ACAP
Association for Community Affiliated Plans

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John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

December 21, 2015

Tim Engelhardt
Director, Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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

Re: Proposed Medicare-Medicaid Plan Quality Ratings Strategy

Dear Mr. Engelhardt:

The Association for Community Affiliated Plans (ACAP) greatly appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to CMS' Proposed Medicare-Medicaid Plan Quality Ratings Strategy.

ACAP is an association of 60 not-for-profit, community-based Safety Net Health Plans located in 24 states. Our member plans provide coverage to over 15 million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare. Nineteen of our plans are Dual-Eligible Special Needs Plans (D-SNPs), fourteen of our plans are managed long-term care plans, and fifteen of our plans are Medicare-Medicaid Plans (MMPs) in the Financial Alignment Demonstration. Collectively, ACAP's MMPs account for close to 30 percent of all enrollment in the Financial Alignment Demonstration.

To date, the Financial Alignment Demonstration has incentivized health plans to develop innovative methods for care delivery and helped hundreds of thousands of beneficiaries in over a dozen states receive better coordinated care. The Demonstration has also reinforced the need for CMS to examine the quality metrics that underpin how plans are evaluated and rewarded for performance. ACAP supports measuring the quality of care furnished by MMPs as this information can be helpful to consumers. It is important that CMS develop interim and long-term quality rating systems for MMPs that use valid and stable quality measures that accurately measure the quality of care of each state's Demonstration. ACAP offers the following comments in an effort to further this goal of accurate quality of care measurement for MMPs.

In reviewing CMS' proposal, ACAP developed the following, overarching comments on both the proposed interim strategy and the longer-term Star Rating system strategy. The positions summarized below are explained in greater detail later in the letter.

- CMS' interim and long-term quality strategies should use measures that are appropriate to the dual-eligible beneficiaries enrolled in each state program. MMPs should be compared only to other plans in their state. CMS should not compare the quality of MMPs across states because the Demonstrations differ in which benefits are included (e.g. behavioral health for individuals with severe mental health issues is carved out in California), which populations are eligible for enrollment, and additional requirements placed on MMPs (e.g., MMPs in Ohio must contract with Area Agencies on Aging for care management).

- CMS should properly test and evaluate the reliability of individual measures before they are applied to an MMP quality rating system (both the interim reporting strategy and the Star Rating strategy). Some of the measures included in CMS' quality ratings strategy are new, have not yet been tested in MMPs, or are currently being tested. CMS should integrate the testing of measures into its timeline before results are reported on the CMS website and before they are tied to MMP payment. CMS should build into its quality strategy time to test data collection and reporting, the appropriateness and reliability of the measures and their definitions, and the accuracy of comparing MMPs within a state to each other on the selected measures.

- CMS should rely on administrative data in forming its quality rating methodology. The unique characteristics of dual-eligible beneficiaries, along with legitimate concerns about survey fatigue, suggest that administrative data will produce a more accurate reflection of a plan's quality.

- Where possible, CMS should display comparable data for Medicare or Medicaid Fee-For-Service (FFS) on the CMS webpage. This will particularly help beneficiaries who are choosing between MMPs and FFS.

Expanded Comments

ACAP's comments are expanded below, with additional background.

Overarching Comments on Interim Quality Strategy and Star Rating System

Given the unique needs of dual-eligible beneficiaries, ACAP supports the use of tested quality measures that are appropriate to this population and that account for how state Demonstration designs may impact plans' ability to provide and coordinate care. Certain measures, while useful for evaluating plans that enroll a broader array of beneficiaries, are less useful when evaluating Demonstration plans. Further, some measures may not be stable over the first few years of the Demonstration due to large or rapid changes in enrollment, or due to changes in the design of the Demonstration. **ACAP urges CMS to test measures and evaluate their reliability before tying them to payments and publicly reporting them. ACAP further urges CMS to be cognizant of how enrolled populations may affect quality measures, particularly where MMPs disproportionately enroll a subset of dual-eligible beneficiaries that may be less likely to perform well on a particular measure, or for whom a particular measure is inappropriate.**

CMS is proposing a set of standardized measures to evaluate MMPs. However, CMS' MMP quality strategies must take into account the ways in which states' existing regulations, MMP requirements, and target enrollment populations impact MMPs' ability to provide care. For example, in terms of benefit structure, California's three-way contract designates behavioral health for individuals with severe mental health issues as a carved out benefit while Massachusetts' contract does not. Financial alignment Demonstration states also differ in their rules governing care coordination, such as Ohio's requirement that MMPs must contract with Area Agencies on Aging (AAA). In terms of enrolled populations, follow-up care is particularly challenging to provide for homeless or transient populations, a group that may be disproportionality enrolled in some state Demonstrations. As a result, MMP quality of care cannot be accurately compared across states. **CMS should promote an even playing field by comparing plan quality exclusively between MMPs within a state.**

For Medicare FFS and in states that still utilize Medicaid FFS, ACAP urges CMS to display comparable FFS quality data on its website. This is a consumer issue: Dual-eligible beneficiaries are given the option of opting out of the Demonstration and staying in Medicare FFS and they should be provided the resources and information necessary to make an informed choice about their care.

CMS' proposal features a combination of plan administrative data and enrollee survey responses. While capturing member experience is important, survey data has many

limitations, and as such, may not accurately reflect enrollees' quality of care. For example, MMPs enroll many individuals with behavioral health conditions, cognitive impairment, and language barriers, all of which may make survey results less reliable. Plans also report that survey fatigue, which can lead to small sample sizes, skewed results and frustrated beneficiaries, is a serious issue for many dual-eligible beneficiaries. Moreover, plans report that some of their dual-eligible enrollees have cell phone data plans with limited minutes available; reliance on survey data raises the trade-off of enrollees using their minutes for care management versus responding to surveys. **Due to the unique characteristics of the dual-eligible beneficiaries and the desire to avoid survey fatigue, ACAP urges CMS to base MMP Star Ratings on administrative data.**

Interim Quality and Performance Information on MMPs

CMS is in the process of constructing its MMP Star Rating system and has not yet decided which measures will be publicly reported for 2016. **ACAP encourages CMS to seek public comment on selected quality measures before it publishes the measure results on its website.**

Given the numerous challenges that arose in the Financial Alignment Demonstration's first year in some states – difficulty in finding beneficiaries, cultivating provider buy-in and educating stakeholders about the new program —measures from the first year of the Demonstration are likely unreliable and not reflective of the true quality of care that beneficiaries are receiving. Moreover, due to the staggered implementation of the Demonstration in different states, 2016 will serve as the first Demonstration year in Rhode Island and the second, third, or fourth year in other states. **CMS should only publish quality measures for plans in their third Demonstration year to ensure consumers do not receive a distorted picture of plan quality.**

With respect to comments on specific measures, as part of its interim proposal, CMS suggested posting data on the Medicare-Medicaid Coordination Office (MMCO) website to compare how plans performed on the eight measures currently used in the 2015 core reporting requirements for all MMPs. One of these measures, "Screening for Clinical Depression and Follow-up," is still in testing phase, and several ACAP plans are participating in a learning collaborative with NCQA focused on this measure. This measure relies on a new method of data collection that utilizes electronic clinical data systems. This measure is not ready for 2016 because it is still under testing and development. Finally, any measures of mental health or substance abuse should be tailored to account for how behavioral health services are organized and delivered in states, such as behavioral health services for severely mentally ill individuals carved out of the Demonstration in California.

ACAP Comments on Proposed Domains for Future MMP Star Rating System

ACAP reiterates the importance of using measures that have been tested for MMPs to evaluate their quality of care, rather than simply applying quality metrics that have been used in other settings. As CMS knows well from its research into HCC risk adjustment, dual-eligible beneficiaries have distinct disease profiles and needs from other beneficiary groups. CMS should keep those differences in mind as it crafts a Star Ratings system.

Community Integration/LTSS
As CMS acknowledges, "[t]his domain is lacking in valid, endorsed outcome measures at present." CMS goes on to list a series of measures that may hold promise in accurately capturing plan quality metrics. Though the measures align with ACAP MMPs' goals, we have concerns about three measures that have not yet been adequately tested in MMPs: "Admission to an Institution (NF or ICF/IID) from the community," "Short Stay NF or ICF/IID Discharge to the Community" and "Long Stay NF or ICF/IID to the Community." ACAP urges CMS to carefully evaluate these measures before implementing them in a quality rating methodology. More broadly, ACAP encourages CMS to consider adjusting measures for enrollees' acuity. Doing so would help ensure that plans are not unfairly penalized. For instance, a plan especially adept at moving enrollees from the institution to the community will likely be left with a nursing home population that is sicker, frailer and at higher risk of falling. Moreover, states determine eligibility for long-term care services and the acuity of those eligible for institutional long-term care may differ across states. Without adjustment for acuity, results on the "fall with injury" measure may be biased unfairly against this plan.

CMS was particularly interested in hearing feedback about the Home and Community Based Services Experience Survey and outcome measures that are used by states for quality assurance like the National Core Indicators – Aging and Disability Tool. As previously stated, ACAP believes that using measures derived from survey response data is a flawed approach for evaluating plans that enroll dual-eligible beneficiaries. The prevalence of language barriers, cognitive impairments, and poverty amongst dual-eligible beneficiaries lead to unreliable data.

CMS requested comments on "care coordinator-to-member ratios." MMP care coordinator-to-member ratios depend on the acuity of patients and the appropriate ratio differs across MMPs and states depending on the individuals enrolled in a given MMP. In addition, this is an area where plans are innovating and experimenting. As such, a set ratio would be too rigid and likely inaccurate for the individuals enrolled in certain MMPs. **ACAP opposes the use of care coordination-to-member ratios**.

Management of Chronic Conditions/Health Outcomes
We reiterate our concerns about reliance on survey data for quality measures for dual-

eligible beneficiaries. Survey fatigue is a real concern among dual eligibles and language barriers, cognitive impairments, and challenges due to poverty (e.g., not having enough minutes on a phone to complete a survey) make survey results unreliable. Moreover, challenges with follow-up care for transient populations – whom may be disproportionately enrolled in some MMPs – is another reason why it is important to only compare quality of care for MMPs within the same state, rather than across states.

Prevention: Screenings, Tests, and Vaccines
Cervical cancer screenings may not be appropriate for subgroups of MMP enrollees. While CMS can set inclusion and exclusion criteria for measures, CMS should strongly consider the possibility of small sample size errors that may emerge as a result of this measure being included.

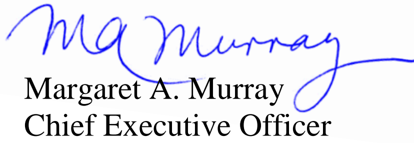
Safety of Care Provided
ACAP requests greater clarity on CMS' proposal to use MDS measures for the safety of care provided in LTC settings. The Long-Term Care Minimum Data Set is complex and current language is unclear as to whether CMS or MMPs, themselves, will be calculating these measures. We also note that MDS focuses on the institutionalized population but fails to measure quality among the community well population. Finally, given that resistance has been high among certain long-term providers, we urge CMS to delay inclusion of such measures until the Demonstrations have had time to mature.

Member Experience with MMPs and Service Providers
ACAP reiterates its concern with the use of survey measures for evaluating the quality of MMPs. Some CAHPS and HOS survey metrics may result in lower scores for plans that serve members with cognitive impairments or advanced stages of illness — especially on questions which rely upon patient recall rather than clinical data. In addition, CAHPS is available only in Spanish and English; D-SNP plans enroll a large number of duals who do not speak either language and are unable to complete the survey. Finally, CAHPS includes a downward case-mix adjustment to the raw satisfaction scores of all duals. However, it is quite possible that duals are enrolled in plans with better customer service and care management approaches that deserve the more positive response. CMS and AHRQ should look more closely at the appropriateness of that case-mix adjustment. Further, low response rates due to fatigue and other factors reduce the reliability of responses.

Plan Performance on Administrative Measures
ACAP notes that LTSS appeals and grievances processes are not integrated in every state's Demonstration. In some states, the appeals and grievances are still processed through pre-existing state systems. This should be taken into account as CMS evaluates measures related to LTSS appeals.

ACAP is prepared to assist with additional information, if needed. If you have any additional questions, please do not hesitate to contact Christine Aguiar at (202) 204-7519 or caguiar@communityplans.net.

Sincerely,



Margaret A. Murray
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