the Innovation Center to solicit purchaser input directly and to leverage existing vehicles to engage with purchasers, including the Health Care Payment Learning and Action Network and Health Care Transformation Task Force.

**Building on a Foundation of Performance Information**

We applaud the Innovation Center for exploring new methods to foster an affordable, accessible health care system that puts patients first. Together with our members, we have explored many initiatives to empower enrollees as consumers, provide price transparency, and increase choices and competition to drive quality, reduce costs, and improve outcomes. For example, PBGH offered a Health Plan Chooser; using this tool, an employee could create

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a customized report card of health plan attributes that ranked health plans in order of suitability for the employee's needs to facilitate the employee's selection of a plan. Through this experience, we identified many of the most important features of a decision aid to help individuals anticipate their likely health care needs based on their health status, weight preferences for a health plan and provider, and understand the options available to them.[2]

Purchasers believe that transparency and consumer choice are critical in managing health care costs in the long term. For the most common health care decisions facing a consumer—choosing a primary care or specialist clinician; a health insurance plan; a hospital, nursing home, or other facility; or a medical treatment or test—there is woefully limited information available to inform those decisions.[3] Inadequate and incomplete information on quality, outcomes, and price is a major barrier to informed consumer decision-making, made worse by the lack of high-value standardized measures across sectors and systems which would enable meaningful comparisons.

Consumers need quality information that is relevant and sufficiently granular for the decisions they face. To choose a provider, consumers need to be able to compare the quality of individual providers, teams, and practice sites. They also need to be able to compare different providers on the same aspects of quality to be able to make a meaningful choice—a need best served by standardized measures. In addition, quality and value in health care goes far beyond adherence to evidence-based clinical standards, and meaningful performance measures must include patient experience of care, and clinical and patient-reported outcomes of care. Payment models based on an incomplete definition of quality and value create incentives that are misaligned with patient needs, driving practice transformation that is inefficient or wasteful. We strongly urge the Innovation Center and CMS more broadly to put patients' information needs at the center by promoting measures that are meaningful to patients, implemented in a standardized way across sectors and payers, and that allows for comparison among providers and organizations. To promote standardization in the short term, we encourage CMS to utilize the multistakeholder-developed core measure sets available for use now, particularly for Innovation Center models such as the various ACO programs.[4]

Looking forward, CMS's recently announced Meaningful Measures initiative is a significant step in the right direction toward high-value information that can support care redesign,

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[2] Consumer Choice of Health Plan: Decision Support Rules for Health Exchanges, Installments I, II, and III. Pacific Business Group on Health, December 2012. http://www.pbgh.org/storage/documents/plan_choice_rules_consumer_decision_support_installments_i_ii_and_iii_120312.pdf

[3] For a discussion of existing tools and sources to support these decisions, see D. Lansky & S. Glier (2015). Using health IT to engage patients in choosing their doctors, health plans and treatments. In M. Adela Grando, R. Rozenblum, & D. W. Bates (Eds.), *Information Technology for Patient Empowerment in Healthcare* (pp. 39-57). Berlin/Boston/Munich: de Gruyter.

[4] For example, the Integrated Healthcare Association, PBGH, and other California stakeholders collaboratively developed an ACO Meaningful Measure Set, which has been incorporated into statewide initiatives. This measure set is similar to the Core Quality Measure Collaborative ACO and PCMH/Primary Care measures.

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consumer choice, and value-based payment.[5] If done right, this initiative can simultaneously reduce provider burden and improve competition in a market-driven health care system. We encourage the Innovation Center to take the spirit of this initiative even further and require that all models include a strong performance measurement component. The ambiguous requirement for Advanced APMs to have a quality component comparable to MIPS leaves much to be desired, and as the Innovation Center contemplates new models we encourage you to use a high bar to assess performance of participants and to evaluate models' success in driving value relative to each other. In some cases, it may be appropriate to include requirements or incentives for reporting even when incentives are not tied directly to performance.[6]

Further, we encourage the Innovation Center to consider models and specific initiatives to advance measurement science (e.g., attribution, risk-adjustment) and measure development in order to define common patient-centered measure sets for a handful of patient populations. Designing measure sets around patients, such as by condition, is the first step toward patient-centered performance measurement. A patient-centered measure set would comprise a harmonized set of patient-centered measure concepts that provide performance information that is meaningful to patients and that meet the needs of value-based payment and public reporting in driving system-wide value. For example, we need outcome measures for shared care planning (e.g., attainment of goals) and care coordination (e.g., good patient experience through care transitions) in addition to outcome measures for care received (e.g., functional status improvement). This approach is orthogonal to CMS's current approach to measures, which starts with clinical practice and physician specialty rather than with patients' needs.[7] Such an investment in performance measurement would improve the ability of all payment and care delivery models across our nation to drive true value for patients and other stakeholders.

In addition to meaningful quality information, consumers need cost information—both the full cost of care and the out-of-pocket costs they face directly—to be able to choose high-value care. We caution the Innovation Center to design consumer-directed care models carefully, and not to expose patients to increased financial risk without easily accessible and meaningful performance information. Patients who have "skin in the game" may be seriously harmed by the inability to distinguish between providers who are best at meeting their

[5] Remarks by Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit, October 30, 2017. Retrieved from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html

[6] For example, in the proposed Cardiac episode payment models, we recommended that CMS offer an incentive to providers who chose to report on patient-reported outcomes for cardiac care through a small number of standardized tools. This reporting can promote more standard use of these patient-centered tools and facilitate the development and testing of patient-reported outcome performance measures, a priority measure gap.

[7] For example, in the 2015-16 Measures Under Consideration list, a clinician measure entitled "Use of Preventive Screening Protocol for Transplant Patients" was considered under the category of dermatology care. Rather than a measure that assesses whether a dermatologist provides appropriate sun protection education to their panel of organ transplant patients, we need a measure or harmonized set of measures to assess whether the population of organ transplant patients are getting all appropriate care in a coordinated way.

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individual needs and those who would be worst at delivering such care. In addition, provider-facing payment arrangements may be negatively impacted by such consumer-facing incentives, as consumers in high-deductible health plans are more likely to delay or forego needed care.[8] Without nuanced benefit design to promote high-value care, consumer-facing arrangements could decrease utilization of both low- and high-value services, impacting patients' long-term health and impeding provider efforts to support and manage population health in ACO and other models.

We believe that such nuanced value-based benefit design is possible. Through the Employer Centers of Excellence Network (ECEN), we work with employers to provide their members access to the highest quality care for joint replacements, spine care, bariatric surgery, and other services. This successful program combines a robust performance-based center selection process, prospectively established bundled payment rates, and value-based benefit design such as low or no consumer cost-sharing to offer the highest value to patients.[9] We suggest a specific opportunity the Innovation Center could pursue in the Appendix: testing a Medicare Centers of Excellence model, which could require any participating centers and providers to report a core set of high-value measures to be eligible for the Center of Excellence designation and corresponding beneficiary benefit incentives.

Thank you for the opportunity to offer our perspective on the Innovation Center's new direction and the best way to achieve our shared goals of an affordable, accessible health care system that puts patients first. In the Appendix following this letter, we share results and lessons learned from a number of programs and models that PBGH and our members have tested along with implications and recommendations for CMS and the Innovation Center. If you would like to discuss our recommendations or ideas, please contact Stephanie Glier, Senior Manager, at sglier@pbgh.org.

Sincerely,

William E. Kramer
Executive Director for National Health Policy
Pacific Business Group on Health

[8] A. Galbraith, S. Soumerai, D. Ross-Degnan, M. Rosenthal, C. Gay & T. Lieu, "Delayed and Foregone Care for Families with Chronic Conditions in High-Deductible Health Plans," *Journal of General Internal Medicine*, (2012) 27: 1105. Retrieved from https://link.springer.com/article/10.1007%2Fs11606-011-1970-8

[9] More information about the results of the ECEN program is included in the Appendix.

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# Appendix

As noted in our letter, PBGH and our members have decades of experience designing, implementing, and scaling various innovations in health care payment, delivery, and transparency. In this Appendix, we offer the results of a selection of these innovations along with implications for the Innovation Center and CMS more broadly.

## Primary Care and Population-Based Payment Models

Improving care for patients with chronic diseases has long been a priority for virtually all purchasers of health care: 40% of a typical large employer's health care spending goes towards caring for the 15% of employees with multiple chronic conditions. From 2009 to 2015 and in partnership with both private and public purchasers, PBGH piloted a care model for the medically complex known as the Intensive Outpatient Care Program (IOCP).[10] IOCP began as an employer initiative in partnership with Boeing, the California Public Employees' Retirement System (CalPERS) and Pacific Gas and Electric Company (PG&E) and through an Innovation Center award, was expanded to 23 medical groups in five states to include patients enrolled in Medicare Advantage, Medicare FFS, dually eligible for Medicare and Medicaid, and a small number of Medicaid-only beneficiaries.

This care management initiative aimed to improve outcomes for medically complex patients by leveraging per member, per month (PMPM) payments to provide patients with trained care coordinators and enhanced access to care. Care coordinators were embedded into primary care physician practices and medical groups and were responsible for some of the key functions of robust primary care: coordination between primary, specialty, and ancillary services; tools for effective self-management; guidance throughout the development and execution of a shared care plan; and connections to behavioral, psychosocial, and community services. Demonstrating success both commercially insured and Medicare/Medicaid populations, the model achieved a 21% reduction in cost of care for IOCP patients enrolled for at least 9 months, a 3.6% increase in patient engagement, a 33% reduction in depression symptoms, and a 4.1% improvement in physical health functioning.

Primary care should be foundational to every patient's experience with the health care system. Particularly for patients who are medically complex, robust primary care is an essential component of high value care that produces good health outcomes and patient experience. We strongly encourage CMMI to design and refine payment and care delivery models to support a multi-disciplinary, team-based primary care model that serves as an easily accessible first point of contact for patients' concerns and questions and anticipates patients' health care needs, in addition to providing the functions of IOCP care coordinators (listed above).

[10] IOCP patients were identified through risk factors such as three or more chronic conditions, eight or more medications, and recent hospitalizations and/or emergency department use and assigned a care coordinator.

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PBGH also leads the Practice Transformation Initiative (PTI), as part of the Innovation Center's Transforming Clinical Practice Initiative (TCPI), to support 4,800 clinicians in their efforts to measurable improve patient care for over 3.5 million patients. PTI provides participating health care organizations with quarterly performance reports (by organization, site and clinician) and customized coaching on how to use data to improve quality, how to build systems that capture data and generate reports, and how to prepare for participation in alternative payment models. The program aims to improve health outcomes for 3.5 million patients and save over $242 million dollars over four years. In our early analysis, the program is already showing some success in improving diabetes management and reducing utilization (i.e., ED visits, inpatient days, overscreening). We attribute some of the early success of this program to our ability to build on the data requirements of California's state-wide pay-for-performance program. In particular, participating stakeholders have been able to come to agreement about a set of measures that are meaningful, parsimonious rather than overwhelming, and that most providers are capable of reporting immediately.

*Implications for the Innovation Center and CMS*

- Primary care is central in ensuring value is delivered for patients throughout the health care system. The benefits of coordinated care and establishing a close working relationship with the patient underlie the role of primary care as foundational for high value care. We recommend that the Innovation Center promote and continue testing primary care models even as it works to expand the availability of APMs for specialists.
- Our experience has shown that ACOs other population-based and primary care-focused models are successful in part because they keep the decision-making and financial risk as close to direct patient care as possible. We urge the Innovation Center to bundle financial risk with decisions about care delivery in the models it tests.
- Similarly, we support the testing of a variety of ACO models along the financial risk spectrum to enable providers to gain experience and progress to taking more financial risk tied to the care of their patient population over time. This must go hand-in-hand with CMS and others offering resources and technical assistance to help providers be successful in undertaking the significant work of adopting a value-based payment and care model.
- When offering models and programs, ensure that CMS's technical assistance is appropriately targeted to the model and participants' needs. From our experience with PTI, we would recommend:
    - CMS should ensure participants in a model are connected to each other to share how they overcome common challenges, share lessons learned and success stories, and transparently share what information is being collected from different participants – ideally in a standardized way. We encourage CMS to be clear from the outset of a program what data collection is required to participate in a model, and remain consistent about those requirements throughout operation and oversight of the model.

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  - Subcontractor roles and scope should be clearly defined to maximize value to participants and CMS, and to avoid overlap and duplication. In addition, requests made by CMS and its subcontractors during the oversight of a model that go beyond the requirements of a model's contract or participation agreement should be limited. We have found that a nontrivial portion of grant resources have been expended responding to such requests, rather than being further invested in the practices at the core of the initiative.

- Looking forward, we encourage the Innovation Center to test models that improve care for high-need, high-cost patients such as those with multiple chronic conditions. In particular, the Practice Transformation Networks and other primary care models could be expanded to Medicaid programs.

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Measurement and Transparency Initiatives

PBGH is deeply committed to the collection and use of meaningful and actionable information to support practice transformation, consumer decisions, and value-based payment. We have undertaken several initiatives to provide tools and information to support informed decision-making by consumers.

1) For almost a decade, PBGH provided a Health Plan Chooser that calculated an out-of-pocket cost estimate for each health plan based on an individual person's demographics (e.g., geography, employer, individual or family plan) and anticipated medical service use and medication intake. The Health Plan Chooser also allowed users to identify high-priority conditions and provided information on the providers, services and programs available to them through each plan. The Health Plan Chooser was adopted by 7 members at its height and used by over 150,000 unique people each year. Each year from user surveys, the Health Plan Chooser received a rating of over 80% on helpfulness in choosing a plan. Many of the lessons learned from our experience informed the design of the Covered California plan chooser – for example, the ability to understand relative out-of-pocket costs among potential health plans is a critical to consumers and the Covered California plan chooser's shop & compare function was modeled directly off of PBGH's Health Plan Chooser.
2) PBGH has also assembled the only multi-payer claims database in California under a contract with the California Healthcare Performance Information System (CHPI), a multi-stakeholder non-profit corporation. Using a set of 25 measures based on administrative claims data, the MPCD combines quality data for more than 12 million people from health plans and Medicare to evaluate physician performance. Through this pioneering work, California is the first state to benefit from published performance ratings at the individual doctor level enabling CA consumers to make more informed healthcare choices and incentivizing CA doctors to improve the quality of care.
3) PBGH administers the Patient Assessment Survey (PAS) which is an annual survey that measures patient experience at the medical group level in California. PAS asks questions on a variety of topics such as whether the patient accessed routine and urgent care on a timely basis, spent sufficient time with and received attention from their physician, and experiences continuity of care. PAS results are publicly available online and comprise 20% of the physician pay-for-performance formula administered by the Integrated Healthcare Association (IHA).
4) We have also worked to improve the collection and use of meaningful performance information through standalone work and as a core component of our system transformation and payment initiatives. For example, we have undertaken a collaboration with the International Consortium for Health Outcomes Measurement (ICHOM) to implement market-wide collection of standardized outcomes measurement in two or three U.S. markets to support population-level uses of

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performance information, outcomes-based decision-making by providers, and value-based payment. ICHOM was formed to drive value-based health care by defining global standards for outcomes measurement and has, since its inception, developed 21 standard condition-specific measure sets representing 45% of the disease burden. This project has a specific focus on PROMs implementation, seeking to overcome barriers to tracking patients longitudinally and to identify measurement standards that enable provider accountability based on statistically valid and effectively risk-adjusted health outcomes data.

*Implications for the Innovation Center and CMS*

- Alignment of measure requirements among payers and purchasers can reduce the administrative burden facing providers while continuing to demonstrate how providers or care models are performing. CMS should align program measure requirements with other purchasers and payers as much as possible, relying on existing measure sets developed with multistakeholder input in the short term (e.g., ACO measures used in California, Core Quality Measures Collaborative core sets, ICHOM standardized sets).
- The Innovation Center should give greater weight and attention to initiatives that are built on multistakeholder collaboration. We have seen that the market does not effectively or consistently create information and tools that support consumer choice and provider competition without such multistakeholder collaboration.
- In the Qualified Entity (QE) program, our experience has led to a number of recommendations:
    - Make QE data available more quickly. If data is unavailable until 8-9 months after the end of the measurement period, the delay significantly inhibits the ability to create a valuable product. One option to do this is to allow the QE the ability to select the claims completion rate that might enable a shorter turnaround timeline.
    - Continue to work with QEs to find flexible solutions to the challenges individual QEs face. For example, the CHPI results currently include Medicare data only at the regional reporting level; individual clinician-level reporting is only available for commercial data due to a policy decision not to undertake review and corrections.

  PBGH would like to extend our thanks to the CMS staff who work on the Qualified Entity program. In the short tenure of the program, the staff and program as a whole have been excellent, responsive, flexible partners.
- Existing All-Payer Claims Databases (APCDs) and Regional Health Information Collaboratives (RHICs) are prime candidates for offering evidence about whether market-based innovations are working. These organizations are established, trusted by various stakeholders, and have the information needed to assess new models'

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success. CMS should consider utilizing APCDs and RHICs to implement and evaluate new market-based innovations.

- Expand patient experience assessment programs to include Medicaid patients, with information captured about individual clinicians and groups. While there is patient experience information for Medicaid managed care plans that can inform state enrollment policies (e.g., default enrollment is to the local plan with the highest CAHPS score), patient experience at the clinician level is critical in driving quality improvement, consumer choice, and value-based payment.

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Maternity Care

From 2012 to 2015, PBGH designed and managed an initiative to reduce the rate of unnecessary cesarean sections in partnership with the California Maternal Quality Care Collaborative (CMQCC) – a statewide perinatal quality collaborative that runs the California Maternal Data Center. By providing access to rapid-cycle performance data, technical assistance, and appropriate financial incentives, PBGH was able to support participating hospitals in reducing their cesarean rates by an average of 20% in less than a year.

The three hospitals that participated in this pilot intervention were asked to enroll in the California Maternal Data Center (MDC), which provided real-time performance feedback to hospitals on a set of perinatal quality measures (e.g., failed induction rates, fetal concerns, cesarean rates). Access to such data at the physician- and patient-level revealed large within-department variations and enabled hospitals to identify the "drivers" (e.g., practice behaviors) contributing to high cesarean rates. CMQCC helped hospitals link the identified drivers of high cesarean rates to specific QI activities by facilitating department-wide conversations and offering an array of tools that the department could assemble into interventions tailored to the hospital's culture and its unique patient population. The final, critical lever in PBGH's intervention was to align hospital and physician payment incentives with the desired outcome: reduced rates of low risk, first time cesarean births. All participating hospitals were required to negotiate a blended case rate for deliveries that reimbursed physicians and hospitals with a single rate regardless of delivery method (cesarean or vaginal). Without this payment reform, participating hospitals would have faced a larger revenue loss for reducing unnecessary cesarean sections.

*Implications for the Innovation Center and CMS*

- Maternity care offers an immediate opportunity to test a cross-sector model. Maternity care is a high priority for purchasers and for Medicaid programs; birth is the most common reason for hospitalization in the U.S. The Innovation Center should build on successful efforts to improve maternity care, such as spreading our pilot to reduce unnecessary cesarean births.
- Other promising models in maternity care include greater use of certified nurse midwives and greater use of birth centers for low-risk births, such as the bundled payment proposal submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) earlier this year.
- Patient experience specific to maternity care is a notable gap in performance measurement; CMS should consider investing in more robust patient-centered measurement of the full maternity episode including prenatal care, antepartum care, and postpartum care through 6 or 12 weeks after birth.

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Employer Centers of Excellence Network

PBGH runs the Employers Centers of Excellence Network (ECEN), a program available to large employers who want to provide their employees with high quality, high value surgical care for hip replacements, knee replacements, spine care, and bariatric surgery. On behalf of participating employers, ECEN selects top-tier facilities and negotiates a single bundled payment rate for each specific procedure to be applied to all care associated with that procedure including pre- and post-operative care. Our negotiated amounts save employers on average 10-15% of what they would have paid under traditional fee-for-service, and the prospective bundled payment gives physicians the freedom to provide services in ways they think will achieve the best outcomes.

ECEN collects performance data on outcomes of care for all patients, including clinical outcomes, patient-reported outcomes, and patient experience, to ensure that patients are getting the care they need. Results have been striking. For one participating employer, less than 1% of ECEN patients experienced re-admission due to surgical complications compared to over 6% of patients who received care at their regular community hospital, and all ECEN patients were able to go directly home after surgery, while over 9% of community hospital patients needed care at a skilled nursing facility (SNF). Additionally, for this employer, 52% of patients recommended for spine surgery by home providers were found by an ECEN center of excellence to not be appropriate surgical candidates; savings from avoiding unnecessary surgery alone are estimated at $1.3 million.

*Implications for the Innovation Center and CMS*

We strongly encourage Medicare to build on private sector innovation by exploring the development of a Medicare centers of excellence (COE) program. We hypothesize that a well-designed Medicare COE program would offer:

- Better health outcomes than typically achieved by FFS providers;
- Lower beneficiary expensed through reduced cost-sharing;
- Program cost savings through more appropriate and higher quality care; and
- Industry-wide quality and affordability improvements due to provider competition.

This approach does not necessitate complex changes in payment or quality oversight. For instance, it may be possible to extend established programs like BPCI to minimize administrative complexity. Key design elements of a COE program model include a prospectively determined bundled price, very stringent quality criteria for selecting facilities, qualification of individual clinicians (e.g., surgeons) within a facility, high expectations for quality measurement and collaboration, and favorable benefit design to encourage patients to choose a COE provider.

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The following are our high-level recommendations for developing a COE program:

1. Identify specific procedures or conditions for which there is a high degree of variation in quality outcomes, patient experience, and total cost of care.
2. Establish a set of criteria to distinguish consistently high performing providers.
3. Determine appropriate financial incentives for providers and patients.
4. Provide technical assistance to providers.
5. Conduct robust evaluations and monitor results, including patient experience and patient-reported outcomes.

From our experience, the Innovation Center's primary challenges are likely to be development of criteria and processes by which COEs apply and are selected, and design of appropriate patient cost-sharing incentives.