



July 1, 2016

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 Rating and Performance Data Strategy Update

Dear Mr. Engelhardt:

Community Catalyst respectfully submits the following comments to the Medicare-Medicaid Plan (MMP) Quality Rating and Performance Data Strategy Update.

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 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, particularly those who are most vulnerable. 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 appreciate the thoughtful responses CMS has provided to stakeholder comments. We especially appreciate CMS recognizing the importance of accounting for enrollees' socioeconomic or disability status when developing plan ratings. We are encouraged to see CMS' commitment to ensuring beneficiary-reported outcomes and experiences as part of the MMP quality rating strategy and look forward to seeing the details of this work in the future. While we recognize that using encounter and administrative data can decrease provider burden, we would like to stress that not all of the measures that are meaningful are reflected in administrative data and that capturing the patients' perspectives on their care experience will be essential. We recognize and applaud the thoughtful work that CMS is doing to move the system in the right direction. We urge CMS to consider our comments on the quality rating strategy

from last November and would like to stress the following as CMS continues its work on MMP quality ratings long-term strategy.

Consumer Engagement

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. We recommend that CMS 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 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.

Consumer Quality of Life/Community Inclusion

We emphasize the importance of assessing 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, and in particular suggest the following potential sources for measures:

- **The HCBS Experience Survey.** This survey is in the final stages of 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 13 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?
- **The Money Follows the Person (MFP) Quality of Life Survey.** This survey was designed specifically to assess outcomes across multiple Quality of Life domains for individuals receiving HCBS, beyond just outcomes related to physical well-being. Developed and implemented as part of the national MFP Demonstration, this survey was designed to measure quality of life in seven domains: living situation, choice and control,

access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction, and health status. It is administered in 44 states.

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.

¹ *Is it Working? Recommendations for Measuring Rebalancing in Dual Eligible Demonstrations and MLTSS Waivers*. January 2014. http://dualsdemoadvocacy.org/wp-content/uploads/2014/01/Rebalancing-in-MLTSS-and-Dual-Eligible-Demo_01.13.14.pdf. Accessed on June 30, 2016. The Commonwealth Fund, *Assessing Care for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative*. March 2014. http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/mar/1724_zainulbhai_care_integration_dual_eligibles_ib.pdf. Accessed on June 30, 2016.

- 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.
- 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.

Addressing 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. Furthermore, we suggest:

- Implementing metrics endorsed by the National Quality Forum (NQF) to assess cultural competency and language services,² as a step toward mitigating provider biases, poor patient-provider communication, and poor health literacy.
- Assessing the extent to which beneficiary goals, needs and preferences are recorded and followed in regards to who may participate on the care team, language and cultural preferences.
- Tracking the use of diverse community-based providers that understand and are able to meet the needs of the population being served, including, where appropriate, the use of community health workers (CHWs).
- Capturing the use of tools to assess, manage and reduce implicit biases among health care providers and measure improved provider-patient communication.³ A potential first step could be providing health care providers with tools such as the Implicit Association Tests

² National Quality Forum, *Healthcare Disparities and Cultural Competency Consensus Standards*. August 2012. http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx. Accessed on June 30, 2016.

³ Institute of Medicine, *What Healthcare Consumers Need to Know About Racial and Ethnic Disparities in Healthcare*. March 2002. <https://www.iom.edu/~media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/PatientversionFINAL.pdf>. Accessed on June 30, 2016.

(IATs)⁴ to assess and manage their own biases,⁵ as well as reporting 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.

Member Experiences with Health Plans and Care Providers

We were pleased to see member experience included as one of the key domains of the proposed star rating system last November. However, in this updated strategy, we do not see additional details on this domain. The 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 disproportionately 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.⁶
- use patient-reported outcomes (PROs) that ask patients about the difference the care they received made in their lives.⁷
- 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.⁸

⁴ 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.

<https://implicit.harvard.edu/implicit/iatdetails.html>. Accessed on June 30, 2016.

⁵ US National Library of Medicine National Institutes of Health. *Physician and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*. November 2013. <http://www.ncbi.nlm.nih.gov/pubmed/23576243>. Accessed on June 30, 2016.

⁶ 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. <http://www.nejm.org/doi/full/10.1056/NEJMs1502361>. Accessed on June 30, 2016. Agency for Healthcare Research and Quality, *Webcast: Public Reporting of Patients' Comments with Quality Measures: How Can We Make It Work?* June 3, 2014. https://cahps.ahrq.gov/news-and-events/events/20140603_QI/webcast_06_03_14_qi.html#anchor2. Accessed on June 30, 2016.

⁷ See, e.g., Hopkins, D. and Huff, J., *Action Brief: Patient Reported Outcomes*, July 2015. http://www.consumerpurchaser.org/files/CPA_Patient-ReportedOutcomesBrief_05.pdf. Accessed on June 30, 2016.

⁸ 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. <http://content.healthaffairs.org/content/32/2/207.abstract>. Accessed on June 30, 2016; 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. <http://www.aafp.org/fpm/2014/0900/p8.html#>. Accessed on June 30, 2016.

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.⁹ 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.¹⁰

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.

Proposed Posting of MMP Performance Measures

We are pleased to see that CMS will post all measures used for Medicare Part C and Part D as well as five of the CMS core MMP reporting measures. While this is a step in the right direction, we note that the proposed measures are largely clinically focused and in our above comments we emphasize the importance of outcome measures that can truly capture beneficiary experience of care. We also urge CMS to consider posting all of the core measures to gain a full picture of the quality of care received by consumers in the MMPs. Furthermore, we strongly urge CMS to share with the stakeholder community how these quality ratings will be presented to, and understood by, consumers besides being posted on the CMS website. 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.

⁹ 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. <http://www.nejm.org/doi/full/10.1056/NEJMp1113631>. Accessed on June 30, 2016; *New Project Seeks to Align Primary and Specialty Care for Older Adults with Complex Chronic Conditions*, May 2014. <http://www.pcori.org/news-release/new-project-seeks-align-primary-and-specialty-care-older-adults-complex-chronic>. Accessed on June 30, 2016; *Quality Measurement to Assess the Performance of Goal Setting and Achievement in the Delivery of Medical and Long-Term Care*, 2015. <http://www.jhartfound.org/grants-strategy/ncqa-person-centered-goals>. Accessed on June 30, 2016.

¹⁰ Reuben & Tinetti.

We believe this Quality Rating Strategy Update presents an important opportunity to design a consumer-centered quality framework for the Medicare-Medicaid population – one that will inform the care of populations with complex care needs. We appreciate this opportunity to comment, and we welcome the opportunity to provide additional input on these issues in the future.

Please do not hesitate to contact me at ahwang@communitycatalyst.org with any questions. As always, thank you for your time and attention to these issues.

Respectfully submitted,

A handwritten signature in black ink, consisting of a large, stylized 'A' followed by a horizontal line that curves upwards and then downwards, ending in a small hook.

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