April 2016:
Public Comment to The Oregon Health Authority's Patient-Centered Primary Care Home (PCPCH) Program Proposed Amendments for January 2017

The Oregon Pediatric Improvement Partnership (OPIP) is committed to partnering with the Oregon Health Authority in improving the quality of care delivered by front-line primary care practices that serve children. This document is informed by our work with over 44 practices across Oregon on implementing elements of PCPCH. It is our view that the Patient-Centered Primary Care Home (PCPCH) Standards are an important component of the statewide effort to achieve the triple aim. We believe that the PCPCH standards have been successful in creating a focus on the foundational concepts of medical home and commend the PCPCH program for this impact. **That said, we believe it is a critical time to ensure that the standards are differentiating in the level and quality of medical homes.** We fear that momentum and commitment to PCPCH by front-line providers will be lost unless meaningful payment reform, across payers and using information from PCPCH attestation, occurs. **We feel this reform is unlikely unless the standards are differentiating in point structure, and that there is validity in a practice's attestation to specific standards.** Additionally, specific standards require different practice-level investments that would benefit from alternative payment reform, and therefore we believe it necessary that the attestations are: 1) reliable and valid, and 2) assign a higher point threshold for standards that require higher practice-level investments, and ones that are in clear alignment with state priorities (e.g. complex care management and behavioral integration). Below are our comments highlighting both positive changes, and opportunities to consider for further improvement.

Proposed 2017 amendments representing positive changes addressing observed weaknesses:

- **3.A Preventive Services-** Updates requiring the identification of areas for improvement will make sites focus on all populations they serve, including children. We have observed that this population has not always been intentionally included in practices that serve adults and children. To ensure reliability and validity of attestations, we recommend age-specific tables, and inclusion of all key services.
- **3.C Mental Health, Substance Abuse, & Developmental Services-** Replacing the "or" with "and" to ensure sites have a developmental screening strategy and a cooperative referral processes with developmental providers for co-management, is critical for practices that care for pediatric populations.
- **5.A Population Data Management**- Including the stratification of practice population according to special health care needs calls out the importance of this population of children. Again, it will be integral that this is assessed within practices that serve adults and children, and that children are included in this process. The technical specifications will need to be clear about the definition and breadth of definition that meets the requirement.
- **6.C Experience of Care**- Making this must-pass, changing the periodicity to every 2 years, and requiring a demonstration of the use of these data for QI are all positive steps to maximally utilizing this important tool. It is important to note however, that OPIP remains concerned that 6.C.3 and 1.A.3 still emphasize attaining a benchmark rate, while not addressing the established concern that practices who use a convenience in-house sample and administration obtain significantly higher rates than practices who use a standardized sample and survey administration to all patients. *(Please refer to OPIP Public Comment-2013 PCPCH Standards Revision for further information)*

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Standards and proposed amendments would benefit from further improvements:

- **2.E Ambulatory Sensitive Conditions-** This standard does not change in the proposed amendments, and could benefit from the addition of more pediatric appropriate measures. Currently, 2 of the 4 measures are for 18 and older, and a third commonly yields very small numbers in pediatric populations. **OPIP Staff recommend the consideration and addition of measure options relevant and valuable to pediatric practices.**
- **3.C Mental Health, Substance Abuse, & Developmental Services-** As noted, we support the changes to 3.C.0. That said, we feel that 3.C.2 and 3.C.3 are standards where significant primary care resources and transformation are needed in order for practices to attest to. Given the synergy with statewide goals on behavioral health integration, we feel that there may be value in breaking out the varied components within 3.C.2 and 3.C.3 to allow for more points to be assigned to these concepts, and to enhance the reliability and validity of responses to the standards in a way that would allow for payers to implement payment reform tied to this specific standard. For example, there is a significant difference in practices who establish a cooperative referral process for co-management versus practices who are co-located, yet they are both included in one tier (3.C.2). Secondly, we think it is imperative to note that within the proposed standard, there is still an enormous barrier for a small site to achieve the highest tier. For example, Oregon has fewer child psychiatrists per capita than many other states (*Massachusetts has about three times the per capita number of child psychiatrists than Oregon, for example*), making the availability of qualified professionals alone a huge barrier to success in this area. If additional standards were created to allow for differentiation on this important concept (which we recommend), we don't feel the tier cut offs should be changed given it may not be feasible or possible for practice to achieve the highest level of care given factors outside of their control. **OPIP Staff recommend the addition of more tiers to this standard given its importance, and practice-level resources needed to achieve the standard. Increase the specificity and language around the standards and what is required to ensure reliability and validity of the responses so that payers would be more likely to use attestations to these standards to support needed payment reform.**
- **5.C.3. Complex Care Coordination-** As noted earlier, the improvements to the Standard 5.A Population Data Management were valuable in ensuring that the group that most benefits from medical home and care coordination can first be identified, and that this population is NOT narrow to a specific condition or small population. OPIP feels that standard 5.C.3's technical specifications should be clear that care plans are to be done for a broad enough population. OPIP's experience has been that some practices have been able to attest to this standard for a small population based on one diagnosis or for one age group, which doesn't meet the intent of the standard or triple aim goal. Lastly, it is our experience that when practices validly and meaningfully achieve this standard, it requires staffing and resources that are often new and transformational. Therefore, there may be value in assigning more points to this threshold given the foundational change it requires. **OPIP Staff recommend that the technical specifications are clear about the breadth and criteria used to establish which populations receive care planning and that it includes eligible patients across the age-span the practice serves. It may be valuable to consider the population identified in standard 5.A.**

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Tier Structure and Alignment with NCQA:

- **Updated tier structure**- the impact of the proposed amendments to the tier structure still creates a top-heavy distribution of practice scoring, providing only minimal improvement from the current state. Again, we strongly recommend reconsideration of the need to make a foundational change in the tier structure, including at Tiers 1-3, given the time sensitive need to enhance the ability to differentiate quality of practices to allow for meaningful payment reform tied to PCPCH. **OPIP Staff recommend that the new 5 tier system be organized in a way that there is more even distribution and differentiation among practices. For example, one option that could be considered (informed by the point distribution provided by the PCPCH program) is:**

Tier	Thresholds*	Difference	Additional Requirements	OPIP Proposal that Would Be More Evenly Distributed
Tier 1	30 - 60 points	30	+ All must-pass measures	30-145 (11% of clinics)
Tier 2	65 - 125 points	60	+ All must-pass measures	150-200
Tier 3	130 – 200 points	70	+ All must-pass measures	205-245
Tier 4	200 - 380 points (or max points)	180	+ All must-pass measures (but don't meet 11 of the 13 specified STAR measures)	250-380
Tier 5 (Current 3 STAR Designation)	300+ points	80	+ All must-pass measures + Meet 11 out of 13 specified STAR measures + All measures are verified with site visit	300 PLUS 11 of 13 standards

- **Table 3 NCQA Recognition and Equivalency**- In the proposed amendments outlined in table 3, an NCQA recognized site is still only able to achieve a tier 3 PCPCH designation. In our experience, the updated NCQA recognition is a **rigorous process that warrants a higher equivalency**, and if not, an explanation of why not. **OPIP Staff recommend that Table 3 outline how NCQA certified sites attain PCPCH Tiers 4 and 5.**

General Comment Regarding Technical Specifications & Integrity of Site Visit Verification

- The reliability and validity of the attestations to the standards is dependent on the specificity and clarity of the technical specifications, and on the integrity of the site visit verification of whether the practice is doing those activities.
- OPIP strongly recommends that the PCPCH Program engage the PCPCH SAC and other stakeholders with significant implementation experience in the development of the technical specifications and what processes count for meeting each standard. OPIP offers to review draft technical specifications.
- It will be imperative that the site verification be comprehensive, thorough, and that the PCPCH Program is supported and encouraged to deny an attestation to a standard when valid evidence is not shown that the practice meets the standards outlined. If practices are given various answers or feedback about what "counts", or a year to modify their processes to meet the standards, then it could negatively impact perceptions about the reliability and validity of the standards and therefore negatively impact the payment reform needed.

Thank you for the opportunity to provide feedback as part of the amendment process. OPIP values our role in providing context informed by work with front-line providers that serve children in Oregon. Any questions or follow-ups with regard to these comments should be directed to OPIP's Director, Colleen Reuland (reulandc@ohsu.edu, (503) 494-0456).

In the Spirit of Collaboration & Partnership, Oregon Pediatric Improvement Partnership Staff

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