COMMUNITY CATALYST

ONE FEDERAL STREET, BOSTON, MA 02110
MAIN: 617.338.6035
FAX: 617.451.5838
www.communitycatalyst.org

December 21, 2015

Tim Engelhardt
Director, Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 315H-01
200 Independence Ave, SW
Washington, D.C. 20201

Submitted via e-mail to: MMCOcapsmodel@cms.hhs.gov

Re: Medicare-Medicaid Plan Quality Ratings Strategy

Dear Mr. Engelhardt:

Community Catalyst respectfully submits the following comments to the Medicare-Medicaid Plan (MMP) Quality Ratings Strategy.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society. We have been working to improve Medicaid and Medicare for consumers for more than a decade, producing tools for consumer advocates to use in state-based advocacy as well as tools for use by other stakeholders.

We support the overall framework and especially appreciate the emphasis CMS has placed on two domains: (1) Community Integration/Long-Term Services and Supports (LTSS) and (2) Management of Chronic Conditions/Health Outcomes. We also are encouraged to see the importance placed on patient-centered care and outcome measures. We urge CMS to consider the following as it considers its long-term quality rating strategy:

- The importance of consumer engagement in the MMPs. Consumers should be viewed as vital contributors in plan decision-making processes and valued participants in a feedback loop in which their input reaches the leadership of the MMP.
- A focus on consumer quality of life, including enrollees' ability to maintain independence and meaningfully participate in work, relationships and community activities, if desired, as well as live in their preferred setting.

- We recommend that the Member Experience domain be more heavily weighted, and include qualitative as well as quantitative information.
- We appreciate the specific attention to mental health and substance use disorders, and we specifically recommend naming those conditions, rather than using the ill-defined term of “behavioral health.”
- To address health disparities, we recommend that, where possible, data be collected and disaggregated by sociodemographic factors such as age, race, ethnicity, primary language, gender identity and sexual orientation and disability status.
- We support the use of measures related to hospitalization for potentially preventable complications and preventable readmissions. We believe that reducing these preventable events is what underpins the theory of how MMPs are supposed to improve care and reduce costs.
- We recommend the quality strategy account for factors related to patients' unique health, social risks and socioeconomic status and examine strategies that address the non-medical factors and social determinants that contribute to health and wellbeing.
- While CMS’ strategy document focuses on rating, we believe that CMS should give equal consideration to how these quality ratings will be presented to and understood by consumers. CMS should engage consumers in the design of its rating strategy, ensure that rating information is presented in a way that is understandable to consumers, and make rating information available to consumers in multiple languages.

We recognize and applaud the thoughtful work that CMS is doing to move the system in the right direction. In that spirit, we submit the following expanded comments that will further strengthen the system for consumers. Our comments focus on the following domains: (1) Community Integration/LTSS (2) Management of Chronic Conditions/Health Outcomes (3) Member Experiences with Health Plans and Care Providers. We also offer comments on the section Interim Quality and Performance Information on MMPs.

Community Integration/LTSS

Consumer Quality of Life

We believe that the core measures in this domain must focus on the key outcome of consumer quality of life, including enrollees’ ability to maintain independence and meaningfully participate in work, relationships and community activities, if desired, as well as live in their preferred setting. We recommend use of consumer surveys to gather this information:

- **The HCBS Experience Survey.** This survey is in the final stages of testing and endorsement and can be used to collect a broad range of important outcome data about consumer quality of life, including community inclusion and engagement, work, and control over all aspects of their daily lives.
- **The National Core Indicators – Aging and Disability survey** focuses on quality of life and outcomes even more than the HCBS survey. While also still in testing, it is already being used by 14 states. Questions that may be particularly important for assessing impact of LTSS are those that ask:
    - Are you as independent as you would like to be?
    - Do you feel in control of your life?

  - Are you doing things inside and outside the home when you want to?
  - Do you like how you spend time during the day?
  - Are you able to see friends and family?
  - Do you need more/different services to live in your choice of setting?

Rebalancing the Focus from Institutions to Community Living

In addition to nursing facility utilization, we recommend consideration of the following additional measures of rebalancing, which are already in use in specific states:[1]

- The percent of enrollees receiving services in the community before receiving services in an institution
- The percent of enrollees who transitioned from an institution to the community and did not return to the institution within a year
- Total number of nursing home certifiable members who did not reside in a nursing home for more than 100 continuous days during the previous reporting period
- HCBS expenditures and institutional LTSS expenditures as a percent of all LTSS expenditures

We also recommend using these outcome measures, many of which are also included in the two surveys highlighted above or used by states:

- Improving health
- Improving mental health
- Improvement/stability in Activities of Daily Living between assessments
- Reduced use of the emergency room
- Reduced hospitalization and nursing home use
- Percent of members with unmet HCBS needs

As CMS notes, outcomes measures are not yet well developed for LTSS, so it is also important to use **process measures**. We recommend consideration of the following process measures, many of which are in use in states already.

- The degree to which services are person-centered**.** Both the HCBS Experience Survey and the NCI-AD survey can provide information on this, including whether the care plan includes all of the services that are important to the consumer and whether the consumer has control over care planning and delivery.
- Timely development of the care plan; how quickly LTSS are started following care assessment and planning; degree to which the care plan reflects personal goals and preferences; the degree to which the care plan is fully implemented

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[1] *Is it Working? Recommendations for Measuring Rebalancing in Dual Eligible Demonstrations and MLTSS Waivers.* January 2014 (available at http://dualsdemoadvocacy.org/wp-content/uploads/2014/01/Rebalancing-in-MLTSS-and-Dual-Eligible-Demo_01.13.14.pdf); The Commonwealth Fund, *Assessing Care for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative*. March 2014 (available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/mar/1724_zainulbhai_care_integration_dual_eligibles_ib.pdf).

- Care coordination as measured by the percent of members with LTSS needs who have someone with expertise in LTSS and independent living on their care team; the percent of consumers who report being able to connect with their care manager whenever they need help
- Rates of problems reported to state oversight council, ombudsmen or other external sources; and number and types of consumer complaints, grievances and appeals
- Increase or decrease in the authorization of personal care hours, or reduction or denial of other LTSS
- Percent of members receiving HCBS who were offered the option to self-direct, and percent of those offered who do self-direct
- Turnover rate and retention rate for direct care workers, as well as the percent of direct care workers who receive training
- The percent of unpaid caregivers whose needs are assessed, and who are offered respite care

Management of Chronic Conditions

We are pleased to see that CMS proposes that this domain count for one quarter of the overall MMP star ratings. It is encouraging to see the recognition by CMS of the burden of chronic conditions among Medicare-Medicaid enrollees and the importance of robust outcomes measures in the rating system.

We agree with CMS' proposal to employ outcome measures related to hospitalization for potentially preventable complications and hospital readmissions. We also recommend the following:

- tracking of avoidable nursing facility stays
- use of Patient Reported Outcomes (PROs) – including physical function and social function
- tracking whether plans have developed and are implementing processes to reduce health disparities across race, ethnicity or type of disability
- tracking whether plans are complying fully with the Americans with Disability Act and the Mental Health Parity and Addiction Equity Act

Care Coordination and Care Transitions

Measures should assess how well MMPs are coordinating care for enrollees, such as through:

- Timely health risk assessments and understanding enrollees' physical, behavioral and functional health needs
- Recording beneficiary goals, needs and preferences in terms of who may participate on the care team, language and cultural preferences
- Engagement of primary care provider in the care team
- Safe and effective care transitions, including:
    - inclusion of care coordinator and/or family caregiver
    - clearly-explained transition instructions in the language preferred by beneficiary
    - transition plans communicated effectively and promptly to members of care team

Diversity of the Care Management Team

We urge CMS to include in the rating system the use of diverse community-based providers that understand the needs of the population being served, such as community health workers (CHWs). CHWs can play an important role in connecting with communities of color and they often can relate to those in their communities on a more personal level and help facilitate coordinated health care services.[2] Having a CHW as a member of the care team can better help coordinate care and manage chronic conditions, which can lead to improved health outcomes and reduce health disparities. CMS should consider tracking the inclusion of CHWs in the care team.[3] There is ample evidence that CHWs are effective in (1) assisting people to access and navigate the health care system and better manage their health conditions, (2) coordinating services for people with multiple chronic conditions, and (3) leading community-wide efforts to identify and address underlying causes of poor health.[4]

Empowering Beneficiaries

We urge CMS to assess MMPs on the strategies they have used to empower beneficiaries in their own care. Empowering beneficiaries is essential to any successful strategy to improve care for those with chronic conditions. Patients and family members must be seen as key members of the care team, not as passive recipients of care. Implementing programs to improve activation among patients with multiple chronic conditions, i.e., providing beneficiaries with the skills and confidence to become actively engaged in their own health care, promises to be a relatively low-cost, but high-impact, way to address chronic disease treatment. We suggest tracking MMPs' use of the following:

- patient activation or patient confidence tools[5] [6] [7]
- chronic disease self-management programs
- shared decisionmaking tools

Health Disparities and Chronic Conditions

Any quality rating strategy must include provisions that address and mitigate the disparities that are prevalent among racial, ethnic, geographic and socio-economic minorities.[8] There are

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[2] Community Catalyst, *Trusted Voices: The Role of Community Health Workers in Health System Transformation*. December 2015 (available at http://www.communitycatalyst.org/resources/publications/document/Community-Catalyst-CHW-Issue-Brief-1.pdf).

[3] Ibid

[4] NYS Health Foundation, *A Critical Link for Improving Health Outcomes and Promoting Cost-effective Care in the Era of Health Reform.* October 2010 (available at http://nyshealthfoundation.org/uploads/resources/community-health-workers-critical-link-october-2010.pdf).

[5] Greene J., et al., *When Patient Activation Levels Change, Health Outcomes And Costs Change, Too,* Health Affairs (March 2015, Vol. 34, No.3).

[6] Donald, M., et al., *The role of patient activation in frequent attendance at primary care: a population-based study of people with chronic disease.* Patient Educ Couns. 2011 May;83(2):217-21.

[7] Sage Publications, *Examining the Role of Patient Experience Surveys in Measuring Health Care Quality*, (available at http://mcr.sagepub.com/content/early/2014/07/11/1077558714541480).

[8] Community Catalyst, *Demographic Health Disparities and Health System Transformation:*

significant racial, ethnic and geographic disparities in the prevalence of chronic diseases. Blacks and Latinos have the highest prevalence of six or more chronic conditions,[9] and disparities in quality of care and health outcomes remain compelling and persistent for people in low-income households, including people of color. Indeed, some disparities related to chronic disease have continued to grow over time.[10]

When aiming to address chronic conditions among Medicare-Medicaid enrollees, we recommend consideration of the following:

- *Data collection and reporting* should include data stratified by sociodemographic factors such as age, race, ethnicity, primary language, gender identity and sexual orientation and disability status. Stratified data collection and reporting are steps toward assessing our progress toward reducing health disparities. CMS should consider implementation of the metrics endorsed by the National Quality Forum (NQF) to assess cultural competency and language services,[11] as a step toward mitigating provider biases, poor patient-provider communication, and poor health literacy.
- The use of tools to assess, manage and reduce implicit biases among health care providers and *measure improved provider-patient communication*.[12] While race and ethnicity are two areas in which providers sometimes demonstrate implicit bias, a number of studies examining clinical decision-making suggest that implicit bias manifests in other areas, including gender and age. Further research is needed to identify effective strategies for mitigating implicit bias among health care providers. However, an important first step is to equip health care providers with tools such as the Implicit Association Tests (IATs)[13] to assess and manage their own biases.[14] We suggest that CMS require that MMPs report the use of implicit bias trainings with staff and providers. CMS should also measure the extent to which the MMP's provider network (as well as its overall workforce) is *culturally and linguistically appropriate* for the population being served.

Drivers and Solutions. November 2015 (available at http://www.communitycatalyst.org/resources/publications/document/Policy-Brief-Demographic-Health-Disparities-Final.pdf).

[9] Centers for Medicare and Medicaid Services, *Chronic Conditions among Medicare Beneficiaries, Chart Book 2012 Edition* (available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf).

[10] Agency for Healthcare Research and Quality, *2014 National Healthcare Quality and Disparities Report: Chartbook on Care Coordination*. May 2015 (available at http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2014chartbooks/carecoordination/2014nhqdr-care.pdf).

[11] National Quality Forum, *Healthcare Disparities and Cultural Competency Consensus Standards.* August 2012 (available at http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx).

[12] Institute of Medicine, *What Healthcare Consumers Need to Know About Racial and Ethnic Disparities in Healthcare*. March 2002 (available at https://www.iom.edu/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/PatientversionFINAL.pdf).

[13] The Implicit Association Test is a computerized measurement tool designed to measure the strength of automatic associations people have in their minds. This test has been used to measure implicit bias in physicians. See https://implicit.harvard.edu/implicit/iatdetails.html.

[14] US National Library of Medicine National Institutes of Health. *Physician and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*. November 2013 (available at http://www.ncbi.nlm.nih.gov/pubmed/23576243).

Substance Use Disorders and Mental Illness

We support the use of outcome measures where possible, including the "improving or maintaining mental health" question from the Medicare Health Outcomes Survey, as CMS suggests. We also recommend using specific questions from the Experience of Care and Health Outcomes (ECHO) consumer survey on mental illness and substance use disorders including rating of ability to deal with daily problems, social situations and to accomplish goals; and the supplemental ECHO question that asks consumers to assess their recovery.

We also recommend consideration of the following outcomes:

- percent of enrollees with a substance use disorder diagnosis who are hospitalized for all causes
- percent of enrollees with a substance use disorder diagnosis who used the emergency room for all causes
- percent of enrollees with a substance use disorder diagnosis who remained drug/alcohol free for one year or reduced their substance use to less problematic levels
- percent of enrollees with a substance use disorder diagnosis who experienced improvements in other health problems
- percent of enrollees who experienced reduced encounters with the criminal justice system
- percent of enrollees who moved from unstable to stable housing situations

We also support CMS' recommendation to incorporate existing or developing process measures for treatment of mental illness and substance use disorders. We support the three measures CMS recommended – follow-up after hospitalization for mental illness, antidepressant medication management, and transmitting care transition records following inpatient discharge. We also recommend including initiation and engagement of alcohol and other drug dependence treatment, which is another core measure in the Financial Alignment Demonstrations.

Additionally, we support efforts to increase screening and brief intervention for substance use disorders. Measures such as these NQF-endorsed measures should be considered:

- percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method and who received brief counseling if identified as an unhealthy alcohol user
- percentage of patients age 18 and older with serious mental illness who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as having unhealthy alcohol use
- percentage of patients ages 18 and older who were discharged from the emergency department for mental health or alcohol or other drug dependence and who had a follow-up visit within seven days after discharge with a professional credentialed to treat mental health or addiction disorders
- hospitalized patients 18 years of age and older who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use and who were offered or provided a brief intervention
- percentage of patients age 18 and older who were screened at least once during the past 24 months for tobacco use, unhealthy alcohol use, non-medical prescription drug use, and

illicit drug use; and who received an intervention for all positive screening results (measure under review)

In addition, we recommend measuring care coordination by the percent of enrollees with substance use disorders and mental illness who have a member of the care team with expertise in these conditions.

Member Experiences with Health Plans and Care Providers

We are pleased to see member experience included as one of the key domains of the proposed star rating system, given the impact member experience of care, which includes the quality of care and member satisfaction, has on overall health outcomes. CAHPS surveys provide useful, albeit limited, information about patient satisfaction. We believe, however, much more can be done to better understand the experiences of all members, especially those from populations that experience disproportionally poor health outcomes.

The value of CAHPS is particularly limited for MMP members with special needs, such as those with cognitive impairments, mental health issues, and substance use disorders. Similar barriers exist for members with other literacy, cultural or linguistic needs. We urge CMS to consider augmenting CAHPS or using alternatives for more accurately capturing member experience that can be conducted in a way that takes these potential barriers into account. For example, CMS could:

- collect elicited patient narratives which more broadly describe encounters with clinicians in patients' own words[15]
- use patient-reported outcomes (PROs) that ask patients about the difference the care they received made in their lives[16]
- employ patient empowerment and activation measures; patient engagement, including patient activation and patient confidence, is increasingly recognized as an important strategy for achieving better health outcomes and care experiences[17]

We recommend that CMS also prioritize the collection of data on consumer engagement at the plan and provider level (advisory boards/governing boards) as part of its quality strategy. The data collected should provide consumers, advocates and other stakeholders with information about how the consumer advisory boards and recruitment of consumers to serve on governance boards are implemented and monitored. It should also collect data on the outcomes of this type

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[15] See, e.g., Schlesinger, M. et al., *Taking Patients' Narratives about Clinicians from Anecdote to Science*, N Engl J Med 2015; 373:675-679. August 13, 2015 (available at http://www.nejm.org/doi/full/10.1056/NEJMsb1502361); Agency for Healthcare Research and Quality, *Webcast: Public Reporting of Patients' Comments with Quality Measures: How Can We Make It Work?* June 3, 2014 (available at https://cahps.ahrq.gov/news-and-events/events/20140603_QI/webcast_06_03_14_qi.html#anchor2).

[16] See, e.g., Hopkins, D. and Huff, J., *Action Brief: Patient Reported Outcomes*, July 2015 (available at http://www.consumerpurchaser.org/files/CPA_Patient-ReportedOutcomesBrief_05.pdf).

[17] See, e.g., Hibbard, J. and Greene, J., *What The Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences; Fewer Data On Costs*, Health Aff February 2013 vol. 32 no. 2 207-214 (available at http://content.healthaffairs.org/content/32/2/207.abstract); Wasson, J. and Coleman, E., *Health Confidence: A Simple, Essential Measure for Patient Engagement and Better Practice,* Fam Pract Manag. 2014 Sep-Oct;21(5):8-12 (available at http://www.aafp.org/fpm/2014/0900/p8.html#).

of engagement such as service change patterns and new initiatives resulting from consumer input, and improved communication and educational materials for consumers based on feedback from consumers.

Goal Driven Measures

Goal-driven measures focus on a patient's individual health goals within or across a variety of dimensions (e.g., symptoms; physical functional status, including mobility; and social and role functions) and determine how well these goals are being met.[18] A goal-driven approach has many advantages:

- It frames the patient-provider discussion in terms of individually desired rather than universally applied health states.
- It simplifies decision-making for patients with multiple conditions by focusing on outcomes that span conditions and aligns treatments toward common goals
- It prompts patients to prioritize which health states are important to them, thus allowing them to be in control when treatment options require trade-offs
- It allows for effective shared decision-making between patient and provider about which treatment strategies will meet the patient’s goals.[19]

While goal-driven measures are under development, we recommend CMS consider collecting data from MMPs about goal-setting. For instance, it could measure whether a provider has had a discussion with a patient about – and documented – his/her goals of care. This conversation could happen as part of a comprehensive risk assessment, the development of an individualized care plan, or during routine patient care.

Finally, measures in the Member Experience domain should be stratified based on socio-demographic information, when collected and reported, to assess the quality of member experiences and potential interventions for diverse populations served by MMPs.

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[18] See, e.g., Reuben, D and Tinetti, M., *Goal-Oriented Patient Care — An Alternative Health Outcomes Paradigm*, N Engl J Med 2012; 366:777-779. March 1, 2012 (available at http://www.nejm.org/doi/full/10.1056/NEJMp1113631); *New Project Seeks to Align Primary and Specialty Care for Older Adults with Complex Chronic Conditions*, May 2014 (available at http://www.pcori.org/news-release/new-project-seeks-align-primary-and-specialty-care-older-adults-complex-chronic); *Quality Measurement to Assess the Performance of Goal Setting and Achievement in the Delivery of Medical and Long-Term Care*, 2015 (available at http://www.jhartfound.org/grants-strategy/ncqa-person-centered-goals).

[19] Reuben & Tinetti.

Interim Quality and Performance Information on MMPs

We concur that CMS should not award star measures to MMPs during the demonstration. However, we urge CMS to post data for all state-specific Financial Alignment Demonstration measures as well as on CMS core measures and Medicare Part C and D measures.

We believe this Quality Rating Strategy presents an important opportunity to design a consumer-centered quality framework. We appreciate this opportunity to comment, and we welcome the opportunity to provide additional input on these issues. Please contact Renée Markus Hodin rmhodin@communitycatalyst.org with any questions. As always, thank you for your time and attention to these issues.

Respectfully submitted,

Robert Restuccia

Robert Restuccia
Executive Director