JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

October 7, 2016

Mathematica Policy Research
Medicaid Quality Measures Project Team
Sent electronically via email to: MedicaidQualMeasures@Mathematica-mpr.com

Re: Quality Measures-MLTSS, HCBS

Justice in Aging appreciates the opportunity to comment as part of the project on Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. **Our comments address the MLTSS and HCBS components of the proposed measures**.

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. Justice in Aging 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 Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

I. General comments on measure design

We believe that the areas of highest priority for measures development are HCBS measures and LTSS measures for managed care and that those measures must specifically address (1) rebalancing, (2) community integration and (3) quality of life. They also must be designed to capture how health disparities are addressed. Further, in the context of the financial alignment dual eligible demonstration project, we have in the past expressed concern about the lack of quality information on the delivery of long-term services and supports (LTSS) in the MMP Quality Ratings Strategy.[1] Uniform measures looking at Medicaid managed care also have been missing and we applaud the steps being taken to develop such measures.

CMS recently released final regulations on Medicaid Managed Care, which require states for the first time to include quality measures on rebalancing, community integration, and quality of life. These rules further require identifying health disparities based on disability status and publicly available External Quality Review reports. This creates greater urgency to invest in measure development and guidance on a menu of measures that could assist states, health plans, and advocates to implement these requirements.

The September 2016 National Quality Forum Final report on Measuring HCBS Quality identified 11 domains, with multiple subdomains, of potential quality measurement for HCBS, many of which lack fully developed quality measures. Community integration is clearly encompassed in the community inclusion and choice and control domains. While quality of life is not identified as a specific NQF domain or sub-domain, we believe it crosses several domains and is best assessed via the perspectives and

[1] See Comments of Justice in Aging on Medicare-Medicaid Plan Quality Ratings (Dec. 21, 2015), available at. http://www.justiceinaging.org/wp-content/uploads/2015/12/Justice-in-Aging_Medicare-Medicaid-Plan-Quality-Ratings-Strategy-12-21.pdf

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

experiences of consumers. This consumer perspective is notably missing from the most of current proposed measures for this project.

Given this context, we believe that the proposed measures for this project, though a good beginning, do not fully address MLTSS and HCBS issues and these measures are insufficient to fully capture quality of MLTSS or HCBS. We encourage the Project Team to develop broader measures that more fully encompass the consumer experience. Further, as currently designed, the measures do not appear to address disparities, including disparities related to race, ethnicity, gender, age, disability, and sexual orientation. We urge that steps be taken so that, through stratification or other techniques, the domain of equity and the identification of disparities can be captured in the measures.

Our specific comments on the measures for Medicaid enrollees in managed long-term services and supports (MLTSS) and the Medicaid HCBS measures are set forth below.

II. MLTSS Measures

Prioritization: In our view the most important measures among those proposed are those that track the ability of plan members to live safely in the least restrictive setting in the community.[2] Thus we believe that Measures # 6, Admission to an Institution from the Community, Measure # 7, Successful Discharge to the Community after Short-Term Institution Stay, and Measure # 8, Successful Discharge to the Community after Long-Term Institution Stay should be prioritized. Within these measures, we recommend stratifying the measures for persons with ID/DD and older adults and persons with physical disabilities, due to the uneven progress toward rebalancing among these different populations. Further, as already noted above, all measures should be designed so that other disparities can be identified.

Need for Additional Measures: We believe however that these measures alone are inadequate to address these important area. One measure that would be particularly helpful is total HCBS and institutional expenditures as a percentage of total LTSS expenditures, a measure that is used in the Kansas MLTSS program.[3] This is a measure that could be applied both to managed care and to fee-for-service Medicaid for dual eligibles. Another measure that would provide important data would be the increase or decrease in the authorization of personal care hours. Increasing hours for individuals can be an effective way to avoid institutionalization and achieve rebalancing. Decreasing hours, in contrast, could conflict with rebalancing goals and increase the chance of institutionalization and hospitalization. One such measure is being piloted in the Virginia Memorandum of Understanding for its dual eligible demonstration.[4][5]

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[2] For a more extensive discussion of the importance of rebalancing measures, see the policy brief prepared by Justice and Aging and others: "Is It Working? Recommendations for Measuring Rebalancing in Dual Eligible Demonstrations and MLTSS Waivers," (Rebalancing Recommendations") available at http://dualsdemoadvocacy.org/wp-content/uploads/2014/01/Rebalancing-in-MLTSS-and-Dual-Eligible-Demo_01.13.14.pdf.

[3] Kansas, Medicaid State Quality Strategy, June 2013, p. 111, p. 81, available at http://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/KS%20KanCare%20Quality%20Strategy%202014.pdf

[4] Virginia MOU, p. 95. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/VAMOU.pdf

[5] For a further discussion of these measures see Rebalancing Recommendations, supra, note 3.

Specific concerns re Measure # 8: We also have specific concerns about Measure # 8. In that measure, the numerator treats return to community residence for 30 or more days as a successful transition from an institutional stay to the community. Transitions from institutions to the community, particularly after long-term stays, are complex. We are concerned that 30 days is not long enough to judge whether a transition has been successful and whether the community supports put in place are adequate to give the individual continuing supports. We urge adopting a longer timeframe. Note, for example, that the measure adopted in the Memorandum of Understanding for the Ohio dual eligible demonstration suggests measuring this transition over a plan year.[6]

Assessment Measures: Assessments and care plans are central components to MLTSS and addressing their quality and effectiveness is an important priority. Nevertheless, we are concerned that the current proposals focus primarily on the administrative measures of whether assessments were completed on time and whether care plans were created on schedule and shared. Timeliness of assessments and care plans should certainly be tracked and plans should be held accountable if they fail to meet required timetables. These measures, however, do not address the quality of the assessments, the content of the care plans, or the extent to which the care plans were implemented. We note particularly Measure # 3, which addresses the percentage of plan enrollees whose care plan was transmitted to key LTSS providers and the primary care provider within 30 days of development or update. While it is certainly important that care plans be shared with all relevant providers, such sharing requires nothing more than an email. Moreover, the measure allows plans 30 days in which to transmit the information. We see this element of the care plan process as a simple contractual obligation where universal compliance should be required, and not as a quality measure on which plans should be graded on a scale. Similarly Measures # 1 and # 2 merely track compliance with contractual obligations rather than quality or outcomes. For these reasons, we have concerns that measures related to beneficiary participation in a care plan and to whether services authorized in a care plan were actually delivered also need to be included.

Pairing: We appreciate the pairing of Measure # 6 with the HCBS measure, Admission to an institution from the community among Medicaid fee-for-service (FFS) home and community-based service (HCBS) users. It is very important that, as quality measures for LTSS and HCBS are developed, they be designed in a way that facilitates comparisons between managed care and fee-for-service, as well as providing comparisons among managed care plans.

III. HCBS Measures

Defining HCBS use: In response to the question of how HCBS use for FFS beneficiaries should be defined, we suggest the definition be broader rather than narrower in order to capture which HCBS services are effective in helping individuals remain living in the community.

Survey population: We were somewhat confused about the population to be included in the duals HCBS measures. The questions on HCBS-1 asked for comments on the FFS population to be included, but the discussion of the composite Patient Access to Services measure, spoke of whether "plans" delivered particular services. Since state designs for delivery of HCBS can take many forms (entirely through

[6] Ohio MOU, p. 89. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OHMOU.pdf

MLTSS, entirely FFS, carve-outs of some services and not others, etc.), it is particularly important that these measures can compare delivery in all types of delivery systems—MLTSS, FFS and hybrid. We ask that for clarification that this will be the case.

Transition from short-term institutional stays: We also believe an HCBS measure should be added measuring successful transitions after short-term institutional stays. This measure for HCBS users would mirror the MLTSS measure. Likewise, HCBS measures should apply to Medicaid FFS as well as Medicaid Managed Care beneficiaries.

Patient Reported Access to Services: As an initial matter, we question whether "patient" is the appropriate term for consumers of HCBS. The term medicalizes community supports and downplays the important concept of consumer direction. Substantively, we have concerns that the measures, though assessing consumer ease of access, do not address the quality or adequacy of the services received. For example, the measure for Access to Personal Aide Assistance does not capture whether the beneficiary's personal aide provided the hours approved in the care plan or whether the services were performed satisfactorily. Fuller consumer experience measures combined with reporting on hours provided and other objective data need to be part of an assessment of quality. The HCBS Consumer Experience Survey and the National Core Indicators Aging and Disability Survey could be sources of such data.

Justice in Aging recognizes the importance of developing quality measurements to improve the care and services provided to Medicare and Medicaid beneficiaries, and we appreciate the commitment of CMS to addressing quality measures for MLTSS and HCBS. Thank you again for the opportunity to comment. If you need additional information, please do not hesitate to contact me at JGoldberg@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Directing Attorney
Justice in Aging