Measure Justification Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, Brandeis University and the National Committee for Quality Assurance, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual eligible beneficiaries"
- People receiving long-term services and supports (LTSS) through managed care organizations
- People with substance use disorders; beneficiaries with complex care needs and high costs; beneficiaries with physical and mental health needs; or Medicaid beneficiaries who receive LTSS in the community

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order #HHSM-500-T0004.

Date:

Information included is current on December 14, 2018.

1. Measure Name/Title (NQF Submission Form De.2):

New Medicaid LTSS Beneficiaries Using HCBS First

2. Type of Measure (NQF Submission Form De.1., NQF Evidence Attachment 1a.1.):

Outcome

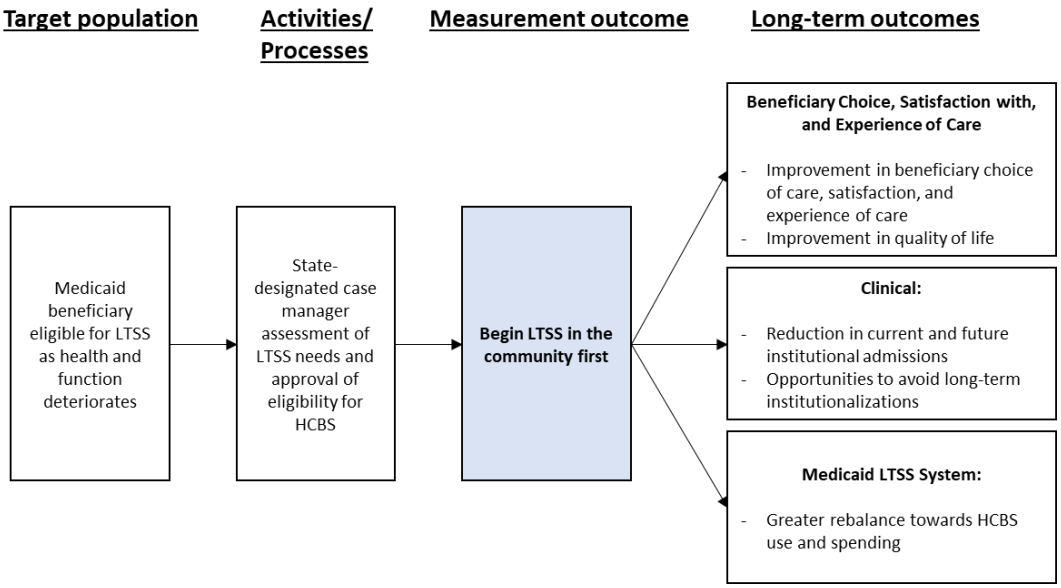
3. Importance (NQF Importance Tab)

3.1 Evidence to Support the Measure Focus (for reference only) (NQF Evidence Attachment Subcriterion 1a.)

3.1.1. This is a Measure of: (NQF Evidence Attachment 1a.1)

Outcome: Access to HCBS

3.1.2. Logic Model (NQF Evidence Attachment 1a.2)



Note: Medicaid beneficiaries may use short-term institutional care for post-acute care. For purposes of this measure, the logic model only includes beneficiaries who have long-term care needs.

Beneficiaries become eligible for LTSS when they meet specific thresholds for clinical and functional impairment and have low incomes and assets. If the beneficiary becomes eligible for LTSS after functional impairment, state-designated case managers assess LTSS need and approve eligibility for HCBS waiver programs and new LTSS users are able to choose HCBS first. Choosing HCBS first leads to measurable changes in long-term outcomes, such as improvement in beneficiary quality of life and the opportunity to avoid long-term institutionalization (see Section 3.1.4 for summary of research on HCBS and beneficiary outcomes).

3.1.3. Value and Meaningfulness (NQF Evidence Attachment 1a.3)

Although this measure is not derived from patient reports, most individuals with long-term care needs prefer to stay at home or in community settings to receive LTSS, rather than reside in an nursing home (Barrett, 2014; Guo et al., 2015a). For example, Guo et al. (2015a) found that among a sample of 81 older adults, most of whom were African-American and at risk in the short-term of needing long-term care, those who needed help with one or two activities of daily living, such as bathing or dressing, had a statistically significant preference for home care over nursing home care.

3.1.4. Empirical Data (for outcome measures) – as applicable (NQF Evidence Attachment 1a.2)

Current state of Medicaid LTSS

In 2013, nearly 5.2 million people received Medicaid-funded long-term services and supports (LTSS) (Eiken, 2017). Of these, 1.5 million (28 percent) only received institutional services[1]; 3.5 million (67 percent) only received home- and community-based services (HCBS)[2]; and the remaining 0.2 million people received both institutional services and HCBS (Eiken, 2017). Medicaid is the largest payer of LTSS, because these supports and services generally are not covered by Medicare or private insurance (Reaves and Musumeci, 2015; Nguyen, 2017).

In the past 20 years following the Americans with Disabilities Act of 1990 and the Supreme Court *Olmstead* decision in 1999, states have made substantial progress in investing and rebalancing their long-term care systems to increase LTSS in home and community-based settings and allowed individuals with LTSS needs to receive services in the least restrictive settings (Musumeci and Claypool, 2014; Reaves and Musumeci, 2015). However, the current system is still biased towards institutional care because federal Medicaid law requires states to cover nursing facility services, while HCBS remains optional (Reaves and Musumeci, 2015; Thach and Wiener, 2018).

Some states, however, have had greater success than others in reducing the risk of long-term nursing home care among those who need LTSS (O'Brien and Fox-Grage, 2017). For example, Oregon and Connecticut encourage nursing home diversion by creating incentives for nursing homes to reduce beds and diversify operation into home health, assisted living, hospice, and/or independent living (O'Brien and Fox-Grage, 2017). States have also developed systems to expedite income and functional status assessments required to qualify for Medicaid HCBS programs and services (O'Brien and Fox-Grage, 2017). For example, Minnesota's Return to Community Initiative, which targets Medicare and private nursing home residents who might be at risk of spending down to qualify for Medicaid, actively identifies individuals who might be a good fit for community-based services based on their clinical and functional data, discusses

[1] Institutional services included those from nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), inpatient psychiatric facilities for individuals under age 21, and hospital services for people age 65 and older in an institution for mental disease.

[2] HCBS included 1915(c) waiver services, personal care services, targeted case management, home health, rehabilitation services, private duty nursing, PACE, adult day care, and HCBS provided through a fee-for-service section 1115 demonstration or a managed care program (e.g., a section 1115 demonstration or a section 1915(b) waiver.

community options with targeted individuals, and connects interested residents to local contacts for HCBS and community transition plans (O'Brien and Fox-Grage, 2017). In Maine, individuals with LTSS needs are contacted before they access services, which allows them to share information about HCBS as an alternative to nursing facility care (O'Brien and Fox-Grage, 2017; Gianopoulos et al., 2001).

Reduction in the need for institutional care

Research has shown that HCBS can reduce the need for institutional care. In a study examining risk factors for long-term nursing home placement among participants in the Connecticut Home Care Program for Elders, those receiving personal care assistance services had significantly lower odds of nursing home placement (Greiner et al., 2014). When an individual completes a nursing facility application, a preadmission assessment is provided in order to determine older adults' eligibility for nursing facility level of care. As part of the screening in Kansas, applicants are also informed about the availability of community-based services and recontacted thirty days after the assessment. Researchers used the recontact information to determine which individuals were diverted (i.e. living in the community) and which had entered a nursing facility. An evaluation of the this program found that it prevented permanent nursing home placement for 57 percent of the sample over the five-year study period (Chapin et al., 2009).

Focusing on the effects of the volume of HCBS care on nursing home placement, Sands and colleagues (2012) found that among enrollees in Indiana Medicaid's HCBS waiver program, each additional five-hour increase in personal care and homemaking services significantly reduced the risk for nursing home placement, and greater volume of these services was associated with even lower risk of nursing home placement. Xu and colleagues (2010) found that in the first month of receiving LTSS through HCBS waivers, individuals receiving five hours of attendant care had a 54 percent lower risk of hospital admissions than those who did not receive attendant care services.

In terms of a quantifiable reduction in the use of nursing home care, Guo, Konetzka, and Manning (2015) found that an additional $1,000 increase in the use of Medicaid-funded home care in the Cash and Counseling Demonstration and Evaluation program reduced nursing facility use by 2.75 days per year on average. In addition, Medicaid beneficiaries who began LTSS benefits in an institutional setting had longer institutional stays compared to those who began LTSS benefits in a community-setting and subsequently needed nursing home care (Stewart and Irvin, 2017). Among 13,609 beneficiaries who initiated LTSS in a community-setting, less than one percent had a long institutional stay (defined as at least 90 consecutive days), while among 1,008 beneficiaries who initiated LTSS in an institutional setting, 73 percent had a long stay (Stewart and Irvin, 2017). These results suggest that diverting institutional placement at the onset of LTSS use is an important aspect of HCBS systems.

Opportunities to avoid long-term institutionalization

While many Medicaid beneficiaries who need LTSS have disabilities that require assistance with activities of daily living and medical conditions that require ongoing monitoring by health care professionals, research has shown that a large number of LTSS users residing in institutional

settings have low care needs that can be more appropriately addressed in community settings. By one estimate, about 5 to 13 percent (16,000 to 42,000, respectively) of Medicaid beneficiaries who were admitted to nursing homes for stays that last at least 90 days were classified as having low care needs, depending on the definition used for "low care" (Mor et al., 2007). Thomas (2014) also found that every 1 percent increase in the population age 65 and older receiving personal care services is associated with a 0.8 percent decrease in the proportion of low-care residents in nursing homes. These studies suggest that there are opportunities for states to identify individuals who are candidates for long-term institutional use and help them transition to the community with HCBS, *before* they become long-term institutional residents.

Improvement in quality of life

As noted above, people with LTSS needs prefer to live at home or in community settings instead of institutions (Guo et al., 2015a). Keeping individuals in the community and out of institutions improves their quality of life. For example, evidence from the Money Follows the Person demonstration program found significant increases in self-reported life satisfaction and living arrangements, two of the seven quality of life domains in the Quality of Life (QOL) survey measuring, one year after Medicaid beneficiaries moved from an institution to a home or community setting in which HCBS were offered (Irvin et al., 2015).[3] Such gains in participant satisfaction were sustained after two years (Irvin et al., 2017). Results also showed significant improvements in the other five quality of life domains from the QoL survey, including reductions in depressive symptoms, unmet need for personal care, and barriers to community integration, as well as gains in satisfaction with care and being treated with respect and dignity by providers (Irvin et al., 2017). These findings suggest an opportunity to improve quality of life among LTSS users by diverting nursing home care and using HCBS first.

Improvement in beneficiary choice of care, satisfaction, and experience of care

Satisfaction of care relates to how beneficiaries experience the care received compared to their standards or expectations (Linder-Peltz, 1982). People using home care and home health services generally report high levels of care satisfaction (Office of Inspector General, 1995; Geron et al., 2000) and a high percentage rate their caregivers as well-trained, helpful, and respectful (Khatusky et al., 2006; Irvin et al., 2017; NQF 2967 Measure Form, 2018). Often, beneficiaries' needs may be better addressed in the community through a less restrictive environment. Analysis of the Money Follows the Person demonstration finds that the personal care needs of individuals are met at significantly higher rates in the community than in institutional settings. In fact, 18 percent of participants reported at least one unmet need for personal assistance services in bathing, meals, medication, and toileting in an institutional setting. One year after transitioning, this percentage dropped to 8 percent, suggesting that

[3] The Money Follows the Person demonstration program was designed to help states rebalance their Medicaid long-term care systems. The program's goals include increasing the use of HCBS and reducing the use of institutionally-based services, eliminating barriers in laws, Medicaid plans, and budgets across states that restrict Medicaid fund use toward letting people get long-term care in their choice of setting, strengthening the ability of Medicaid programs to provide HCBS to people choosing to transition out of institutions, and to put procedures into place to provide quality assurance and improvement of HCBS.

unmet needs for personal care are reduced in the community setting (Irvin et al., 2017). Individuals with the most severe care needs experience the greatest benefit of this transition to the community (Irvin et al., 2017).

Impact on LTSS costs

Due to the differences in the nature and intensity of services provided in the community and institutions, the per user expenditures for HCBS are much less than per user expenditures for institutional care. In 2015, the median annual cost for nursing facility care was $91,000 while home health aide services and adult day health care were $45,760 and $17,940, respectively (Reaves and Musumeci, 2015).

Increasing HCBS expenditures is associated with lower average rates of Medicaid LTSS cost growth over time. An analysis of state spending data from 1995 to 2005 showed that expanding HCBS entailed a short-term increase in spending which was followed by a reduction in institutional spending and long-term cost savings (Kaye, LaPlante, and Harrington, 2009). Further, states that gradually increased spending on HCBS saved money compared to the amounts that they would have spent had nothing been done to shift expenditures away from institutional services (Kaye, 2012). Other studies explored the relationship between state-level HCBS expenditures and LTSS users' risk of nursing home admissions. Again, the results are modest, but states with higher levels of HCBS expenditures were generally associated with lower individual risk of nursing home admissions (Muramatsu et al., 2007; Hahn et al., 2011; Ballou et al., 2013; Blackburn et al., 2016). In particular, a Florida study examining the relationship between county-level Medicaid HCBS waiver expenditures and low-care nursing home residence in 2007 found that a $10,000 increase in per-enrollee HCBS waiver expenditures was significantly associated with a 3.5 percentage-point reduction in low-care nursing home resident prevalence (Hahn et al., 2011). In 2007, nursing homes in Florida had, on average, 8 percent of low-care nursing home residents and the state had an average Medicaid HCBS waiver expenditures per enrollee of approximately $13,000 per year (Hahn et al, 2011). Thus, the study results roughly translate to a reduction in 3 to 4 low-care nursing home residents in a facility with 100 beds (Hahn et al, 2011).

References:

Ballou, Jeffrey, Valerie Chen, Dean Miller, and Audra Wenzlow. "Medicaid-Financed Institutional Services: Characteristics of Nursing Home and ICF/IID: Residents and Their Patters of Care." Report prepared for the Office of the Assistance Secretary for Planning and Evaluation (ASPE). Cambridge, MA: Mathematica Policy Research, August 2013. Available at: https://aspe.hhs.gov/report/medicaid-financed-institutional-services-characteristics-nursing-home-and-icfiid-residents-and-their-patterns-care/c-associations-between-lengths-stay-nursing-homes-and-state-policy-related.

Barrett, Linda. "Home and Community Preferences of the 45+ Population 2014." Washington, DC: AARP, September 2014. Accessed October 24, 2018. Available at: https://www.aarp.org/content/dam/aarp/research/surveys_statistics/il/2015/home-community-preferences.doi.10.26419%252Fres.00105.001.pdf.

Blackburn, Justin, Julie L. Locher, and Meredith L. Kilgore. "The Effects of State-Level Expenditures for Home- and Community-Based Services on the Risk of Becoming a Long-Stay Nursing Home Resident After Hip Fracture." *Osteoporosis International*, 2016, vol. 27, no. 3, pp. 953-961.

Chapin, Rosemary, Beth Baca, Kelley Macmillan, Roxanne Rachlin, and Mary Zimmerman. "Residential Outcomes for Nursing Facility Applicants Who Have Been Diverted: Where Are They 5 Years Later?" *The Gerontologist*, 2009, vol. 40, no. 1, pp: 46-56.

Eiken, Steve. Medicaid Long-Term Services and Supports: Beneficiaries in 2013. Report by Truven Health Analytics. Cambridge, MA: Truven Health Analytics, September 22, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltss-beneficiaries-2013.pdf

Geron, S. M. "Using Measures of Subjective Well-Being and Client Satisfaction in Health Assessments of Older People." *Health Care in Later Life* 1, no. 6 (1996): 185-196.

Gianopoulos, Christine, Elise J. Bolda, Mollie Baldwin, and Louise Olsen. "What works? Maine's statewide uniform assessment and home care planning system tells all." *The Gerontologist* 41, no. 3 (2001): 309-311.

Guo, Jing, R. Tamara Konetzka, Elizabeth Magett, and Willian Dale. "Quantifying Long-Term Care Preferences." Medical Decision Making, vol. 35, no. 1, 2015, pp. 106-113.

Guo, Jing, R. Tamara Konetzka, and Willard G. Manning. "The Causal Effects of Home Care Use on Institutional Long-Term Care Utilization and Expenditures." Health Economics, vol. 1, suppl. 1, 2015, pp. 4-17.

Greiner, Melissa A., Laura G. Qualls, Isao Iwata, Heidi K. White, Sheila L. Molony, M. Terry Sullivan, Bonnie Burke, Kevin A. Schulman, and Soko Setoguchi. "Predicting Nursing Home Placement among Home- and Community-Based Services Program Participants." *American Journal of Managed Care*, vol. 20, no. 12, 2014, pp. e535-e536.

Hahn, Elizabeth A., Kali S. Thomas, Kathryn Hyer, Ross Andel, and Hongdao Meng. "Predictors of Low-Care Prevalence in Florida Nursing Homes: The Role of Medicaid Waiver Programs." *The Gerontologist*, 2011, vol. 51, no. 4, pp. 495-503.

Irvin, Carol V., Alex Bohl, Kate Stewart, Susan R. Williams, Allison Steiner, Noelle Denny-Brown, Andrea Wysocki, Rebecca Coughlin, Jason Smoot, and Victoria Peebles. "Money Follows the Person 2015 Annual Evaluation Report." Report by Mathematica Policy Research. Cambridge, MA: Mathematica Policy Research, May 11, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf.

Kaye, H. Stephen, Mitchell P. LaPlante, and Charlene Harrington. "Do noninstitutional long-term care services reduce Medicaid spending?." *Health Affairs* 28.1 (2009): 262-272.

Kaye, H. Stephen. "Gradual rebalancing of Medicaid long-term services and supports saves money and serves more people, statistical model shows." *Health affairs* 31.6 (2012): 1195-1203.

Linder-Pelz, Susie. "Toward a theory of patient satisfaction." *Social science & medicine* 16, no. 5 (1982): 577-582.

Mor, Vincent, Jacqueline Zinn, Pedro Gozalo, Zhanlian Feng, Orna Intrator, and David C. Grabowski. "Prospects for Transferring Nursing Home Residents to the Community." *Health Affairs*, 2007, vol. 26, no. 6, pp. 1762-1771.

Muramatsu, Naoko, Hongjun Yin, Richard T. Campbell, Ruby L. Hoyem, Martha A. Jacob, and Christopher O. Ross. "Risk of Nursing Home Admission among Older Americans: Does States' Spending on Home- and Community-Based Services Matter?" *Journal of Gerontology. Series B: Psychological Sciences and Social Sciences*, 2007, vol. 62, no. 3, pp. S169-S178.

Musumeci, MaryBeth and Henry Claypool. Olmstead's Role in Community Integration for People with Disabilities under Medicaid: 15 Years After the Supreme Court's Olmstead Decision. The Henry J. Kaiser Family Foundation, June 2014. Accessed October 24, 2018. Available at: http://files.kff.org/attachment/issue-brief-olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-15-years-after-the-supreme-courts-olmstead-decision.

National Quality Forum (NQF). "CAHPS Home- and Community-Based Services Measures." Washington, DC: NQF. Accessed November 26, 2018. Available at: http://www.qualityforum.org/Qps/MeasureDetails.aspx?standardID=2967&print=0&entityTypeID=1

National Quality Forum (NQF). "Quality in Home- and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement." Final Report. Washington, DC: NQF, September 2016. Accessed October 24, 2018. Available at: http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx

O'Brien, Ellen and Wendy Fox-Grage. "State Strategies to Reduce the Risk of Long-Term Nursing Home Care After Hospitalization." Washington, DC: AARP Public Policy Institute, October 2017. Accessed October 24, 2018. Available at: http://www.longtermscorecard.org/~/media/Microsite/Files/2017/reducingtheriskoflongtermnursinghomecareafterhospitalization.PDF.

Office of the Inspector General. Medicare Beneficiary Satisfaction With and Understanding of Home Health Services. U.S. Department of Health and Human Services; Washington, DC.: 1995.

Reaves, Erica L. and MaryBeth Musumeci. "Medicaid and Long-Term Services and Supports: A Primer." Washington, DC: Kaiser Family Foundation, December 2015. Accessed October 24,

2018. Available at: http://files.kff.org/attachment/report-medicaid-and-long-term-services-and-supports-a-primer.

Reinhard, Susan, Jean Accius, Ari Houser, Kathleen Ujvari, Julia Alexis, and Wendy Fox-Grage. "Picking Up the Pace of Change: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." Washington, DC: AARP, The Commonwealth Fund, and the SCAN Foundation, June 14, 2017. Accessed October 24, 2018. Available at: http://www.longtermscorecard.org/2017-scorecard

Ryan, Jennifer and Barbara Coulter Edwards. "Health Policy Brief: Rebalancing Medicaid Long-Term Services and Supports." *Health Affairs*, September 17, 2015. Accessed November 20, 2018. Available at: https://www.healthaffairs.org/do/10.1377/hpb20150917.439553/full/.

Sands, Laura P., Huiping Xu, Joseph Thomas, III, Sudeshna Paul, Bruce A. Craig, Marc Rosenman, Caroline C. Doebbeling, and Michael Weiner. "Volume of Home- and Community-Based Services and Time to Nursing-Home Placement." *Medicare & Medicaid Research Review*, vol. 2, no. 3, 2012, pp. E1-E21.

Stewart, Kate and Carol V. Irvin. "Does Early Use of Community-Based Long Term Services and Supports Lead to Less of Institutional Care?" Cambridge, MA: Mathematica Policy Research, 2017. Accessed October 29, 2018. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/hcbsasadiversiontoiltc.pdf.

Thach, Nga T. and Joshua M. Wiener. "An Overview of Long-Term Services and Supports and Medicaid: Final Report." Assistance Secretary for Planning and Evaluation: Office of Disability, Aging and Long-Term Care Policy, May 2018. Accessed October 24, 2018. Available at: https://aspe.hhs.gov/system/files/pdf/259521/LTSSMedicaid.pdf.

Thomas, Kali S. "The Relationship Between Older Americans Act In-Home Services and Low-Care Residents in Nursing Homes." *Journal of Aging and Health*, 2014, vol. 26, no. 2, pp: 250-260.

Xu, Huiping, Michael Weiner, Sudeshna Paul, Joseph Thomas, Bruce Craig, Marc Rosenman, Caroline Carney Doebbeling, and Laure P. Sands. "Volume of Home- and Community-Based Medicaid Waiver Services and Risk of Hospital Admissions." *Journal of the American Geriatrics Society,* 2010, vol. 58, no. 1, pp: 109-115.

3.1.5. Systematic Review of the Evidence (NQF Evidence Attachment 1a.3)

Not applicable. See Section 3.1.4 for empirical evidence supporting this measure.

3.1.6. Other Sources of Evidence (NQF Evidence Attachment 1a.4)

Not applicable. See Section 3.1.4 for empirical evidence supporting this measure.

3.1.6.1 Briefly Synthesize the Evidence (NQF Evidence Attachment 1a.4.1)

Not applicable. See Section 3.1.4 for empirical evidence supporting this measure.

3.1.6.2 Process Used to Identify the Evidence (NQF Evidence Attachment 1a.4.2)

Not applicable. See Section 3.1.4 for empirical evidence supporting this measure.

3.1.6.3 Citation(s) for the Evidence (NQF Evidence Attachment 1a.4.3)

Not applicable. See Section 3.1.4 for empirical evidence supporting this measure.

3.2 Performance Gap – Opportunity for Improvement (NQF Measure evaluation criterion 1b)

3.2.1 Rationale (NQF Submission Form 1b.1)

Most individuals with long-term services and supports (LTSS) needs want to live at home or in community settings, and the Supreme Court Olmstead decision obligates states to provide LTSS in the most integrated setting appropriate to the needs of qualified beneficiaries (Guo et al., 2015; Reaves and Musumeci, 2015). Although states have made significant progress in rebalancing their LTSS systems to provide more HCBS, many Medicaid beneficiaries still reside in institutions, even though they may prefer to receive care in the community or they do not need institutional level of care. A key goal of HCBS is to delay admission to an institution or to divert people from them, and evidence suggests that there is significant variation across states in the rate of institutional admissions among Medicaid HCBS users (Reinhard et al., 2017).

3.2.2 Performance Scores (NQF Submission Form 1b.2)

There is wide state variation in the percentage of Medicaid LTSS beneficiaries who first receive services in home and community settings rather than in nursing homes (Irvin et al., 2016; Reinhard et al., 2017). Among the 39 states for which data were available in 2012, the mean was 58.0% (Irvin et al., 2016), and among the five top-performing states, an average of 80 percent of new LTSS users first receive HCBS rather than institutional services, compared with 30 percent among the bottom five states (Reinhard et al., 2017). Such variation indicates significant opportunity for improvement in state performance on this measure.[4] More recent data on state performance scores will be examined during measure testing and tested for validity and reliability.

3.2.3 Summary of Data Indicating Opportunity (NQF Submission Form 1b.3)

Not applicable. Data indicating opportunity will be determined during measure testing.

3.2.4 Disparities (NQF Submission Form 1b.4)

Not applicable. Disparity data will be determined during measure testing.

3.2.5 Provide summary of data if no or limited data (NQF Submission Form 1b.5)

Not applicable. Disparity data will be determined during measure testing.

[4] While Mathematica has calculated this measure for AARP's LTSS Scorecard several times, it has not been empirically tested for scientific acceptability according to CMS Blueprint and NQF standards – the focus of this measure testing exercise.

4. Scientific Acceptability (NQF Scientific Acceptability Tab)

4.1 Data Sample Description (NQF Testing Attachment 1.)

4.1.1 What Type of Data Were Used for Testing? (NQF Testing Attachment 1.1.)

Not applicable. Scientific acceptability will be determined during measure testing.

4.1.2 Identify the Specific Dataset (NQF Testing Attachment 1.2.)

Not applicable. Scientific acceptability will be determined during measure testing.

4.1.3 What are the Dates of the Data Used in Testing? (NQF Testing Attachment 1.3.)

Not applicable. Scientific acceptability will be determined during measure testing.

4.1.4 What Levels of Analysis were Tested? (NQF Testing Attachment 1.4.)

Not applicable. Scientific acceptability will be determined during measure testing.

4.1.5 How Many and Which Measured Entities were Included in the Testing and Analysis? (NQF Testing Attachment 1.5.)

Not applicable. Scientific acceptability will be determined during measure testing.

4.1.6 How Many and Which Patients were Included in the Testing and Analysis? (NQF Testing Attachment 1.6.)

Not applicable. Scientific acceptability will be determined during measure testing.

4.1.7 Sample Differences, if Applicable (NQF Testing Attachment 1.7.)

Not applicable. Scientific acceptability will be determined during measure testing.

4.1.8 What were the Social Risk Factors that were Available and Analyzed? (NQF Testing Attachment 1.8.)

Not applicable. Scientific acceptability will be determined during measure testing.

4.2 Reliability Testing (for reference only) (NQF Testing Attachment 2a2.)

4.2.1 Level of Reliability Testing (NQF Testing Attachment 2a2.1.)

Not applicable. Reliability will be determined during measure testing.

4.2.2 Method of Reliability Testing (NQF Testing Attachment 2a2.2.)

Not applicable. Reliability will be determined during measure testing.

4.2.3 Statistical Results from Reliability Testing (NQF Testing Attachment 2a2.3.)

Not applicable. Reliability will be determined during measure testing.

4.2.4 Interpretation (NQF Testing Attachment 2a2.4.)

Not applicable. Reliability will be determined during measure testing.

4.3 Validity Testing (for reference only) (NQF Testing Attachment 2b1.)

4.3.1 Level of Validity Testing (NQF Testing Attachment 2b1.1.)
Not applicable. Validity will be determined during measure testing.

4.3.2 Method of Validity Testing (NQF Testing Attachment 2b1.2.)
Not applicable. Validity will be determined during measure testing.

4.3.3 Statistical Results from Validity Testing (NQF Testing Attachment 2b1.3.)
Not applicable. Validity will be determined during measure testing.

4.3.4 Interpretation (NQF Testing Attachment 2b1.4.)
Not applicable. Validity will be determined during measure testing.

4.4 Exclusion Analysis (for reference only) (NQF Testing Attachment 2b2.)

4.4.1 Method of Testing Exclusions (NQF Testing Attachment 2b2.1.)
Not applicable. Exclusions will be determined during measure testing.

4.4.2 Statistical Results from Testing Exclusions (NQF Testing Attachment 2b2.2.)
Not applicable. Exclusions will be determined during measure testing.

4.4.3 Interpretation (NQF Testing Attachment 2b2.3.)
Not applicable. Exclusions will be determined during measure testing.

4.5 Risk Adjustment or Stratification for Outcome or Resource Use Measures (for reference only) (NQF Testing Attachment 2b3.)

4.5.1 Method of Controlling for Differences (NQF Testing Attachment 2b3.1.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.2 Rationale Why Risk Adjustment is Not Needed (NQF Testing Attachment 2b3.2.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.3 Conceptual, Clinical, and Statistical Methods (NQF Testing Attachment 2b3.3a)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.4 Conceptual Model of Impact of Social Risks (NQF Testing Attachment 2b3.3b)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.5 Statistical Results (NQF Testing Attachment 2b3.4a.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.6 Analyses and Interpretation in Selection of Social Risk Factors (NQF Testing Attachment 2b3.4b.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.7 Method Used to Develop the Statistical Model or Stratification Approach (NQF Testing Attachment 2b3.5.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.8 Statistical Risk Model Discrimination Statistics (such as, c-statistic, R^2) (NQF Testing Attachment 2b3.6.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.9 Statistical Risk Model Calibration Statistics (such as the Hosmer-Lemeshow statistic) (NQF Testing Attachment 2b3.7.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.10 Statistical Risk Model Calibration—Risk Decile Plots or Calibration Curves (such as the Hosmer-Lemeshow statistic) (NQF Testing Attachment 2b3.8.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.11 Results of Risk Stratification Analysis (NQF Testing Attachment 2b3.9.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.12 Interpretation (NQF Testing Attachment 2b3.10.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.5.13 Optional Additional Testing for Risk Adjustment (NQF Testing Attachment 2b3.11.)
Not applicable. Risk adjustment or stratification will be determined during measure testing.

4.6 Identification of Meaningful Differences in Performance (for reference only) (NQF Testing Attachment 2b4.)

4.6.1 Method (NQF Testing Attachment 2b4.1.)

Not applicable. Meaningful differences in performance will be determined during measure testing.

4.6.2 Statistical Results (NQF Testing Attachment 2b4.2.)

Not applicable. Meaningful differences in performance will be determined during measure testing.

4.6.3 Interpretation (NQF Testing Attachment 2b4.3.)

Not applicable. Meaningful differences in performance will be determined during measure testing.

4.7 Comparability of Multiple Data Sources/Methods (for reference only) (NQF Testing Attachment 2b5.)

4.7.1 Method (NQF Testing Attachment 2b5.1.)

Not applicable. Comparability of multiple data sources will be determined during measure testing.

4.7.2 Statistical Results (NQF Testing Attachment 2b5.2.)

Not applicable. Comparability of multiple data sources will be determined during measure testing.

4.7.3 Interpretation (NQF Testing Attachment 2b5.3.)

Not applicable. Comparability of multiple data sources will be determined during measure testing.

4.8 Missing Data Analysis and Minimizing Bias (for reference only) (NQF Testing Attachment 2b6.)

4.8.1 Method (NQF Testing Attachment 2b6.1.)

Not applicable. Missing data bias will be determined during measure testing.

4.8.2 Missing Data Analysis (NQF Testing Attachment 2b6.2.)

Not applicable. Missing data bias will be determined during measure testing.

4.8.3 Interpretation (NQF Testing Attachment 2b6.3.)

Not applicable. Missing data bias will be determined during measure testing.

5. Feasibility (NQF Feasibility Tab)

5.1 Data Elements Generated as Byproduct of Care Processes (NQF Measure Evaluation Criterion 3a./3a.1)

5.2. Electronic Sources (NQF Measure Evaluation Criterion 3b.)

5.2.1. Data Elements Electronic Availability (NQF Submission Form 3b.1.)

5.2.3. eCQM Feasibility (NQF Submission Form 3b.3.)

Not applicable. This measure is not an eCQM.

5.3 Data Collection Strategy (NQF Submission Form 3c.)

5.3.1. Data Collection Strategy Difficulties (optional) (NQF Submission Form 3c.1.)

5.3.2. Fees, Licensing, Other Requirements (NQF Submission Form 3c.2.)

6. Usability and Use (NQF Usability and Use Tab)

6.1 Use (NQF Measure Evaluation Criterion 4a.)

6.1.1 Current and Planned Use (NQF Submission Form 4.1.)

A version of this measure is one of 25 indicators of state LTSS system performance, publicly reported in the LTSS State Scorecard, produced and sponsored by AARP, The Commonwealth Fund, and The SCAN Foundation. The 2017 Scorecard was the third edition, following the first edition in 2011 and a second edition in 2014. The Scorecard's goal is to stimulate dialogue among key stakeholders, and encourage them to collaborate on strategies for improving each state's LTSS system. See http://www.longtermscorecard.org/methodology for more information about the data used for each indicator, including the one on which the measure described in this MJF is based, as well as the method used to rank states.

6.1.1.1 Reasons for Not Publicly Reporting or Use in Other Accountability Application (NQF Submission Form 4a.1.2.)

6.1.1.2 Plan for Implementation (NQF Submission Form 4a.1.3.)

To be determined after measure testing.

6.1.2 Feedback on the Measure by Those Being Measured or Others (NQF Measure Evaluation Criterion 4a2.)

6.1.2.1 Technical Assistance Provided During Development or Implementation (NQF Submission Form 4a2.1.1.)

6.1.2.3 Feedback on Measure Performance and Implementation (NQF Submission Form 4a2.2.1.)

Not applicable. Feedback on the measure will be compiled after measure testing.

6.1.2.4 Feedback from Providers Being Measured (NQF Submission Form 4a2.2.2.)

Not applicable. Feedback on the measure will be compiled after measure testing.

6.1.2.5 Feedback from Other Users (NQF Submission Form 4a2.2.3.)

Not applicable. Feedback on the measure will be compiled after measure testing.

6.1.2.6 Consideration of Feedback (NQF Submission Form 4a2.3.)

Not applicable. Feedback on the measure will be compiled after measure testing.

6.2. Usability (NQF Measure Evaluation Criterion 4b)

6.2.1 Improvement (NQF Submission Form 4b1.)

This is a new measure, and implementation of this measure is still under consideration.

6.2.2 Unexpected Findings (NQF Measure Evaluation Criterion 4b2., NQF Submission Form 4b2.1.)

This is a new measure, and implementation of this measure is still under consideration.

6.2.2.2 Unexpected Benefits (NQF Submission Form 4b2.2.)

This is a new measure, and implementation of this measure is still under consideration.

7. Related and Competing Measures (NQF Related and Competing Measures Tab)

7.1 Relation to Other NQF-Endorsed Measures (NQF Measure Evaluation Criterion 5, NQF Submission Form 5.)

Not applicable. No related or competing measures were identified.

7.2 Harmonization (NQF Submission Form 5a., 5a.1., 5a.2.)

Not applicable. No related or competing measures were identified.

7.3 Competing Measures (NQF Submission Form 5b., 5b.1.)

Not applicable. No related or competing measures were identified.

Additional Information (NQF Additional Information Tab)

Appendix

Supplemental Materials

Contact Information

Co.1. – Measure Steward Point of Contact

Co.1.1. Organization

Centers for Medicare & Medicaid Services

Co.1.2. First Name

Roxanne

Co.1.3. Last Name
Dupert-Frank

Co.1.4. Email Address
Roxanne.Dupert-Frank@cms.hhs.gov

Co.1.5. Phone Number ( ) ext.
410-786-9667

Co.2. – Developer Point of Contact (indicate if same as Measure Steward Point of Contact)

Co.2.1. Organization
Mathematica Policy Research

Co.2.2. First Name
Melissa

Co.2.3. Last Name
Azur

Co.2.4. Email Address
mazur@mathematica-mpr.com

Co.2.5. Phone Number ( ) ext.
202-250-3518

Other Additional Information

Ad.1. Working Group/Expert Panel Involved in Measure Development

Dual Eligible/HCBS Beneficiaries Technical Expert Panel:

- Carol Raphael, Manatt Health Solutions (Chair)
- Ann Hwang, MD, Community Catalyst
- Ari Houser, PhD, AARP Public Policy Institute
- Dennis Heaphy, MPH, Disability Policy Consortium
- Joe Caldwell, PhD, Lurie Institute on Disability Policy at Brandeis University
- Lauren Murray, BA, National Partnership for Women and Families
- Maggie Nygren, EdD, American Association for People with Disabilities
- RoAnne Chaney, MPA, Michigan Disability Rights Coalition
- Mary Lou Bourne, National Association of State Directors for Developmental Disabilities Services
- Raina Josberger, MS, New York State Department for Health
- Jason Rachel, PhD, Virginia Department of Medical Assistance Services
- Balu Gadhe, MD, CareMore
- Patricia Kirkpatrick, MJ, RN, CPHQ, Amerigroup Corporation
- Cheryl Phillips, MD, Special Needs Plans Alliance
- Diane McComb, MSEd, American Network of Community Options and Resources

- Steve Guenthner, BS, Almost Family, Inc.
- Bonnie Marsh, RN, BSN, MA, Health Services Advisory Group
- Brian Abery, PhD, University of Minnesota
- Lisa Iezzoni, MD, Harvard Medical School
- Pamela Parker, MPA, Independent Consultant-Integrated Care
- Valerie Bradley, MA, Human Services Research Institute

Ad.2. Year the Measure Was First Released

Not applicable. This is a new measure.

Ad.3. Month and Year of Most Recent Revision

Not applicable. This is a new measure.

Ad.4. What is your frequency for review/update of this measure?

Not applicable. This is a new measure.

Ad.5. When is your next scheduled review/update for this measure?

Not applicable. This is a new measure.

Ad.6. Copyright Statement

Not applicable. This is a new measure.

Ad.7. Disclaimers

Not applicable. This is a new measure.

Ad.8. Additional Information/Comments

Not applicable. This is a new measure.