November 17, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-3321-NC

Dear Mr. Slavitt,

Thank you for the opportunity to respond to this Request for Information regarding the Merit-based Incentive Program and Alternative Payment Model in the Medicare program. We, the co-chairs of the Consortium for Citizens with Disabilities Health task force, were glad to see many proposals reflecting the need to improve health equity and outreach to underserved populations, including people with disabilities. Medicare covers large portions of people with disabilities, and exerts considerable market power in setting standards for the private insurance market. In order to improve health care for all people living with disabilities, we strongly support payments to physicians that prioritize access to care and improving the health of people with disabilities and chronic conditions.

Merit-Based Incentive Payment Systems

Quality Performance Category

In order to capture the experiences and preferences of people with disabilities and chronic conditions, CCD recommends that the MIPS quality measures include:

- Person* experience, including patient reported outcomes
- Person and family engagement
- Care coordination and transition between care settings
- Person-centeredness

*Note: CCD prefers "person" over "patient," consistent with social (non-medical) model of disability. The National Quality Forum has adopted this standard in their reports to CMS on person- and family-centered care, and in other reports.

The Department should also carefully monitor the Hartford Foundation-Scan Foundation funded person-centered planning project operated by the National Committee on Quality Assurance

available here: http://www.ncqa.org/HEDISQualityMeasurement/Research/SettingGoalswithVulnerablePeople.aspx . The project holds hope for demonstrating person-centered planning for persons with complex health needs enrolled in health plans, although some traditional medicine practices have been identified as barriers to authentic person-centered planning. The most recent report is here: http://www.ncqa.org/Portals/0/HEDISQM/Research/Policy%20Report_Final%20Report_TSF%202-1.pdf

Regarding the statutorily established "physician-focused payment model technical assistance committee," CCD encourages continued reliance on the statutorily recognized balanced multi-stakeholder measure endorsement process, currently through the National Quality Forum. The active and meaningful beneficiary and family involvement and engagement in quality measurement and development work should be equally emphasized with physician involvement and engagement.

Finally, we support the idea that reporting mechanisms should include the ability to stratify the data by demographic characteristics such as race, ethnicity and gender. We recommend that reporting mechanisms also include the ability to stratify data based on disability. For validated questions on disability status, see the disability questions used in the American Community Survey available at: https://www.census.gov/people/disability/methodology/acs.html

Resource Use Performance Category

While we appreciate the need to monitor and reduce costs in Medicare, we are concerned that including resource utilization as a measure under the MIPS could discourage doctors from seeing patients with disabilities who may have claims that result in increased costs as a result of their disabilities. While resource use is a MIPS category under current law, we encourage CMS to develop a payment system that encourages providers to do their best to reduce health disparities and prevent the onset of chronic and other conditions, while not financially punishing providers who treat patients with existing conditions and disabilities.

Clinical Practice Improvement Activities Performance Category

We strongly support the inclusion of Promoting Health Equity and Continuity as a subcategory of Clinical Practice Improvement and that this subcategory include "maintaining adequate equipment and other accommodations (for example wheelchair access, accessible exam tables, lifts, scales, etc.) to provide comprehensive care for patients with disabilities." For a measure of office accessibility, we recommend using the standards issued by the U.S. Access Board on the accessibility of medical diagnostic equipment. While the Access Board has not yet issued final standards, encourage CMS to use the Access Board's Advisory Committee Report and Proposed Standards as guidelines in the meantime. We also support the other elements of the subcategory, including serving Medicaid beneficiaries, people dually eligible for Medicare and Medicaid, accepting new Medicaid beneficiaries, and participating in the network of plans on the Federally-facilitated or state-based Marketplaces.

We also encourage CMS to include programmatic accessibility as a measure of clinical practice improvement. Examples of programmatic accessibility include modification of wait times, office hours, appointment times, appointment timeliness rules, and other business practices to make an office more accessible to individuals with disabilities. More examples are available from the Disability Rights Education and Defense Fund:
http://dredf.org/healthcare/Healthcarepgmaccess.pdf

We also support including subcategories in Social and Community Involvement and Achieving Health Equity. Measures of Social and Community Involvement should include referrals to local community disability services like Centers for Independent Living and Protection & Advocacy legal agencies. We support that the subcategory of Achieving Health Equity including achieving high quality for people with disabilities and behavioral health conditions, as well as racial and ethnic minorities, sexual and gender minorities, people living in rural areas, and people in health professional shortage areas (HPSAs).

Feedback Reports

We support the idea that feedback reports should include data that is stratified by race, ethnicity, and gender to monitor trends and address gaps towards health equity. We would also recommend that data be collected on disability status and reported with race, ethnicity, and gender. For validated questions on disability status, see the disability questions used in the American Community Survey available at: https://www.census.gov/people/disability/methodology/acs.html

Alternative Payment Models

We appreciate the goal of moving health systems toward alternative payment models and new delivery systems that move away from fee-for-service and place value and quality over volume. Both the MIPS and APM include advancements in paying for quality and value. We also appreciate the need for APMs to be innovative and not-yet-defined. However, advancements made in paying for improved health equity and accessibility under the MIPS should not be lost under APMs. We encourage CMS to include the measures of accessibility, health equity, and social and community involvement in APMs.

Physician-Focused Payment Models

We support the concept of increasing transparency in the Physician-Focused Payment Model (PFPM) process and the role that will be played by a PFPM Technical Advisory Committee. We also recommend technical assistance and not only for small practices and practices in Health Professional Shortage Areas, but also for the communities and individuals that experience health disparities and healthcare delivery inequities under present payment models. While we are not seeking to diminish or replace provider-oriented technical assistance, providers themselves are not the only stakeholders who have a vital interest in developing and disseminating appropriate PFPMs that will reward provider behavior that engages with consumers and provides physically and programmatically accessible healthcare. Whether members of communities that are subject

to health disparities work with community advocates, or in concert with providers or other stakeholders, we believe their input is critical to the development of successful PFPMs.

Thank you for this opportunity to provide comments. For questions or more information, please contact Rachel Patterson at rpatterson@christopherreeve.org or 202-715-1496.

Sincerely,

CCD Health Task Force Co-Chairs

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