



November 17, 2015

Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
US Department of Health and Human Services  
Attn: CMS-3321-NC  
P.O. Box 8016  
Baltimore, MD 21244-8016

**RE: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (CMS-3321-NC)**

Dear Mr. Slavitt:

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Request for Information (RFI) released regarding the implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models and Incentive Payments for Participation in Eligible Alternative Payment Models.

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. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We have been working to improve Medicare for consumers for more than a decade, producing tools for consumer advocates to use in state-based advocacy as well as tools for use by other stakeholders.

We appreciate the opportunity to provide comments on this significant proposed rule that has potential to enhance value in health care for Medicare beneficiaries and transform the Medicare system. We recognize and applaud the thoughtful work that CMS is doing to move the system in the right direction. In that spirit, we submit the following comments that will further strengthen the system for consumers.

We have included detailed comments below, but want to highlight areas we find most significant: beneficiary engagement; disparities reduction; and fostering and incentivizing a

culture of partnership and learning in the provider community. We would also like to note that the below areas, as well as our detailed comments, are applicable to Patient-Centered Medical Homes.

### **Beneficiary Engagement and Education**

Beneficiary engagement in care is a critical factor in achieving better health outcomes, especially for those with chronic conditions. Beneficiaries and their caregivers must be seen as key members of care teams, not as passive recipients. We encourage the use of incentives that ensure beneficiary engagement and education and suggest opportunities for meaningful engagement. Furthermore, we believe at the core of any transformation, beneficiaries and their advocates must be engaged at all decision-making levels:

1. At the *individual level*, where beneficiaries become active, engaged and knowledgeable participants in their own health and health care;
2. At the *system level*, where beneficiaries and their advocates must be able to engage with the delivery system itself, for example, by serving on advisory councils and/or governance boards.
3. At the *policy level*, where beneficiaries and their advocates have a seat at the tables where experiences from the individual and delivery system levels are being heard and decisions are being made, alongside payers, policymakers and other stakeholders.

### **Disparities Reduction**

We applaud the efforts in the MACRA RFI to address health care disparities by incorporating data stratified by race, ethnicity, gender and other measures of health equity in quality measurement and reporting. This is a necessary step for building our understanding of disparities facing populations with disproportionately poor health outcomes. The implementation of MACRA represents a transformative opportunity to address the persistent problems of disparities in treatment and outcomes for low-income people, people of color and other historically marginalized and underserved populations such as people with disabilities and those with a minority sexual orientation or gender identity. Addressing disparities should consist of a multi-pronged strategy:

- the collection and dissemination of stratified data by race, ethnicity, primary language, gender identity and sexual orientation for measuring success
- a proactive approach to improving cultural competence and reducing implicit bias
- appropriate risk adjustment to address both clinical and non-clinical factors that impact cost and outcomes
- a commitment to address social determinants of health.

We appreciate the opportunity to highlight these strategies for moving the needle even further on disparities reduction for Medicare beneficiaries.

### **Fostering and Incentivizing a Culture of Partnership and Learning**

We appreciate the commitment outlined in the RFI regarding improving person-centered care. It will be critical for providers and provider organizations to understand how to use stratified data mentioned above in a meaningful way. Building this understanding will require long-term support and system-level infrastructure, substantial incentives and new processes for

implementing changes based on patient experience and feedback. Furthermore, meaningful involvement of patients and their families will require a shift to a culture of learning and partnership among providers and patients, and we encourage payment reform models that have potential to foster and incentivize building that culture.

We thank you for your consideration of these issues as you adopt and implement changes to the Medicare program.

## **A. Merit-Based Incentive Payment System (MIPS)**

### **3a. Reporting Mechanisms Available for Quality Performance Category**

In establishing the reporting mechanisms for the MIPS quality performance category, it is critical that CMS require Eligible Professionals (EPs) to report on measures that matter most to consumers and their family members. This requires CMS to take a broader view of patients' health status by including **functional status** and **quality of life** in addition to more traditional clinical measures.

In evaluating performance around functional status and quality of life, CMS should require EPs to collect and report – at the provider level – information on patient-reported outcomes (PROs). PROs, which can be collected by asking the right questions in patient surveys, are valuable for several reasons, including:

- They can be used to support shared decision making, allowing patients and clinicians together to make more informed treatment choices based on patients' own priorities and goals.
- They can support goal-setting and track patient progress towards meeting their goals.
- They have a strong effect on clinical outcomes.
- They can contribute to a reduction in the frequency of costly and ineffective procedures.
- They can offer a basis for true value comparison among providers.

While we believe that CMS should collect both process and outcomes measures, we believe that more weight should be given to outcomes measures such as preventable hospital admissions and readmissions.

Finally, as we note above under the section titled: *Disparities Reduction (pg. 2)*, CMS should require that reporting mechanisms include the ability to stratify the data by specific demographic characteristics that will help to understand and then address health disparities. This type of data collection is a critical component to understanding performance of providers and provider groups under MIPS and is consistent with the requirements of the Affordable Care Act.<sup>1</sup> We urge CMS to be transparent in the data collection process and provide a status report on whether/how MIPS is helping to reduce disparities within the Medicare program.

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<sup>1</sup> We note that the Affordable Care Act requires "any federally conducted or supported health care or public health programs, activities or surveys" to collect and report data stratified by race, ethnicity, sex, primary language, geography and disability status to the extent practicable. See *42 U.S.C. § 300kk (codifying ACA § 4302(a))*

## 5. Clinical Practice Improvement Activities Performance Category

### *Promoting Health Equity and Continuity*

We are encouraged to see the emphasis that CMS has placed on promoting health equity and continuity. In order to strengthen clinical practice activities we strongly urge CMS to consider the following cultural competency priorities:

- Ensure a **culturally and linguistically appropriate provider network** that meets the needs of the population being served.
- **Ongoing cultural competency training** is critical to improving the quality of services delivered and should be part of staff and provider continuing education.
  1. As a part of ongoing training, we strongly urge the requirement for provider and provider group training on understanding implicit bias. This is critical to improve provider-patient communications and reduce implicit biases among health care providers.<sup>2</sup> While race and ethnicity are two areas in which providers sometimes demonstrate implicit bias, a number of studies examining clinical decision-making suggest that implicit bias manifests in other areas, including gender and age. Further research is needed to identify effective strategies for mitigating implicit bias among health care providers. However, an important first step is to equip health care providers with tools such as the Implicit Association Tests (IATs)<sup>3</sup> to assess and manage their own biases.<sup>4</sup> We suggest that CMS create incentives that reward health care providers who undergo implicit bias trainings and demonstrate perspective-taking and individuation when providing patient care to improve clinical level practices; and
  2. Require providers and provider groups to have their staff trained on population health management and their role in improving health outcomes for targeted populations with unmet needs in their community.
- Invest in a **health care workforce** that can meet the physical, behavioral, social and economic needs of patients
  1. For example, the use of Community Health Workers (CHWs) in the delivery system can play an important role in connecting with low-income, communities of color on a more personal level to facilitate coordinated health care services.<sup>5</sup> CMS should

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<sup>2</sup> Institute of Medicine Report, “What Healthcare Consumers Need to Know About Racial and Ethnic Disparities in Healthcare” Retrieved: <https://www.iom.edu/~media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/PatientversionFINAL.pdf>

<sup>3</sup> Implicit Association Test is a computerized measurement tool designed to measure the strength of automatic associations people have in their minds. This test has been used to measure implicit bias in physicians <https://implicit.harvard.edu/implicit/iatdetails.html>

<sup>4</sup> US National Library of Medicine National Institutes of Health (November 2013). Physician and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities <http://www.ncbi.nlm.nih.gov/pubmed/23576243>

<sup>5</sup> Community Catalyst, “Trusted Voices: The Role of Community Health Workers in Health System Transformation”, November 2015. Retrieved: <http://www.communitycatalyst.org/resources/publications/document/Community-Catalyst-CHW-Issue-Brief.pdf>

consider including mechanisms for incorporating – *and reimbursing* – CHWs.<sup>6</sup> There is ample evidence that CHWs are effective in (1) assisting people to access and navigate the health care system and better manage their health conditions, (2) coordinating services for people with multiple chronic conditions, and (3) leading community-wide efforts to identify and address underlying causes of poor health.<sup>7</sup>

- Expand Data Collection
  1. In addition to stratification of data, as noted in the *Disparities Reduction* (pg. 2) section, we **recommend reporting and analysis of data at the community and population levels** in order to gain a better understanding of beneficiaries’ social circumstances, which could potentially have an effect on their health and well-being, and identify opportunities to address health disparities through upstream interventions. We encourage CMS to use the new consensus metrics developed by the National Quality Forum (NQF) to assess cultural competency and language services.<sup>8</sup> Implementing these measures is critical in addressing provider biases, poor patient-provider communication, and poor health literacy.
  2. It is critical to train providers to collect and report comprehensive patient data. Providers and provider organizations also need to understand how to use these data in a meaningful way (e.g. in care planning/coordination). There is a real opportunity to build this understanding through long-term support and system-level infrastructure, substantial incentives and alternative payment arrangements, and new processes for monitoring and addressing health disparities.
  3. Finally, we urge any evaluation to be conducted in a transparent process with data available for public viewing and a comment period. A key lesson learned through the Financial Alignment Initiative (FAI) is that while it includes an evaluation, there has been virtually no public reporting of data on the initiative’s progress. Lack of data makes it difficult for beneficiaries and advocates assessing the benefits of the demonstration or identifying areas that need improvement.
- Maintain accessibility standards<sup>9</sup>
  1. It is critical to maintain accessibility standards both in terms of physical accessibility and programmatic accessibility such as appropriate scheduling, communication on medical information, and provider staff training and knowledge. We also recommend conducting regular assessments of provider competency, physical barriers of provider practice locations, and equipment, such as use of appropriate exam tables or

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<sup>6</sup> Edward H. Wagner, et al. “Improving Chronic Illness Care: Translating Evidence Into Action” *Health Affairs*, 20, no.6 (2001):64-78; Available: <http://content.healthaffairs.org/content/20/6/64.full.html>

<sup>7</sup> NYS Health Foundation (October 2014). A Critical Link for Improving Health Outcomes and Promoting Cost-effective Care in the Era of Health Reform. <http://nyshealthfoundation.org/uploads/resources/community-health-workers-critical-link-october-2010.pdf>

<sup>8</sup> National Quality Forum (August 2012). Healthcare Disparities and Cultural Competency Consensus Standards. [http://www.qualityforum.org/projects/Healthcare\\_Disparities\\_and\\_Cultural\\_Competency.aspx](http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx)

<sup>9</sup> Disability Competent Care Self-Assessment Tool: [https://www.resourcesforintegratedcare.com/sites/default/files/Disability-Competent%20Care%20Self%20Assessment%20Tool\\_508%20Compliant.pdf](https://www.resourcesforintegratedcare.com/sites/default/files/Disability-Competent%20Care%20Self%20Assessment%20Tool_508%20Compliant.pdf) and Disability Rights and Education Defense Fund “Defining Programmatic Access to Healthcare for People with Disabilities” Retrieved: <http://dredf.org/healthcare/Healthcarepgmaccess.pdf>

diagnostic equipment. The data gathered from these assessments – which should be publically available – may be used to make improvements.

### *Social and Community Involvement*

We are encouraged to see clinical activities and social/community involvement in the same category. To further strengthen this relationship, we recommend:

- CMS collaborate with consumer advocacy groups and local community-based organizations to reach and educate the target population.
- Track and publically report contracts with community and social services providers
- Collect and track beneficiary experiences beyond the quantitative data, such as patient narratives, to better understand trends and use to improve care and measure health outcomes
- We also believe that in the context of clinical practice improvement that practices should work to develop systematic mechanisms to engage patients and community members, including, but not limited to patient advisory groups and patient representation on governing bodies along with the necessary training and support to make these activities meaningful.

### *Achieving Health Equity*

- In order to achieve health equity, providers and provider practices must be appropriately incentivized. We recommend:
  1. Risk-adjustment mechanisms that aim to reduce preventable hospital readmissions and account for factors related to patients' unique health, social risks and socioeconomic status.
  2. We urge using payment arrangements to incentivize strategies that address the non-medical factors and social determinants that contribute to health and wellbeing (e.g., housing, public safety, access to education and job opportunities, language services, availability of places to exercise, healthy food choices and other environmental factors). For example, ensuring information sharing and connections between providers and community-based resources, agencies and organizations is vital in order to connect patients to appropriate community supports and services that can lead to better health outcomes.
  3. Incentivize ways health professionals recognize, address and reduce implicit bias when delivering health care services to diverse communities. See section on *Promoting Health Equity and Continuity* (pg. 4) that discusses implicit bias.
  4. We want to stress the concerns around value-based payment models that have the unintended consequences of shifting resources away from providers that disproportionately care for low-income communities and communities of color, which could have the effect of making disparities worse. We urge CMS to keep this in mind when implementing different approaches to reduce health disparities and ensure that providers serving this population are reimbursed appropriately.

### *Integration of primary care and behavioral health*

- We are pleased to see a category of integration of primary care and behavioral health as part clinical practice activities, and support what is being proposed. To further strengthen, we recommend:
  1. Open lines of communication between providers and sharing of records **when the patient allows**
  2. "Warm handoffs" if necessary providers are not part of the same team.
  3. Ensure that recovery supports and a recovery philosophy govern care and that providers are working in tandem toward that goal. However, also apply a philosophy of reducing problematic substance use, and concurrent harm, where patient is not ready to enter recovery.
  4. Ensure inclusion of medication-assisted treatment (MAT) for substance use disorders, as well as medication management for mental illness; ensure that providers are trained in MAT and in managing medications for mental illness and know when to hand off to a specialist
  5. Full and equal inclusion of services for substance use disorders, not just as a co-occurring illness
  6. Train providers in conducting formal screening (validated questionnaires administered in a nonjudgmental manner) and in early intervention for substance use disorders (SBIRT<sup>10</sup> or an appropriate alternative)
  7. Create standard for screening (validated questionnaire) for substance use at every visit as part of overall patient screening, and include in online provider checklists and reminders.

## 7. Other Measures

We would recommend the following measures for consideration:

- Appropriate access to the provider office (such as exam tables, ramps, assisted communication, etc.)
- Culturally and linguistically competent services (interpreter, materials in other languages, availability of assistive communication technology)
- Reporting on trainings that provider and provider staff attended, particularly around ADA & independent living (IL) training and cultural competence, and implicit bias
- Availability of appropriate transportation with equipment
- Geriatrics specialty/training<sup>11</sup>
- Patient experience measures that report the qualitative data of patient experience; synthesized reports of patient care experience can give a consumer on the website an opportunity to understand other patient experiences with a particular provider or provider organization

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<sup>10</sup> Resource from National Council on Behavioral Health: <https://www.thenationalcouncil.org/topics/screening-brief-intervention-referral-treatment-sbirt/>

<sup>11</sup> The Lewin Group and Community Catalyst produced two issue briefs [Geriatrics-Competent Care: An Introduction](#) and [Geriatrics-Competent Care: Multidisciplinary Geriatric Assessments](#) following the webinars presented last year. These offer basic tools to orient providers and health plans about care for their older adult beneficiaries. For more information, go to <https://www.resourcesforintegratedcare.com/>.

- Patient-reported measures, including ones that capture patient activation – a patient’s knowledge, skills and confidence for managing their own health

## 8. Development of Performance Standards

We believe it is important to ensure the collection and accurate reporting of data that will ultimately lead to better health outcomes. Therefore, we encourage CMS, in its development of performance standards, to include the following types of person-centered measures:

- *Patient engagement:* The current Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient/caregiver experience measure set has the potential to gauge components of the patient experience, but patient engagement tools such as the Patient Activation Measure or the Health Confidence tool have the potential to go even further by elevating the role of patients in their own care and equipping patients with the confidence and knowledge necessary to take action to manage and improve their health.
- *Patient-reported outcomes:* As noted earlier, patient-reported outcomes measures have the potential to improve health – especially for populations that experience disproportionately poor health outcomes – and to empower patients to meaningfully engage in their health and well-being.

We also urge CMS to include reductions of health disparities into overall quality improvement goals and to adopt tools that support measuring disparities and undertaking interventions. We recognize potential obstacles providers may face in collecting and reporting these attributes. Therefore, we support a phased-in approach starting with a financial incentive for stratified data collection and reporting for:

- Patient satisfaction measures (e.g. provider biases, poor patient provider communications and ADA compliance),
- Measures of access and care delivery (e.g., missed appointments and immunization rates),
- Patient engagement measures (e.g. patient activation and health literacy rates), and
- Use of NQF metrics<sup>12</sup> to assess cultural competency and language services.

## 11. Public Reporting

- We support CMS’s position to stratify data by race, ethnicity and gender. We urge the inclusion of primary language, gender identity and sexual orientation, as well.
- We would urge CMS to work with state and locally based consumer advocacy groups to assess which measures are clinically relevant and accurate to publically report. Meaningful feedback from consumers can help providers and provider groups fine-tune their care delivery by rethinking organizational priorities, addressing current problems and spearheading new initiatives.
- Extend consumer concept testing that is part of physician compare website to MIPS and ensure that it is as consumer-friendly and consumer-focused as possible. We would urge

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<sup>12</sup> See National Quality Forum’s Healthcare Disparities and Cultural Competency Consensus Standards: [http://www.qualityforum.org/projects/Healthcare\\_Disparities\\_and\\_Cultural\\_Competency.aspx](http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx)



CMS to include relevant people with disabilities, who have a different set of needs than older Americans on Medicare, and also conduct testing in other languages to account for Medicare beneficiaries whose first language is not English.

## **B. Alternative Payment Models (APMs)**

APMs represent an important and desirable change in the Medicare system. Given the financial incentive to participate in APMs is a powerful lever to drive change, CMS must pay careful attention not only to the quality measurement strategy under MIPS that will translate across to APMs, but also other structural aspects of APMs that are necessary to ensure that risk-bearing provider entities are truly oriented to acting in the best interest of patients. These include: the role of patient choice; the importance of eligible APMs having a robust consumer engagement strategy at both the level of individual patients and an effective consumer advisory/governance structure; a multi-dimensional approach to quality reporting that captures not only quality scores but also allows patients, advocates and the public to access qualitative information such as patient narratives and grievances; and complaint information due process protections.<sup>13</sup>

### **1. Information Regarding APMs**

#### **b. Payment Incentive for APM Participation**

We urge the Secretary to consider risk adjustment based on population health measures such as socio-economic status (SES) for calculating incentive payments for APM participation. People in lower socio-economic brackets tend to have higher risk factors and more social, economic and clinical challenges in dealing with chronic health problems. Additionally, they are more likely to require expensive interventions or have adverse outcomes. We believe risk adjusting payment based on SES is necessary, especially as we move toward settings where provider systems are increasingly taking on risk. Without risk-adjustment payment based on SES, there will be an incentive to avoid or undertreat low-income patients, and resources will be shifted away from communities where they are needed most.

#### **f. Regarding EAPM Entity Requirements**

##### **(1) Definition**

In order to be considered an EAPM we believe that in addition to bearing more than nominal risk and tying incentives to quality measures as discussed more below, that additional criteria should address important structural aspects that should be present in risk-bearing entities, especially related to meaningful patient and community engagement at the levels of the individual patient and the practice or delivery system; robust consumer information education and transparency; team-based care and person-centered care planning; and grievance and appeals.

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<sup>13</sup> See Community Catalyst comments on CMS proposed rule: CMS-1631-P The Physician Fee Schedule. [http://www.communitycatalyst.org/resources/comment-letters/document/Community-Catalyst-Comments-on-CMS-1631-P\\_Phy-Fee-Sch.pdf](http://www.communitycatalyst.org/resources/comment-letters/document/Community-Catalyst-Comments-on-CMS-1631-P_Phy-Fee-Sch.pdf)

## **(2) Quality Measures**

As mentioned above, given the powerful incentives for clinicians to practice in APMs, it is important that we use the right quality measurements to evaluate the performance of health care providers and to reduce health disparities. APM structures provide an opportunity to improve quality measurement by collecting meaningful information from those who are experiencing care – patients and their families. A criterion we urge the Secretary to consider when determining quality measures used to identify an EAPM entity and to qualify for the Combination All-Payer Medicare Payment Threshold is that the quality measure sets include patient-centered quality measures, including patient experience surveys like CAHPS. Please see our comments under *Development of Performance Standards* (pg. 8). Patient-centered quality measures can be adopted as intermediate measures for ACOs, patient-centered medical homes and other new and emerging APMs. As we previously mentioned, we urge the Secretary to consider quality measures that help us better understand implicit bias among providers and the potential impact this bias might have on quality of care. Please see our comments on implicit bias under *Promoting Health Equity and Continuity* (pg. 4).

Finally, we urge that the requirement that APM quality measures be comparable to those used under the MIPS, not be interpreted in a way that locks in an over-emphasis on process measures. We need to allow for the improvement of quality measurement by expanding use of patient reported outcomes; stratifying quality measures to identify disparities in treatment/outcomes; measuring or reporting on patient experience and patient engagement and by including qualitative approaches such as patient narratives and grievances or complaints. We must also recognize that EAPMs may be complex organizations integrating many different types of providers and, therefore, it may be possible to use quality measures that go beyond those used to evaluate individual clinicians, for example measures that address population health and social determinants may be appropriate.

## **(3) Use of Certified EHR Technology**

Core health IT function that providers will need as they serve their patient populations include privacy protections and security safeguards. In order to provide highest possible quality care, physicians need the fullest possible information about patients. However, it is challenging to balance the sometimes conflicting priorities of consumer privacy and quality care. We recommend that physicians must work with patients to ensure language clearly describes why and how their health information will be stored, exchanged, used and protected, the opportunity to opt out, and other beneficiary rights. Patients should have the ability to opt out of data sharing. Physicians should utilize community resources such as the State Health Insurance Assistance Programs (SHIPS) and Aging and Disability Resource Centers (ADRCs) to help patients understand their options regarding data. SHIPS and ADRCs must be trained and prepared to answer questions about data sharing in order to be a meaningful resource. Finally, offering patients electronic access to their medical records and other health information may help them understand the importance of (and minimize concerns regarding) data sharing.

## **2. Information regarding physician-focused payment models**

#### **d. Required information on Model design**

- In addition to requiring information about the method for attributing beneficiaries to participants, the committee should consider criteria related to a plan for informing and educating beneficiaries about attribution and what it means for their care delivery. Furthermore, plans should also include information about how APM providers will be incentivized and supported to elicit patient perspectives, preferences and choice.
- We support the requirement for models to address potential evaluation approaches and urge the committee to consider robust and meaningful input from beneficiaries, their families and their advocates as a necessary method for evaluation.

### **C. Technical Assistance and Support for Transformation**

As practices undertake clinical improvement activities, we recommend that CMS provide practices with additional technical assistance to support sustained transformation. As we state in the beginning of our comments, the fostering of change will require long-term support, particularly in-depth technical support, and system-level infrastructure support. We were glad to see the earmark for technical assistance resources in the legislation; however, we believe resources for capacity building around beneficiary engagement at all levels should be available for all practices (not just those in rural areas).

Practice transformation can be a daunting process for even the most dedicated clinicians. In our experience, with regards to meaningful beneficiary engagement, clinicians often struggle with the essential step of partnering meaningfully with patients and families, and yet we know that such partnerships are an effective and vital strategy for improving quality of care, patient experience, safety and efficiency.

For most clinicians and practices, partnering with patients and families in care redesign is uncharted territory. While some clinicians have begun to work more collaboratively with patients and family members in individual patient care, the concept of working together with patients to redesign care at the practice/system level and in governance is less familiar and requires significant cultural change. To leverage partnerships with patients and families to achieve real transformation, providers need ongoing, tailored technical assistance. In our experience, practices also need concrete operational tools and resources to help guide them through the process. CMS can play a pivotal role in ensuring that primary care practices are connected to strong and experienced organizations that:

- Have in-depth knowledge of, and expertise in, delivery system models and quality improvement strategies aimed at achieving a more patient- and family-centered, high quality health care system;
- Provide tailored, detailed and intensive technical assistance, guidance and support; and
- Have experience with successfully engaging multiple stakeholders – including beneficiaries, caregivers, advocates, providers and local community organizations – in deliberative processes and change efforts.

Consumer advocacy organizations are often called upon to provide technical assistance around beneficiary engagement<sup>14</sup>, but are not adequately resourced to engage in that work without the compensation that other technical assistance services receive. While we are pleased to see CMS's growing interest in beneficiary engagement, we urge the agency to consider how it structures request for proposals to advance this work – for example, by encouraging vendors to formally partner with and dedicate resources to consumer organizations to provide this assistance. Robust support and assistance, paired with a staged approach to support continuous progress toward quality goals, are crucial to helping practices transform care.

We believe that this RFI encourages important steps to enhancing value in health care. We appreciate this opportunity to comment, and we welcome the opportunity to provide additional input on these issues. Please contact Michael Miller at [mmiller@communitycatalyst.org](mailto:mmiller@communitycatalyst.org) with any questions. As always, thank you for your time and attention to these issues.

Respectfully submitted,



Robert Restuccia  
Executive Director  
Community Catalyst

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<sup>14</sup> See Community Catalyst's Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities: <http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement>