Driver 5: Environment to Support Comprehensive Primary Care

To meet the aims of CPC, practices needed to operate in an environment that was supportive of the changes in care that they were making. Commercial and public payers aligned with CMS in this alternative payment model, providing payment that was not visit-based, and offering the opportunity for practices to share savings.

Each CPC region made efforts to aggregate or align the delivery of data to practices and the demands for quality reporting from practices. Through a multi-stakeholder process, the CPC initiative engaged with regional stakeholders to create the environment to support comprehensive primary care and to align CPC with regional and statewide health care reform efforts.

While Drivers 1 through Drivers 4 focus on changes within the practice walls, Driver 5 turns outward to the external environment. It includes working with external stakeholders and partners who will affect both individual and collective primary care practices that work toward the CPC aims of better health, better care and lower costs for patients.

Driver 5: The Secondary Drivers

The secondary drivers below support the Environment to Support Comprehensive Primary Care:

5.1 Engaged Community

Focuses on the concepts of engaging the medical and non-medical community at the local, state and regional levels to align work toward the CPC aims of better health, better care and lower costs for patients and families, in addition to supporting practices in their own efforts.

5.2 Aligned Payment Reform

Focuses on reforming reimbursement and payment structures, delivery and usability of payer data, reporting and quality metrics, as well as how these elements align throughout a region or market.

Secondary Driver 5.1: Engaged Community

This section focuses on the concepts of engaging the medical and non-medical community at the local, state and regional levels to align work toward the CPC aims of better health, better care and lower costs for patients and families, in addition to supporting practices in their own efforts.

The phases of the work in CPC:

- At the start of CPC, each region formed multi-stakeholder groups by recruiting diverse partners across the state to be contracted as Multi-stakeholder Faculty (MSF).
- MSF groups created their own meeting schedules and formats to regularly convene and work toward goals they identified.
- Initial activities of these MSF groups included identifying major stakeholders in their region and/or market and conducting outreach to inform potential partners of the CPC initiative's goals and efforts.
- MSF and practice leaders joined or created relevant stakeholder meetings, joined coalitions (such as payer meetings, leadership, care management or transitions of care coalitions) and participated in data/information exchange networks in their markets.
- By the initiative's third year, all regions included payers in their major multi-stakeholder meetings, and the majority worked on data exchange and/or aggregated data as at least one major area of work.
- Over the initiative's final year, stakeholder groups worked to solidify groups and communication streams that were making progress to try to ensure continuity and sustainability.

Change Concepts for engaged community

- Engage stakeholders with an interest in better care, better health outcomes and lower overall cost of care in support of CPC practices
- Support processes that integrate care across the Medical Neighborhood

Engaging key players within a market and community is critical to supporting practices and ensuring the spread of transformation. To do so, one must take time to understand the culture and build relationships with these key players. It is important to ensure that the right people are at the table and constantly assess for new opportunities to incorporate critical voices into the conversation.

Change Concept: Engage stakeholders with an interest in better care, better health outcomes and lower overall cost of care in support of CPC practices

It is necessary to engage partners in the support of transforming health care, outreach and education regarding initiatives to spark awareness and then create engaged, interested parties. When initiating this work, it is important to think broadly about who might be interested in similar goals, who might benefit from progress in these areas and who might influence the success or overall environment. Some might be external to traditional health care partners, such as employers or unions. Some parties might initially seem to be competitors among themselves, such as various payers. It is important to assess and then address the specific benefits and/or effect that each individual stakeholder should experience from participating in a collaborative effort.

For initiatives such as CPC, initial engagement was supported by brief, clear messaging through concise outreach materials and talking points about the initiative's goals and benefits as a whole, as well as the importance of and effect for each type of stakeholder. It is also critical to remember that an individual initiative likely has much in common with other programs or initiatives in the area that may already have engaged support. Alignment with other efforts should extend the circle of stakeholders and build relationships based on supporting the overall environment for the mutual benefit of all parties.

Change tactics CPC practices and payers have used:

- Engage consumers, employers, unions and other regional or local entities in support of Comprehensive Primary Care practices
- Engage policymakers at the regional or state level in the work of Comprehensive Primary Care practices
- Ensure that other regional or state primary care improvement efforts are aware of and can align with CPC practices

Implementation tips for engaging stakeholders

- Identify a system integrator to facilitate the conversations and bring parties together.
- Conduct an environmental scan throughout the region to identify potential stakeholders and partners.
- Create concise but engaging materials to guide conversations.
- Create a communication structure to follow up with interested parties.
- Keep organized lists with partners' contact information.
- Connect interested parties with each other to form groups or subgroups with similar interests.

Change Tactic: Engage consumers, employers, unions and other regional or local entities in support of Comprehensive Primary Care practices

Many entities not only affect the overall environment in which health care functions, but they also stand to benefit from better health and better health care. Employers, for example, benefit from healthier staff. Their policies and insurance choices can directly affect how their staff accesses health care services. It is important to identify major organizations that have a large presence in an area and/or touch many lives. Framing the work, goals and benefits in language that is accessible and relevant to potential partners should assist in obtaining an audience and aligning mutual goals.

Throughout CPC, each region found different partners that were relevant in their markets. This included, but was not limited to, practice leaders, patient representatives, small businesses, large employers and/or unions, cooperative extension offices, community and/or statewide coalitions focused on population health, local universities — including medical, pharmacy, and public health institutes — and associations, such as hospital and pharmacy associations. All of this work started by scanning the environment for potential partners and then frequently reaching out to those identified.

Essential components

- Identify potential stakeholders who have similar aims or who have a large presence in your market.
- Create a presence in the community by attending meetings, joining groups and coalitions, and learning about initiatives and aims that may interest potential partners.
- Reach out to potential stakeholders to learn about their organization and goals, all while educating them about Comprehensive Primary Care and its benefits.
- Find common ground and language to ensure that stakeholders are on board with supporting the same work and same aims.
- Record key points from conversations with potential partners to ensure continuity of your work together, and connect partners with other parties to generate strong networks.
- Provide engaged stakeholders updates regarding progress, outcomes and challenges as you move forward with this work.

Considerations for your initiative

- Each region or market has unique opportunities and unique challenges. It can be helpful to learn about other markets' strategies or partners, but these are not usually applicable to other areas.
- Both individual practices and non-practice entities can initiate this work. Ideally, through program-related learning events and meetings, all parties working on engaging external support should communicate with each other.

Change Tactic: Engage policymakers at the regional or state level in the work of Comprehensive Primary Care practices

Gathering partners and aligning goals are important aspects of creating change in the overall environment. Yet, this is often not sufficient to gain widespread, systemic or sustainable change on its own. Changing or creating new policies that generate a supportive environment is usually critical to sustain progress over time. Policy and policymaker are broad terms that encompass everything from state regulations to more localized, regional or county policy, or even a specific organization's written policies and procedures. The process for engaging, informing and gaining ground with policymakers is similar to working with all stakeholders. The critical step with this strategy is to move the dialogue and actions into a more permanent, written and sanctioned policy.

All of the multi-stakeholder groups in the seven CPC regions included representation from the state level, as well as major organizations in their stakeholder meetings, to help inform state and regional policy. An example of state-level policy work in CPC includes work conducted by the New York multi-stakeholder faculty advising the New York State Department of Health as it worked on the State Innovation Model (or SIM) plans for advanced primary care standards to be implemented statewide. Many groups also work regionally or more locally with major payers (insurance companies) to align data and/or quality measures and create policy/procedure for producing practice-level reports.

Essential components

- Invite representatives from major state health organizations to join stakeholder groups and meetings.
- Incorporate state priorities and goals into the larger multi-stakeholder work to build alignment and establish strong connections regarding mutual aims and efforts.
- Empower stakeholders, including faculty, payers and practice leaders, to take an active role in advising or shaping language for state or regional policy.
- Connect this work directly with the practice community to allow bi-directional information exchange and continued relationship building. This can be accomplished by inviting stakeholders to program meetings and activities, presenting data, outcomes or progress reports in these venues, or holding panels or breakout sessions where bi-directional communication is encouraged.

Considerations for your initiative

- Because individuals within an organization or position change, it is important to engage multiple people from an organization. Provide tangible materials or communication to share with the organization and leadership outside of individual meetings and conversations.
- In many markets, coalitions or meetings likely exist that did not originate from your program. If you can join and become an agenda item, you can have more frequent communication than that scheduled solely by your own group.

Change Tactic: Ensure that other regional or state primary care improvement efforts are aware of and can align with Comprehensive Primary Care practices

Learning about other initiatives and efforts aimed at improving primary care, payment reform and higher quality health care is essential for finding and engaging stakeholders, as well as leveraging collective efforts toward mutual aims. While the first steps involve identifying and understanding these efforts, as well as elevating the awareness of your own initiative, the next steps focus on creating alignment. There is often overlap of major concepts or goals between improvement efforts, yet there will likely be differences in language, specific strategies and targets, use of data and reporting requirements. These differences can often be distracting and challenging for practices or stakeholders seeking involvement in more than one initiative. Strong communication among the stakeholders can often dispel many of the perceived differences and lead to acceptable changes that create better alignment.

The CPC initiative aligned with several major improvement efforts and models across the country, including Patient-Centered Medical Home efforts, several different SIM grants and payment reform efforts.

Essential components

- Identify improvement efforts and initiatives at the state and regional level that have significant overlap in at least one of your primary goals.
- Create lines of communication among involved parties to learn about each other's work and goals.
- Determine areas of natural overlap or alignment as well as areas where differences exist.
- Leverage the overlap by making it explicit to all stakeholders, including individual participating practices.
- Work to reconcile areas where minor differences exist, such as similar, yet not identical, quality measures or reporting options.
- Share progress of this alignment with actual partners and potential partners.

Considerations for your initiative

- Practices will often be involved with or at least considering multiple initiatives at the same time. These involve project managers, administrators or those who are responsible for submitting requirement reports. Identifying the right team members to recognize the differences and similarities of the multiple programs is important.

Measuring Success for Change Concept: Engage Stakeholders

Building relationships, understanding culture and fostering collaboration and full engagement require time and are difficult to measure. Creating a charter for the group that outlines overarching, long-term goals, as well as specific, short-term and action-oriented goals, is essential for measuring a stakeholder group's effectiveness. Begin by considering the following three levels of measurement: strategic alignment, relative advantage of ideas and engagement of the stakeholders.[1] The following are examples of potential goals/measures that may be helpful at various stages in this work.

Initial start-up goals and measures:

- Type of organizations represented in the group
- Number of various types of stakeholders coming to stakeholder meetings, such as the number of payers or number of employers
- Frequency of contact with parties that expressed interest after learning about your initiative
- Number of meetings attended or groups joined by your team for external partners

Ongoing goals and measures:

- Number of active groups that have at least one active participating party or representative from the initiative
- Attendance of stakeholders at learning sessions or events that include individual practices
- Progress toward strategic alignment
  - Changes made to options for the reporting of various initiatives to create better alignment
- Number of new ideas/actions for the group
- Adoption or implementation of new ideas/actions
  - Inclusion of representatives from your initiative in policy-related boards or activities
  - Successful adoption of specific data goals, such as aligned data reports or aggregated data from payers

[1] http://www.innovationmanagement.se/2012/03/06/measuring-the-practice-of-collaborative-innovation/

Change Concept: Support processes that integrate care across the Medical Neighborhood

Improving communication and collaboration across the Medical Neighborhood are significant work streams and goals for practices engaged in individual transformation efforts. This same concept and work are critical at the larger, community-wide level to create a supportive environment for practices and stakeholders alike. At this level, the work involves more than just individual agreements between two entities, such as the practice and a hospital. Instead, it involves a more robust understanding and sharing of mutual goals to improve the environment and care for all partners and patients. Often, the aim of this work includes creating standard communication tools and procedures to implement in as many individual settings as possible.

This work should start and progress as a true collaborative effort; it should involve listening to all entities about their goals, needs, challenges and ideas. Many CPC practices and stakeholders established community-wide coalitions or working groups to take on this effort. Teams frequently described them as "transitions of care" efforts rather than the term "Medical Neighborhood." This language was often helpful, as most health care organizations were at least partially evaluated and reimbursed based on the success of outcomes related to transitions, such as readmissions, ER visits, ambulatory-care sensitive admissions or other measures deemed as potentially avoidable harm and/or cost. Whatever the language or specific forum for these collaboratives, it is essential to engage partners from the widest base possible and frame goals and strategies in ways that meet the collective need.

Change tactics CPC practices and payers have used:

- Engage hospitals, nursing facilities, pharmacies and other ambulatory providers and community-based services

Implementation tips for integrating care across the Medical Neighborhood

- Identify leadership or a team to carryout implementation.
- Identify all major facilities and active parties that intersect in the care of your patient population.
- Assess current partnerships or compacts that already exist between various services and determine gaps.
- Set up meetings to begin building formal partnerships with identified organizations.
- Develop agreement expectations.
- Develop standardized referral work streams.
- Determine points of contact at each organization to address issues when they arise.
- Track the number of referrals and patient experience at the organization.

Change Tactic: Engage hospitals, nursing facilities, pharmacies and other ambulatory providers and community-based services

Many diverse partners comprise the Medical Neighborhood. These include physical facilities, such as hospitals, short- and long-term nursing facilities, and urgent and ambulatory care centers. Other organizations and services engaged in health care services throughout the community are also part of the Medical Neighborhood, including home health agencies, pharmacies, mental and behavioral health services and community-based health programs. While it is helpful for individual practices to formalize partnerships with key partners, it is ideal that the entire neighborhood aligns basic and common communication streams. This can help prevent duplicating services, conflicting or confusing information for patients and missed opportunities to prevent harm or promote health.

CPC practices and stakeholders worked with a range of partners to align their work and create a stronger overall culture of collaboration in their Medical Neighborhood. External parties initiated some of this work — such as large hospital systems seeking to decrease their readmission rates — while others created new forums or coalitions to engage all partners. The essential takeaways for this work included finding mutual benefits and value for all partners and making communication and tools as concrete as possible.

Essential components

- Engage the widest possible variety of partners and voices, as all parties can affect the health and outcomes of patients.
- Create a collaborative environment where all needs and strategies are heard.
- Hold structured, frequent meetings to advance this work.
- Create concrete tools, work streams or procedures that are standardized across the group, though flexible for individual sites/partners.

Considerations for your initiative

- Consider alternating who hosts and/or runs meetings to encourage equal contribution and collaborative spirit.
- Some coalitions or collaboratives found that creating subgroups was helpful for advancing all of the work that needed to take place in a timelier manner.
- Consider adding community partners to the practice's Patient and Family Advisory Council (PFAC).
- Consider how health IT could improve the flow of information between organizations.

Measuring Success for Change Concept: Support Processes That Integrate Care Across the Medical Neighborhood

Process measures

- Number of formal agreements
- Number of informal agreements (nothing written, but a verbal agreement)
- Number of referrals sent to each organization
- Percentage of time medical information is received from partner organizations
- Follow-through on agreed timeframe metrics (for example, intake within three days)

Outcomes measures

- Patient satisfaction with partner organizations
- Partner organization satisfaction

Secondary Driver 5.2: Aligned Payment Reform

This section focuses on reforming reimbursement and payment structures, delivery and usability of payer data, reporting and quality metrics, and how these elements can be aligned throughout a region or market.

The phases of the work in CPC:

- Before CPC, it was uncommon for insurance companies to work together to align measures, reporting and payment mechanisms.
- With CPC, participating payers in each market were required to build relationships and communicate with each other to achieve some basic goals laid out by the CPC initiative, as well as work toward goals the payers set for themselves within each market.
- Because of these public/private payer partnerships, practices began consistently receiving more actionable data reports, had aligned reporting requirements on agreed upon measures and had a diversified payment structure including care management fees and performance-based incentives in the form of shared savings.
- A major focus of the public/private partnership within each market was data. Specifically, the discussions centered on what measures to focus on, what performance data to provide to practices, how to give practices access to patient-level cost and utilization data, and how and when to provide this data. Practices received both aggregate practice-level feedback and patient-level data files from CMS every quarter. In May 2014, CMS began sharing with practices, payers and stakeholders quarterly, region-level reports on descriptive trends and implementation findings. CMS also shared practice-level data used to identify different outcomes. Outcomes were relative to all CPC practices.
- All payers across all markets have aligned with CMS, providing non-visit based payments and an opportunity to share in savings. Each payer uses its own methodology for patient attribution and risk adjustment, and payers do not coordinate on payment among themselves. Over the initiative's final year, many markets have achieved full data aggregation, while others have successfully aligned measures and reports to aid practices in better interpreting their performance and patient-level data.

Change Concepts for aligned payment reform

- Use population-based payment to purchase comprehensive primary care services
- Provide actionable, timely cost and utilization data to practices
- Reward practice actions to reduce total cost of care through shared savings and other mechanisms
- Align quality metrics

To meet the CPC aims, practices must operate in an environment that supports the changes in care that they are making. Payment reform is a key element of this support, because it funds practices to do their work differently. Commercial and public payers aligned with CMS in this alternative payment model, which provided population-based payment and the opportunity for practices to share in savings.

The strategies developed across CPC markets included forming data workgroups charged with identifying areas of alignment and the mechanics for making this alignment actionable for practices. Workgroups met consistently throughout the course of the CPC initiative until markets achieved full data aggregation or aligned reporting. The workgroups then began to meet less often, and shifted their focus to communicating data and reports, when and how frequently payers released reports, and providing practices with patient-level data. In markets where a functioning Health Information Exchange (HIE) existed, data aggregation and alignment were much more actionable due to the ease of practices accessing and using this data. HIEs typically made the data much more timely and accessible compared with the lag of payer-based reports delivered through a web portal.

Change Concept: Use population-based payment to purchase comprehensive primary care services

A common saying is that to get a different outcome you must begin with a different process. The CPC initiative set out to achieve different outcomes in the participating practices, specifically improved quality and improved experience at a lower cost. To achieve these outcomes, CPC asked payers to reimburse practices in a different way for the care they provide to patients. CPC asked payers to use a population-based payment beneficiary and retrospective opportunities to share in any net savings generated throughout the initiative's last three years. To ensure that this population-based approach would be successful, payers had to begin with prospectively assigning each member or beneficiary to a primary care provider/care team. Payers commonly refer to these assignments as "patient panels" and typically communicate them to practices through attribution reports. Each payer regularly provides each CPC practice with its panel of patients (quarterly for most payers). Following this empanelment process at the payer level, payers created a methodology for risk adjusting beneficiaries. Payers shared this risk determination with practices and adjusted their care management fees based on the risk of each patient they served. This step was critical for allowing practices to identify their panel of patients, think through how the insurance company saw the patients (risk), and how they should prioritize each of these patients in their specific risk stratification process.

Implementation tips for population-based payment

- Payers must establish their formula for patient attribution.
- Payers must determine their risk adjustment methodology to account for different patient populations in each practice.
- Payers must determine their per-beneficiary per-month care management fee based on the level of risk.
- Payers must communicate the model for financial support with participating practices.

Each CPC payer agreed to provide non-visit based financial support to participating primary care practices in their region. Each payer's specific approach was different. However, the support allowed practices to invest in the infrastructure, staffing, education and training necessary for the delivery of the five primary care functions outlined in Driver 1. In addition, after two years in the model, CMS began offering practices opportunities to share a portion of any savings achieved during the previous performance period. Other payers also designed shared savings methodologies and distributed additional incentives.

Change tactics CPC practices and payers have used:

- Prospectively align every member or beneficiary with a primary care provider, care team or practice
- Provide a per-member or per-beneficiary per-month supplement to fee for services for comprehensive primary care
- Use a methodology shared with practices to risk adjust per member/beneficiary per month
- Align standards for comprehensive primary care services

Change Tactic: Prospectively align every member or beneficiary with a primary care provider, care team or practice

Practices and payers have to create processes to align members or patients with a practice or specific care team. When this work occurs within the payer organization, we call it attribution; when this occurs inside the practice, we call it empanelment. Aligning every member of a health plan to a practice allows the payer to distribute care management fees appropriately. Aligning every patient to a provider or care team allows the practice to support population health, risk stratification of needs and chronic care management.

Insurance companies worked within their organizations and the data workgroups to create a complex risk stratification and attribution process for prospectively assigning each beneficiary to a primary care provider. They accomplished this through meticulous testing of algorithms and other risk assignment methods, typically using a modification of Medicare's Hierarchical Condition Category (HCC). Through this assignment, payers could identify who their beneficiaries were seeing, or had seen, and provide their providers with updated patient panel lists to encourage proactive care management.

Creating patient panels improved how practices and providers learned about their assigned patient population. Payers provided panel reports (in their attribution reports) quarterly, in which they outlined each patient's assigned risk profile. Practices used these attribution reports to ensure that they were attending to all of their assigned patients' needs. A common concern was that practices were not familiar with some patients assigned to them. One possibility is that practices had not seen these patients in several years and assumed that these patients were seeking care elsewhere, when in fact they were not seeking care at all. Attribution reports gave practices a means to proactively reach out to these patients and reestablish a plan of care that reassessed the patient's health. Practices used each payer's attribution report to align the payer's risk assessment of each patient with the practice's risk stratification process. This allowed practices to ensure that they were aligning their view of patients with that of the payers.

Essential components

- Payer
  - Create a feedback loop for practices to provide feedback on reports (ease of access, usability, timeliness), provide feedback on attribution and to ask questions or seek clarifying information on assigned patients. This may include working alongside practice representatives and other members of the data workgroup to ensure that practices can easily understand and act on attribution reports.
- Practice
  - Access and review attribution reports regularly.
  - Identify and contact patients on your attribution reports who have not been into the office recently. If an insurance company assigns a patient to your practice, that patient is yours according to that payer. The payer incorporates that patient's data into your performance data. Therefore, practices should reach out to patients who are on their attribution lists, but who have not been in the practice recently, to ensure they receive proper management of their conditions.
  - Integrate patients identified as "high risk" on the attribution report into the practice's high-risk patient population.

Considerations for your initiative

- Payer
  - Consider strategizing with other insurance companies on successful methods for assigning patient panels and risk methodologies.
- Practice
  - Consider the timing, modality and frequency of each payer's report. How will this affect your QI strategy and review of reports?

Change Tactic: Provide a per-member or per-beneficiary per-month supplement to fee for services for comprehensive primary care

Non-visit based financial support is designed to allow practices to invest in the infrastructure, staffing, education and training necessary for delivering the five primary care functions (Driver 1): access and continuity, planned care and population health, risk-stratified care management, patient and caregiver engagement, and coordination of care across the Medical Neighborhood. These payments support care that may not be reimbursed in a traditional fee-for-service payment model but is essential to providing comprehensive primary care. Practices often used these funds to support a care manager's salary, to upgrade health IT to support empanelment or to start up a Patient and Family Advisory Council.

To enable practices to manage patients more proactively, CMS designed CPC to include a per-member, per-month (PMPM) payment structure to supplement traditional fee-for-service reimbursement. This PMPM payment structure allowed practices to invest fully in this new model of care. They used these dollars to hire critical personnel, such as care managers, or to build a strong health IT foundation that allowed practices to mine data for monitoring patients and for meeting the initiative's reporting requirements.

Private and public payers within each CPC market also developed a PMPM payment structure. Developing this structure required each organization to research and plan how to build a risk-stratification model with accompanying fees that provide the best coverage for the patient population they serve. Payers typically distributed these fees quarterly in a lump sum payment that was inclusive of each patient on the practice's attribution report. The attribution reports commonly contain the patient's risk assignment and the dollar amount the practice receives each month for that patient's care. Payers distributed the payments prospectively for services rendered in the following quarter.

Essential components

- Payer
  - Identify a PMPM payment scale based on patient risk assignment.
  - Educate practices on the process of distributing the PMPM payment and create a feedback loop for two-way communication between practices and payers.
  - Ensure practices are aware of the potential for recoupment and explain scenarios and process.
- Practice
  - Stay informed on payer processes for disseminating PMPM payments; review attribution reports as soon as they are accessible.
  - Assess your practice using a current state versus future state required to meet the goals of the initiative/transformation; set your budget accordingly.

Considerations for your initiative

- Practice
  - More dollars may be required initially to lay the right foundation to support transformation at the practice. For example, in years 3 and 4 of CPC, the average PMPM for Medicare was $15. It was $20 in years 1 and 2.
  - Anticipate occasional recoupments as patients roll on and off the attribution reports.

Change Tactic: Use a methodology shared with practices to risk adjust per member/beneficiary per month

Each payer determined its own risk adjustment methodology to account for different patient populations in each practice. CMS used the HCC risk score. Some payers used other publically available, claims-based models produced by 3M, Milliman and Optum. Yet others used other proprietary formulas to assign risk. Claims-based risk adjustment requires two steps. First, complete a risk assessment by measuring the relative health acuity of each individual in a population by using data elements from a standard health care claim. Second, adjust risk by comparing the average risk assessment of individuals enrolled to adjust payments.

After identifying and adopting a risk-scoring methodology, payers then applied the risk algorithms to each beneficiary covered by a provider in the CPC initiative. This resulted in a PMPM payment that was risk adjusted and better accounted for the level of care each beneficiary needed. Common labels for payers' risk scores were high-risk, moderate- to high-risk, low- to moderate-risk, and low-risk. Attribution reports alerted practices of each beneficiary's risk score. The payer-assigned risk scores become actionable when practices reconcile them with their own risk stratification scores. This ensures that practices have a comprehensive view of each patient's "risk."

Essential components

- Payer
  - Identify and test methodologies for assigning risk based on the beneficiary population served.
  - Communicate risk assignment of each beneficiary to his or her assigned provider/practice and clearly explain the risk-assignment methodology.
- Practice
  - Review risk assignment of each patient and reconcile the payer's assigned risk with the practice's internal risk stratification methodology, as outlined in **Secondary Driver 1.3: Risk-stratified Care Management**.
  - Educate the care team on coding basics, specifically concerning risk scoring such as HCC. Practices must be knowledgeable of basic coding processes and risk-scoring methods to ensure that they are adequately describing the level of severity for each patient when submitting claims. For insurance purposes, patients are only as sick as the provider outlines in the medical billing process.

Considerations for your initiative

- It is important for practices to have their own risk-scoring methodology (see **Secondary Driver 1.3: Risk-stratified Care Management**) that encompasses factors not captured in claims-based risk scoring. This includes socioeconomic factors and psychosocial conditions. This methodology should allow inclusion of other information about a patient's lifestyle only a provider or caregiver might know.

Change Tactic: Align standards for Comprehensive Primary Care services

Because participating practices are working toward achieving the same five primary care functions described in Driver 1, the model creates a baseline or standard for care over time. The functions are achievable in different ways as long as practices meet the CPC aims of better care, smarter spending and healthier people.

Payers often used the data workgroups to decide which measures or standards they would focus on. Though most markets did not come to full aggregation of their data, all were able to agree on a set of standards and a similar approach for reporting on each standard to practices. Standards/measures were commonly National Quality Forum Measures, as well as cost/utilization measures on inpatient and outpatient services.

From the practices' perspective, this alignment was critical for prioritizing their focus on patient care. Keeping up with different measures for each insurance company was burdensome for the practices. Before CPC, many practices were overwhelmed with this task and often became more focused on checking a box within their EHR to get "credit" than on spending critical time listening to their patients. Physicians commonly complained of this burden and expressed their frustration with reporting.

Essential components

- Payer
  - Organize data workgroups to foster communication between payers.
  - Identify a clear set of measures/standards upon which each payer agrees to focus.
  - Streamline reporting requirements for identified measures so that there is continuity for practices. It is critical for payers to understand the process/requirements their measures/standards require of practices and their health IT software.
  - Communicate alignment to practices with clear definitions of each measure (claims-based and EHR-derived).
- Practice
  - Understand measures/standards and what is required to report on each.
  - Work with the EHR vendor to ensure the practice can use the EHR to report on each measure/standard.
  - Review available reports from payers on standards/measures and implement improvement efforts focused on aligned measures.

Considerations for your initiative

- Practices should consider other programs in which they may participate, along with how they can align QI efforts across programs and payers.

Measuring Success for Change Concept: Use population-based payment to purchase comprehensive primary care services

For payers: The following measures will help you evaluate population-based payment:

- Percent of practices accessing quarterly attribution reports in a timely manner
- How the practice's utilization of PMPM payments affect cost and utilization measures
- Identification of aligned measures and their ability to predict cost/utilization drivers
- Feedback from practices on usability of attribution reports

For practices: The following measures will help you evaluate population-based payment:

- Number of patients on attribution reports that have not been seen in the last 12 months
- Alignment of payer-identified risk levels with practice-determined risk of each patient

Change Concept: Provide actionable, timely cost and utilization data to practices

Participating payers and CMS had a shared goal of providing participating practices with actionable data related to the total cost of care and utilization of services. Each payer provided data related to their respective beneficiaries/members at least once a quarter. This included a list of beneficiaries attributed to a specific practice, as well as the cost and utilization data available via claims data for these beneficiaries. Payers provided the cost and utilization data solely to that practice, and they did not share it with other practices or other payers. The benefit of this approach is that practices can access data from multiple payers in one data-aggregated source. Data aggregation eliminates the need to log into five or more web pages or portals; instead, it offers a single point of access that increases the likelihood that practices use the data.

Multi-payer data alignment is challenging contractually, politically, and technically. Multi-payer data alignment can also be expensive. Using a neutral convener, along with a few payer advocates, is instrumental in addressing these challenges and achieving data aggregation.

Data was a critical piece of practice transformation. The CPC initiative used cost, quality, utilization and patient experience data to guide improvement efforts at the practice and system level. It is essential for practices to have data on their current performance to set goals and outline changes to processes to produce positive changes in outcomes data. Additionally, it is important for practices to be able to monitor this data regularly and determine whether their targeted work is effective. These reports provide important insight into the effectiveness of practice workflows and validation when determining whether the processes they are putting in place are producing positive outcomes in cost and utilization.

Implementation tips for cost and utilization data

- Develop a practice/payer partnership to identify what claims-based data is key to supporting practice transformation, and include this data in cost/utilization reports and patient-level files.
- Offer training to practices about how to access and navigate the data portal.
- Produce motivational cost/utilization reports.
- Deliver reports at least quarterly, in the least burdensome way, to practices.
- Dedicate personnel to review reports each quarter that identify trends and areas of opportunity, along with how to turn data into action at the practice level.

Change tactics CPC practices and payers have used:

- Provide at least quarterly reports of timely data, by provider and practice, about services received by beneficiaries from outside of the primary care practice
- Notify providers and practices of ER visits and admissions, as soon as possible
- Engage with practices to improve the usability and functionality of data reports

Change Tactic: Provide at least quarterly reports of timely data, by provider and practice, about services received by beneficiaries from outside of the primary care practice

Many practices do not have health IT tools that display the services provided to their patients outside of their practices' walls. Reports from the payers can help to increase awareness of these services. Many CPC practices used payer reports to focus on hospital and emergency department (ED) care. This data can help to guide the risk stratification and care management of patients that may benefit from additional primary care services. The most robust data aggregation tools allow practices to drill down by diagnosis code, age or admit/discharge data to a subset of patients for additional outreach. There is often a 60- to 90-day lag between the date of service and the date details are available to populate a report. This is because data from the payers is claims-based. For this reason, practices should consider multiple options for data rather than relying solely on claims data.

All payers in CPC regularly produced claims-based cost and utilization reports for practices, with the most common frequency being quarterly. CMS labeled their quarterly reports as "feedback reports." These feedback reports included practice-level data on cost and utilization rates, including but not limited to the categories listed to the right.

Through these feedback reports, practices could identify trends in their performance as well as see how they compared to the market average and other comparable practices. These reports highlighted performance using tables and graphs, and they identified areas where the practice might be an outlier (at least 20 percent higher or lower than comparable practices). Practices and system-level representatives found this data helpful when identifying areas of opportunity for changing workflow and processes at the practice and system levels. Monitoring this data every quarter allowed practices to identify trends in their performance and determine whether they were focusing their efforts in the right direction. Despite the age of this data (typically six months), practices still found it useful when monitoring their performance over time in key cost and utilization areas.

Common Cost/Utilization Categories

Beneficiary Demographics
- Number of beneficiaries
- Age and gender

Expenditures
- Unadjusted
- Risk-adjusted

Hospital Admissions
- Any cause admissions
- Ambulatory care sensitive condition admissions
- 30-day readmissions

Emergency Department Visits
- Total ED visits
- Outpatient ED visits
- ED visits that led to inpatient admission

Percent of Expenditures by Service
- Inpatient and outpatient
- Lab and imaging
- Primary and specialty care
- Home health and skilled nursing

Essential components

- Payer
  - Identify data categories that are meaningful to practices and support transformation efforts.
  - Develop a reporting format and method for communication that is least burdensome for practices. Prioritize ease of access for the practice when formulating the communication method.
  - Write reports in plain language that can be understood easily by practice teams, which will make it more likely to be actionable. Practices and payers often misunderstand each other's messaging.
  - Ensure a feedback loop for gathering information from practices on the usability of reports.
- Practice
  - Identify personnel responsible for obtaining and reviewing reports each quarter.
  - Use multiple sources of data to guide improvement efforts.
  - Be transparent with the data across the practice. It can be a great engagement tool for personnel.
  - View data over time. Trends in data are much more valuable than single data points.

Considerations for your initiative

- Practice
  - Payer data is typically at least six months old due to claims processing timelines. This is to ensure that data is more accurate. Debate continues whether older, but more accurate, data is more valuable than less accurate data released sooner.
  - Consider how coding processes affect cost/utilization outcome data. Ensure that personnel are knowledgeable in diagnosis coding to ensure that claims accurately represent patients. This affects risk-adjusted measures.

Change Tactic: Notify providers and practices of ER visits and admissions, as soon as possible

Across CPC, regions had different approaches to sharing admission, discharge and transfer information quickly. Claims data from the payers did not typically support real-time communication. Some successful approaches implemented by practices include DIRECT messaging, the use of a state Health Information Exchange (HIE), gaining access to a hospital's electronic health record, building statewide messaging systems and requesting Admission, Discharge, and Transfer (ADT) alerts.

Prior to the CPC initiative, a majority of practices stated that they were not proactively or regularly following up with patients who had recent emergency room visits or hospital discharges. Follow-up was not occurring for a multitude of reasons, including but not limited to personnel time and resources, a lack of knowledge of ED or hospital discharge information and the lack of relationships with local hospitals and EDs. If follow-up was occurring, it generally was the result of a hospital calling an office to make an appointment for a discharged patient. Practices typically relied on the hospital or the patient to make the appointment, rather than proactively reaching out to each patient following a discharge.

Recognizing this challenge, CMS began developing patient-level files that would accompany the quarterly feedback reports. These files are broken out by patient, the location of his or her visit, expenditures associated with the visit, primary and secondary diagnoses, discharge disposition, and whether the visit was a 30-day readmission and/or for an ambulatory care sensitive condition. Over the course of this initiative, CMS had worked to make these files highly actionable by responding to practice suggestions for edits and additions.

Though this data was several months old, practices still found value in reconciling what they knew about their patients (in regard to admissions) with what the payer had on record. Being able to reference patient-level files retrospectively proved beneficial in keeping up with patients' utilization of inpatient and outpatient services. It was common for practices to assign personnel to this report each quarter who could reconcile their transitions of care work. Each quarter, teams reviewed the information to ensure that they were aware of each patient's visits to the hospital and emergency room. If they were unaware, they reached out to that patient. Additionally, practices are able to sort the CMS file to identify common primary and secondary diagnoses for admissions, readmissions and ED visits. They used this data to target their condition-specific improvement efforts. One system developed a self-management toolkit in an effort to reduce COPD admissions and readmissions. This system monitored the tool's effect through multiple sources of data, including the patient-level cost/utilization files.

Essential components

- Payer
  - Identify data categories that are meaningful to practices and support transformation efforts.
  - Develop a reporting format and method for communication that is least burdensome for practices.
  - Define the terms and rates of the data so that practices clearly understand what the data is telling them.
  - Ensure a feedback loop for gathering information from practices on usability of the reports.
- Practice
  - Identify personnel responsible for obtaining and reviewing reports each quarter.
  - Be transparent with the data across the practice. It can be a great engagement tool for teams.
  - View data over time. Trends in data are much more valuable than single data points.
  - Use reports to identify areas of opportunity for focused improvement efforts such as chronic disease management, improvement of communications with home health, and/or the identification of familiar faces and determining where these patients are seeking care.

Considerations for your initiative

- Payer
  - Consider creating a focus group of practice representatives to vet all reports for ease of access and usability.
- Practice
  - Payer data is typically at least six months old due to claims processing timelines. This is to ensure that data is more accurate. Debate continues about whether older, but more accurate, data is more valuable than less accurate data released sooner.
  - Consider which hospitals and EDs send you data daily. Are there others that appear in your patient-level file? Can you form relationships with them to ensure that you capture as many patients as possible for follow-up?

Change Tactic: Engage with practices to improve the usability and functionality of data reports

Data reports alone cannot influence practice transformation. Data must be usable at the practice level and include actionable, relevant data points. A small group of users should review and test payer reports and portals. This should happen before they go-live to the entire region. After deploying a report, payers should solicit formal and informal feedback from users. Formal surveys and focus groups are useful, as are informal conversations about the usability of the reports. Practices and payers often use different vocabulary. Certain terms may need changing or clarification to promote understanding by the practice users. Hosting a stakeholder group with representatives from payers and practices can be a good way to capture feedback and support productive dialogue regarding the functionality of data reports.

Early in the initiative, CPC practices shared that they rarely reviewed payer reports due to time and resource constraints. Not only were they strapped for time, they did not see the value in the reports. However, after focused technical support by regional learning faculty, practices began to recognize the data's value. They became much more engaged and interested in how to use data, they even began making suggestions and asking for additional data points. Practices relayed these suggestions and ideas to payers through various means, including direct practice communication, regional learning faculty, data workgroups, and management and planning calls. Payers began to compile this feedback and incorporate suggestions into future releases of quarterly feedback reports.

Essential components

- Payer
  - Provide a routine mechanism for practices and practice support personnel to give feedback on the usability of reports.
  - Ensure that all practices are aware of their ability to provide feedback and how it should be provided.
  - Encourage frequent feedback via formal and informal outreach to practices.
- Practice
  - Dedicate personnel time for review and analysis of these reports. Consider how these reports could be more actionable; log questions and suggestions for payers.
  - Participate in opportunities to provide feedback on these reports.

Considerations for your initiative

- Payers may consider creating a focus group of practice representatives to vet all reports for ease of access and usability.
- Respect each environment. People have limitations on what they can accomplish. For example, the delay in the claims-based data may not be resolved. Identify how to make it actionable anyway.
- Appreciate the language barrier. Payers and practices may understand the same scenario but use different terminology to describe it.

Measuring Success for Change Concept: Provide actionable and timely cost and utilization data to practices

For payers, these measures will help you evaluate the usefulness of data provided to practices:

- Percent of practices accessing quarterly feedback reports (including patient-level files) in a timely manner
- Amount of feedback received on usability of reports when requested
- Adoption of additions or edits to feedback reports

For practices, these measures may help you find actionable data points in the payer data:

- Monitor trends in targeted cost/utilization categories over time, and implement processes for targeted improvement
  - Identify a condition-specific focus (e.g., targeted self-management, implementing evidence-based care) from the patient-level file for reducing the number of 30-day readmissions and/or ambulatory care sensitive conditions. Monitor the effectiveness of a new process through the number of admissions.
  - Identify potential balancing measures such as decrease in inpatient services that led to an increase in primary care and outpatient services. (Balancing measures are changes designed to improve one part of the system causing new problems in other parts of the system.)
- Monitor the percent of patients listed on the patient-level file for whom that the practice was unaware of their admission or discharge.

Online (external) resources for measuring and improving quality

Science of Improvement: Establishing Measures (2016). The authors discuss the use of process, outcome and balancing measures for learning and process improvement. http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx

Change Concept: Reward practice actions to reduce total cost of care through shared savings or other mechanisms

At the onset of the CPC initiative, CMS set out to pay practices differently to encourage improved outcomes. CMS provided practices in CPC with two types of enhanced accountable payments: a monthly care management fee (per-member, per-month structure) and a shared savings opportunity payment. CPC practices had the opportunity to earn Medicare shared savings in the last three years of the initiative (2014, 2015 and 2016).

All payers throughout each CPC market aligned with CMS, providing non-visit based payment and an opportunity to share in savings. Each payer created a methodology for patient attribution and risk adjustment. Payers did not coordinate with each other on the specifics of these payments.

CMS designed its shared-savings methodology to reward practices for achieving better care, better health outcomes and lower total cost of care. As a balance measure to cost, practices were required to maintain or improve quality (measured by quality indicators) to be eligible to share in any savings. This alignment helped ensure that the practices focused their resources on the transformation work inside their practice and met all payers' expectations in the process.

Change tactics CPC practices and payers have used:

- Use shared savings, or a similar methodology, to reward achievement of better care, better health outcomes and a lower total cost of care
- Seek alignment between payment incentives, contract terms and the five Comprehensive Primary Care functions (Driver 1)

Implementation tips for rewarding practices

- Payers should identify shared savings methodology, including historical baseline benchmarking, that practices can obtain. Ensure it includes appropriate balance measures.
- Practices should assess their eligibility to participate in shared savings to ensure they, and their software, meet the requirements.
- Practices should monitor shared savings measures on a regular basis and make data-driven process improvements.
- Payers should ensure that the methodology, requirements and benchmarks are clear and understandable for practices. Be open to feedback and questions.

Change Tactic: Use shared savings, or a similar methodology, to reward achievement of better care, better health outcomes and a lower total cost of care

The concept of shared savings allows the practice to benefit when achieving strong financial results. Financial incentives can be motivating to practice teams. In CPC, practices have used these incentives to fund bonuses, invest in new technology and fund additional care management personnel, supplies and tools. Because these types of incentives cannot be guaranteed, the overarching payment structure should also include a consistent source of revenue that supports day-to-day transformation work, such as a PMPM care management fee. Practices can become frustrated and discouraged when they do not meet shared savings targets. Payers should anticipate this and provide enough data so that practices can identify gaps and areas for improvement in the next performance period.

To reward practices for their achievement of better care, better health outcomes and lower total cost of care, each payer in the CPC initiative developed its own methodology for shared savings. CMS created a method for calculating a historical baseline for markets and developed its methodology as follows:

1. CMS calculates shared savings at the CPC region level.
2. CMS uses claims experience in the region to estimate future expenditures.
3. If a region spends less than the expenditure target by more than 1 percent, CMS shares the savings.
4. The relative proportion of care management fees in the region determines a practice's share.
5. Only practices that maintain or improve quality of care are eligible to share in savings.

CPC resources related to shared savings methodologies

Comprehensive Primary Care Initiative Shared Savings Methodology (2016). This paper describes the technical details for the methodology CMS uses to determine shared savings for CPC practices. https://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Shared-Savings-Methodology-PDF.pdf

CMS's regional shared savings methodology produced both opportunities and challenges. This approach promoted transparency and collaboration within markets to improve the collective outcomes. Many markets gained consent from all practices to share their cost and utilization data transparently. Transparency improved engagement across practices and provided a platform for peer-to-peer matching and sharing that centered on various areas of practice operations and cost/utilization categories.

A practice must have access to usable data to track its progress toward established targets. Sometimes this data is part of the EHR or registries within the practice, but, at other times, the payer must supply this data. For example, CPC challenged practices to create net savings in their total cost of care. Each practice needed data from participating payers to track its total cost of care. Prior to this model, most practices only had access to the cost of care that they provided at their respective practices. In addition, practices should understand the methodology used to determine shared savings in advance of the shared savings payment. This can help a practice strategically target areas to achieve better care, smarter spending and healthier people. In addition, because most payers had slightly different shared savings methodologies, it took time to vet the requirements fully and engage in the necessary reporting for each one. A multi-payer, data aggregation platform allows practices to review data from multiple payers, all in one place. If this is not feasible, it can be helpful for each payer to provide aligned reports about similar measures in a similar format and on the same distribution timeframe.

Essential components

- Payer
  - Provide data regularly that practices can use to guide practice changes that create shared savings.
  - Conduct extensive research on shared savings methodologies, including by calculating a historical baseline before determining what will best serve practices/populations; ensure balance measures are in place.
  - Outline clear benchmarks for achieving shared savings and communicate them to practices.

- Practice
  - Seek out clear benchmarks for cost/utilization, quality and patient experience, in addition to improvement efforts, to target these benchmarks.

Considerations for your initiative

- A region-level approach may not be best; practices may default to acting in their own interests.
- Identifying specific measures and benchmarks that are directly reflective of the total cost of care is challenging because of the complexity of populations and statistical analysis.

Change Tactic: Seek alignment between payment incentives and contract terms and the five Comprehensive Primary Care functions (Driver 1)

Payers should design their payment incentive programs to match the tasks outlined in the five primary care functions and those in their reporting requirements (in CPC, these were the milestones that CMS issued at the start of each program year). Consistency in measures and reporting timeframes helps streamline practices' administrative requirements. In addition, the model as a whole has an increased likelihood of success if practice transformation efforts focused on a short, incremental list of key activities or milestones. Some practices reported that, in situations where program requirements were varied and disparate, their ability to do the work becomes unsustainable. The practice then moves into "box checking" mode. To avoid this issue in CPC, the Innovation Center streamlined requirements and clearly communicated expectations about reporting requirements and payment methodologies in advance.

CPC payers were encouraged to create methodologies for shared savings that were mindful of practice proficiency in the five comprehensive primary care functions, along with their terms of participation. To foster alignment, CMS outlined the requirements listed below.

To receive a payment, practices must meet the following requirements:

- Practices must have participated in the model for the entire performance year (January 1 through December 31).
- Practices must have submitted the required number of electronic clinical quality (eCQM) measures for the performance year.
- Practices must have earned at least half of the possible points for the performance year from any combination of measures.

CMS created a methodology based on expenditures, quality measures (EHR and claims-based), patient experience measures and practices' ability to report eCQM measures at a practice-level in its EHR. CMS assigned quality points to measures. For each performance year, practices were required to earn half of the possible quality points from any combination of measures and benchmark gates. In 2015, CMS scored practices on these types of quality measures: five practice-level Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience measures, three regional claims-based quality measures and nine (out of 13) practice-level electronic eCQMs. For more details about the methodology for aligning payment incentives with contract terms and the five comprehensive primary care functions, please see the Comprehensive Primary Care Initiative Shared Savings Methodology document: https://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Shared-Savings-Methodology-PDF.pdf

Essential components

- Payer
  - Understand terms of practice participation and the five comprehensive primary care functions, and then align payment incentives accordingly.
  - Clearly outline shared savings methodology, including requirements and benchmarks, to practices via multiple avenues (e.g., written documentation, webinar or office hours for Q&A with practices).
- Practice
  - Understand payers' shared savings methodologies and ensure that your practice can meet the eligibility requirements for shared savings. It is suggested that you work with your EHR vendor.
  - Align improvement work with benchmarks for shared savings.

Considerations for your initiative

- Payers may consider creating a focus group to help develop the methodology description so that practices can easily understand the metrics, along with how they influence shared savings.

Measuring Success for Change Concept: Reward practice actions to reduce total cost of care through shared savings or other mechanisms

For payers, these measures will help evaluate your shared savings mechanisms:

- Number of practices eligible for shared savings
- Number of practices receiving shared savings
- Amount of shared savings achieved

For practices, these measures will help you track your progress toward achieving shared savings:

- Monitor performance in identified shared savings measures
- Monitor ability to meet reporting requirements for shared savings

Change Concept: Align quality measures

At the onset of any transformation project, it is important to identify how to measure its success. CPC asked private and public payers within each CPC market to align standards or measures to lessen the burden on practices and to focus improvement on specific high-value areas of care.

CMS outlined three types of quality measures for alignment: quality of care, patient experience and cost of care. Payers often used the data workgroups to determine which measures or standards they would focus on within each measure type. All payers were able to agree on a set of measures and a similar approach for reporting on each of these measures to practices. They adopted National Quality Forum measures as electronic clinical quality measures. Cost and utilization measures commonly include hospital admissions, 30-day readmissions, outpatient ED visits and other services, such as specialty care. CMS chose the Consumer Assessment of Healthcare Providers and Systems for Clinicians and Groups Survey (CG CAHPS) to measure patient experience and encouraged other payers to do the same. Practices commonly measured patient experience through surveys based on the CAHPS survey and through feedback from patient and family advisory councils.

Change tactics CPC practices and payers have used:

- Seek alignment on all three types of CPC quality measures (quality of care, patient experience and cost of care) with CMS and other major payers in the market

Implementation tips for aligning quality measures

- Payers should create avenues for identifying, discussing, and selecting aligned measures that are mindful of practices and populations.
- Practices should ensure that they are able to capture necessary measures and focus improvement efforts on aligned measures, all while tracking performance on an ongoing basis.
- Payers should consider the number of measures required and limit reporting to the most important of those measures.
- Payers can further promote regional alignment and teamwork to work toward a goal by focusing on two to three key quality measures across a region.

Change Tactic: Seek alignment on all three types of CPC quality measures (quality of care, patient experience and cost of care) with CMS and other major payers in the market

To achieve the CPC aims of better care, smarter spending and healthier people, CPC practices focused on metrics related to the quality of care, patient experience and cost of care. Many payers and practices used measures outlined by the National Quality Forum (NQF) to track quality of care. Examples include measures to track diabetes control, blood pressure control, cancer screening rates, falls screening, LDL management and depression screening. Practices occasionally used homegrown surveys or standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to collect patient experience measures. Payers typically used claims data to measure the cost of care for a single encounter, a bundle of services or by overall cost. To reduce the practices' administrative burden, limit the total number of measures they need to report. In addition, consistency of measures and definitions will support regional alignment of the transformation work in the community. There is synergy when multiple members of the Medical Neighborhood work together to improve a specific quality measure.

From a practice perspective, this alignment was critical when prioritizing focus areas for patient care. Practices reported that keeping up with different measures for each insurance company was burdensome. Prior to CPC, many practices were overwhelmed with this task, and they often became more focused on "checking a box" within their EHR to get "credit" than on spending critical time listening to their patients. Physicians often complained of this burden and expressed their frustration with competing measures, nuances in measure definitions and labor-intensive reporting processes. Payer alignment around these key measures allowed practices to align their focus as well. This lessened the reporting burden and allowed for more time focused on enhancing patient care.

Essential components

- Payer
  - Organize a data workgroup to foster communication among payers.
  - Identify a clear set of measures that each payer agrees to focus on. It is critical for payers to understand the process/requirements that their measures require of practices and their health IT software.
  - Streamline reporting requirements for identified measures so that there is continuity on reporting for practices.
  - Communicate alignment to practices with clear definitions of each measure (claims-based and EHR-derived).
- Practice
  - Understand measures and what is required to report on each.
  - Work with your EHR vendor to ensure that there is the ability to report on each measure.
  - Review available reports from payers on measures and implement improvement efforts focused on aligned measures.

Considerations for your initiative

- Payers may consider creating a focus group that includes practice representatives who can inform this process (report content, selection of measures, reporting process, frequency and method of communication).
- Practices should consider how they could align their overall QI efforts across payers and other programs that they participate in.

Measuring Success for Change Concept: Align quality measures

The following measures will help you evaluate whether your quality measures have alignment:

- Monitor the ability to gather data for each measure from participating practices
- Evaluate whether the focus measures are the right drivers for advancing the initiative's aims
- Identify trends among practices for each measure

Resources for Driver 5

Comprehensive Primary Care Initiative Shared Savings Methodology (2016). This paper describes the technical details for the methodology CMS uses to determine shared savings for CPC practices. https://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Shared-Savings-Methodology-PDF.pdf

Science of Improvement: Establishing Measures (2016). The authors discuss the use of process, outcome and balancing measures for learning and process improvement.
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx