

November 17, 2015

Via online submission to www.regulations.gov

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.
Washington, DC 20201

Re: Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (CMS-3321-NC)

Dear Administrator Slavitt:

Disability Rights Education and Defense Fund (DREDF) appreciates the opportunity to provide responses to the Center for Medicare and Medicare Services' (CMS) Request for Information regarding the Merit-based Incentive Program and Alternative Payment Model in the Medicare program (RFI). As an organization founded by people with disabilities and parents of children with disabilities, we have long advocated for equally effective and barrier-free healthcare for people with disabilities of all ages. We strongly support the repeal of the Medicare sustainable growth rate (SGR) methodology for updating the physician fee schedule (PFS) effected by Section 101 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and its replacement with a new Merit-based Incentive Payment System (MIPS).

We also welcome CMS's recognition in the RFI of MIPS as a way to improve the delivery of Medicare services to many Medicare recipients who experience health and healthcare disparities. For many millions of people with various disabilities and people who are acquiring disabilities as they age, the RFI questions are extremely timely, given recent broadening acknowledgement – including within CMS itself -- of people with disabilities as a group subject to health disparities and in need of health equity.¹ MIPS, Alternative Payment Models (APMs), and Physician-focused payment Models (PFPs) could all be critical tools for building a healthcare reimbursement system that rewards Medicare physicians for providing appropriate medical expertise, physically and programmatically accessible healthcare, maintenance of the functional capacity needed for independent living in a chosen community, and being team members in an overall system of care that meets the complex coordination needs of people with disabilities and chronic conditions.

¹ "CMS Equity Plan for Improving Quality in Medicare." Centers for Medicare and Medicaid Services, Office of Minority Health. September 2015. Accessed October 16, 2015. http://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf; Krahn, Gloria L., Deborah Klein Walker, and Rosaly Correa-De-Araujo. "Persons With Disabilities as an Unrecognized Health Disparity Population." *American Journal of Public Health*. Vol 105, No. S2 (2015): S198-206.

Below we address some of the priority questions specified in the extension of the comment period contained in Federal Register 2015-26568 (CMS-3321-NC2) in the order of their appearance in that document.

MIPS EP Identifier and Exclusions

DREDF is not strongly attached to any particular identifier for participating MIPS Eligible Professionals (EPs), such as Tax Identification Numbers (TIN) or National Provider Identifier (NPI). The important factor for us is that the identifier must be capable of identifying EPs in **all** of the places/offices/facilities where they actually practice. This is because the accessibility component of the subcategory of Promoting Health Equity and Continuity within the Clinical Practice Improvement Activities Performance Category will need to be **location-specific**. The fact that an EP has a height-adjustable exam table in an office where he spends 20% of his practice should not be interpreted as meaning that the EP in question maintains accessible equipment or provides “comprehensive care for patients with disabilities,” or that the actual or virtual physician group that he practices with does so. The MIPS identifier may therefore need to be more specific and include the capacity to specify actual practice locations. Practice location is generally unnecessary for the other purposes where an EP has combined and multiple identifiers

We note that a distinct practice-specific MIPS-EP identifier may help alleviate concerns expressed in the RFI at 80 FR 59104 about exempting only EPs that are part of a qualifying APM since a unique identifier capable of being linked to the locations where a particular individual EP practices should also be capable, in the “split-TIN” context, of avoiding overbroad identification with a TIN that is associated with a qualifying APM. Presumably the concern identified at 80 FR 59104 about MIPS EPs potentially switching unique identifiers or unintended consequences may still apply, but as long as **all** of a particular provider’s unique identifiers are linked to that particular provider, including all the providers’ possible practice affiliations and locations, the problem may be lessened. The EP should not get to “choose” which identifier applies, and some identifiers merit a performance multiplier while others do not, the provider should neither be eligible for full enhancement nor subject to full penalty. That is, if a provider or a group practice of not more than 10 EPs has accessible equipment available for 80% of patients, 80% of Medicare payments should be recognized as meeting Clinical Practice Improvement Activities criteria, while the other 20% remains unenhanced, thereby provide ongoing incentive to reach 100% of patients.

Virtual Groups

For DREDF, the question of allowing a virtual group of EPs to tie its performance together even if EPs in the group do not share the same TIN is linked to the larger question of whether and how participation in a virtual group would enhance any virtual group provider’s capacity and performance related to his or her patients. From the viewpoint of accessibility and healthcare barrier removal, what does it matter to consumers if an EP joins a rare specialty virtual group where the providers are all in separate states? Does the virtual group enhance and facilitate referral between and among providers for the group’s patients with disabilities and chronic conditions? Does

it share accessible equipment? Does it encourage specialized consulting and the exchange of disability cultural competency knowledge among the group's providers? If quality and resource use are not improved for *all* consumers, including persons with disabilities, then we are unsure of the purpose behind allowing the providers in a virtual group to share their performance measures.

Quality Performance Category

DREDF deeply appreciates that MIPS will attempt to measure and capture EP composite performance through the four categories of quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology (CEHRT). We also support the explicit incorporation of accessibility and accommodation needs within the clinical performance improvement activities category. Nonetheless, from the viewpoint of the disability community, it is impossible to separate physically and programmatically inaccessible healthcare from healthcare that is poor quality and misuses resources.

Ultimately, process-oriented measures that have been historically developed for people without disabilities fail to incentivize providers to maintain responsibility for maintaining the health and functioning of people with disabilities. Why should a provider spend resources on a height-adjustable table when less expensive fixed height tables enable full examinations of women without disabilities, and why should a provider spend additional time giving smoking cessation counseling to a Deaf individual when such counseling can be more quickly provided to patients without communication disabilities? DREDF recommends that quality as a component of composite performance must inherently address accessible processes needed by persons with disabilities, as well as outcome measures, including self-reported outcomes, that can be identified as outcomes experienced by persons with disabilities.

In addition, we stress that accessible processes and health outcomes for persons with disabilities cannot be captured unless **persons can identify themselves through voluntarily answering disability-related questions**. The RFI raises the idea that quality-reporting mechanisms should include the ability to stratify the data by demographic characteristics such as race, ethnicity and gender. Of course we support the capture of sufficient information on the personal characteristics mentioned, but we also highly recommend the addition of disability status to this list. 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>

Moreover, for quality measures to fully address the healthcare needs of people with disabilities, we recommend that MIPS quality scores include measures that address the unique healthcare needs of people with disabilities and chronic conditions as they relate to:

- Care coordination and transition between care settings, and between sources of healthcare coverage (e.g., from Medicaid eligibility to dual Medicaid and Medicare eligibility)

- Person-centered care planning and goal-setting
- Supported decision-making
- Person and family engagement
- A person's choice to live in, and receive care in their community of choice

Resource Use Performance Category

DREDF understands that MIPS score performance, as a matter of principle and of law, must include resource use. We support the use of public resources that will reward EPs who operate efficiently and sustainably. Nonetheless, we think it is critical for resource use, if the category is to contribute to greater well-being and effective healthcare for people with disabilities, to encourage providers to thoughtfully balance short term and long-term resource use. An EP who spends additional time or orders particular therapies now for a person with a disability may very well avoid diminished functionality and greater long-term costs down the road. Resource use that rewards providers for giving timely and appropriate care now to persons with disabilities in the community will reduce more expensive emergency and institutional care for many of those same individuals. We ask CMS to incorporate additional stakeholder input and data on these measures, and develop a payment system that encourages providers to think systemically and with forethought in their resource use, to ensure that providers are not financially hurt when they provide appropriate care to patients with disabilities and chronic conditions.

Clinical Practice Improvement Activities Performance Category

DREDF strongly supports this category's incorporation of accessibility-related performance measures, and also enthusiastically supports the incorporation of an element to encourage EPs to maintain "adequate equipment and other accommodations (for example, wheelchair access, accessible exam tables, lifts, scales, etc.) to provide comprehensive care for patients with disabilities." DREDF is deeply aware of the degree to which the still widespread lack of such accessible equipment presents grave barriers to effective healthcare for people with mobility, strength and other disabilities.² We believe that EPs can be further directed toward the work of the U.S. Access Board, which was directed under the Affordable Care Act to issue standards on the accessibility of medical diagnostic equipment. The Access Board has not yet promulgated final standards, but they have issued an Advisory Committee Report and Proposed Standards as interim guidelines. We also support quality improvement measures identified in this subcategory that will affect people with disabilities, such as improving clinical practices for 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.

² Mudrick NM, Breslin ML, Liang M, and Yee S. "Physical Accessibility in Primary Health Care Settings: Results from California On-Site Reviews." *Disability and Health Journal* 5 (2012) 159-167; Lagu, T *et al.* "Access to Subspecialty Care for Patients with Mobility Disabilities: A Survey." *Ann. Intern. Med.* (2013) 158: 441-446.

On this front, DREDF raises California's "best practice" of gathering information on the physical accessibility of managed care Medi-Cal provider offices, and now Cal Mediconnect provider offices. See: DPL 14-005 (PDF) Facility Site Reviews / Physical-Accessibility Reviews:

<http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDDualsPlanLetters.aspx>. By our estimates, California plans now have physical accessibility information, including information on accessible weight scales and tables, for approximately 30,000 provider offices. This is information, and a tested practice of gathering accurate information acquired by trained 3rd party surveyors, that can serve as a model for other states and for Medicare as they institute this quality measure.

However, as critical as accessible medical and diagnostic equipment is for people with disabilities, the common availability of such equipment will not, by itself, lead to "comprehensive care for patients with disabilities." The presence of the equipment requires accommodations relating to efficient and consistent scheduling practices and procedures that capture and meet the accommodation needs of individuals with disabilities. This leads us to the recommendation that this section needs to be strengthened through additional, clarifying language that specifically addresses the need for programmatic accessibility, modification of policies and procedures, and disability cultural competency, without which comprehensive care for people with disabilities will never be achieved. A quick glance at healthcare settlements entered by the Department of Justice and the Health and Human Services Office for Civil rights will reinforce how disability-specific prejudice and discrimination continue to exist in the healthcare context, whether out of maliciousness or ignorance.

Examples of programmatic modifications that may be needed by individuals with disabilities include:

- Extended appointment times for individuals with disabilities that affect the speed and clarity of their communication or who use communication devices;
- Coverage of anesthesia for dental services when necessary for an individual with a disability to access dental or other medical care;
- Assistance with dressing or undressing;
- Putting appointment systems into place that will ensure that accessible examination rooms and/or equipment are available for the use of those individuals with disabilities who need them and
- Modification of wait times, office hours, and other business practices that may not be accessible for individuals with disabilities.

DREDF has done extensive work in this area and further examples of programmatic access are available on our website at: <http://dredf.org/public-policy/health-access-to-care-old/defining-programmatic-access-to-healthcare-for-people-with-disabilities/> . Quality clinical improvement for people with disabilities must include measures that address programmatic access.

Finally, 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).

Meaningful Use of Certified EHR Technology Performance Category

In the past DREDF has, on its own and in concert with such umbrella groups as the Consumer Partnership for e-Health, called for EHR performance measures that prioritize fully accessible online and electronic access for persons with disabilities, in their capacity as *both* healthcare consumers and healthcare providers. We continue to call for such accessibility, and adherence with existing WCAG 2.0 standards, as a measure of provider performance in the CEHRT category.

With regard to the question of whether captured quality data should be capable of being transmitted, and not just captured or calculated, we think its transmission is ultimately important for purposes of monitoring and enforcement. Our experience at the state level in California is that information on the accessibility of provider offices is required to be maintained in Medi-Cal plan databases and purportedly used in online plan provider directories. The degree to which plan provider directories are actually updated with accessibility information varies widely among plans, and the state's monitoring or use of that information to direct improvement is very limited. If accessibility and other EP quality data were required to be securely transmittable from the beginning, it would help alleviate some of the technical barriers to Medicare monitoring of quality information.

Alternative Payment Models

We support the goal of moving health systems toward alternative payment models and new delivery systems that move away from fee-for-service, and prioritize value, quality and care coordination over volume to the potential benefit of people with disabilities. We also appreciate the need for APMs to be innovative and not-yet-defined. However, both the MIPS and APM are intended to include advancements in paying for quality and value. Those standards and requirements that are meant to ensure that health inequities and disparities are addressed under MIPS, as well as the encouragement of physical and programmatic accessibility, should not be foregone in the APMs. We recommend that CMS include the measures of accessibility, health equity, and social and community involvement in APMs.

Physician-focused Payment Model

We support the concept of increasing transparency in the PFPM process and the role that will be played by a PFPM Technical Advisory Committee. However we strongly recommend the embedded provision for technical assistance not only to small practices and practices in Health Professional Shortage Areas, but to the actual communities that experience health disparities and healthcare delivery inequities under present payment models. This is obviously a highly technical area, as evidenced by the fact that every current member of the PFPM Technical Advisory Committee appears to be a physician with experience in payment models and/or reimbursement methods. While we are not

seeking to diminish or replace provider-oriented technical assistance, providers themselves are clearly not the only stakeholders who have a vital interest in developing and disseminating appropriate PFPs that will reward provider behavior that engages with consumers, acknowledges consumer capacity and expertise in their own health needs, and recognizes and provides equally effective and 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 PFPs and should be incentivized through technical assistance criteria, as well as proposal selection criteria, that recognizes consumer participation. We also recommend the inclusion of direct consumer input on the PFP Technical Advisory Committee itself as it evaluates proposals and before it makes recommendations.

Thank you for the opportunity to comment on this important RFI. Please do not hesitate to contact me with any questions or concerns about the above.

Yours Truly,

A handwritten signature in cursive script, appearing to read "Silvia Yee".

Silvia Yee
Senior Staff Attorney