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

LAKESHORE

November 18, 2017

Submitted electronically to [CMMI_New Direction@cms.hhs.gov](mailto:CMMI_New Direction@cms.hhs.gov)

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

## Re: Innovation Center New Direction—Request for Information

The American Association on Health and Disability and Lakeshore Foundation appreciate the opportunity to provide a response to the above-referenced Request for Information (RFI).

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.

On October 23, AAHD joined **No Health Without Mental Health** and two other national mental health organizations in submitting comments to the CMS Innovation on focus area #7 Mental & Behavioral Health Models. We refer you to this submission and highlight a few of the recommendations below.

On November 17, our colleague organization – **Partnership To Improve Patient Care** – submitted comments on patient engagement and person-centeredness. Both AAHD and the Lakeshore Foundation associate ourselves with these detailed and appropriate recommendations. [Many persons with disabilities prefer terminology referring to themselves as "persons," (or beneficiaries, or consumers) rather than "patients." This is particularly true outside of the acute care medical facility setting.] But we fully endorse the PIPC concepts, particularly:

1. Need for clear and consistent process for patient and beneficiary engagement
2. Need for detailed criteria for person-centeredness in the CMMI evaluation
3. Need to build and strengthen beneficiary safeguards

**Guiding Principle: Beneficiary Choice –Clarity in Communications**

The first and second guiding principles in the RFI address choice and tools needed to exercise choice. We support beneficiary empowerment so they can make the best choices possible. To make that happen, all beneficiary communication about a demonstration, both at the start and throughout, should be in consumer-tested simple language, and accessible to individuals with disabilities and to those with limited proficiency in English.

**Guiding Principle: Beneficiary Choice--Tools and Assistance, Including Publicly Reported Quality Measurements**

Among the guiding principles set out in the RFI is giving beneficiaries "the tools and information they need to make decisions that work best for them." To exercise informed choice, beneficiaries need easy-to-use and accessible tools that allow them to compare options. They also need to have free personalized assistance available to help them understand their options and their chosen coverage, something that is especially important for the many older adults and persons with disabilities who have difficulties using online resources.

We have been actively involved with committees of the **National Quality Forum** since 2012. We strongly reaffirm patient reported outcomes (PROs), **CAHPS (Consumer Assessment of Healthcare Providers and Systems**), patient and recipient documented experience and perspective as part of the value determination. We emphasize the value of shared decision-making tools. Systems serving persons with intellectual and other developmental disabilities for 20 years have used person-centered mechanisms and processes to document personal experience and provide accountability and change in such systems [through the **National Core Indicators** (NCI) and **Council for Quality and Leadership, Personal Outcome Measures** (POM)]. During the past several years, NCI has been modified and piloted for persons with physical disabilities and aging recipients of home and community-based services and supports and POM has been modified and piloted for persons with severe mental illness. CMS needs to continue to innovate, modify, expand, and pilot existing tools, such as NCI & POM to larger populations.

The National Quality Forum has submitted multiple reports to CMS and other entities within HHS, using consensus, identifying multiple measure gaps. These documented gaps provide an agenda for CMS innovation.

## Guiding Principle: Beneficiary Choice--Voluntary participation

The RFI stresses the importance of provider choice and incentives, favoring voluntary demonstrations. We urge that, more importantly, beneficiary participation in any demonstration that impacts their receipt of services should also always be voluntary. 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 mandatory.

Beneficiaries with multiple chronic conditions and significant disabilities 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.

## Medical/General Health-Behavioral Health Integration

Evidence-based value-added *models* of integrated care *are limited in number*. However, the ones that are out there, clearly show value. More effective models need to be developed, tested and disseminated with incentives and supports to allow for wide-scale implementation.

An important conclusion from the accumulating data on value from adult integrated medical-BH care management, is that the *necessary components of integrated care* are: targeting of high-need, high-cost patients; longitudinal care management assistance; and a treat-to-target, measurement-based, multi-disciplinary medical-BH approach.

CMS should direct the Innovation Center to set a firm new prioritized direction towards accelerating the development of additional effective integrated care models in the medical setting.

CMMI should support and incentivize integrated care models that will work in the real world of clinical practice. This includes finding innovative, step-by-step approaches for behavioral health integration into small and medium-size practices, e.g. 5 clinicians or less, which constitute well over 50% of U.S. primary care sites.

At the same time, there has to be recognition that patients with serious and persistent mental illness will still have specialty BH services available to them, and their medical care augmented in an expanded medical-BH setting when needed.

We encourage HHS and CMS to convene the state intellectual/developmental disability administrators and state mental health administrators, to address integrated services and supports for persons with co-occurring intellectual and developmental disability and mental illness. State ID/D systems have co-occurrence data and examples of integrated delivery (see NCI).

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkeross10@comcast.net.

Sincerely,

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