



**Comments to the Centers for Medicare & Medicaid Services
Re: Medicare Program; Revisions to Payment Policies Under the Physician
Fee Schedule and Other Revisions to Part B for CY 2016
(CMS-1631-P)
Submitted by Community Catalyst
September 8, 2015**

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) in response to the proposed rule released regarding changes to the physician fee schedule and other Medicare Part B payment policies.

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. We have included our detailed comments in the following letter, but want to highlight areas we find most significant: beneficiary engagement/education; disparities reduction; and fostering and incentivizing a culture of partnership and learning.

Beneficiary Engagement/Education

As noted throughout this letter, in order for the proposed payment reforms to be effective, beneficiaries must be engaged and educated about decisions being made and changes to their care. Beneficiary engagement in care is a critical part of achieving better health outcomes, especially for those with chronic conditions. Beneficiaries and their caregivers must be seen as key member of care teams, not as passive recipients. Throughout this letter, we encourage incentives to ensure beneficiary engagement and education and suggest opportunities for engagement to happen in meaningful ways.

Disparities Reduction

Disparities in quality of care and health outcomes remain compelling and persistent for people in low-income households, including people of color. Indeed, some disparities related to chronic disease have actually grown larger over time. We applaud the efforts in the proposed rule 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. We appreciate the opportunity to highlight additional 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 these rules to greater involvement of patients and their families in decision-making, self, care, activation and understanding of their health condition and its effective management, which has potential to improve person-centered care. The potential also lies in the ability of providers and provider organizations to collaborate with patients and their families as partners in the care experience and in efforts to improve health outcomes. While collecting and reporting patient-reported outcomes and experiences is a good step for improving person-centered care, providers and provider organizations also need to understand how to use this data 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 that culture.

We believe that beneficiary engagement/education, disparities reduction and a culture of partnership and learning will be critical to the success of any reforms that affect the Medicare program and its beneficiaries. Our detailed comments below

also emphasize these important areas, and we thank you for your consideration of these issues as you adopt and implement changes to the Medicare program.

Section III B. (41793 – 41799) Chronic Care Management (CCM) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

We strongly support CMS's comprehensive definition of the scope of CCM services for RHCs and FQHCs that includes a patient-centered plan of care document, creation of electronic care plans, management of care transitions, and coordination with home and community based services, etc. However, to improve both care quality and health outcomes, it is absolutely critical that RHCs and FQHCs adopt a health IT system that facilitates the safe and secure sharing of information, not just between its providers, but among patients, families, and other designated caregivers.

We applaud the requirements that RHCs and FQHCs use certified health IT to ensure timely access to CCM services for beneficiaries. The use of other means of communications (i.e. secure messaging, internet or other asynchronous non face-to-face consultation methods) in addition to telephone access would further enhance patient and caregiver engagement in care. To better serve a diverse base of beneficiaries, we urge CMS to ensure that such communication methods are conducted in a culturally and linguistically appropriate manner. We support the requirements that RHCs and FQHCs inform beneficiaries of the availability of CCM services and the opportunities to either use these services or opt out at any time. Notices and agreements of the use of CCM services should be written in plain language (rather than medical jargon) in patients' preferred languages and accessible to those with visual, hearing, cognitive, and communication impairments.

Section III. E. (41801 – 41802) Part B Drugs

According to MedPac, Medicare spending on biologics totaled about \$13 billion in 2007, with the top six biologics accounting for 43 percent of spending on separately billed drugs in Medicare B.¹ Given that Medicare spending on biologics is expected to grow significantly, we support a number of strategies to address these costs, including the proposed update to the ACA's payment approach for biosimilar biological products.

CMS proposes to clarify that the payment amount for biosimilar biological products is based on the Average Sales Price (ASP) of all National Drug Codes (NDC) assigned to the biosimilar biological products included within the same billing and payment code. In general, products that rely on a common reference product's

¹ MedPAC Report to the Congress: Improving Incentives in the Medicare Program. Chapter 5: Medicare payment systems and follow-on biologics. Page 119. June 2009.

biologics license application will be grouped into the same payment calculation. This update will bring the methodology in line with that used for multisource small molecule drugs. For these multisource drugs, both the brand and generic versions of the drug receive the same ASP+ 6 percent payment rate based on the weighted average of ASPs for all equivalent brand and generic products. This creates an important incentive in Part B for physicians to purchase lower cost drugs which they then administer to their patients. Their profit is the “spread” between the purchase price and their reimbursement by Medicare Part B. Currently, however, a biosimilar is paid at 100 percent of its own ASP, plus 6 percent of the ASP for the reference biologic.² With this change, there will be the same incentive for physicians to choose lower cost biosimilar biologics. Now that a biosimilar pathway has been approved as part of the ACA and the first product has now been approved by FDA, this update to the payment method will allow Medicare to maximize the potential of biosimilar biologics to lower costs through competition.

Rising prescription drug prices promise to have a significant impact on Medicare and in turn on costs for beneficiaries. Given that Medicare does not presently have the authority to negotiate over manufacturers’ prices, it is critical the program use all the tools at its disposal to reduce these costs, while protecting access of beneficiaries to evidence-based treatment. According to a recent Kaiser poll, a large majority of the public (72 percent) view the cost of prescription drugs as unreasonable and the public is supportive of a number of actions they view as an effective way to combat high prescription drug costs. For instance, 8 in 10 (83 percent) favorably view allowing the federal government to negotiate with drug companies to get a lower price on medications for people on Medicare, while 72 percent view this as effective. In addition, more than 7 in 10 favor limiting the amount drug companies can charge for high-cost drugs for illnesses like hepatitis or cancer (76 percent).³

We therefore wholeheartedly support Medicare’s efforts through this clarified rule to lower the costs of biosimilar biological products in Part B.

Section III H. (41807 – 41716) Physician Compare Web Site

2. Public Reporting of Performance and Other Data

We applaud the inclusion of stakeholders to ensure measures are clinically relevant and accurate. We would urge CMS to incorporate state and locally based consumer advocacy groups into the stakeholder mix. Meaningful feedback from consumers can

² MedPAC Report to the Congress: Improving Incentives in the Medicare Program. Chapter 3: Part B drug payment policy issues. Pg. 67 June 2009.

³ Kaiser Tracking Poll. August 20, 2015. <http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-august-2015/>

help providers and provider groups fine-tune its care delivery by rethinking organizational priorities, addressing current problems and spearheading new initiatives.

We are pleased to see the use of consumer concept testing to ensure that Physician Compare is as consumer-friendly and consumer-focused as possible. In their consumer testing measures, we would urge 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.

We strongly urge CMS to include information about provider accessibility on the website. It is vitally important for consumers to know if the provider they choose is compliant with the Americans with Disabilities Act (ADA). Providers and provider groups should be required to report this information as part of their quality reporting requirements. They should report on elements such as:

- Accessible parking lot spaces
- Ramps to get into the building
- Accessible elevators
- Accessible exam room tables
- Training on independent living philosophy

3. Proposed Policies for Public Data Disclosure on Physician Compare

a. Value Modifier

We support the use of the green check mark to indicate that a provider is participating in the Medicare quality program. However, in order for this to work effectively, it is important to educate beneficiaries about the website and what Value Modifier means for their care. We would strongly urge CMS to work with consumer advocacy groups to reach the target population and collaborate on educating this population.

c. PQRS GPRO and ACO Reporting & d. Individual EP PQRS Reporting & e. Individual EP and Group Practice QCDR Measure Reporting

Again, we support making quality measures publically available on the Physician Compare web site; however for this to work effectively, beneficiary education will be critical. We would strongly urge CMS to work with consumer advocacy groups to reach the target population and collaborate on educating this population.

g. Patient Experience of Care Measures

We strongly support making patient experience survey measures available on the website. It will be vitally important to educate beneficiaries on what the measures

mean and who they can contact for further information in order to make an informed decision.

4. Seeking Public Comment for Possible Future Rulemaking

a. Quality Measures

We would recommend the following measures for future consideration to be reported on the Physician Compare website:

- 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](#) (See I. 7. (2))
- Availability of appropriate transportation with equipment
- Geriatrics specialty/training
- 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
- Patient reported measures, including ones that capture patient activation – a patient’s knowledge, skills and confidence for managing their own health

b. Medicare Advantage

We support making Medicare Advantage information linked to the Physician Compare web site.

c. Value Modifier

We support the inclusion of additional value modifier cost and quality data on Physician Compare. As mentioned above, we encourage beneficiary education on what Value Modifier means for their care, and we would strongly urge CMS to work with consumer advocacy groups to collaborate on educating this population.

e. Measure Stratification

We strongly support including practice level data stratified by race, ethnicity and gender on the website. This will allow consumers to make informed choices based on their preferences and give stakeholders valuable information on gaps and trends in the system based on demographics. We urge the inclusion of primary language, gender identity and sexual orientation, as well. Please refer to our rationale on

quality data stratified by race, ethnicity, sex, primary language and disability status on Section III I below on page 7 of this document.

Section III. I (41815 – 41880) Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

2. Requirements for the PQRS Reporting Mechanism

To achieve more equitable health care outcomes, it is crucial to incorporate disparity reduction goals into overall quality improvement goals and to adopt tools that support measuring disparities and undertaking interventions. We are pleased to see that CMS intends to take steps toward implementing the collection and reporting of quality data stratified by race, ethnicity, sex, primary language and disability status within each of the PQRS reporting mechanisms.

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), and
- Patient engagement measures (e.g. patient activation and health literacy rates).

Because demographic data collection depends on self-reported information from individual beneficiaries, we encourage CMS to develop informational materials to educate beneficiaries about the reasons for and importance of collecting demographic data. It is equally important that providers are properly trained to collect these data to ensure questions asked are culturally appropriate.

During the first phase, providers should be required to use the consensus metrics developed by the National Quality Forum (NQF) to assess cultural competency and language services.⁴ Where quantitative data is not possible, providers should use qualitative methods (e.g. interviews and surveys) in conjunction with community needs assessment data collected by local authorities for public health accreditation or regional planning efforts to identify disparities and develop short-term as well as a long-term agendas for improving health care quality for beneficiaries experiencing disparities.

5. Proposed Criteria for Satisfactory Reporting for Group Practices Participating in the GPRO

⁴ National Quality Forum (August 2012). Healthcare Disparities and Cultural Competency Consensus Standards. http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx

We are encouraged to see support for a movement toward payment for outcomes and patient experience measures that have the potential to provide a more accurate understanding of health and well-being and ways to address and improve health outcomes. When considering measures for possible inclusion, we encourage CMS to prioritize the inclusion of cross-cutting patient-reported outcomes measures and patient experience and activation measures that have the potential to achieve better outcomes, especially for populations that experience disproportionately poor health outcomes and that have potential to empower patients to meaningfully engage in their health and well-being. While we understand the potential burden the modification of measure sets may place on providers, we would like to ensure that measurement results in the collection and accurate reporting of data that will ultimately lead to better health outcomes.

Patient engagement, including patient activation and patient confidence, is an increasingly important strategy for achieving better health outcomes and care experiences. 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 activation tools 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. We recognize that patient activation measures are relatively new and require more development and refinement. As mentioned above (Section I. 2.), we hope CMS will consider a phased-in approach to implementing these important aspects of measuring and reporting. In addition, we strongly urge CMS to consider opportunities to ensure that providers and provider organizations have the support and infrastructure necessary to adapt these measures in their practice and understand and use the data in meaningful ways that will ultimately lead to improved health outcomes.

7. Request for Input on the Provisions Included in the Medicare Access and CHIP Reauthorization Act of 2015

a. The Merit-Based Incentive Payment System (MIPS): Clinical practice Improvement

(1) Expanded Practice Access

We are encouraged to see expanded practice access, including same day appointments for urgent needs and after-hours access to clinician advice, as part of MIPS scoring for a year performance period. We recommend that CMS add specific details to further strengthen this category to enhance access. At the minimum, the following measures should be considered when evaluating the effectiveness of expended practice access:

- Measures for access during office hours for urgent care should include: same-day appointments, telephone and email consultations, waiting time, and group visits;
- Measures for after hour access should include: evening and weekend schedules, on-call evening or weekend visits, telephone and email consultations, and waiting time; and
- Measures for accessibility for beneficiaries with special needs (i.e. beneficiaries with physical disabilities, limited English proficiency (LEP) people, and those with visual, hearing, cognitive, and communication impairments).

(2) Population Management

We are encouraged to see population health as part of the clinical practice improvement to determine performance scores under MIPS. In order to further strengthen this category and improve care delivery at the practice level:

- Require providers and provider groups to use data on race, ethnicity, and primary language to provide timely interventions by working in collaboration with community groups to identify “hot spots” in the community where providers/provider groups serve to gain a better understanding of the needs in their community and use data to address unmet needs;⁵
- Require 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. Implicit bias among health care providers is a key contributing factor to health disparities because it negatively affects treatment delivery and medical interactions between providers and patients.⁶ 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 Associate Tests \(IATs\)](#)⁷ to assess and manage their own biases.⁸ 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

⁵ See discussion [here](#) of how Dignity Health in California by refocusing services towards high-need areas, which resulted in cost savings to the system.

⁶ See <https://www.iom.edu/~media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/PatientversionFINAL.pdf>

⁷ 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>

⁸ 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>

- 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.

(3) Care Coordination

In addition to the activities listed in the proposed regulations, we strongly urge CMS to include the following activities as part of clinical practice improvement:

- Use case management techniques such as targeting individuals most at need, conduct more face-to-face interventions rather than just relying on the telephone; develop a care plan based on consumer goals; ensure assessment of non-medical needs and strategic interventions such as nutrition needs and home-safety;^{9 10 11}
- Use Community Health Workers (CHWs), since most CHWs have experience in providing care to underserved, racial and ethnic populations facing cultural and linguistic barriers to care;
- As a part of timely exchange of clinical information, ensure appropriate medication management therapy;
- Appropriate coordination across the full range of community based support services and in the most integrated setting, especially those providers/provider groups serving dually eligible individuals. It will be of utmost importance to coordinate Medicaid and Medicare services to ensure that gaps in services are not experienced; and
- Collaborate with community based organizations on care coordination activities.

(4) Beneficiary Engagement

As mentioned, beneficiary engagement in care is a critical part of achieving better outcomes, especially for those with chronic conditions. Beneficiaries and their caregivers must be seen as key members of the care team, not as passive recipients. Implementing programs to improve activation among patients with multiple chronic conditions, i.e. providing beneficiaries with the skills and confidence to become actively engaged in their health care, promises to be a relatively low-cost, but high-impact, way to address chronic disease treatment. At the minimum, we recommend that CMS add the following requirements to the list included in the proposed rules under this category:

- Ensure that beneficiaries have easy and timely access to their medical records and health information;

⁹ Lynn J. Reliable and Sustainable Comprehensive Care for Frail Elderly People. JAMA. 2013;310(18):1935-1936.

¹⁰ http://altarum.org/sites/default/files/uploaded-related-files/MedicaringCommunities_042815.pdf

¹¹ See e.g. Neighborhood Health Plan of Rhode Island news release 5/26/15: *Neighborhood's innovative new home-based care program for highly complex and costly members shows strong initial results. Health@Home claims data show a 26 percent reduction in Emergency Room visits and a 30 percent reduction in medical inpatient days. The Program is projected to save at least \$2.7 million in the first year.*

- Improve health literacy for beneficiaries;
- Make quality measurement more salient and usable for beneficiaries; and
- Establish a strong, independent ombuds program that not only helps individuals through grievance and appeal processes and tracks trends, but collects and analyzes data on denials, grievances and appeals, and makes that data publicly available in a timely manner.

(5) Patient Safety and Practice Assessments

Patient safety in care delivery should be encouraged and incentivized in all clinical settings as a clinical practice improvement activity, and furthermore, as a way to improve value in health care. In addition to the activities listed in the proposed regulations (clinical or surgical checklists and practice assessments) and the payment approaches aimed at incentivizing reductions in hospital readmissions and complications, we urge CMS to consider patient safety activities that also address health disparities to further strengthen this category. Cultural and linguistic differences between patients and providers may lead to increased risk of safety incidents for patients if the provider is not sensitive to providing care that is appropriate or accepted by each patient. Increased trust between patients and providers and increased patient confidence and activation should be considered to help prevent medical errors.

b. Alternative Payment Models

Payment reforms are an integral part of moving our health care system away from fee-for-service payment to a higher-value health care system that will support a healthier population. With the HHS target to have 50 percent of Medicare payments made through alternative payment models by 2022, all players in the health care system – providers, hospitals, patients, payers – need to move towards a higher-value system.

The following reflect Community Catalyst’s recommendations to guide the transition towards alternative payment models in a way that is accountable and empowering for patients, especially the most vulnerable.

(1) Alternative Payment Models (APMs) should emphasize (or elevate) patient-centric quality measurement, including both quantitative and qualitative information. APM structures provide an opportunity to improve quality measurement by collecting meaningful information from those who are experiencing care – patients and their families. APMs should prioritize patient-centered quality measures, including patient experience surveys like CAHPS, elicited patient narratives, data on patient grievances and complaints, patient-reported outcomes measures, and patient empowerment and activation measures. While we understand the potential burden the modification of measure sets may place on Accountable Care Organizations (ACOs), the collection and accurate

reporting of patient-centered quality data has potential to equip providers and patients with information and tools necessary to improve health outcomes and care experiences and lower costs.^{12 13 14 15} Patient-centered quality measures can be adopted as intermediate measures for ACOs, patient-centered medical homes and other new and emerging delivery and payment structures.

(2) ACOs and other APMs also have an opportunity to incentivize reductions in potentially avoidable hospital readmissions and complications, which have serious and negative consequences for patients' health. Hospital payment rates, adjusted based on appropriate data, risk adjustment and benchmarks identification, provide a better alternative for improving care and reducing wasteful costs than other kinds of dangerous tactics such as provider rate cuts, benefit cuts and cost-sharing increases.

(3) APMs should prioritize the incorporation of disparity reduction goals in the overall quality improvement goals and the adoption of tools that support disparities measurement and interventions. Disparities in quality of care and outcomes stratified by income, race and ethnicity remain significant and persistent.¹⁶ Several studies have found that patient activation is currently an area where there is a significant race-based disparity, but also an area where improvement is possible. For instance, White patients are statistically more likely to be more empowered than African American or Hispanic patients, particularly when there is a language barrier involved.¹⁷ Other studies have concluded that White Americans are more likely to consider their relationship with their doctor as equitable (in relation to the power dynamic) than Hispanic or Black Americans. This likely leads them to ask more questions, be more engaged/assertive, and be more comfortable taking an active role in their care.¹⁸

Data collection within APMs should accurately capture race, ethnicity, gender identity, sexual orientation and preferred language in individual person-level surveys.¹⁹ APMs should be required to use the new consensus metrics, developed by the National Quality Forum (NQF), to assess cultural competency and language

¹² Hibbard, Judith H., and Jessica Greene. "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs." *Health Affairs* 32.2 (2013): 207-214.

¹³ Greene J. , Hibbard JH, Sacks R, Overton V, Parotta CD. When Patient Activation Levels Change, Health Outcomes And Costs Change, Too, *Health Affairs* (March 2015, Vol. 34, No.3). <http://content.healthaffairs.org/content/34/3/431.short>

¹⁴ Donald M, Ware RS, Ozolins IZ, Begum N, Crowther R, Bain C. *The role of patient activation in frequent attendance at primary care: a population-based study of people with chronic disease.* <http://www.ncbi.nlm.nih.gov/pubmed/20598825>

¹⁵ http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86

¹⁶ <http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr14/2014nhqdr.pdf>

¹⁷ <http://content.healthaffairs.org/content/30/10/1888.full>

¹⁸ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3423181/>

¹⁹ <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=23>

services.²⁰ Implementing these measures is critical to address provider biases, poor patient-provider communication, and poor health literacy, which are all barriers to quality health care that can lead to disproportionately poorer health outcomes.

(4) APMs should 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). 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. APMs should encourage investment in a health care workforce that can meet the physical, behavioral, social, and economic needs of patients.

(5) APMs should include robust consumer protections. As new models of payment are developed that push providers to take on increased risk, reward, and responsibility, it is important to prioritize robust consumer protections.

Consumer protections include choice in enrollment, provider selection, transparency regarding provider incentives, and a fair appeals process. Consumers should be notified of providers' and facilities' participation in any new payment model, including disclosure of any provider or facility financial incentives or shared savings opportunities. Consumers should be clearly informed of the opportunity to opt-out of new payment models. Furthermore, an external appeals process should be available to consumers whose providers or care facilities are participating in a new payment model that offers providers/facilities the opportunity to profit from savings generated through the program.

Consumers must be protected against any form of discrimination. APMs should be prohibited from discriminating against individuals eligible to enroll in, participate in, or align with any alternative payment models on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, or disability. Moreover, APMs may not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, health status, or disability.

Finally, consumers must be notified of any data sharing that is part of the APM. Consumers should be notified as to why and how their health information will be stored, exchanged, used and protected, the opportunity to opt-out, and other beneficiary rights. Any data sharing that is part of an APM must be compliant with federal and state law.

²⁰ http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx

(6) Consumers and consumer advocates should have meaningful participation on APM governance boards. APM governance boards should be representative of the diverse patient population served by strengthening the representation of consumer advocates, patients and families. It is especially important to engage patient and family representatives in reviewing patient-reported information such as complaints and grievances and developing responses to that information. Decision-making should also consider consumers and beneficiaries as part of the feedback loop in which their input and ideas are carried up to the leadership. Consumers need to weigh in on APM design and implementation in a meaningful way in order to ensure that they provide comprehensive, coordinated, patient and family-centered care that patients want and need while helping to drive down costs.

We urge these additional requirements governance bodies:

- Establish these member boards at the local or regional level to ensure they represent the full range of members;
- Provide the board with periodic reports on patient grievances and appeals, quality assessments including results of patient experience and quality of life surveys and actions resulting;
- Consult with the board about significant changes in policy and program administration;
- Keep records of input from the advisory committee and how it addresses that input; and
- Publicize the existence of the board and how individual consumers may contact the governance board to raise questions or issues.

We urge CMS to identify minimum responsibilities of the board. Mandated responsibilities should include: participation in policy development, program administration and oversight, including input into quality strategies, quality assessment, quality rating systems and state monitoring systems; reviewing quality outcomes, reviewing consumer satisfaction data, reviewing data on consumer complaints, grievances and appeals; and vetting proposed new policies.

We want to be especially deliberate about the consumer experience. A review of Oregon's Coordinated Care Organizations (CCOs) reveals a shortfall in delivering on their potential to improve the consumer experience.²¹ CCOs are not achieving the expected standards of helping to provide accurate and complete information about how the CCO is structured and how decisions are made. Members are uninformed about how to communicate concerns to the CCO. Without transparency and robust feedback loops, consumers are not empowered to navigate the health care system they are in and are limited in how much they can manage their health.

²¹ The Consumer Confidence Project Steering Committee. (August 2015). Consumer confidence Project: Report of Pilot Results. Retrieved from http://ophi.org/download/PDF/CCP%20Report_FINAL.pdf

(7) Price transparency is needed to facilitate a system that rewards value and support consumer choice.

Price transparency will support use of bundled payments by enabling a primary provider responsible for coordinating a patient's care to make better referrals to high-value specialists and keep costs lower. A study on price transparency for MRI scans, for instance, found that informing patients of price differences between providers reduced costs-per-test by nearly 20 percent and increased price competition.²²

We urge CMS to include price information for an entire episode of care, standardized definitions for an episode of care and other terms necessary for consumers to understand the information, and easy access to information about provider networks and covered meds. The ACA already provides the authority necessary to provide price information to enrollees. Section 1311(e) (3) (C) requires exchange plans to provide the dollar amount that an enrollee would pay for a specific treatment by a specific in-network provider through a website. Section 2715A extends this requirement to all employer plans. Yet, to date, HHS and the U.S. Department of Labor have not implemented or enforced these requirements.²³

Section III. L (41884 – 41892) Medicare Shared Savings Program

1. b. Proposed New Measure to be Used in Establishing Quality Standards that ACOs Must Meet to be Eligible for Shared Savings.

We applaud CMS' efforts to address gaps in quality measurement. However, we have concerns related to the domination of process measures that represent a single factor among many others that interact to determine outcomes. We urge CMS to replace process measures with quality measures that have potential to capture outcomes data, which is what matters to patients and their families.

We are especially pleased with the inclusion of patient-reported outcome measures (PROMs), and we encourage CMS to facilitate the movement of the market toward adoption of PROMs in routine care and performance reporting by including such measures in its provider incentive programs. We urge CMS to move these measures from the reporting domain into the payment domain on the same schedule as most of the other measures – with reporting in Year 1 and payment in Years 2 and 3 – and not allow them to lag behind the other measures in the set.

²² <https://www.americanprogress.org/issues/healthcare/report/2015/02/26/107394/payment-reform-action-plan-meeting-the-new-medicare-payment-reform-target/>

²³ <https://www.americanprogress.org/issues/healthcare/report/2015/02/26/107394/payment-reform-action-plan-meeting-the-new-medicare-payment-reform-target/>

We believe that this proposed rule 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 Angela Jenkins at ajenkins@communitycatalyst.org with any questions. As always, thank you for your time and attention to these issues.

Respectfully submitted,

A handwritten signature in cursive script that reads "Robert Restuccia".

Rob Restuccia
Executive Director
Community Catalyst