JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

December 21, 2015

Tim Engelhardt, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare-Medicaid Plan Quality Ratings Strategy

Dear Director Engelhardt,

Justice in Aging appreciates the opportunity to comment on the Medicare-Medicaid Plan Quality Ratings Strategy.

Justice in Aging, formerly the National Senior Citizens Law Center, uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicaid and Medicare, with a focus on long-term services and supports and the particular needs of those dually eligible for Medicare and Medicaid coverage.

We support and appreciate the Centers for Medicare and Medicaid Services (CMS) and the Medicare-Medicaid Coordination Office (MMCO) efforts to develop a Quality Ratings Strategy for Medicare-Medicaid Plans (MMPs). This is the first effort at the federal level to develop a comprehensive rating system that incorporates managed long-term services and supports (LTSS) and we are hopeful it will serve as a model for future quality endeavors. All consumers should have access to quality information before enrolling in a health care plan and the Quality Ratings Strategy is an important step in cultivating and sharing medical, administrative, and LTSS quality information.

We support the strong focus on evaluating MMP efforts to enhance community integration and advance access to LTSS. As a central goal of the Financial Alignment Initiative (FAI) is shifting LTSS delivery away from an institutional setting and into the home and community, we commend MMCO for prioritizing LTSS and community integration in the draft strategy.

We remain concerned that rating and quality data are not yet available to the over 370,000 dual eligible individuals enrolled in MMPs and the millions of individuals who have been subject to the passive enrollment process. Demonstration participants cannot be expected to make informed decisions regarding enrollment or continuity in health care plans without any information on the quality of care delivered. The lack of publicly available quality information

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on MMPs, and the inability of consumers to compare MMPs,[1] underscores our position that CMS should not allow MMPs to conduct any aggressive enrollment actions.

Our detailed comments below follow the order of the draft document:

Overview:
We appreciate CMS' effort to develop a star ratings system for MMPs. During the design of the FAI, our organization, in collaboration with many national aging and disability organizations, requested that CMS develop rebalancing measures to be incorporated into the MMP's star ratings.[2] We are pleased CMS is sharing their vision in the Quality Ratings Strategy (QRS) for both an MMP Star Rating System and an Interim Quality Reporting Plan.

Domains:
The proposed weight, one-quarter, given to the Community Integration/LTSS domain demonstrates CMS values this as a core component of the MMP's care delivery goals. We agree with proposed one-quarter weight for Community Integration/LTSS.

Community Integration/LTSS:
The four measures outlined in the QRS draft should be included in the final star rating system. In addition to these measure. We recommend adding the following existing measures to the Interim Quality Reporting Plan and eventually using them in the Star Rating System:

- Total HCBS and institutional expenditures as a percentage of total LTSS[3]
- Number and percent of MMP participants whose record contains documentation indicating a choice of community-based services versus institutional care[4]
- Percent of waiver individuals who experienced a decrease/increase in the authorization of personal care hours[5]

This domain should also evaluate access to self-direction. There is growing concern that managed care is creating barriers to self-direction. Concrete data will help CMS and stakeholders understand managed care's impact on self-direction. Several states are already utilizing self-direction measures, including:

- Percent of care coordinators that have undergone state-based training for supporting self-direction under the demonstration[6]

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[1] Medicare.gov's "Search Plan by Name" currently states "Not Enough Data Available" when searching all Medicare-Medicaid Plans by Plan ID.
[2] *Is it Working? Rebalancing Measures in Dual Eligible Demonstrations and MLTSS Waivers,* available at: http://dualsdemoadvocacy.org/wp-content/uploads/2014/01/Rebalancing-in-MLTSS-and-Dual-Eligible-Demo_01.13.14.pdf.
[3] See KanCare Program, Medicaid State Quality Strategy, pg. 112, available at: http://www.kancare.ks.gov/download/Attachment_J_State_Quality_Strategy.pdf (September 2014).
[4] KanCare Quality Strategy, pg. 47.
[5] See Virginia Memorandum of Understanding, pg. 95, available at: https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/vamou.pdf.
[6] See South Carolina Memorandum of Understanding, pg. 117, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SCMOU.pdf (October 2013).

- Percent of participants directing their own service through the consumer-directed personal assistance option at the plan each demonstration year.[7]

One promise of the demonstration was plan flexibility to provide supplemental benefits. These additional flexible benefits were to be included in the individual's care plan to address the dual eligible individual's need and help the individual remain at home and in the community. We are concerned that few MMPs are using their flexibility under the FAI's capitation model to offer enhanced flexible benefits. These concerns may be inaccurate, but advocates lack any information on supplemental benefit delivery. The Community Integration/LTSS domain should include reporting on MMP supplemental benefits delivery and access to services.

We understand gaps exist for tested, endorsed and outcome-oriented LTSS and care coordination measures and we appreciate the multiple entities working to develop consensus-based measures in this field. In the gap explanation, CMS notes the agency is working to test a set of measure for managed long-term services and supports programs (pg. 4). These tested measures, along with the state-specific Reporting Requirements and the Core Quality Withhold Measures, provide a measure foundation that CMS should utilize and share. This information platform exists and should be shared without further delay.

Additional Domains: *Management of Chronic Conditions/Health Outcomes; Prevention: Screenings, Tests, and Vaccines; Safety of Care Provided; Member Experience with Medicare-Medicaid Plan and Service Providers; Plan Performance on Administrative Measures*

Management of Chronic Conditions
We agree with the measurement vision of this domain. In particular, we strongly support the HOS measurement of improving or maintaining mental health, under the Management of Chronic Conditions domain.

The measures related to hospitalization and rehospitalization should recognize that many hospitalized patients are called outpatients, even though they may occupy a bed for multiple nights, receiving care and services that are identical to the care and services received by patients who are classified as inpatients. Ignoring outpatient status or observation status for hospitalization voids the validity of hospitalization/rehospitalization measures.[8]

Safety of Care Provided
This domain should include a measure of nurse staffing levels, particularly registered nurse staffing levels, in nursing facilities. In 2014 the HHS Inspector General released a report finding failure by skilled nursing facility (SNF) staff to monitor residents or a delay in providing

[7] See New York Memorandum of Understanding, pg. 106, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMOU.pdf (August 26, 2013).
[8] See the Center for Medicare Advocacy's analysis on hospitalized Medicare patients in observation status, available at: http://www.medicareadvocacy.org/?s=observation+status&op.x=0&op.y=0.

necessary care was a key cause of adverse events or other harm to Medicare beneficiaries.[9] CMS is now in the process of developing a payroll-based system, as required by the Affordable Care Act, to replace the self-reported staffing information that nursing facilities provide at the time of the annual survey. A valid nurse staffing measure would give the public important information about the quality of care provided by a nursing facility.

Member Experience with Medicare-Medicaid Plan
The QRS draft indicates the Member Experience domain will be comprised of measures based on CAPHS surveys. This raises concerns as the CAPHS health plan survey is limited to seven domains[10] that omit several essential elements of MMP plan delivery: person centered care planning, access to services without discrimination, and LTSS care coordination.

We recommend the inclusion of person-centered planning measures under the Member Experience with MMPs and Service Providers domain. While person-centered planning is almost universally understood as a necessary component of an effective LTSS delivery system, we are concerned that at the MMP and service provider level there is a lack of clarity about how to effectively deliver person-centered planning services. When CMS promulgated the home and community-based services (HCBS) Medicaid rules in 2014, the agency took a significant step by developing the framework to define the right to person-centered planning. The next step is evaluating whether or not MMPs and service providers are implementing the framework in a manner that benefits LTSS consumers.

We join our colleagues in recommending that CMS look at the HCBS Experience Survey and the National Core Indicators Aging and Disability (NCI-AD) for a number of questions that could be used to determine access to person-centered planning. These questions could be added to the CAHPS member experience survey. For example, the *Choosing Your Services* domain of the HCBS Experience Survey includes questions such as:

- Did you work with someone to develop your service plan?
- Does your service plan include things that are important to you?
- Do your feel your staff know what's on your service plan, including what is important to you?
- Who would you talk to if you wanted to change your service plan?

We are also concerned about the lack of measures relating to nondiscrimination protections in health care programs. The current CAHPS Survey lacks any measures to help CMS understand plan compliance with the ACA's 1557 nondiscrimination protection. At a minimum, the survey should query the individual on MMP and/or provider discrimination on the basis of race, color national origin, sex, disability or age. To help CMS and consumers understand the MMP's compliance with 1557 protections, the questions should explore:

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[9] Inspector General, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, OEI-06-11-00370, page 28 (Feb. 2014, http://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf.
[10] Medicare Advantage and Prescription Drug Plan CAHPS Survey, About the Survey, available at: http://ma-pdpcahps.org/content/homepage.aspx.

- potential MMP and provider communication barriers for people who are limited English proficient;
- potential MMP and provider access and care challenges on the basis of sex, sexual orientation and /or gender identity; and
- potential MMP and provider access and care challenges to people with a disability.

These proposed nondiscrimination survey questions should be a part of CMS' 1557 monitoring and enforcement efforts.[11]

Finally, the CAHPS care coordination questions are limited to questions about whether or not the individual's *doctor* assisted with managing different providers and services.[12] In the MMP, all individuals should have access to a specific care coordinator and the plan should evaluate quality of the care coordinator. The NCI-AD offers a model for questions about the individual's care coordinator that can be incorporated into the CAHPS survey questions. The Member Experience domain should explore the individual's access to a care coordinator through questions like:[13]

- Do you have a care coordinator?
- Can you reach your care coordinator when you need to?
- Has your care coordinator talked to you about services that might help with your needs?

Plan Performance on Administrative Measures

We strongly endorse the focus on timeliness and accuracy of LTSS appeals under the Plan Performance for Administrative Measures domain. In the current Medicare Part C & D Star Rating framework, Part C Domain 5, "Plan Makes Timely Decisions about Appeals," and "Reviewing Appeals Decisions" is a particularly helpful factor for counselors assisting consumers in selecting a plan. Appeals of service denials have long been a primary challenge for Medicare beneficiaries, with 38% of the calls received by the national Medicare Rights Center's helpline relating to private Medicare Advantage and Part D service plan denials.[14] Failure to timely and appropriately handle appeals also has been a recurrent theme in CMS audit findings for Medicare Part C and Part D plans.[15] As CMS develops the Administrative Measures domain, we strongly urge the agency to measure MMP performance at all levels of appeal and ensure this MMP-level data is available to the public.

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[11] For recommendations on 1557 monitoring and enforcement, see Justice in Aging Comments on Nondiscrimination in Health Programs and Activities Proposed Regulation, pg. 18, (November 9, 2015), available at: http://www.justiceinaging.org/wp-content/uploads/2015/11/Justice-in-Aging-Nondiscrimination-Comments.pdf.

[12] See pg. 6, Medicare Advantage and Prescription Drug Plan (MA & PDP) CAHPS Survey, available at: http://ma-pdpcahps.org/Documents/2016_Medicare_Advantage_(MA_only)_%20English_Mail_%20Survey.pdf.

[13] Questions adopted from the NCI-AD Consumer Survey, Pilot Results (January 2015), available at: http://www.nasuad.org/sites/nasuad/files/NCI-AD%2520Final%2520Pilot%2520Results.compressed.pdf.

[14] Medicare Trends and Recommendations: An Analysis of 2013 Call Data from the Medicare Rights Center's National Helpline (March 2015), available at: http://www.medicarerights.org/pdf/2013-helpline-trends-report.pdf.

[15] See Part C and D Enforcement Actions at https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html.

Interim Quality and Performance Information on MMPs:
We appreciate the proposal to post quality information starting in 2016. As the first demonstration launched in 2013, it is critical that CMS post interim quality information without further delay. For dual eligible individuals making enrollment decisions, and for advocates and counselors trying to advise on Medicare Advantage and MMP options, it is unproductive and risky to make decisions without any MMP quality information.[16]

We agree that the combination of existing Part C and D measures, along with the core MMP reporting requirements offer a primary baseline for CMS data reporting. In addition to these data sets, each state's specific Quality Withhold Measures and Reporting Requirements should be shared on the CMS website as part of the Interim Quality Performance Information. After several years of implementation and data cultivation, it is reasonable to expect that CMS share this information publicly. We understand that because state specific measures are different in the different states, there are challenges to comparing quality *across* the states. However, as all MMPs in each state must adhere to the same Reporting Requirements, Quality Withhold Measures, and core requirements, it makes sense to share the information for MMP comparisons *within* the state.

We look forward to the publication of the Interim Quality and Performance Information in 2016 and hope that CMS will promptly make a robust collection of data publicly available.

Thank you for the opportunity to reflect on the proposed Quality Rating Strategy. We appreciate CMS' efforts in strengthening the delivery system for dual eligible individuals. Please let us know if we can be of further assistance in this development by contacting Fay Gordon (FGordon@justiceinaging.org) or Georgia Burke (GBurke@justiceinaging.org).

Sincerely,

Kevin Prindiville
Executive Director

[16] There is currently no federal, publicly reported quality information on any of the MMPs. Medicare.Gov's PlanFinder currently states "Not Enough Data Available" when searching all Medicare-Medicaid Plans by Plan ID.