



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

June 27, 2016

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

Re: CMS-5517-P

Dear Mr. Slavitt,

Thank you for this opportunity to comment on the Notice of Proposed Rulemaking regarding the Merit-based Incentive Payment System and Alternative Payment Model under the Physician Fee Schedule. The Consortium for Citizens with Disabilities is a coalition of national disability organizations working together to advocate for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

Medicare covers large portions of the millions of people in the United States living with disabilities and chronic conditions, 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 and chronic conditions, we strongly support payments systems that prioritize access to care and improve the health and functional status of people with disabilities and chronic conditions. We are providing comments on the areas of the rule with particular impact on people disabilities.

Merit-Based Incentive Payment Systems

Clinical Practice Improvement Activities Performance Category

In response to the Request for Information on this topic, we strongly support the inclusion of Promoting Health Equity and Continuity as a subcategory of Clinical Practice Improvement, especially with the section on “maintaining adequate equipment and other accommodations (for example wheelchair access, accessible exam tables, lifts, scales, etc.) to provide comprehensive care for patients with disabilities.” We were very disappointed to see that this section, including accessibility, was not included in the NPRM and urge CMS to reinstate this section in the final rule.

Despite 26 years of implementation of the Americans with Disabilities Act (ADA), too many physician and other provider offices remain inaccessible to people with disabilities. We wish that maintaining accessible equipment was considered a current practice expectation, but real-world experience shows that this is simply not the case. The CMS Office of Minority Health has itself recognized inaccessibility of health care as a problem and included physical access as one of six major priorities to addressing health disparities in the [CMS Equity Plan for Improving Quality in Medicare](#).

Examples of activities that could show improvement over time and go beyond current practice expectations include:

- Adhering to the forthcoming standards of the U.S. Access Board for medical diagnostic equipment
- Replacing inaccessible equipment with accessible equipment
- Remodeling or redesigning an office to meet accessibility standards in areas other than medical diagnostic equipment
- Training staff on best practices in serving people with disabilities, including appropriate appointment lengths, person-centered care, disability etiquette, and
- Reducing wait times for patients with disabilities for whom long wait times are a barrier to care

If the subcategory of Promoting Health Equity is not included in the final rule, we believe that access for people with disabilities should be included in the statutorily defined subcategory of Expanded Practice Access.

Finally, we were pleased to see Achieving Health Equity included in the final rule, because it includes 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). We support including Achieving Health Equity in the final rule.

Patient Reported Outcomes

The CCD Task Force on Health joins many other consumer, participant, and patient organizations in supporting and recommending strengthening of CMS proposed “patient reported outcomes and patient experience” quality measures as a component of the MACRA proposed payment models. Such proposed measures, reports and experiences should result in better health outcomes, improved care coordination and improved patient experiences of care.¹ We provide the following recommendations:

Performance measures, measure categories, and measure reporting

¹ For brevity, we refer in various places in our comments to “patient” and “care,” given that the Quality Payment Program is rooted in the medical model. People with disabilities frequently refer to themselves as “consumers” or merely “persons.” Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider often intersect.

We applaud CMS for identifying and emphasizing the types of measures that offer the most value to consumers and purchasers: measures of outcomes, appropriate use, patient safety, efficiency, patient experience, and care coordination. However, we believe it is necessary to specifically call out and prioritize patient-reported outcomes (PROs) and PRO-based measures (PROMs). While outcomes are proposed as priority measures, this category typically refers to clinical outcomes rather than PROMs. PROMs and other measures using patient-generated data assess issues that are important to patients and are a key element of patient-centered care, enabling shared decision-making and care planning.

We recommend the following improvements to the proposed rule:

- *Patient-reported outcome measures (PROMs) should be given greater weight throughout the proposed rule.*
- *CMS should continue soliciting multi-stakeholder input on the available and required measures through the CMS funded National Quality Forum Measure Applications Partnership (MAP).*
- *CMS should update patient sampling requirements over time*

Patient experience measures

As noted above, we applaud CMS for emphasizing the importance of patient experience measures by including this category in the list of priority measures. Patient experience of care is a key tenet of a person-centered health care system and patient experience measures are critical for quality improvement, consumer choice, shared decision making, participant-directed services, and value-based purchasing. The CCD Task Force on Health joins other consumer advocates suggesting widespread use of CAHPS (Consumer Assessment of Healthcare Providers and Systems) tools for value-based purchasing programs. We strongly encourage CMS to require a CAHPS measure for all MIPS eligible clinicians in groups of two or more.

Reporting CAHPS at the individual clinician-level is expensive under the current model, but costs could be markedly reduced if electronic administration or a short-form survey were allowed.² We acknowledge the shortcomings of the CAHPS instruments and we support their evolution into tools that provide meaningful information to consumers. Such tools should be efficient to administer and offer providers real-time feedback for practice improvement.³

² The recent short form patient experience survey project conducted by Massachusetts Health Quality Partners and the California Healthcare Performance Information System offers evidence that both a short form version of the CAHPS survey and email-based administration provide comparable results to a long form version. More information about this project and its results can be found here: <http://www.mhqp.org/EmailLinks/Short%20Form%20PES-Research%20Findings.pdf>.

³ The National Institute for Disability, Independent Living, and Rehabilitation Research (NIDILRR) currently supports a research effort by the Westchester Institute for Human Development to adapt and test CAPHS survey instruments for persons with intellectual disabilities.

Finally, despite the need for improvements in existing patient experience measures, consumers urgently need this information and CMS should not delay requiring the collection and reporting of this information using currently available tools.

- *CMS should require clinicians in groups of two or more to report a standard patient experience measure.*
- *Short-form surveys, electronic administration, and alternate instruments can reduce the burden of surveying while improving utility to patients and clinicians.*

Annual Determination of Updated Quality Measures in MACRA

To maintain the emphasis on high priority measures, we recommend that CMS continue to use the CMS funded, NQF MAP pre-rulemaking process in determining the final list of quality measures each year. The MAP plays a critical role in ensuring that the voices of consumers, purchasers, and other stakeholders are heard.

We appreciate the opportunity to comment on this important rule. If you have any questions, please contact Rachel Patterson at rpatterson@christopherreeve.org or 202-715-1496.

Sincerely,

The CCD Health Task Force Co-chairs:

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