

June 27, 2016

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The Honorable Sylvia Matthews Burwell
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W. Washington, D.C. 20201

Re: Medicare Program; Merit-Based Incentive Payment System and Alternative Payment Model Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-P)

Dear Secretary Burwell and Administrator Slavitt:

The Disability Rights Education and Defense Fund (DREDF) appreciates the opportunity to respond to the proposed rule for Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive established as a program under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). DREDF is a leading national law and policy center that works to advance the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. We are committed to eliminating barriers and increasing access to effective healthcare for people with disabilities.

Our letter primarily responds to the request for comment made by the Centers for Medicare and Medicaid (CMS) in proposing two additional subcategories for future consideration under the Clinical Practice Improvement Activity (CPIA) performance category. DREDF strongly supports the Secretary's inclusion of both the Promoting Health Equity and Continuity subcategory, and the Social and Community Involvement subcategory. We will address each in turn.

Clinical Practice Improvement Activity: Promote Health Equity Subcategory

We are dismayed and puzzled by the NPRM's failure to immediately adopt the Promote Health Equity subcategory which explicitly includes "maintaining adequate equipment and other accommodations (for example, wheelchair access, accessible exam tables, lifts, scales, etc.) to provide comprehensive care for patients with disabilities." CMS itself has recently recognized

how urgently and widely people with disabilities need physical accessibility, and programmatic accommodations such as changes in policies and procedures, to receive equally effective care. The CMS Equity Plan for Improving Quality in Medicare,¹ issued in September 2015, included the two priorities of improving communication and language access for people with disabilities and individuals with limited English proficiency, and increasing physical accessibility of health care facilities, among its six stated priority areas.

We understand that § 414.1365 of the proposed rule adds the subcategories of “Achieving Health Equity,” “Integrated Behavioral and Mental Health”, and “Emergency Preparedness and Response,” which together comprise three of the five CPIA subcategories on which comment was requested in the MIPS and APMs RFI. We support the addition of these three subcategories and appreciate that people with disabilities will benefit from incentivizing MIPS eligible clinicians on these three fronts, especially since people with disabilities are explicitly included among the underserved populations on which MIPS eligible clinicians are being incentivized to achieve high quality.

Nonetheless, the proposed rule’s apparent choice of the Achieving Health Equity subcategory over the Promoting Health Equity subcategory makes little sense when the two can and must work hand-in-hand. The Achieving Health Equity subcategory focuses on improving the quality of care for underserved populations while the Promote Health Equity subcategory motivates all providers to address known healthcare barriers. MIPS eligible clinicians who currently provide care to underserved populations such as people with behavioral health conditions, racial and ethnic minorities, people with disabilities, and so forth, *should* be rewarded to achieving high quality care. At the same time, these are *the very population categories* that have a disproportionate correlation with poverty and low income, and that rely on Medicaid and subsidized marketplace or state exchange coverage. The insufficient numbers of Medicaid providers who accept Medicaid or are able to take on new Medicaid patients is a widely acknowledged healthcare barrier.² It is not enough to reward MIPS eligible clinicians who work with underserved populations without simultaneously addressing the need to increase the number of Medicaid providers.

In the same vein, DREDF agrees that it is vitally important to reward MIPS eligible practitioners who particularly work on improving and maintaining high quality care for people with disabilities, and for this purpose, this subcategory would probably work best as a multiplier that could enhance other measures rather than as its own performance category. At the same time, the distinct Promoting Health Equity and Continuity category acts as a needed incentive to every MIPS eligible clinician to maintain adequate accessible equipment and provide accommodations to people with disabilities. People with disabilities should not be limited in their provider choices to those who particularly focus on working with, or improve care to, underserved populations. Individuals who did not previously have disabilities but who

¹ Centers for Medicare & Medicaid Services, Office of Minority Health. “The CMS Equity Plan for Improving Quality in Medicare Equity Plan,” September 2015.

² Paradise, J., “Medicaid Moving Forward.” Kaiser Family Foundation Issue Brief, March 2015. Available at: http://kff.org/report-section/medicaid-moving-forward-issue-brief/#endnote_link_144992-23. (“Physician participation is more limited in Medicaid than in Medicare or private insurance.”)

acquire functional limitations such as vision or mobility impairments as they age may especially wish to maintain their provider relations, and have the right to do so since those providers are very likely obligated under the Americans with Disabilities Act of 1990 (ADA) and other federal and state disability rights laws to provide the kinds of physical, equipment and provider accommodations that those individuals need. Moreover, the failure to incentivize accessible barrier removal among *all* MIPS eligible clinicians in general may have the unintended consequence of overwhelming and thereby dis-incentivizing those relatively few providers who are fully equipped and prepared to provide high quality care to people with a range of disabilities. The Promoting Health Equity and Continuity subcategory explicitly captures precisely the incentives needed to provide a “carrot” for addressing *known and documented* accessibility barriers, in addition to the “stick” of the ADA.

As DREDF has previously noted, there is an increasing body of evidence and information indicating how many barriers people with disabilities encounter when seeking needed healthcare. Some of the barriers to comprehensive, quality health care are present in the physical environment—for example, cramped waiting and exam rooms, inaccessible bathrooms, and inaccessible equipment (such as exam tables, weight scales, and imaging and other diagnostic equipment).³ Other forms of discrimination that prevent people with disabilities from attaining appropriate and effective healthcare take the form of the failure to provide needed policy modifications and reasonable accommodations, which in turn affects healthcare treatment decisions and outcomes.

Physical Barriers

With respect to physical barriers, research indicates that more than 3 million adults residing in the United States require a wheelchair for mobility.⁴ The ADA requires full and equal access to healthcare services and facilities for people with disabilities, yet patients with mobility impairments are frequently denied services, receive less preventive care and fewer examinations, and report longer waits to see subspecialists despite this mandate. A study recently published in the Annals of Internal Medicine reports the results of telephone interviews with specialty practices concerning their willingness to accept and capacity to accommodate patients with disabilities. Medical residents at a hospital in Springfield, Massachusetts telephoned 256 specialty practices in locations across the country and asked if the practice could accommodate a patient who was described as a large individual who used a wheelchair and who was unable to independently transfer. Fifty-six practices (22%) reported that they could not accommodate the patient. Nine practices (4%) reported that the building was inaccessible. Forty-seven (18%) reported that they were unable to transfer a patient from their wheelchair to an examination table. Only twenty-two (9%) reported the use of height adjustable

³ Mudrick, N.R.; Breslin, M.L.; Liang, M.; and Yee, S. (2012) “Physical Accessibility in Primary Health Care Settings: Results from California On-site Reviews,” *Disability and Health Journal*, October, Vol. 3, Issue 4, Pages 253-261.

⁴ Brault M. Americans with Disabilities: 2005. Current Population Reports, P70-117. Washington, DC: U.S. Census Bureau; 2008. Accessed at www.census.gov/prod/2008pubs/p70-117.pdf on 14 December 2012.

tables or a lift for a transfer director. Finally, the study reported that gynecology is the subspecialty with the highest rate of inaccessible practices (44%).⁵

Something as fundamental to health management as weight measurement remains elusive for people with disabilities. A California study reported, for example, that among over 2300 primary care practices, only 3.6 percent had accessible weight scales.⁶ Related research reveals that wheelchair users report almost never being weighed even though weight measurement is a crucial metric for many types of health care including determining anesthesia and prescription dosages, and ongoing health and fitness monitoring.

Lack of Programmatic Access

The failure to provide needed policy modifications and reasonable accommodations as required by current disability rights laws affects healthcare treatment decisions and outcomes. For example, lack of effective communication when Sign Language interpreters are not provided for Deaf patients or print materials are not available in alternative, accessible formats for people with visual impairments can lead to ineffective communication about medical problems and treatment. Accommodations such as alternative formats are not offered or available even when their necessity is clinically obvious and predictable. For example, there is a high correlation between diabetes and vision loss, but printed self-care and treatment instructions in alternative formats such as Braille, large font type, CD, or audio recording, and accessible glucometers, are rarely available although the ADA and Section 504 of the 1973 Rehabilitation Act requires the provision of auxiliary aids and services when required for effective communication. Other common problems include provider failure to modify routine diagnostic procedures in order to accommodate an individual's disability or to establish policies that allow for extended or flexible exam times. Some patients require additional time to communicate effectively, dress and undress, or transfer from their wheelchair or scooter to a diagnostic device or exam table or be positioned for an exam. When such accommodations are not available, providers may make incorrect diagnosis and treatment decisions and serious health problems sometimes are not properly diagnosed or treated. The result can be unequal healthcare that affects the quality and length of life for many.⁷

Moreover, insufficient knowledge of how to provide accommodations or ignorance about the critical need for accommodations can result in people being injured in the very process of seeking care. For example, patients with disabilities have been injured when they are transferred to exam tables by untrained staff, given improper dosages of medication or anesthesia due to lack of proper weight measurement, and when pressure sores develop because providers waive physical exams for wheelchair users who cannot transfer to exam

⁵ Lagu, T. et al. Access to Subspecialty Care for Patients With Mobility Impairment, Annals of Internal Medicine. 2013; 158:441 – 446.

⁶ Mudrick, Breslin, Liang, 2012.

⁷ Kirschner, K.L., Breslin, M.L., Iezzoni, L.I., & Sandel, E. (2009) "Attending to Inclusion: People with Disabilities and Health-Care Reform," *PM&R*, Oct 1, Vol. 10, Pages 957-63.

tables.⁸ Finally, people with disabilities report putting off needed preventive and routine care due to the significant distress associated with seeking accessible care but receiving inaccessible care, and therefore frequently must rely on emergency department treatment as a last resort once a treatable condition has become acute.⁹

We understand that CMS seeks to systematically develop through MIPS “a process that will have increasingly more stringent requirements over time,” but that should mean requiring increasingly strong adherence to a complete set of national quality improvement goals that address known barriers from the outset, not the establishment of a patchwork of goals that are instituted when sufficient comments are received. For example, bullets 5 to 7 below establish a set of increasingly stronger ways to meet the obligation to maintain adequate equipment and other accommodations that is set forth in the Promoting Health Equity and Continuity subcategory; movement along this continuum of activities will naturally occur over time for individual offices and facilities. Bullet 4 inherently allows for a snapshot of the kind of accessibility improvement over time that is sought through the subcategory. Our recommendations for the kinds of specific recommended activities that could accompany the Promoting Health Equity and Continuity subcategory include:

- Consistently asking patients for voluntary information about their functional impairments, using the six-disability related questions that have been validated for use in the federal American Community Survey;
- Maintaining and updating information about patient accommodation needs, and maintaining functional impairment and accommodation needs in the clinician’s electronic health records;
- Developing a system of “alerts” or other timely display on patient accommodation needs in a manner that allows office staff and clinicians to provide for accommodation needs before the patient arrives (i.e., an alert that indicates when an ASL or other language interpreter must be engaged, an alert that specifies that a patient must be placed in an office with sufficient wheelchair turning radius and accessible equipment, and so forth).
- Recording statistical information about the percentage of patients that have been asked about their functional limitation and accommodations, the kinds of accommodation requests that are made, and when and how often accommodation requests are met over time
- Acquiring at least one accessible weight scale and height-adjustable exam table in advance of the forthcoming standards of the US Access Board for medical diagnostic equipment;

⁸ J. M. Glionna, “Suit Faults Kaiser’s Care for Disabled; Courts, Advocates Say Provider Fails to Give Equal and Adequate Treatment to the Handicapped. Chain Says It Complies with Disabilities Act,” Los Angeles Times (record edition), July 27 2000, p. 3.

⁹ A recent study by National Institutes of Health researchers found that working-age adults with disabilities account for a disproportionately high amount of annual emergency department visitors.

Rasch, E. K., Gulley, S. P., & Chan, L. (2012). Use of emergency departments among working age adults with disabilities: A problem of access and service needs. *Health Services Research*, 48(4), 1334-1358.

Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12025/references>

- Meeting the US Access Board standards for medical diagnostic equipment as new equipment replaces older equipment;
- Meeting the regulatory standards for medical diagnostic equipment when the Access Board standards are adopted, with scoping requirements, by the US Department of Justice;
- Establishing quarterly or other periodic staff checklists of the office to ensure that physical accessibility and equipment have not been blocked by such barriers as furniture that blocks aisles and under-counter or sink access;
- Establishing staff policies and trainings on requesting accommodation information and needs from patients who may need special booking procedures, reduced waiting times, quieter waiting areas, or longer appointments;
- Replacing inaccessible equipment with accessible equipment
- Remodeling or redesigning an office to meet accessibility standards in areas other than medical diagnostic equipment
- Staff training procedures on disability etiquette and the person-centered care;
- Staff training procedures on the very limited clinical reasons that can appropriately form the basis for referring a person with a disability to another provider for services that first brought the person to the original provider, and training on ensuring that the referral is made and communicated;
- Employing staff that have received ongoing education and certification on disability-related accommodation needs, etiquette, and/or disability rights.
- Providing notice to the public of accommodation rights and complaint procedures when those rights are not met.

Social and Community Involvement

The degree to which the people with disabilities can maintain their health, wellbeing and capacity to live independently in the community depends not only on clinical care, but on the receipt of appropriate home and community-based services and supports (HCBS). The Affordable Care Act has spurred many demonstration projects and innovative attempts among states to integrate long-term services and supports (LTSS) delivery, including HCBS, with acute medical care. It is critical that these attempt to integrate care do not develop in a vacuum, with primary care and other clinical providers that fail to integrate the decades of experience and established relationships that live in the community-based organizations that historically provide HCBS service delivery to people with various disabilities.

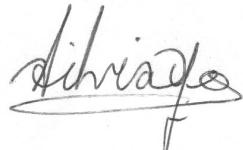
For this reason, DREDF believes that the Social and Community Involvement subcategory needs to be incentivized for MIPS eligible clinicians. The subcategory could include the following activities for measurement and improvement over time:

- Completed contracts with established HCBS service providers such as Independent Living Centers and Area Associations on Aging;
- Maintain accurate records of completed referrals under contracts with community-based organizations;

- Establishing regular forums or meetings where community-based organizations can give MIPS eligible clinicians feedback on how the referral process or other contractual relations are working;
- The use of voluntary screening tools that evaluate an individual patient's need for HCBS, especially unmet social and community involvement needs;
- Developing referral information about community services related to the social determinants of health such as housing, employment, food security and so forth, and keeping the information current through periodic reviews;

Thank you again for this opportunity to comment on the proposed rule. We have repeatedly seen how improving accessibility among MIPS eligible clinicians can have a profound impact on the quality and accessibility of care for people with disabilities. The development of MIPS provides a timely and ideal opportunity to motivate providers to address known and long-held accessibility concerns that will have profound positive impacts on the health, lives, and capacity of people with disabilities to live full and productive lives within their communities.

Yours truly,



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