



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

March 3, 2011

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Coordinator

Subcommittee to the National Advisory Council on Healthcare Research and Quality  
Agency for Healthcare Research and Quality  
540 Gaither Road  
Rockville, MD 20850

**RE: Health Quality Measures for Medicaid Eligible Adults**

Dear Dr. Wilson:

The Consortium for Citizens with Disabilities Health Task Force writes to applaud the National Advisory Council on Healthcare Research and Quality Subcommittee for your efforts to improve the quality of care for Medicaid eligible adults. In response to your notice on publishing a Core Set of Health Quality Measures for Medicaid Eligible Adults, we recommend adding measures that address the wide variety and range of disabilities evident within the Medicaid population.

According to the Kaiser Commission on Medicaid and the Uninsured, people with disabilities and seniors represent about 25 percent of Medicaid enrollment and account for about 67 percent of Medicaid spending. In the face of these sobering statistics, we offer in our recommendations below potential sources for your consideration when determining additional quality measures for Medicaid eligible adults with prevalent functional and activity impairments.

We believe the efforts to identify health quality measures within Medicaid provides an opportunity to also address Section 4302(a) of the Affordable Care Act, which requires data collection and reporting on health status and disability, as well as other factors. The Act specifies that in collecting data, the Secretary shall require that any reporting requirement imposed for measuring quality of a public health program include requirements to collect data by disability status.

Quality measures should acknowledge that people with certain functional impairments simply do not receive specific types of care because required examination or diagnostic equipment is inaccessible, accommodations that facilitate communication such as Sign Language interpreters for Deaf patients are not provided, or health care providers make incorrect assumptions about care based on disability stereotype. Consequently, measures

must be devised that acknowledge that barriers indeed exist and that assess progress toward mitigating or removing them. Measures must also be developed that will indicate progress over time toward ensuring that more people with disabilities receive generally accepted health promotion and disease prevention tests and procedures, which will help reduce preventable diseases. The failure to establish and adopt such measures perpetuates the invisibility of barriers to care within the nationwide system of health care delivery, which receives substantial public funding to provide care for people with disabilities. Adding a few key measures to the Core Set of Health Quality Measures for Medicaid-Eligible Adults is a critically important first step that will spur action on the part of health policy and care delivery stakeholders, and lead the way for the development of additional measures over time.

We recognize that the core quality measures identified in the Notice for Comment are currently voluntary. But as the healthcare system gradually adopts a pay-for-performance model, we ask that you please be mindful of the resources that such reporting will require from providers that treat individuals with disabilities and chronic conditions. To the extent possible, we believe that appropriate incentives should be established to encourage providers to take the time necessary to collect and record data on quality measures.

### **Recommended Sources for Additional Core Measures on Disability and Function**

#### *Home and Community Based Services*

The Deficit Reduction Act of 2005 directed the Agency for Healthcare Research and Quality (AHRQ) to develop home and community-based services (HCBS) quality measures for the Medicaid program. As part of that work, AHRQ conducted an environmental scan to identify measures in the domains of client functioning, client satisfaction, and program performance in order to assess the quality of Medicaid HCBS programs nationwide. The resulting report from that scan can be found at:

<http://www.ahrq.gov/research/ltc/hcbsreport/>

We highly recommend HHS review and consider for incorporation [tested functioning measures](#) and [tested program performance measures](#), as appropriate.

#### *Rehabilitation and Habilitation Services*

The Boston University Research and Training Center for Measuring Rehabilitation Outcomes developed the [Activity Measure for Post Acute Care](#) (AM-PAC), with support, in part, from the National Institute on Disability and Rehabilitation Research and the National Institute of Child Health and Human Development. We bring your attention to the AM-PAC measures for Change in Basic Mobility NQF 0429 and Change in Daily Activity Function NQF 0430. These items have received time-limited endorsement from NQF. They are in the public domain, use the International Classification of Function (CF) as a base, and utilize computer adapted testing, which may lower any implementation burden.

Medicare’s [Continuity Assessment and Record Evaluation](#) (CARE) tool was designed to measure outcomes in physical and medical treatments while controlling for factors that affect outcomes, such as cognitive impairments and social and environmental factors. Many of the items are already collected in hospitals, SNFs and HHAs. Four major domains are included in the tool: medical, functional, cognitive impairments, and social/environmental factors. These domains either measure case mix severity differences within medical conditions or predict outcomes such as discharge to home or community, rehospitalization, and changes in functional or medical status. From this tool, we recommend you to the measures under “Part VI Functional Status: Usual Performance A. Core Self Care and B. Core Functional Mobility.” For details, see the [Interim CARE Tool](#), page 18 and 19.

In addition, the Subcommittee recommended Core Measures 38 – 42 under Management of Chronic Conditions, which target people with mental health conditions, and these could be adjusted for people with other impairments. For example, “People with (mobility, vision, hearing, cognitive, sensory, developmental, intellectual) impairments: receive a colonoscopy after age 50 (or a mammogram after age 40).”

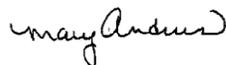
Finally, we commend you to another source, the “[Assessment of Health Plans and Providers by People with Activity Limitations \(AHPPAL\)](#)” - a version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that was modified to better measure and reflect the experiences of people with disabilities. Responses to the survey are used to case-mix adjust the beneficiary responses and to create a disability profile for each medical group or health plan.

We appreciate your consideration of these sources for measures to include in your selection of core health quality measures for Medicaid eligible adults. We recognize that there are a number of other sources not listed above on quality measures for how the healthcare system treats disability and chronic conditions. The sources listed above are meant to be a starting point for the very important task of implementing appropriate quality measures that reflect the healthcare experience of large portion of Medicaid eligible adults – those with disabilities and chronic conditions.

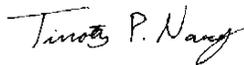
For more information, please do not hesitate to contact any of the co-chairs below.

Sincerely,

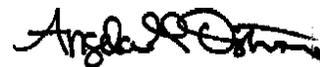
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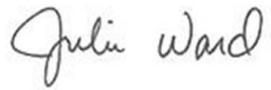
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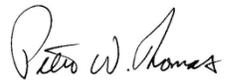
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