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VIA ELECTRONIC SUBMISSION
MMCOcapsmodel@cms.hhs.gov

Tim Engelhardt, Director
Medicare-Medicaid Coordination Office (MMCO)
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare-Medicaid Plan Quality Ratings Strategy

The Medicare Rights Center (Medicare Rights) is pleased to submit comments on the interim Medicare-Medicaid Plan Quality Rating Strategy. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over two million Medicare beneficiaries, family caregivers, and professionals.

The following comments are informed by our experience working with dually eligible beneficiaries and their families, and particularly by our work in New York State, where we work closely with the Department of Health on the implementation the Fully Integrated Dual Advantage (FIDA) program through our leadership on the Coalition to Protect the Rights of New York's Dually Eligible (CPRNYDE).[1] For additional information, please contact Casey Schwarz, Senior Counsel for Education and Federal Policy, at CSchwarz@medicarerights.org or 212-204-6271 and Stacy Sanders, Federal Policy Director at SSanders@medicarerights.org or 202-637-0961.

Thank you for the opportunity to comment on the proposed Medicare-Medicaid Quality Ratings System. We support the overall framework, goals, and vision for the Medicare-Medicaid Plan rating system "at maturity."[2] Below we express our broad support for this initiative and the high standards outlined in the proposal as well as our specific concerns and questions regarding the details of implementation.

I. Specific Domains

a. Community Integration/LTSS

The domain "Community Integration/LTSS" is critically important and we appreciate the weight that CMS proposes to give to measures in this domain. As measures are developed, we encourage CMS to incorporate a range that reflects the varying needs of dually eligible individuals, harmonizing the goal of rebalancing care with the goal

[1] For more information on CPRNYDE, visit: www.nyduals.org
[2] As described on pages 1-2 of the Medicare-Medicaid Plan Quality Ratings Strategy

of ensuring that nursing home care is high quality. Rebalancing the long-term care system to reduce its exclusive reliance on nursing homes is an important goal that both expands beneficiaries' options and is strongly favored by many older adults and people with disabilities. Nevertheless, some dually eligible beneficiaries must receive their care in nursing homes, or choose to, and the quality of that care must be evaluated.

In addition, we encourage CMS to refrain from using Medicare-Medicaid Plan (MMP) star ratings to penalize plans that provide necessary nursing facility care. New York utilizes a state-specific measure in FIDA that reports the number of enrollees who did not reside in a nursing facility as a proportion of the total number of enrollees in a plan. This measure could be further strengthened if the denominator excluded any enrollees who needed to reside in a nursing facility and could not have safely remained in the community.

New York's Long Term Care Rebalancing for FIDA, in contrast, is a good example of how to truly capture rebalancing. This measure reports the number of enrollees who were discharged to a community setting from a nursing facility and did not return to the nursing facility during the measurement year as a proportion of the number of enrollees who resided in a nursing facility the previous year. This measure allows MMPs, states, and CMS to monitor the movement of enrollees from the nursing facilities into the community and provides a better picture of whether MMPs are successfully keeping people out of nursing facilities. We support CMS in identifying measures that reach this large and growing population of dually eligible beneficiaries.

We recognize that community integration and LTSS measures have lagged behind acute care measures, and we appreciate CMS' efforts to identify measures and criteria that are sufficiently developed and reliable to offer meaningful information in the context of the MMP quality measure scheme. It is important that these measures reflect the goals of home and community-based service provision because, as noted above, the majority of older adults and people with disabilities prefer to remain in their homes.

We encourage CMS to look to the National Quality Forum's (NQF) Workgroup on HCBS Outcome Measures to develop the definition, framework, and sub-domains that can guide the development of quality rating measures within this complicated domain. We also urge CMS to look to many state-specific measures and systems that have been developed in states moving to MLTSS that could be adopted, tested, and implemented on a broader scale if found to be reliable and useful.

b. Management of Chronic Conditions/Health Outcomes

We agree with the measurement vision of this domain. In particular, we strongly support the inclusion of the measurement of improving or maintaining mental health, under the "Management of Chronic Conditions" domain. Additionally, we agree with CMS that process measures should be employed in the absence of valid outcome measures for conditions prevalent among Medicare-Medicaid enrollees. However, this is only a first step, and we encourage CMS to work with NQF to identify and develop outcome measures for these conditions and for the treatment of mental illness and substance abuse.

We also note that this domain includes two measures related to hospitalization and re-hospitalization. In developing and incorporating these measures, we encourage CMS to include hospitalized patients who stay overnight, whether they are called outpatients or inpatients for Medicare billing purposes.

c. Prevention: Screenings, Tests, and Vaccines

We recommend that this domain be expanded to consider measures of broader applicability, such as falls, heart disease, flu vaccines, and screenings for cancers in addition to cervical cancer. Inclusion of seasonal influenza vaccine and pneumococcoal vaccine, in addition to, or instead of pneumonia vaccine may be more appropriate and generally applicable to the dually eligible population.

We also recommend adding measures on falls prevention, like those included in New York State's FIDA program. MMCO might want to consider a measure that was recommended by the NQF MAP Dual Eligible Beneficiary Workgroup in its February 2014 report (NQF Endorsed Measure Number 101).[3] This is a process measure that assesses the following three areas: (1) Screening for Future Fall Risk; (2) Multifactorial Risk Assessment for Falls; and (3) Plan of Care to Prevent Future Falls. While this measure has been primarily used for individuals aged 65 and older, the NQF Duals Workgroup suggested that this measure be expanded and tested for anyone at risk for falls, including younger individuals with disabilities.

We support measures on pressure ulcers (rate and prevention). While these measures have been used in home health and nursing home settings, they are also relevant to acute and post-acute settings. While a case can be made for inclusion in the area of LTSS quality, they may conceptually fit better in the category of "Health Outcomes."

d. Member Experience with Medicare-Medicaid Plan

The draft MMP star rating system indicates the "Member Experience" domain will be comprised of measures based on CAPHS surveys. While we appreciate the attention and focus on beneficiary experience, we are concerned that the CAPHS health plan survey is limited to seven domains and omits several essential elements of MMP delivery: person-centered care planning, access to services without discrimination, and LTSS care coordination.[4]

In particular, we encourage CMS to expand the measures relating to nondiscrimination protections in health care access. We support the development of CAPHS survey questions that query the individual on MMP and/or provider discrimination on the basis of race, color, national origin, sex, disability, or age. We also encourage CMS to continue to emphasize the importance of cultural competency in care, and to incorporate measures to evaluate culturally competent care practices and outcomes.

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.[5] In MMPs, individuals should have access to a specific care coordinator and the plan should evaluate the quality of that care coordinator. As such, we suggest that the "Member Experience" domain explore an individual's access to a care coordinator.

e. Plan Performance on Administrative Measures

We strongly support the development of measures related to the timeliness and accuracy of appeals and the appropriate handling of complaints, including quality of care and adequacy of care complaints. Appeals of service denials have long been a primary challenge for Medicare beneficiaries, with 38 percent of the calls received by the

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[3] National Quality Forum (NQF), "2014 Interim Report from the MAP Dual Eligible Beneficiaries Workgroup," (February 2014), available at: https://www.qualityforum.org/Publications/2014/02/2014_Interim_Report_from_the_MAP_Dual_Eligible_Beneficiaries_Workgroup.aspx

[4] Medicare Advantage and Prescription Drug Plan CAHPS Survey, "About the Survey," (2015) available at: http://ma-pdpcahps.org/content/homepage.aspx#AboutSurvey

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

Medicare Rights national helpline relating to Medicare Advantage (MA) and Part D service plan denials.[6] Failure to timely and appropriately handle appeals also has been a recurrent theme in CMS audit findings for MA and Part D plans.[7] As CMS develops the "Administrative Measures" domain, we urge the agency to measure MMP performance at all levels of appeal and ensure this MMP-level data is available to the public.

[6] Morales, S., Bennett, R., and S. Sanders, "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
[7] Centers for Medicare & Medicaid Services (CMS), "Part C and D Enforcement Actions" (2015), available at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html