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PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

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Via e-mail to info@CalDuals.org

Comments on Draft Quality Metrics

Dear Dr. Kohatsu and Dr. Kizer:

Thank you for the opportunity to comment on the draft document entitled "California Dual Demonstration DRAFT Quality Metrics (8/14/12)," which was discussed during the conference call of August 14 for the Quality and Evaluation workgroup. We have actively participated in the workgroup and are keenly aware of the importance of quality of care to the dual eligible population.

The Current Draft Is Extremely Broad; the Next Draft Should Focus More Heavily on Which Quality Measures Can Adequately Describe a Plan's Overall Quality of Care.

Our principal concern continues to be the overall effectiveness of the quality improvement process. Measuring quality is not enough — any and all quality measures must be utilized in a manner that improves care and protects beneficiaries from harm.

We understand that the design process proceeds in stages, and that casting a wide net for quality measures now is not necessarily inconsistent with a more nuanced review of quality measures in the future. That being said, however, the current aggregation of potential quality measures seems from our perspective to be extremely broad, with little unifying structure. The conversation during the workgroup conference call seemed to be focused almost exclusively on whether a particular quality measure was a valid measurement of a particular aspect, with essentially no consideration of whether that aspect would be a valuable measure of a plan's quality of care.

In this vein, we asked during the call why particular measures were considered

appropriate for quality withholds, and whether those measures were chosen largely because relevant data may be relatively accessible. From the answer to the question, we have been given the impression that, indeed, specific quality measures have been tentatively designated for quality withholds largely because the relevant data is more accessible. As a result, it is unclear whether such quality measures will be a good overall measurement of a plan's quality.

Consider, for example, the measures tentatively suggested to determine quality withholds for the first year. They are:

- Percent of members with initial assessments completed within 90 days of enrollment (#29).
- Behavioral Health Shared Accountability Process Measure (#73).
- Disenrollment Rate for Cause (#76).
- Encounter date submitted accurately and completely in compliance with contract requirements (#91).
- Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements (#92).
- Percent of best possible score the plan earned on how easy it is to get information and help when needed (#93).
- Percentage of respondents who always or usually were able to access care quickly when they needed it (#94).

We understand that data may be particularly hard to come by for the first year but, even so, these measures seem extremely skimpy for the purposes of deciding when a plan should be denied reimbursement.

Furthermore, a similar problem presents with regard to the measures suggested to be used for determining withholds for years two and three. Those measures are:

- Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner (#3).
- Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented (#4).
- Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication (#22).
- Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year (#42).
- Percent of members discharged from a hospital stay who were readmitted to

a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason (#43).

- Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year. (#44)
- Percent of plan members who got a vaccine (flu shot) prior to flu season (#60).
- Behavioral Health Shared Accountability Enhanced Process Measure for Evidence of Data Sharing and Joint Care Planning (Year 2) and Reduction in Emergency Department Use for Seriously Mentally Ill (SMI) and Substance Use Disorder (SUD) Enrollees (Year 3) (#74).

These measures, although they appear more robust than the measures suggested for the first-year withholds, nonetheless seem too limited for a withholding of payment. Without these measures being expanded into a more comprehensive set, we foresee the quality withhold process becoming relatively meaningless. Because the measures will be so limited, no plan will be at real risk of losing reimbursement, and the quality withhold process will not affect quality of care in any meaningful way.

Accordingly, we recommend that as soon as possible the design process give greater consideration as to what types of measurements could legitimately describe a plan's overall quality of care. The current list suggests 94 potential measures. We recommend that the list be focused to address the concerns that we have explained.

Potential Issues Regarding Specific Proposed Quality Measures.

Language Access and Health Disparities (#12 and #27)

In our view, one of the most important benefits of managed care could be the improvement of access and quality of care for those who are limited English proficient (LEP), racial and ethnic minorities, people with disabilities, and other historically underserved groups. While we appreciate the inclusion of two measures relating to language access (#12 and #27, call center wait times for interpretation and TTY/TDD services), we believe that these measures represent a very narrow sliver of the health care experiences of those at risk of marginalization. One way to measure plan performance in reducing health disparities would be to disaggregate other access and health outcome measurements by LEP status, race/ethnicity, and disability. Another important metric would be the direct

evaluation of plans' ability to deliver culturally competent care.[1] (Cultural competence is mentioned, but with no details, in proposed measure #10.)

Percent of High Risk Residents with Pressure Ulcers (Long-Stay) (#28)

Only one of the proposed measures focuses on nursing home care. By contrast, Medicare's Nursing Home Compare website includes 13 long-stay quality measures (including Percent of High Risk Residents with Pressure Ulcers) and 5 short-stay quality measures. We are aware that CMS has expended significant time and money into developing and testing the quality measures available through the Nursing Home Compare website, and are curious as to why California's current draft includes only one of these measures.

Complaints and Appeals (#75); Psychiatric bed days (#78); and Increasing medication adherence (#81)

The draft includes no explanation of what these measures would include.

LTSS Quality Measures (located generally from quality measure #83 to end)

Our letter of June 28 had pointed out the relatively few quality measures relating to LTSS, and recommended adding some of the measures identified by the National Quality Forum. Thank you for adding measures that address LTSS. The current draft is certainly a step in the right direction in this regard, even though LTSS measures continue in our opinion to be underrepresented. We recognize that LTSS measures in general are less developed than others, given the availability of data and the history of quality measure development.

Specifically, we recommend that LTSS consumer satisfaction measures (#89) be augmented to include the ability of consumers to determine and evaluate their own individual goals for LTSS. It is important that LTSS quality measures encompass both health and independent living outcomes, depending on their relative importance to the particular consumer.[2] Ideally, these measurements should be linked to the uniform assessment process planned for future development.

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[1] *See, e.g.*, Quyen Ngo-Metzger et al., *Cultural Competency and Quality of Care: Obtaining the Patient's Perspective* (Oct. 2006), available at http://www.commonwealthfund.org/usr_doc/Ngo-Metzger_cultcompqualitycareobtainpatientperspect_963.pdf.

[2] Examples of such person-centered measures are seen in Wisconsin's PEONIES measurement system, and in the personal outcome measures developed by the Council on Quality and Leadership. ("PEONIES" is an acronym for Personal Experience Outcomes — Integrated Interview and Evaluation System.)

As always, we appreciate the opportunity to comment on the development of the quality improvement system. Please feel free to call with any questions or suggestions.

Sincerely,

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