June 27, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Notice of Proposed Rulemaking on Medicare Program; Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Medicare Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-P)

Dear Acting Administrator Slavitt:

Community Catalyst is pleased to submit these comments to the Quality Payment Program (QPP).

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation is a hub devoted to teaching, learning and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers, particularly those who are most vulnerable.

We are pleased to see the proposed rule moves the health care system away from one that is based solely on fee-for-service, and towards a system that focuses on better coordination, quality and value of care.

The proposed rule will have sweeping and lasting changes on this nation's health care system, and most importantly, on the consumers the system serves. In light of this, we would like to raise the following issues:

1. The importance of consumer engagement

2. The imperative to address health care equity

3. The need for quality measures that meaningfully capture patient experiences and outcomes

4. The impact on underserved communities

5. The critical role of risk adjustment

6. The importance of consumer protections as providers take on financial risk

We address each of these six topics in our comments below.

1. The importance of consumer engagement

A Clinical Practice Improvement Activity (CPIA) is an activity that "relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes." Increasing evidence points to the importance of consumer empowerment and engagement as a means of quality improvement and cost savings.[1]

While we appreciate the inclusion of beneficiary engagement activities in the proposed CPIA Inventory, we note that with but one exception – "collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan," which is rated as "high" – all beneficiary engagement activities are weighted as "medium." We recommend that CMS assign a higher weighting to the following activities in order to encourage entities participating in the Merit-based Incentive Payment System (MIPS) to prioritize them:

- Provide condition-specific chronic disease self-management support programs or coaching, or link patients to such programs in the community.
- Provide self-management materials at an appropriate literacy level and in an appropriate language.
- Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal-setting with structured follow-up, teach back, action planning or motivational interviewing.
- Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure (PAM) or "How's My Health").
- Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified electronic health record (EHR) technology.
- Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.
- Engage patients and families to guide improvement in the system of care.

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[1] See, e.g., Ahn S, Basu R, Smith ML, Jiang L, Lorig K, Whitlaw N, Ory MG. The impact of chronic disease self-management programs: healthcare savings through a community-based intervention. *BMC Public Health.* 2013; 13:1141; Carman KL, Dardess P, Maurer M, Sofaer S, Adam K, Bechtel C, Sweeney J. Patient and family engagement: a framework for understanding the elements and developing interventions and policies. *Health Aff.* 2013; 32(2): 223-231. Greene J, Hibbard JH, Sacks R, Overton V, Parrotta CD. When patient activation levels change, health outcomes and costs change, too. *Health Aff.* 2015; 34(3): 431-437.

We believe that payment arrangements that qualify as Advanced Alternative Payment Models (APMs) and that encompass a comprehensive model of care (such as an Accountable Care Organization), should include more robust consumer engagement activities. At a minimum, these arrangements should:

- Convene a consumer advisory council that fairly represents the entity's patient and family caregiver population. These councils should be mechanisms for gathering regular and meaningful input and feedback, and an integral part of the entity's quality improvement activities.
- Use additional strategies to assess the patient experience of care such as surveys, town-hall-style meetings and focus groups.
- Provide condition-specific chronic disease self-management support programs or coaching or link patients to such programs in the community.

Finally, the proposed rule requires that medical home models seeking to become Advanced APMs must meet two elements, at a minimum:

- Model participants include primary care practices or multi-specialty practices that include primary care physicians and practitioners and offer primary care services.
- Empanelment of each patient to a primary clinician.

In addition, the proposed rule goes on to state that the medical home model must have at least four of the following seven elements:

- Planned coordination of chronic and preventive care.
- Patient access and continuity of care.
- Risk-stratified care management.
- Coordination of care across the medical neighborhood.
- Patient and caregiver engagement.
- Shared decision-making.
- Payment arrangements in addition to, or substituting for, fee-for-service payments (e.g, shared savings, population-based payments).

We submit that all seven of these elements are requisite hallmarks of a medical home model participating in an Advanced APM and urge CMS to expand the required elements to include all seven.

2. The imperative to address health equity

We know that health disparities related to demographics such as race, socioeconomic status, sexual orientation, gender identity and disability status persist.[2,3,4] For example, Blacks and

[2] 2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy. Agency for Healthcare Research and Quality, Rockville, MD; May 2016. http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/index.html. Accessed on June 25, 2016.

Latinos have the highest prevalence of six or more chronic conditions,[5] and significant disparities in quality of care and health outcomes persist for people in low-income households. The implementation of the QPP represents a transformative opportunity to address the persistent problems of disparities in treatment and outcomes for historically marginalized and underserved populations. We encourage CMS to take advantage of this opportunity to improve overall quality of care and the health of the nation.

We appreciate and support the addition of "Achieving Health Equity" as a subcategory of activities under the CPIA performance category. We urge CMS to further strengthen the category in the following ways:

- Expand the activity section to go beyond simply accepting patients from marginalized communities. Activities should promote and incentivize improvement in care and health outcomes for those populations, such as cultural competency[6] or implicit bias trainings.[7] Implementing these activities can help address provider biases, poor patient-provider communication, and poor health literacy and ensure that patients are cared for by providers who have the skills and tools necessary to serve them in an effective way.
- Incentivize providers who reduce disparities in their selected quality measures.
- Consider reassigning the weight for using standardized processes for screening for social determinants of health as "high," given the impact social, environmental and behavioral influences have on health outcomes.

We note that apart from the recommendations for the CPIA performance category, there appears to be little else in the proposed rule that would help address the troubling health disparities that persist in our country. We therefore also urge CMS to consider the following opportunities to further address health disparities and advance health equity:

- Report health outcomes through data stratified by race, ethnicity, disability status, gender, primary language, gender identity and sexual orientation.
- Establish payment arrangements that incentivize strategies that address the non-medical and social determinants that contribute to health.
- Establish processes for ongoing monitoring and evaluation of disparities reduction as part of the implementation of the Quality Payment Program to identify interim outcomes, impacts and opportunities for improvement over time and at the national level.

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[3] Byne W. LGBT health equity: steps toward progress and challenges ahead. *LGBT Health*. 2015;2(3):193-195.

[4] Krahn GL, Walker DK, Correa-De-Araujo R. Persons with disabilities as an unrecognized health disparity population. *Am J of Public Health*. 2015; 105 Suppl 2: S198-S206.

[5] Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chart Book 2012 Edition; 2012. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf. Accessed on June 25, 2016.

[6] National Quality Forum. Healthcare Disparities and Cultural Competency Consensus Standards. National Quality Forum, 2012. http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx. Accessed on June 25, 2016.

[7] Chapman EM, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med. 2013*; 28(11): 1504-1510.

3. The need for quality measures that meaningfully capture patient experiences and outcomes

A major goal of the QPP is to move toward a more integrated, person centered system of care, a goal that Community Catalyst shares and fully embraces. To meet that goal, we believe it is important to ensure that quality measures reflect the goals, preferences and needs of consumers, in particular low-income older adults and other vulnerable Medicare enrollees.

The rule notes that the quality measures for Advanced APMs must be "comparable" to those used for MIPS. We note that many of the measures proposed for MIPS are relatively granular, and do not represent the "big dot" measures which the Health Care Payment and Learning and Action Network indicated are essential for population-based payment.[8]

We also emphasize the importance of patient experience and patient-reported outcomes. We agree with the statement in the proposed rule that "outcome measures are more valuable than clinical process measures and are instrumental to improving the quality of care patients receive."[9] We believe that Advanced APMs should be required to adopt a robust set of Patient Reported Outcome Measures, patient experience measures, and information about care coordination, access to social supports, and person- and family-driven care planning.

We believe strongly that both measure development and measure selection, particularly for Advanced APMs, should be guided by strong consumer input.

Along with a robust consumer input strategy, we also recommend CMS add more specificity around the requirements for the care delivery models used in Advanced APMs. Meaningful health system transformation must emphasize improved care delivery, not only value-based payment.

Finally, we note that when it comes to Advanced APMs, the measure set should be designed so that when taken together, the measure set covers all of the pertinent domains of care experience. We believe that the "a la carte" approach taken by MIPS is not appropriate for comprehensively assessing the quality of Advanced APMs.

4. The impact on underserved communities

The QPP will significantly change the way providers serving Medicare beneficiaries are paid. Small provider groups and independent providers may be disproportionately affected by the new payment methodologies, as they have fewer resources available to them to implement practice change and may be less able than large provider groups to spread risk throughout a large patient panel. We are concerned that the potential effect on small providers could disproportionately harm medically underserved communities, as well. For instance, research conducted by the Center for Health Care Strategies in 2009 found that in some states, as many as 50 percent of

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[8] Accelerating and aligning population-based payment models: performance measurement draft white paper. Health Care Payment Learning and Action Network; April 22, 2016.http://hcp-lan.org/workproducts/pm-whitepaper-draft.pdf. Accessed on June 25, 2016.

[9] Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule. Federal Register 2016; 81(89): 28187.

Medicaid beneficiaries were served by practices with three or fewer providers.[10] We recommend that as the QPP is implemented, CMS monitor the impact on providers working in underserved areas. Monitoring any changes in the health care workforce in underserved areas would create an early warning system for potential negative effects of the program on underserved communities.

5. The critical role of risk adjustment

It is important to the success of both the MIPS and Advanced APM tracks that payments to clinicians fairly account for patient characteristics that may affect quality scores or resource use. These characteristics include clinical factors but may also include sociodemographic factors such as income, race and educational attainment levels. Failure to adequately adjust payments to account for these factors may result in a shift in resources away from physician practices that disproportionately serve more vulnerable populations[11] and may give providers a disincentive to serve these patients.

As noted above, we believe that any move to value-based payments must have the reduction of disparities as a central focus. A redirection of financial resources away from communities with the greatest health and social needs would therefore be a perverse result. We appreciate CMS' commitment to consider the results of the forthcoming report from the Assistant Secretary for Planning and Evaluation with respect to risk adjustment and socioeconomic status and look forward to reviewing that report. However, we want to underscore our view that the other strategies that we suggest in these comments to promote health equity are unlikely to be successful if they are working at cross-purposes with a payment approach that financially disadvantages providers who serve the highest proportion of those patient groups that have historically faced the greatest barriers in accessing health care.

6. The importance of consumer protections as providers take on financial risk

We note that the QPP incentivizes providers to move toward Advanced APMs. The proposed rule defines a financial risk criterion that includes a total risk of at least 4 percent of expected expenditures, marginal risk of at least 30 percent, and a minimum loss ratio of no more than 4 percent. There is also a financial risk criterion that applies to Medical Homes, that is a percentage of Medicare Parts A and B revenue, with percentages increasing from 2017 to 2020 and beyond.

As providers, including smaller providers, are increasingly pushed toward Advanced APMs, we ask CMS to carefully review the solvency requirements that are included in Advanced APM programs and to issue guidance on best practices to protect consumers in the face of provider losses. These could include requirements for reinsurance or risk-based capital standards, and for state and federal oversight. These also should include consumer protections such as the consumer's right to know what risk arrangements a provider is taking on, freedom for consumers to choose their provider, access to all covered services, easy-to-navigate appeals and grievances systems, and easy-to-read, accessible program materials for beneficiaries including those with

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[10] Moon J, Weiser R, Highsmith N, Somers SA. The relationship between practice size and quality of care in Medicaid. Center for Health Care Strategies, Inc.; 2009. http://www.chcs.org/resource/the-relationship-between-practice-size-and-quality-of-care-in-medicaid/. Accessed on June 25, 2016.

[11] Friedberg MW, Safran DG, Coltin K, Dresser M, Schneider EC. Paying for performance in primary care: potential impact on practices and disparities. *Health Aff*. 2010; 29(5):926-932.

disabilities, speech and vision limitations and limited English proficiency.

Given the lessons from the failures of a large number of physician groups in the late 1990s as these groups took on risk-based arrangements, resulting in significant disruptions in care for consumers, it is imperative that CMS set out clear best standards to be adopted across its Advanced APM programs. We anticipate that commercial and state-based APM programs will eventually adopt similar risk thresholds in order to align with federal standards, making it even more important that CMS provide clear guidance from the outset to ensure consumer protections in the eventuality of provider losses.

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In closing, we recognize the tremendous challenge facing CMS as it endeavors to move our health care system from one based on volume to one based on value. A health care system based on fee-for-service too often fails patients with complex conditions and the QPP is an important step towards better coordination, quality and value of care. We appreciate the opportunity to comment and to provide recommendations to help ensure that these dramatic changes to the health care system improve the health of consumers and communities, particularly those who are the most vulnerable and/or underserved.

Please do not hesitate to contact me at ahwang@communitycatalyst.org should you have any questions or if you would like additional information.

Sincerely,

Ann Hwang, MD
Director, Center for Consumer Engagement in Health Innovation