CENTER FOR CONSUMER ENGAGEMENT in health innovation
A better way to better health. For everyone.

October 7, 2016

**Submitted electronically to: MedicaidQualMeasures@mathematica-mpr.com**

Mathematica Policy Research
Medicaid Quality Measures Project Team

Re: Comment on Medicaid Quality Measures

Dear Project Team:

The Center for Consumer Engagement in Health Innovation at Community Catalyst appreciates the opportunity to provide comments on the Medicaid Quality Measures Project Team's measure specifications and justification for quality measures currently under development and testing.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation (Center) is a hub devoted to teaching, learning and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers.

We have been working to improve home and community-based services for consumers for the last five years, producing tools for consumer advocates and other stakeholders to use in seeking improvements, supporting the work of consumer advocates as they engage with individuals who are dually eligible for Medicare and Medicaid and/or who rely on long-term services and supports. Working to ensure care is person- and family-centered is at the core of what we do.

We recognize the critical role of quality measurement – for payers, providers and consumers alike – to identify high-quality care and for improving the quality of care. As the nation's health care system moves increasingly to one where payment is tied to value, the demands placed on quality measurement are ever increasing. The shift to value-based payment – with substantial incentives for providers to cut costs of care – asks much of quality measures. Quality measurement is the chief bulwark against stinting on necessary services and must ensure that payment models that incentivize lower cost have neutral or positive effects on the quality care. From this perspective, particularly in the realm of home and community-based services and substance use disorders, we are far from where we need to be. This is why the work of this project is so critical.

When taken as a whole, we are disappointed that the package of measures does little to address the serious gaps that have been identified in quality measurement, particularly for home and community-based services. We note that the recently finalized NQF report on quality measurement in home and community-based services identified 11 domains of quality and noted a marked maldistribution of available measures and measure concepts, such that several of these domains are underrepresented. We specifically note the domains of consumer leadership in systems development and equity as being important gaps, and are disappointed that none of these measures appear to address these gaps.

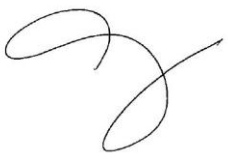
The measures under development also do not address the need for measures that reflect patient-reported outcomes or quality of life, and instead reflect a heavy reliance on administrative measures. For example, of the 8 measures under development for MLTSS, 4 are administrative measures relating to the documentation, updating and transmission of a care plan. At best, the administrative task of documenting, updating and transmitting care plans is only an intermediate step toward quality care, and these measures do not at all speak to whether the care plan met the members' needs, whether the care plan itself was ever carried out, and what the quality was of the services provided under the care plan. These measures seem more appropriate as contract requirements, not as measures of quality.

Of the entire slate of 17 measures presented for review (8 for MLTSS, 6 for Duals, and 3 for other categories), only 4 are patient-reported measures (and one of the 4 is a composite of the other 3). We do not see how this project, which is intended to fill critical gaps in measurement, will be successful at doing so if it continues the bias toward administrative and claims-based measures that do not capture the consumer voice.

We also note that the information provided does not address how these measures address disparities, including disparities related to race, ethnicity, gender, age, disability and sexual orientation. We would appreciate more information about how this could be addressed through stratification or other techniques.

Given the importance of quality measurement to the success of value-based payment, we hope that Medicaid will reconsider its selection of measures for this project. Our specific comments about each measure are below. Should you have any questions or wish to discuss these comments further, please do not hesitate to contact me at 617-275-2827 or ahwang@communitycatalyst.org.

Sincerely,



Ann Hwang, MD
Director, Center for Consumer Engagement in Health Innovation

| Measure Name | Comments |
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| **BCN-1-All-cause emergency department utilization rate for Medicaid beneficiaries with complex needs and high costs** | It is not clear to us that another measure of ED utilization is the most important priority for measure development. We also question whether the proposed denominator (including all Medicaid beneficiaries with complex needs and high costs) will be helpful, given the broad range of patient subpopulations included. |
| **SUD-5-Continuity of Care after detoxification for alcohol and/or drugs** | We recommend shortening the follow-up time to 7 days to align with American Society of Addiction Medicine Practice Improvement recommendations, and VA quality measures. Following detox, it is critical to have quick follow-up to engage people in treatment and services. Two weeks is too long. |
| **PMH-1-Follow-up care for adult Medicaid beneficiaries who are prescribed an antipsychotic medication** | Follow-up following prescription of antipsychotics is critical because of their potent impact and their significant side effects. However, since this is a claims-based measure, claims wouldn't show if the medications were even discussed during a follow-up visit or if the critical issues that need to be assessed are in fact assessed. We do not believe that this measure captures the most important aspects of this issue, which would be better reflected in outcomes or patient-reported outcomes measures. If the measure does move forward, we would suggest including in the denominator changes in antipsychotic medications as well as new prescriptions. Also, we suggest adding case managers to the list of people who could do follow-up visits. All visits should be done in person or by video conference, not through written communication or phone only. |

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| **Duals-1: Hospitalization for Ambulatory Care Sensitive Conditions** | If this measure is to move forward, it would be important to understand differences by race, ethnicity, gender, disability, homelessness, sexual orientation and geographic location. Separate risk adjustment models may be needed for older and younger duals. |
| **Duals-3-4-5: Patient-Reported Access to Services Composite** | For this measure and the measures that make up the composite measure, we appreciate the inclusion of these patient-reported measures. However, we believe it is important not just to ask about ease of access but about the quality/appropriateness of the services. This is missing from these measures. |
| **Duals-3: Access to Counseling or Treatment** | Same comment as above. We appreciate the inclusion of these patient-reported measures. The Measure Justification Form notes, "Research has found evidence of racial disparities in access and utilization of mental health services" and "...compared to whites, racial and ethnic minorities were less likely to receive needed care, more likely to receive poor-quality care and overall less access to mental health services." We would like to know how data from this measure will be reported in order to address these disparities. |
| **Duals-4: Access to Personal Aide Assistance** | See comments to composite measure. We appreciate the inclusion of these patient-reported measures. |

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| **Duals-5: Access to Medical Equipment** | See comments to composite measure. We appreciate the inclusion of these patient-reported measures. We appreciate that the measure includes whether it was "easy to get or replace the medical equipment **needed** in the last six months"; we would add that timeliness is also an important consideration. |
| **HCBS-1: Admission to an institution from the community among Medicaid fee-for-service (FFS) home and community-based service (HCBS) users** | We are concerned about the definition of short stays as 100 days or less, because it becomes increasingly difficult for people to return to the community after even 30 days. This timeframe should be much shorter. |
| **MLTSS-1: Comprehensive LTSS Assessment and Update** | We are concerned about the undue focus (4 of 8 measures) on administrative measures. Measuring whether a care plan was documented misses the mark in terms of whether the care plan meets the consumer's needs or even whether the care plan was acted upon. If this measure does move forward, we further note that the required elements of the assessment should be revised. For example, "Mental and behavioral health" is missing any mention of substance use disorders. Instead, these are included under "risks" with falls, which is not an appropriate way to categorize these diseases. Moreover, the proposed category of "preferences" doesn't include anything about preferences for setting in which the consumer lives, for work, educational or community engagement opportunities, or for providers. Nowhere in the survey categories is there anything explicit about quality of life. |
| **MLTSS-2: Comprehensive LTSS Care Plan and Update** | See above comments. In addition, the timeframe of 120 days from enrollment is too long. |

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| **MLTSS-3: LTSS Shared Care Plan** | See above comments. This measure assesses whether providers were given the plan. At a minimum, we should be measuring whether the person got the services in their care plan. We rank this measure very low in terms of "importance." This seems more appropriate as a contractual requirement rather than as a measure of quality. |
| **MLTSS-4: Re-assessment and Care Plan Update After Discharge** | See above comments. |
| **MLTSS-5: Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls** | We note that with this measure, CMS is developing yet another administrative measure. |
| **MLTSS-6: Admission to an institution from the community among MLTSS beneficiaries** | We are concerned about the definition of short stays as 100 days or less, because it becomes increasingly difficult for people to return to the community after even 30 days. This timeframe should be much shorter. |
| **MLTSS-7: Successful transition after short-term institutional stay among Managed Long Term Services and Support (MLTSS) enrollees** | We are concerned about the definition of short stays as 100 days or less, and believe this time frame should be shorter. In addition, we are concerned that 30 days in the community is too short to measure "successful discharge to the community" and this threshold is not justified in the presented materials. This measure could potentially have value if the timeframe for community dwelling was extended for 6 months and paired with a quality of life measure in determining success. Results need to be stratified between the ID/DD population and the aging and physical disability population because there has been much more progress toward HCBS for people with ID/DD than there has for people who are aging or have other disabilities. It would also be good to separate out people with a primary mental health or SUD diagnosis. |

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| **MLTSS-8: Successful transition after long-term institutional stay among Managed Long Term Services and Support (MLTSS) enrollees** | See comments to MLTSS-7. |