



November 20, 2017

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Blvd  
Baltimore, MD 21244  
Submitted via: [CMMI\\_NewDirection@cms.hhs.gov](mailto:CMMI_NewDirection@cms.hhs.gov)

Re: Centers for Medicare & Medicaid Services: Innovation Center New Direction

Dear Administrator Verma:

Community Catalyst respectfully submits the following comments in response to the request for information (RFI) regarding the Innovation Center's new direction.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, 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 focuses on health system transformation and bringing 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 that are most vulnerable.

We appreciate the opportunity to comment on the new direction of the Center for Medicare and Medicaid Innovation. The innovation center has a vital role to play in transforming the health system to better meet patients' needs and the models promoted by CMMI will have significant and far-reaching impacts on patients across the country. This is particularly true for low-income and vulnerable consumers, including older adults, people with disabilities, people with chronic health conditions, children with special health care needs, and communities of color, who face serious disparities in health outcomes. That is why it is imperative that, when defining its new priorities, the innovation center place the highest of value on the particular needs of these populations. Many of the themes highlighted in the RFI are especially troubling from the perspective of low-income and vulnerable consumers. We are concerned that many of the ideas CMMI is considering promoting would have disproportionately negative impacts on the very populations CMS is supposed to serve. With that in mind, **we ask that CMMI consider two overarching objectives as it sets a new agenda:**

## **1. Creating a Health System that is Person-Centered**

The health system can be incredibly difficult to navigate for any patient, and this is especially true for vulnerable and complex patients who are managing multiple health conditions and face socio-economic challenges. The ultimate aim of any health transformation effort should be to provide high quality, accessible, affordable and well-coordinated care that is in line with the patient's goals, values and preferences. Care should be delivered by providers working as a team with the patient at the center, and patients (and family and caregivers where applicable) should be treated as full partners in their health care. Building this type of system requires a culture shift with long-term investments. Patient experience and engagement will be critical to weave into the fabric of all CMMI models.

## **2. Reducing disparities in health outcomes and improving equity in the health care system**

CMMI's agenda should be driven by the goal of building a society in which *everyone* has a fair opportunity to achieve their full health potential, regardless of race, income, age, gender, gender identity, sexual orientation, disability or health status, or zip code. CMMI should reject any models that perpetuate inequalities and actively work to implement models that will reduce disparities.

**In service of those two overarching objectives, we ask that CMMI test and promote models of care that do the following:**

### **1. Include strong and sustainable mechanisms for consumer engagement**

People with Medicare and Medicaid are uniquely positioned to explain how changes to the program might affect them, which makes bringing consumer engagement to the forefront in model design an important tool. Beneficiary and stakeholder participation is critical for several reasons: By exploring the perspectives of people with Medicare, CMS can better fit the model's design to the needs, abilities, and desires of affected populations. Additionally, beneficiaries and their families and caregivers may be better able to identify participation barriers they might face within a model. Consumer engagement also ensures that beneficiaries buy into models and will stick with them through their duration. People who feel a system reflects their needs and concerns are more likely to be willing and engaged participants and people who feel they are heard are more likely to stay with a particular model, plan, or provider, making possible longer-term analysis of patient outcomes and increasing the chance of positive provider influence over behaviors.

In the same way that CMS has been providing robust assistance to providers as they adopt new models of care, it is critically important to engage the patients who will be directly impacted by changes in how care is paid for and delivered. We hope that the administration will uphold its stated commitment to creating a patient centered health system by meaningfully engaging consumers in the design, implementation and evaluation of new payment and care delivery models, as well as by promoting models of care that encourage patient engagement at the clinical level.

On a policy level, we ask that CMS:

- Include requirements for patient and family engagement in the design, implementation, and ongoing evaluation of all new models.
- Continue to support existing requirements for consumer engagement, including the consumer advisory committees that are part of the dual demonstrations.
- Include patients and family members along with other stakeholders on advisory panels and committees
- Provide funding, consumer education, and necessary supports to ensure the accessibility and sustainability of consumer engagement efforts
- Invest in consumer education and options counseling activities
- Ensure all beneficiary communication about a demonstration, both at the start and throughout, is in consumer-tested simple language, and accessible to individuals with disabilities and to those with limited proficiency in English.

Consumer engagement is also critical at the clinical level. Numerous studies show that engaged consumers have better health outcomes. Patients who score highly on patient activation measures are more likely to engage in preventive behavior; adhere to treatments for chronic illness; have normal BMI, blood pressure, and cholesterol measures; and are less likely to have unmet care needs.<sup>1</sup> In order to ensure patients are engaged in their care at the clinical level, we ask CMMI to design and implement models that promote shared decision making and participation in evidence based self-management programs. We also ask that CMMI ensure new payment models are accompanied by quality measures that focus on consumer-reported outcomes and experience, particularly regarding quality of life.

## **2. Include Consumer Protections and Robust Oversight and Value Consumer Choice**

In addition to the guiding principles discussed in the RFI, a principle that should always be of prime importance is inclusion of consumer protections, along with oversight so that those protections are effective. All demonstrations should ensure that beneficiaries are not harmed by changes. Strong consumer protections must be in place, including effective appeals and grievance processes, adequate and genuinely available provider networks, and strong quality and safety standards. To be effective, these protections must be accompanied by oversight and enforcement. CMS has an overarching obligation to beneficiaries to provide robust oversight of providers and plans, an obligation that is even more important when new models are being tried and unexpected issues arise that could harm beneficiaries.

Additionally, while the RFI stresses the importance of provider choice and incentives, favoring voluntary demonstrations, we hope CMMI will also promote beneficiary choice. Demonstrations are, by their very nature, trials of untested systems meant to address deficiencies. Testing those systems should be a choice available to beneficiaries and not

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<sup>1</sup> Hibbard, J., & Greene, J. (2013). What the evidence shows about patient activation: Better health outcomes and care experiences; fewer data on costs. *Health Affairs*, 32(2), 207–214. doi:10.1377/hlthaff.2012.1061

mandatory. Beneficiaries with multiple chronic conditions have often spent months or years developing provider networks that work well for them. They should always be given the option to keep their providers and not be required to disrupt their care to participate in a demonstration.

### **3. Value Primary Care and Prevention**

We are disappointed to see that the RFI emphasizes the development of specialty models without addressing the importance of primary care. Primary care can play a critical role in lowering costs, while significantly improving patient outcomes. CMMI has already made great strides in testing primary care focused models, but there is much more that can be done and it is crucial that primary care remain a priority for the innovation center moving forward. We ask that CMMI focus on developing and promoting payment and delivery models that improve access to primary care providers and preventive health services, support care coordination, and encourage primary care providers to work in partnership with patients to develop and meet health care goals. This includes but is not limited to continuing and expanding CPC and CPC+ demonstration projects; expanding the availability and use of care coordinators, case managers, and community health workers; encouraging and compensating providers who use shared decision making; and providing access to and reimbursement for evidence based self-management programs.

We also ask that CMMI design primary care payment models with the needs and circumstances of primary care providers in mind. Primary Care is not the driver of high costs in the health care system and spending on primary care is actually associated with lower costs. This makes primary care fundamentally different from other areas of the health system that CMMI might hope to address and models addressing primary care need to be designed with this difference in mind. Primary care providers may be less prepared to take on significant risk than other providers, and most of the cost savings realized by improve primary care will be seen in other areas of the health system, such as reduced ER usage or hospital admissions.

### **4. Focus on improving access to and integration of mental, behavioral, and oral health services**

For far too long, services for mental illness and substance use disorders have been siloed from physical health, and often from each other. Oral health has been similarly siloed and not given adequate attention in the development of new payment and delivery models. However, addressing a person's need for services for mental illness, substance use disorders, and oral health is essential in ensuring improved health outcomes and is a necessary component of patient centered care. We urge that CMMI place an emphasis on developing models that focus on treating the whole person and improve coverage and integration of mental health, substance use disorders, and oral health services into primary care.

For mental health and substance use disorders, we urge you to:

- Provide financial incentives for the full integration of both substance use disorders and mental health services jointly in Medicaid health homes, and in multi-payer patient-centered medical homes. In current practice, most health homes address substance use or mental illness but not both. Integration should include extensive case management across conditions.
- Promote incorporation of effective prevention and early intervention strategies such as SBIRT (for substance use disorders and for depression) as universal practice at primary care visits.
- Incentive use of peer supports in all models for treatment of substance use disorders and mental illness.
- Promote incorporation of comprehensive services for substance use disorders including prevention, early intervention, detoxification, residential, outpatient, medication-assisted treatment, and long-term recovery services in all integrated models, including ACOs.
- Promote the Hub and Spoke model of addiction treatment that has been successful in Vermont.
- Promote the Collaborative Care model of integrating mental health and substance use disorders treatment into primary care.
- Not use episodic payment models for substance use disorders

For oral health, we urge you to:

- Focus on strategies to expand access to oral health coverage, for example testing a Medicare dental coverage pilot and evaluating outcomes.
- Promote integrated referral systems, where dentists screen for health needs and refer to a physician (and vice versa).
- Encourage the use of shared electronic health records (EHR) systems that allow both dental and medical providers to easily view each other's entries. A recent study showed that access to integrated information technology is one of the leading barriers to oral health integration.<sup>2</sup>
- Implement models that emphasize the co-location of services and integrated care delivery. Especially promising are new models where a dental hygienist, dentist, or dental therapist works in a primary care office or clinic or a nurse practitioner or physician's assistant works in a dental office.
- Include incentives in new payment and delivery models that encourage integration of oral and physical health.

## **5. Address the social determinants of health**

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<sup>2</sup> Mloro, M & Vujicic, M. (2016) Physicians Dissatisfied with Current Referral Process to Dentists. American Dental Association. Available at: [http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief\\_0316\\_5.pdf?la=en](http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0316_5.pdf?la=en)

There is mounting evidence that addressing social and economic factors, such as poverty, education, housing and food security and racial discrimination, is critical to improving health outcomes. Social factors account for nearly a third of deaths in the US every year and factors such as stress, low incomes, and low education levels are directly associated with poorer health outcomes or premature death.<sup>3</sup>

We believe that the federal government can do more to promote approaches to health that address the social barriers preventing individuals and communities from achieving health and well-being. Specifically, we ask that CMMI:

- Develop new demonstration models for Medicaid that could fund social services such as housing and nutrition support that have been demonstrated to improve health. These demonstrations should be rigorously evaluated to assess their impacts on health outcomes and costs, and to identify best practices.
- Revise ACO demonstration models to add a provision for a percentage of shared savings to be invested in community health programs that address disparities and the needs of the community.
- Focus on promoting partnerships between Medicaid programs and community-based organizations (CBOs) and social service providers.
- Include incentives and structures in new payment and delivery models that encourage providers to screen for social service needs and refer to appropriate services.
- Promote data collection and standards around social determinants of health.

## **6. Meet the needs of people with complex health conditions**

People with complex health conditions have very different needs from the general population and thus new models of payment and delivery that may work for some patients will not work for these populations. For example, efforts to increase price transparency are often irrelevant or counterproductive for patients with rare or complex needs who have limited choices in terms of providers or treatment options, or who most benefit from care that is well coordinated and grounded in longitudinal relationships with care providers. Patients whose biometric markers are impacted by underlying genetic diseases are not well served by models that pay providers based on improving those particular markers. Additionally, long-term care needs are a major priority for these populations. Often the long-term goal for many patients with complex conditions or disabilities is not about curing a disease but about ensuring the person can live comfortable, productive lives in their home and community.

For these reasons, CMMI must be mindful of how broader models might impact populations with complex health needs differently. Many of the suggestions we have already laid out can help ensure models meet the needs of these populations, for example ensuring there are strong consumer engagement mechanisms and promoting models of care that are based on patient driven health goals. In addition to these asks, we ask that

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<sup>3</sup> Heiman, H & Artiga, S. (2015) Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation. Available at: <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

CMMI build on the work already being done to address to the needs of populations with complex health needs by continuing many of the promising programs and models that are underway or have proven effective in the past.

- Work closely with the Medicare-Medicaid Coordination Office to continue testing and evaluating innovative models of care delivery for patients who are eligible for both Medicaid and Medicare (dual eligible), including the Financial Alignment Demonstrations that are already underway.
- Promote increased access to home and community based services through waivers and the continuation of programs such as Money Follows the Person and the Balancing Incentive Program
- Expand community-based models of care for individuals with complex needs, including Programs of All-Inclusive Care for the Elderly (this includes innovative PACE-like pilot programs that also serve the under 55 population) and the Independence at Home Demonstration.
- Continue to prioritize care delivery models focused on care coordination and case management that use a team-based approach to care. To optimize effectiveness and efficiency, a wide range of health care providers – direct care workers, nurses, pharmacists, physicians, physical therapists, psychologists, and social workers – along with consumers and family caregivers at the center of the team, must all work together to provide quality care.

**CMMI should NOT test or promote models that do the following:**

**1. Increase Out-of-Pocket Costs for Consumers:**

We are extremely concerned by the mention in the RFI of “Consumer Directed Care” models and ask that CMMI not test or promote any models that attempt to lower costs and alter consumer behavior by increasing their “skin in the game.” This includes allowing state Medicaid programs to implement or raise premiums or copayments, promoting programs that require contributions to health savings accounts, and removing beneficiary cost protections that prohibit providers from charging patients more than Medicare allows. There is little evidence that these methods accomplish their aims and ample evidence that they harm consumers’ access to care. Studies have shown that even small out-of-pocket costs reduce access to care, especially for those with low incomes or chronic illnesses.<sup>4</sup> In addition, numerous studies show that increased premiums are linked to lower health insurance enrollment rates for children, especially those with low incomes. Recent evaluations out of West Virginia and Indiana indicate that implementing financial incentives and penalties for low-income populations might not be effective at reducing costs and altering consumer behavior. Indiana found that individuals who enrolled in the basic health plan, which has narrow coverage and utilizes copays, were

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<sup>4</sup> One study out of Wisconsin found that the addition of a \$10 premium for Medicaid beneficiaries made them more likely to exit the program. This study also found that it was the premium itself and not the amount of the premium that caused people to leave the program, showing that even small out-of-pocket costs, like the ones implemented in Indiana, can significantly reduce access to care (Dague, 2014). A study of Oregon’s Medicaid enrollment following cost-sharing changes found similar results, with nearly half of program participants who were surveyed leaving the program following increases in premiums and copayments (Wright et al., 2005).

more likely to use the emergency room for both emergency and nonemergency visits than individuals enrolled in plans that are more comprehensive.<sup>5</sup>

## **2. Create barriers to accessing coverage or impede access to medically necessary services**

In addition to models that rely on increased out-of-pocket costs, we also ask that CMMI not test or promote models of care that create other, non-financial barriers to care access. This includes work requirements, drug testing, and plan designs that limit access to certain benefits or that cut benefits categorized as “non-essential”, but that many individuals require for good health, like adult dental benefits. There is little evidence suggesting that these methods lower cost or alter participant behaviors in the manner intended. In fact, these models often lead to increased administrative costs and burdens on state Medicaid programs. In West Virginia, Medicaid beneficiaries who enrolled in a “basic plan” that limited their access to certain benefits were more likely to visit the emergency room, including for nonemergency visits, than other Medicaid enrollees.<sup>6</sup> The majority of Medicaid beneficiaries are already working and even more are in households with working family members. And of those who don’t work, over a third have an illness or disability that prevents them from doing so. Work requirements attempt to solve a problem that doesn’t exist and will only add heavy administrative and paperwork burdens on families and state Medicaid programs.<sup>7</sup>

## **3. Dis-incentivize providers to serve low-income or complex patients**

One difficulty of implementing payment models that are tied to positive health outcomes, is that such models can disincentive providers from caring for more complex patients who may be more likely to have poor health outcome measures. It is important that any payment models supported by CMMI recognize the greater degree of difficulty in caring for patients with complex needs, including social and behavioral health needs, as well as their physical health needs. Payment models should not penalize providers who care for low-income, high needs, and complex patients. This means implementing performance measures and risk adjustment strategies (such as stratification) that recognize the increased difficulty of caring for patients with complex needs, without dis-incentivizing providers to make improvements that address health disparities in their practice. Incentive schemes that reward only high relative performance without considering improvement or that are administered on a zero sum basis are likely to have the perverse effect of directing financial resources away from where they are needed most. We appreciate the work CMS has been doing to fine tune risk adjustment strategies to ensure complex

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<sup>5</sup> Lewin Group. (2016). Indiana Healthy Indiana Plan 2.0: Interim evaluation report. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf>

<sup>6</sup> Gurley-Calvez, T., Kenney, G., Simon, K., & Wissoker, D. (2016). Impacts on emergency department visits from personal responsibility provisions: evidence from West Virginia’s Medicaid redesign, *Health Services Research*, 51(4), 1424–1443. doi:10.1111/1475-6773.12434

<sup>7</sup> Wikle, Suzanne. (2017). Medicaid Works: No Work Requirement Necessary. Center for Law and Social Policy, Available at: <https://www.clasp.org/sites/default/files/publications/2017/10/Medicaid%20works-no%20work%20requirement%20necessary.pdf>



patients are not harmed and we hope that CMMI will consider this complexity as it develops new models of payment.

**4. Have disproportionately negative impacts on low-income consumers or people with complex health needs**

Many of the models already addressed in these comments, such as those that increase cost-sharing or create barriers to accessing care, disproportionately impact patients who are low-income or have complex health and social needs. Models with such disproportionate impacts expressly work against CMS's stated vision that "All CMS beneficiaries have achieved their highest level of health, and disparities in health care quality and access have been eliminated." In addition to following the principles we lay out here, we ask that CMS explicitly consider the impact of any model developed on vulnerable and complex patients prior to implementation. If that model would have disproportionately negative impacts on these populations, CMMI should not go forward with testing the model.

**Finally, we ask that the process for designing, testing and evaluating models be done in a transparent manner that includes opportunities for public input; and that CMMI make all data and evaluations publicly available in accessible formats in a timely manner.** Over 117 million people are covered by the Medicare and Medicaid programs and, as we pointed out in the opening of our comments, the models designed and tested by the innovation center will have profound impacts on how these populations pay for and receive their care. Patients and other stakeholders should fully understand how CMMI's work impacts them and have ample opportunity to provide input on this work. To that end, we are disappointed that this RFI was not conducted using the regular federal regulatory process, where stakeholder comments are made public and CMMI responds directly to the comments received. As the Innovation Center moves forward in mapping out its new agenda, we hope it will make a commitment to transparency in responding to feedback and clearly and publicly articulate the reasoning behind its new vision.

We appreciate the opportunity to weigh in as CMMI begins defining its path forward and we look forward to working with you to ensure the needs of low-income consumers and patients with complex health needs are taken into account. Please do not hesitate to contact me at [ahwang@communitycatalyst.org](mailto: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