National
MLTSS
Health Plan Association

October 5, 2017

Mathematica Policy Research
P.O. Box 2393
Princeton, NJ 08543-2393

Support with Modifications for "HCBS-10: Self-direction of services and supports among people receiving LTSS through managed care organizations"

On behalf of the National MLTSS Health Plan Association, thank you for this opportunity to comment on the quality measures being developed for Medicaid participants who receive LTSS in the community. The Association supports the HCBS-10 measures of self-direction with modifications.

The National MLTSS Health Plan Association is a national organization of leading managed care organizations that contract with states to take risk for and manage Medicaid long-term services and supports (MLTSS). Our member organizations include Aetna Inc., AmeriHealth Caritas, Anthem Inc., Centene Corporation, Commonwealth Care Alliance, L.A. Care Health Plan, Molina Health Care Inc., Health Plan of San Mateo, Tufts Health Plan, UPMC Health Plan, and WellCare Health Plans, Inc.

Is the candidate measure useful for measuring important domains of quality for the Medicaid population?

The two rates included in this measure – the offer rate and opt-in rate of self-direction services among Medicaid participants enrolled in MLTSS plans – primarily reflect on the MLTSS plan's mechanism for offering self-direction to participants. However, there are many factors outside of plans' control that influence whether participants are offered and opt for self-direction, including state eligibility rules and service capacity. Some MLTSS participants may be ineligible for self-direction based on issues such as cognitive impairment.

While it is useful to measure how well plans execute offers of self-direction, it would be more meaningful to focus on the subset of MLTSS plan participants eligible for self-direction, rather than all plan participants. We believe more appropriate metrics would be:

1) the percentage of participants eligible for self-direction who receive an offer of self-direction, and
2) the self-direction opt-in rate among participants eligible for self-direction who receive an offer.

Moreover, we believe a more valuable measure would address members' success and satisfaction with self-direction.

Does the measure duplicate information already systematically reported by health plans to the state (if so, which state)?

Some states ask for health plans to report information similar to this measure.

Are you aware of any new or additional studies that should be included in the MJF that support (or weaken) the justification for developing the measure?

No.

Are the measure specifications in the MIFs clear?

As expressed above, we believe this measure would be more accurate and more useful if the opt-in rate denominator were based on plan participants eligible for self-direction.

Is the proposed denominator exclusion appropriate? Are there other exclusions that should be considered?

As stated above, we recommend that the measure denominators be amended to exclude participants not eligible for self-direction. We have no additional exclusion recommendations.

Is a 12-month measurement period appropriate?

This measure should use a specified 12-month time period to make the results comparable across plans.

Should the measure rates be stratified?

The measure rates should be stratified by age and by disability subpopulations, such as SMI, physically disabled, and IDD.

How should enrollees who switch between self-directed and agency-directed care during the measurement period be treated?

HCBS users should not be counted more than once in the numerator, even if they transitioned between agency-directed and self-directed care multiple times during the measurement period. Further, we recommend that participants should be included in the opt-in numerator if they elect to self-direct *any* amount or number of their services, even if they mix self-directed and agency-directed care.