



American Association on Health & Disability

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AAHD - Dedicated to better health for people with disabilities through health promotion and wellness



LAKESHORE

November 17, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Attention: CMS 1612 P; Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-3321-NC: MACRA – Medicare Merit-Based Incentive Payment and Alternative Payment Models

Dear Mr. Slavitt,

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments in response to the Request for Information regarding the Merit-based Incentive Program and Alternative Payment Model in the Medicare program. We were glad to see many proposals reflecting the need to improve health equity and outreach to underserved populations. 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.

We endorse the complete comments submitted to HHS by the Consortium for Citizens with Disabilities (CCD). We helped to draft these comments and repeat them here. We endorse the complete comments submitted by the Partnership To Improve Patient Care (PIPC), although we prefer “person-centered” language, rather than “patient-centered” language. We associate ourselves with our colleague organization submitted comments: Consumer-Purchaser Alliance and National Partnership for Women and Families.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore’s programs with the University of Alabama, Birmingham’s research expertise.

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 July 2014 NQF MAP report to CMS observes: “one single term cannot apply to all individuals in all situations; in actuality, an individual with many needs may self-identify as a person, client, or patient at a single point in time...” “The task force agreed to use the word ‘person’ as an over-arching term to encompass the health and healthcare needs of all individuals, regardless of age, setting, or health status.”

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.

We thank you again for the opportunity to comment on the proposed rule. If you have any question please contact Clarke Ross at clarkeross10@comcast.net.

Sincerely,



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Member, National Quality Forum (NQF) workgroup on persons dually eligible for Medicare and Medicaid and NQF population health task force (<http://www.qualityforum.org/>) and NQF representative of the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports (<http://www.c-c-d.org/>). 2015-2016 and 2014-2015 NQF duals workgroup liaison to the NQF PAC/LTC workgroup. Member, ONC (Office of the National Coordinator for Health Information Technology) Health IT Policy Committee, Consumer Workgroup (<http://www.healthit.gov/policy-researchers-implementers/federal-advisory-committees-facas/consumer-empowerment-workgroup>). Member, SAMHSA Wellness Campaign National Steering Committee – January 2011-September 2014. (<http://promoteacceptance.samhsa.gov/10by10/>).

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