CMS Response to Public Comments Received Regarding Planned Information Collection for the Evaluation of the Multi-payer Advanced Primary Care Practice Demonstration
(Document Identifier: CMS-10436)

The Centers for Medicare and Medicaid Services (CMS) received comments from the public in response to a summary of proposed information collection published in the *Federal Register* on May 31, 2012 regarding the evaluation of the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration (Document Identifier: CMS-10436).

The first commenter, a state agency, had no recommended changes to CMS's planned information collection in relation to this evaluation, but voiced strong support for the medical home model of care and for CMS's efforts to support it through the MAPCP Demonstration and the Comprehensive Primary Care Initiative. The other commenter, a patient advocacy group, described specific patient-centered principles, strategies, policies, and practices that they believe are important features of the medical home model, and recommended considering addressing these areas in the evaluation of the MAPCP Demonstration. They also urged CMS to consider incorporating these areas in any expansions of the MAPCP Demonstration.

Below we summarize this second commenter's comments about important components of the medical home model and our responses. We note in these responses that the information collection that prompted the May 31, 2012 *Federal Register* notice consisted of site visit interviews to be conducted in the fall of 2012; subsequent information collections covering other types of data that will be collected as part of this evaluation are expected to be described in future OMB information collection requests and their accompanying *Federal Register* notices. That being said, the second commenter's comments have not only been useful to MAPCP evaluators in revising the 2012 site visit interview protocols, but will also help inform future information collections involving 1) focus groups with Medicare and Medicaid beneficiaries and their caregivers and 2) survey of practices participating in the MAPCP Demonstration, and, 3) conducting site visit interviews in future years. Our responses to the second commenter's comments are as follows:

1. **Advanced primary care must assure ready (or timely) access to care and consultation with patients and families outside of regular business hours.**

   Response: The site visit interviews planned as part of the evaluation of the MAPCP Demonstration will examine early efforts by demonstration leaders and participating payers and providers to assure ready access to care and for Medicare and Medicaid beneficiaries, dual eligibles, and other special populations. The current site visit interview protocols (referenced in the attached table) include general questions to interviewees about whether and what steps are being taken to improve access. Interview time constraints make it unfeasible to inquire about all possible strategies, policies and practices to assure ready (or timely) access, but we have added a few additional questions and/or probes to our interview protocols where possible and appropriate in an attempt to obtain more specific responses from interviewees on this topic.

2. **Care coordination should be focused on, with specific emphasis on the use of multidisciplinary care teams to coordinate care obtained from physicians, hospitals, home care agencies, nursing homes, and community resources. Also, specific mechanisms that support transitions**

across care settings, including discharge from hospital to home, should be focused on, with appropriate involvement of the patient's primary care provider.

Response: The 2012 site visit interview protocols will examine early efforts by demonstration leaders and participating payers and providers to improve care coordination for Medicare and Medicaid beneficiaries, dual eligibles, and other special populations. The current protocols (referenced the attached table) already include general questions about what steps are being taken (if any) to improve care coordination and care transitions, including questions about whether the practices are using care coordinators, hiring additional staff to help with care coordination and transitions, and whether/how health information technology (HIT) is being used to facilitate care coordination and transitions. Interview time constraints make it unfeasible to inquire about all possible strategies or policies and practices, but we have added a few additional questions and/or probes to our interview protocols where possible and appropriate in an attempt to obtain more specific responses from interviewees on this topic.

3. **Patients should be asked who, if anyone, they want involved in their care. One tool that may be used to assess the role of a patient's family and caregiver is DECAF, developed by Eric Coleman (http://www.caretransitions.org/).**

Response: We inquire about general strategies that primary care providers are using to improve patient and family or caregiver engagement (see table). We have also added a question to the practice protocol and the community health team protocol related to this subject. In addition to the practice protocol for this round, we will keep this suggestion in mind for future rounds of site visits and other data collection methods used for this evaluation (e.g., practice surveys and beneficiary focus groups).

4. **The commenter is pleased that certain outcomes of care will be evaluated, particularly access to and coordination of care, clinical quality of care and patient safety, and beneficiary experience of care. They also note that to ensure meaningful quality measurement and improvement, practices should report on particular types of quality measures (e.g., measures that are standardized, endorsed by NQF, relevant to patients and family caregivers, and that help consumers compare providers). They also recommend longitudinal measurement, inclusion of data on private-payer or commercially-insured individuals, measures that will help assess and reduce disparities, and measures that are in alignment with other CMS work, as called for in the National Quality Strategy.**

Response: Outcomes of care for Medicare and Medicaid beneficiaries, dual eligibles, and other special, vulnerable populations will be primarily addressed through other components of this evaluation (e.g., a patient experience survey and claims data analysis) that are not covered by this particular information collection request.

However, the current protocols (referenced in the attached table) include general questions about outcome data payers in the state receive from and provide to practices, and evidence or perceptions about whether the demonstration has improved outcomes to date. Additionally, the site visits will be conducted annually over a three-year period, allowing us to track evidence or perceptions about the demonstration's impact on outcomes over time.

Interview time constraints make it unfeasible to inquire about all possible strategies or policies and practices, but we have added a few additional questions and/or probes to our interview

protocols where possible and appropriate in an attempt to obtain more specific responses from interviewees on this topic.

5. **The commenter commends CMS for explicitly including beneficiary experience of care in the measures that will be part of the evaluation. They also strongly urge that advanced primary care practices to: 1) use, at a minimum, the PCMH CG-CAHPS survey; and 2) beyond that annual experience survey, solicit real-time feedback from patients. For example, through focus groups, interviews, patient walk-throughs, and patient/family advisory councils.**

   Response: Beneficiaries' experience of care will be primarily addressed through other components of the evaluation (e.g., patient experience surveys and focus groups with Medicare and Medicaid beneficiaries).

   The current site visit interview protocols (referenced in the attached table) include general questions about patients' experience of care, whether and what survey instruments are being used to assess it, and early perceptions of whether the demonstration is or will be able to improve experiences of care for Medicare and Medicaid beneficiaries, dual eligibles, or other special, vulnerable populations.

   Interview time constraints make it unfeasible to inquire about all possible strategies or policies or practices, but we have added a few additional questions and/or probes to our interview protocols where possible and appropriate in an attempt to obtain more specific responses from interviewees on this topic.

6. **The commenter commends CMS for emphasizing the importance of community resources, including the solicitation's identification of integration and coordination with community resources and allowing payment for community-based resources that support primary care. The solicitation does not require one method of linking practices with community resources but provides examples of how an initiative might do so (e.g., establishing networks of community resources, sharing of staff providing these services by small independent practices, or linking with a practice with existing sources of community support). We believe these are important methods of linking practices with community support and urge CMS to consider how the different state initiatives approach this important element of patient-centered primary care.**

   Response: The current protocols (referenced in the attached table) include general questions about primary care provider linkages to community health networks/teams and resources, including whether or not community health teams or networks exist or are being established and how the health plans and practices work with them. Additionally, we have developed a specific site visit interview protocol for staff from community health teams or networks, Office of Aging Staff, and other patient advocates and are seeking to interview key individuals from these agencies.

   Interview time constraints make it unfeasible to inquire about all possible strategies or policies or practices used to link primary care providers with the full range of community resources, but we have added a few additional questions and/or probes to our interview protocols where possible and appropriate in an attempt to obtain more specific responses from interviewees on this topic.

7. **The commenter strongly supports aligning health information technology requirements with the HITECH meaningful use (MU) definition. They also strongly encourage CMS to use the MU criteria as a floor, but be willing to go beyond them to ensure that HIT can be used to achieve the goals of advanced primary care. Requiring advanced primary care providers to collect caregiver names, the specific roles they play in the patient's care, and their contact information and 2) incentivizing them to include patient-generated data (i.e., the results of functional assessments or depression scales) in the electronic medical record are two ways the practices can advance understanding of how to use HIT to improve patient and family engagement and care coordination.**

   There are two requirements in particular that CMS should require advanced primary care practices to go beyond. Practices should provide patients online access to their health information (this was a menu item for MU stage 1, thus not required). Furthermore, CMS should require practices to use the data on disparity variables they are already collecting for stage 1 MU to stratify quality measures by those variables.

   Response: The current protocols (referenced in the attached table) include general questions about health information technology. Interview time constraints make it unfeasible to inquire about all possible strategies or policies or practices used to in relation to HIT and aligning medical home efforts with MU. However, we have added question(s) and probe(s) where most appropriate and possible about whether patients have online access to their health information; whether demographic data being collected for stage 1 MU (note: we assume that is what is meant by "disparity variables"—see next comment) are being collected, reported on, and used to stratify quality measures; and alignment between the clinical quality measures and other reporting requirements of the state's medical home efforts and stage 1 MU criteria. Given the early stage of the MAPCP Demonstration and challenges providers are having meeting stage 1 MU requirements, we are not inquiring about whether and how states are requiring medical homes to go beyond stage 1 MU requirements.

8. **The commenter was pleased the MAPCP demonstration solicitation identified, as central to the demonstration, the delivery of care consistent with evidence-based guidelines in historically-underserved areas. To ensure that advanced primary care addresses disparities, the commenter believes practices should also undertake to conduct or provide the following:**

   - Collection and stratification of data on patients' race, ethnicity, language, gender and disability status in order to identify and address disparities. At a minimum, entities should collect this data using HHS/OMH survey standards, released in October 2011. However, where feasible, the commenter encourages adoption of the recommendations from the 2009 IOM report for the standardized collection of more granular race/ethnicity data.
   - Appropriate translation/interpreter services and accommodations for patients with limited English proficiency (LEP), cultural differences, and disabilities
   - Effective oral communication for all LEP individuals regardless of whether translation or other thresholds are met. It has been a longstanding recognition under Title VI of the Civil Rights Act of 1964, reiterated with the enactment of the nondiscrimination provision in §1557, that oral communication with LEP enrollees must be provided to every individual, regardless of whether thresholds to provide written materials are met.
   - Provide notices and vital documents in alternative formats, and effectively communicate to people with communication, print, and mobility disabilities, whatever the medium of communication.

- Recognition of health literacy as a component of patient/family caregiver communication and language needs
- Organizational policies that stress the importance of working to overcome barriers, and incorporate flexibility to ensure that policies, procedures, and provider practices can be tailored to accommodate patient/family care needs, beliefs, and cultural values.

Response: The current protocols (referenced in the attached table) include general questions about any strategies or policies or practices used to meet the needs of special or vulnerable populations, including: Medicare and Medicaid dual eligibles; children; racial and ethnic subgroups; people living in rural or inner-city areas; and persons with chronic illness, mental illness, or disabilities. Interview time constraints make it unfeasible to inquire about all possible strategies or policies and practices used to use deliver care consistent with evidence-based guidelines in historically underserved areas or to address/reduce disparities. However, we have added a few additional questions and/or probes to our interview protocols where possible and appropriate in an attempt to obtain more specific responses from interviewees on this topic. See table for additional detail.

9. **The commenter believes the most effective strategy to achieve truly patient-centered advanced primary care is to engage patients and their family caregivers collaboratively not only in their own care, but also at the practice level and system level – in practice redesign, planning, governance, quality improvement, and evaluation.**

The commenter goes on to say that it supports the position in the MAPCP Demonstration solicitation that beneficiaries be able to participate effectively in decisions concerning their own care. The commenter notes that they believe this includes:

- *Care planning* – meaning the patient (and family caregiver as appropriate) is a core member of the care team, and actively participates in developing and updating care plan.
- *Shared decision-making* – meaning the practice has processes in place for informing and engaging patients/family caregivers in their health and health care through the use of patient specific educational materials and shared decision-making. Too often, patients/family caregivers are prescribed treatments without fully understanding the benefits, costs, side effects, and/or alternative options. Shared decision making should not be limited only to conditions where the evidence for a particular treatment option is unclear – rather, shared decision making should occur in the context of any preference-sensitive conditions in which decision making tools are already available.

The commenter goes on to say that the MAPCP Demonstration solicitation also requires initiatives to have specific mechanisms to support patient self-management, and notes that they define patient self-management as follows:

- Patients are supported in building the skills, knowledge, and confidence they need to manage their health and health care, maintain maximum function, overcome barriers, and achieve personal goals
- Patient self-management is rooted in a collaborative partnership between patient and provider.
- Patients, and family caregivers as appropriate, are supported "where they are" in their capacity for patient self-management and supported in increasing that capacity.

- Patient self-management activities are linked to a care plan, developed together with the patient (and family caregiver, as appropriate), that reflects their wants and needs, is tailored to their life situation, and has realistic, achievable goals.
- A support structure ensures patients and family caregivers have the information they need and are continuously supported. This includes ready access to their medical records, evidence-based information to support their care decisions, a "point person" they can call with questions, a system for follow-up after hospital discharge or other transitions of care, and connection with community-based resources.

Response: The current protocols (referenced in the attached table) already include general questions about strategies or policies and practices used to engage patients. Interview time constraints make it unfeasible to inquire about all possible strategies or policies and practices used. However, we have added a few additional questions and/or probes to our interview protocols where possible and appropriate in an attempt to obtain more specific responses from interviewees on this topic. See table for additional detail.

10. **In several places the commenter notes that although the patient-centered practices they recommend are consistent with the NCQA PCMH criteria, real collaborative engagement will require additional effort.**

Response: The decision about what medical home assessment or recognition tool is used resides with the MAPCP Demonstration states and their state-based payer partners, as CMS is joining these pre-existing state multi-payer demonstrations. Six states have chosen to use NCQA's 2008 or 2011 PCMH recognition standards and two states (MI and MN) are using "homegrown" medical home assessment or recognition tools developed by the state or a prominent private payer in the state. Our current site visit interview protocols inquire about why the state choose a particular medical home assessment or recognition tool, how well respondents feel the tool assesses a practice's medical home capabilities, and how such information is used. As noted above, the protocols include some questions about efforts to engage patients and family or caregivers. See attached table for additional details.