

Home and Community Based Services (HCBS) Measures Technical Expert Panel (TEP) Meeting #2 Summary Report: June 22, 24, and 25, 2020

Background

TEP Purpose

The Centers for Medicare & Medicaid Services (CMS) contracted with The Lewin Group (Lewin) to develop and maintain a standard set of HCBS measures through project number HHSM-500-201400033I, task number 75FCMC19F0004, entitled Home and Community Based Services Measure Development, Endorsement, Maintenance, and Alignment Contract. HCBS measure development and maintenance activities include:

- Coordinate and align activities for a diverse measure set related to HCBS (i.e., Functional Assessment Standardized Items [FASI], Consumer Assessment of Healthcare Providers and Systems [CAHPS®] Home and Community Based Services Survey [HCBS CAHPS®], and managed long-term services and supports [MLTSS]) across CMS, as well as those external to CMS;
- Maintain identified existing measures and develop new HCBS measures for National Quality Forum (NQF) endorsement where appropriate; and
- Identify risks, challenges, and mitigating strategies to help move forward CMS's vision of high quality, efficient, person-focused health care that optimizes the benefits associated with the use and exchange of standardized data collection.

Meeting Objectives

This meeting specifically focused on gaining TEP input regarding: 1) the results of the FASI and HCBS CAHPS® (NQF 2967) environmental scan and literature review (ES/LR); and 2) eight measures and concepts for potential development. Appendix A includes a list of TEP members who participated in Meeting #2.

Welcome and Kick-Off Meeting Review

The recap of the April 2020 Kick-Off meeting included discussion of re-specification of existing measures vs. development of new measures and a review of the HCBS CAHPS® Survey, FASI, and MLTSS.

Results from the Maintenance Environmental Scan/Literature Review

Required as part of the [CMS Measures Management System \(MMS\) Blueprint](#), the ES/LR ensures that measure developers review all of the relevant research pertinent to their measures. Lewin presented its ES/LR focused on the FASI set and performance measures and the HCBS CAHPS® Survey and measures to the TEP.

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The HCBS CAHPS® measures, originally endorsed by NQF in 2016, will undergo endorsement maintenance review by the Patient Experience and Function Project soon. Lewin will submit the two FASI performance measures for initial endorsement review by NQF's Patient Experience and Function Project in fall 2020.

HCBS CAHPS® Measure Description and Specifications

HCBS CAHPS® (NQF 2967) is comprised of measures derived from a cross-disability survey to elicit feedback from adult Medicaid beneficiaries receiving HCBS about their experience with LTSS they receive in the community and delivered to them from a state Medicaid HCBS program.

Summary of TEP Discussion and Recommendation

The TEP reinforced the need for autonomy, choice, and decision-making for HCBS participants as core elements for assessing HCBS experience. When compared to other CAHPS® surveys, HCBS CAHPS® focuses more on autonomy than other primarily acute/post-acute care focused experience surveys; the HCBS CAHPS® asks more questions than other CAHPS survey regarding whether the individual takes part in developing their plan. We will continue to include the subject of autonomy as part of ongoing discussions with stakeholders.

HCBS CAHPS® ES/LR Emerging Themes

A number of emerging themes suggest potential changes to the measures as currently specified outlined below.

Experience of Care Instrument Harmonization

The ES/LR indicated a need for instrument harmonization. The Quality of Life Home Care Index and Quality of Care Questionnaire represent two experience surveys similar in scope to the HCBS CAHPS® Survey. This alignment could improve the face validity of the instrument, but the changes may create complexity in survey administration and score calculation. Updates to the instrument may require additional testing to verify continued scientific acceptability.

Summary of TEP Discussion and Recommendation

TEP members supported the harmonization of the survey instruments (i.e., Quality of Life Home Care Index and Quality of Care Questionnaire with HCBS CAHPS® Survey). The TEP members advised Lewin to consider the complexity across surveys and ensure recipients of HCBS can link the survey questions to the appropriate caregivers and services.

TEP members support harmonization of the instruments. After creation and reasonable testing, CMS could create flexibility by adding new items to an otherwise intact tool. While this could cause initial burden and result in a longer survey, it may provide an effective strategy for increasing adoption due to the flexibility.

Expanding the *About You* Section of the HCBS CAHPS® Survey to Socioeconomic Status

Evidence from the literature underscores the relationship between socioeconomic status and unmet need. With adding socioeconomic status, the instrument could better evaluate gaps in care based on socioeconomic status, but respondents may view it as an infringement on privacy. It may not be necessary when used with Medicaid beneficiaries because eligibility requires low income.

Summary of TEP Discussion and Recommendation

TEP members supported expanding the *About You* section to assess socioeconomic status, but emphasized the need to get the wording of the question correct to ensure individual privacy and properly assess respondent's socioeconomic status.

TEP members confirmed that socioeconomic status plays a significant role in LTSS outcomes and HCBS services for all populations served. Only by capturing this information about these gaps, can states begin to address them.

CMS and Lewin should consider the great variance in socioeconomic status for those who complete the HCBS CAHPS® Survey. Many older adults spend down their assets, but did not experience a disadvantaged life. For those with intellectual and developmental disabilities (I/DD), individual and/or family background can often inform the quality of care they receive. Questions should target both personal and family background, education, as well as other areas of variability.

To properly address socioeconomic status, the TEP indicated that survey questions should focus on ability to access typical social determinants of health (SDOH), such as housing or transportation. Asking these questions may lead to a better picture of socioeconomic status and addressing insecurities in SDOH specifically can close gaps.

HCBS CAHPS® Survey Measures of Care Coordination

The literature emphasizes the importance of collaboration between aging and disability organizations and integrated care entities, such as Medicaid managed care organizations (MCOs) and hospital systems. The measure scores could inform the need for improved care coordination, but changes to include measures of care coordination create increased complexity in survey administration and score calculation. Updates to the instrument may also require additional testing.

Summary of TEP Discussion and Recommendation

The HCBS CAHPS® Survey currently includes questions which address care coordination. Optional modules for HCBS CAHPS® on care coordination and other topics could provide greater flexibility for users at the state level.

Care coordination, a foundational building block to exchanging information across MCOs and hospital systems, can contribute to measuring adequacy of services and improve outcomes. CMS and Lewin should consider the domains of completeness, timeliness, and usability of the information shared.

Objective, critical data on care coordination can be difficult to document accurately. Recipients of HCBS may have trouble identifying who provides each of the services they receive. Additionally, not all states use the same definition of care coordination. The wording of the question and the definition of care coordination should be very explicit to ensure standardization across survey users.

TEP members recommended that CMS consider an optional module for care coordination so that states have flexibility in whether they measure coordination of services through CAHPS®. There may be other ways to measure this as well. For example, some states require coordination with other organizations and could measure the number of contracts or the organizations with whom they have contracts.

FASI Measure Description and Specifications

The FASI includes a set of functional assessment items which supports two FASI measures and focuses on daily function, assistive devices, and living arrangements, as well as the individual's goals.

FASI ES/LR Emerging Themes

A number of emerging themes from the ES/LR suggest potential changes to the measures as currently specified outlined below.

Harmonization of the FASI with Other Functional Assessments

Several articles highlighted additional functional assessments that may warrant further exploration and potential alignment. Alignment of the FASI instrument with these tools could allow its use more broadly and improve its face validity, but doing so could also lead to less consistency with the post-acute care assessment, increased complexity, and require additional testing.

Summary of TEP Discussion and Recommendation

Overall, the TEP supported harmonization of the FASI with other functional assessments. Many states and entities use other instruments for evaluating functionality. Harmonization would reduce overall burden for those who rely on multiple instruments. Additionally, an individual's perception of their ability does not always match what they physically can do. Including the observation of physical ability can provide an additional perspective to how an individual sees their abilities.

Life-Space Mobility (LSM) as a Domain for Potential Inclusion in the FASI

LSM measures the outcome of physical deterioration and social isolation in geriatric populations by assessing the range, independence, and frequency of movement over the four weeks preceding assessments. It could allow more broad use of the FASI instrument and improve face validity, but it could lead to increased complexity and may require additional testing for scientific acceptability.

Summary of TEP Discussion and Recommendation

Overall, the TEP members recognize the importance of measuring and addressing social isolation in the HCBS community. However, the TEP members also indicated other ways to address loneliness among older adults.

The TEP noted that social isolation and loneliness have an impact on the health of the elderly. Measuring and addressing these issues could have a meaningful impact on quality of life and healthcare costs. TEP members encouraged CMS and Lewin to consider social connectedness as another way to measure LSM. They also noted that states have increasingly showed interest in addressing loneliness. Some states measure social isolation using existing instruments, but many others do not have the data to effectively address social isolation. It would be important to harmonize data elements across instruments currently in use.

Existing tools measure loneliness, including surveys of current data collection efforts across adult day care centers and three items in the HCBS CAHPS® Survey. Some MLTSS plans use a Three-Item Loneliness Scale.

Gait Characteristics as a Domain for Potential Inclusion in the FASI

FASI does not include gait speed and other gait kinematics, but other studies and tools often use them to assess frailty and fall risk. Adding these components to the FASI instrument could allow its use more broadly and improve face validity, but it could lead to increased complexity and may need additional testing.

Summary of TEP Discussion and Recommendation

The identification of gait details to the general fall and gait item of the FASI as potential additions, resulted in TEP members indicating an interest in evaluating similarities in the FASI to other assessments, such as interRAI and the Supports Intensity Scale. Lewin plans to conduct an analysis of assessment instruments. The TEP endorsed the use of objective measures, like a timed get-up-and-go test, to minimize self-reporting issues. However, they cautioned CMS and Lewin to also consider how to measure an assessor's interpretation of their observations during an assessment.

Artificial Intelligence (AI) and Telehealth's Potential Role in the FASI

Other emerging areas in the literature include AI and telehealth/remote monitoring. Telehealth and remote monitoring could observe and improve functional outcomes at a distance. AI and telehealth could reduce burden for the administration of FASI. Allowing AI to manage data entry would improve objectivity of data collection and result in more consistent scores. However, adoption and use of AI remains low, which could make it difficult to implement.

Summary of TEP Discussion and Recommendation

TEP members recognized the importance of AI and telehealth. Their use will continue to increase, and the TEP recommended CMS create a way to measure AI and telehealth effectiveness. The TEP noted that use of AI could also lead to increased accuracy in assessments. The TEP expressed concern that advanced technologies like AI and telehealth may not be available in all HCBS communities, especially those that contain a disproportionate number of underserved populations.

Overestimation of Functional Ability, Need for Assistance, and Fear of Falling

Some publications question the validity of functional assessment scores. One article notes that functional assessment tools typically overestimate independence, specifically related to self-care and functional mobility. Several articles discuss the relationship between falling and perceived functional ability.

Summary of TEP Discussion and Recommendation

TEP members have experienced both under- and overestimation of abilities for different motivations. Additionally, many recipients of HCBS have different cultural backgrounds and language barriers that could lead to discrepancies in the data collected. The TEP thought that objective questions could help to mitigate this problem and recommended that CMS and Lewin consider an additional module for calibrating assessment of functional ability.

General Discussion

Summary of TEP Discussion

CMS hopes to encourage state adoption and implementation of the HCBS CAHPS® Survey and FASI and the use of their available measures. The TEP indicated that states encounter barriers to adoption as a result of the lack of financial reimbursements for quality measures and measure overload from required reporting. Yet, access to data and the ability to identify areas of improvement motivate states to pursue quality measures.

The TEP also noted that the interpretation of scores and data change throughout the life cycle of a measure. Upon the development of a new measure, it typically improves over the first five to ten years, but after that time period, data begins to stabilize with less improvements over time. Stabilization does not necessarily indicate low quality care because many HCBS recipients' status may not change or improve. Additionally, the TEP acknowledged the importance to consider which provider can improve the results and how they will be affected by the data related to the quality measures.

Review of Measures and Concepts

Following the review of background research, the TEP provided input regarding eight HCBS measures and concepts. The TEP rated the measures and concepts for both importance and potential impact.

Approach to Identifying Measures for Respecification and Concepts for Development

Using the steps outlined in the [CMS MMS Blueprint](#), Lewin identified potential measures for re-specification and concepts for development relying heavily on NQF's HCBS measure domains and CMS's HCBS recommended measure set.

Summary of TEP Discussion and Recommendations

TEP members proposed multiple areas for further consideration not represented by the eight measures and concepts. One TEP member suggested leveraging principles of community inclusion and person-centered planning to address gaps in equity. Under evaluated areas related to equity noted include structural items such as housing and transportation, which remain critical to effective functioning of the HCBS system. Data availability, however, limits the feasibility of developing such measures. While TEP members suggested adding items related to equity to the HCBS CAHPS® Survey, this suggestion was out of scope for the current TEP conversation.

Although many choice and control measures exist, very few are operationalized in ways that allow their use for holding a managed care organization accountable or evaluating provider activity with a tie back to reimbursement. TEP members indicate that the existence of many NCI and NCI-AD measures within a particular domain does not mean that they are relevant for every context or that measure development in that area is complete.

Community inclusion is often incorporated as a quality measure in MLTSS, but usually looking very narrowly at institution to HCBS transitions. An important trend in HCBS now is a focus on transitions within the HCBS spectrum. One option is developing community inclusion measures which look at transitions in the HCBS spectrum, such as looking at movement from group homes to individual houses, or facility based work to integrated work.

TEP members also noted that person-centered planning may not be widely practiced in MLTSS, and is in general less widely used outside of the I/DD and disability populations. The NQF Committee on person-centered planning report has recommendations worth consideration on how to integrate person-centered planning into measurement.

Concept #1: Caregiver Access to Resources

Lewin presented this concept as assessing how family and informal caregivers access information, training, respite care, and other forms of support available to them in their communities.

Summary of TEP Discussion and Recommendations

The TEP noted that accounting for all types of caregivers a person may have, formal and informal, paid and unpaid, live-in and visiting remains important. As a result, how to define "caregiver" becomes critical and The TEP recommended that CMS and Lewin take into consideration people with multiple caregivers. Individuals also often identify people as caregivers who do not identify themselves as caregivers.

Although out of the scope of this measure, a question emerged of whether or not caregivers use respite services or other resources available to them. Several questions emerged about how to obtain data for this measure, most of which Lewin will determine during testing. This includes whether this concept would be based on data about services and supports or about asking caregivers if they feel that they

have access to resources. Some CAHPS surveys and assessment tools include questions for family caregivers, so the existing surveys may provide a model. On TEP member suggested that Hospice Compare's "Family Experience of Care" section could provide a resource.

Using qualitative approaches may offer a better understanding of what caregivers find effective across data sources (e.g., caregivers, the person, providers, service coordinators). Wide variances likely exist across these sources, particularly funders and caregivers.

The TEP indicated that health plans should be accountable for caregiver access to resources. Several states already require caregiver assessments for MLTSS plans. NCQA has also made providing caregiver resources a requirement for accreditation for HCBS Service Coordination Entities.

Concept #2: Caregiver Burnout

This concept will assess measurable factors that can impact the likelihood of an informal or family caregiver becoming overwhelmed from providing care.

Summary of TEP Discussion and Recommendations

The TEP suggested that any future specifications for this concept should avoid using the term "burden," which can have negative connotations.

Presented as a process measure related to causes of burnout, the TEP would like to focus on change in burnout over time or impact of interventions on burnout. The TEP stressed the importance of the measure being actionable. They also wanted to take into account the great variability across caregivers and how they perceive and carry out their role, such that different people can become burned out for very different reasons. Caregivers may also deny burnout. Factors for caregiver burnout could vary according to culture or community. The TEP recommended a thorough structured evaluation viewed through multiple lenses to identify factors.

Many patients have caregivers who give up, particularly ones supporting HCBS consumers with severe mental illness. Although this concept would look directly at outcomes for caregivers, one would expect a correlation with beneficiary or patient outcomes. TEP members supported the idea of a relationship between beneficiary quality of life and caregiver burnout and suggested that there may also be a connection between caregiver burnout and abuse and neglect.

This concept may be of greater priority than the access to resources concept, which might lend itself to a combination of the two concepts related to caregivers.

Measure #3: Hospitalization for Ambulatory Care Sensitive Conditions for Dual Eligible Beneficiaries (DUALS-1)

Lewin would re-specify this measure from the existing DUALS-1 measure, currently used in the Financial Alignment Initiative (FAI) core measure set for Medicare-Medicaid Plans (MMPs). For dual eligible beneficiaries age 18 years and older, this measure assesses state-level observed and risk-adjusted rates of hospital admissions for ambulatory-care-sensitive conditions (ACSC) per 1,000 beneficiaries for ACSC by chronic and acute conditions.

Summary of TEP Discussion and Recommendations

TEP members were divided on the relevance of this measure to HCBS as currently specified. Some TEP members felt that this can help measure the impact of HCBS on health care. HCBS providers and caregivers can help people with things that should improve the management of chronic conditions at home. The TEP thought this measure could reflect workforce training and their ability to help people identify when they need to seek care and when to seek care earlier. The TEP considered it an opportunity for earlier intervention in the HCBS population, especially for those who live with comorbid

disease. The TEP noted evidence that HCBS caregivers can reduce the hospitalization rate via training in the home on how to recognize issues and when to see a doctor.

Others felt that this is a good measure, but not necessarily appropriate for use as an HCBS measure. It speaks to the integration of service availability and access rather than any contribution of HCBS. HCBS providers do not have the ability to affect the numerator action, hospitalization, for this measure. The services measured by this metric represent multi-systems issues, and hospitalization might not be a function of caregiver failure. Some TEP members thought caregivers should not be held solely accountable. Some also noted that risk adverse states encourage HCBS participants to go to the hospital no matter what.

Among TEP members who felt negatively about measuring avoidable hospitalizations, they considered accounting for communication from the caregiver to the primary care provider or care manager would bring responsibility back more clearly to HCBS. A preventable emergency department visit measure would be another good topic to consider.

A TEP member noted that approximately 75% of HCBS members are dually eligible for Medicare and Medicaid (duals), which would require Medicare claims access to calculate the measure so that should be a consideration during respecification. The TEP also cautioned careful consideration about handling data from the pandemic given the prevalence of many of the conditions may be influenced by COVID-19 (but this caveat applies to all measures relying on data collected during the pandemic). Lewin noted that measure developers will treat data for 2020 differently likely across the board. SARS-CoV-2, the virus that causes COVID-19, could be added as a factor evaluated within the acute composite rate's numerator.

The TEP indicated that state level data does present some complications for risk adjustment. Lewin indicated a closer examination could occur during the feasibility assessment. The original developer of DUALS-1 created a model that addresses individual characteristics of the consumer.

A TEP member noted an Agency for Healthcare Research and Quality (AHRQ) measure on avoidable hospitalizations that addresses care, health, and welfare issues reflecting on the care the person received. This measure is in more of a gray area when talking about HCBS measures in particular. Lewin added that the diseases (e.g., pressure ulcer) in the specifications are Patient Safety Indicators measured by AHRQ.

Measure #4: Elder Maltreatment Screen and Follow-Up Plan

This measure would re-specify a Merit-based Incentive Payment System (MIPS) measure that assesses the percentage of patients aged 65 and older with a documented elder maltreatment screen using an elder maltreatment screening tool on the date of encounter and a documented follow-up plan on the date of the positive screen.

Summary of TEP Discussion and Recommendations

TEP members suggested that the re-specified measure expand the target population to include the non-elderly HCBS population, as maltreatment happens to people of all ages. As part of re-specifying for the under-65 age group, the TEP recommended Lewin bring content area experts in that population into the process.

The current specifications require a clinician to perform the screen, but TEP members support expanding this to home-care providers and service coordinators to increase usability for the HCBS population.

TEP members noted that most state MLTSS contract already measure the actions captured by the measure's numerator. The University of Minnesota (UMN) has a measure under development, NCI-AD has a question, and HCBS CAHPS® has a question that addresses consumer maltreatment. One TEP member suggested other development efforts have this covered; in particular, UMN's work includes a

focus on actionable outcomes - not just on screening, but on actual results and demonstration of actions taken to either respond to or prevent abuse. As a recent undertaking, the UMN elder abuse measure has been interrupted in the pilot stage due to COVID-19.

TEP members also noted that none of the validated instruments that capture process for abuse and neglect have demonstrated an impact on outcomes. It is not an issue amenable to giving someone a questionnaire. Unlike child abuse which has characteristics injuries, there are no similar findings with elder abuse compared to accidents. Some TEP members thought the measure that is needed is whether or not MLTSS plans and fee-for-service HCBS programs are actually acting on the data.

A few years ago Senator Chris Murphy raised concerns about the lack of major incident reporting in HCBS funded LTSS for people with I/DD (e.g., group homes). The Department of Health and Human Services (DHHS) has been assessing processes in states and identified major variance in reporting and compliance. This seems like a critical point to consider and integrate with the maltreatment question. It started as a query about whether states had reporting processes, then DHHS learned early on that even if states had good processes, DHHS did not have a process to determine whether or not there was compliance or a system for follow-up. This project could expand to develop measures to meet all the model practices specified in the [report](#). AHRQ has also developed a composite draft measure on avoidable incidents.

The report also explains how DHHS went about data collection. DHHS used crude diagnosis code for ED claims. For children, this is appropriate for abuse and neglect, but it is unclear how diagnosis codes really represent indicators of abuse in the adult population. Related to childhood injury diagnoses as compared to adults, there are a handful of injuries where there is rarely another real reason for them occurring other than abuse. There are no consistent physical correlations of abuse in adults. There are some ICD-10 codes used in family medicine for adult-related abuse. In the adult population, there is often a cycle of abuse in which victims come forward, then retract the complaint. That is something to think about in terms of how to help people and empower them.

General Discussion on Measures and Concepts #1 to #4

TEP members reiterated the importance of developing outcome measures as well as the issue of communication between HCBS providers and the health care system. There are several pilots and partnerships in MLTSS where in-home care workers receive extra training and are part of the interdisciplinary care team. There is another project with an app where the caregiver has direct communication with the care manager.

TEP members also reiterated choice and control as important areas for measure development, specifically outcomes in the context of settings within the HCBS spectrum, given the implementation of the HCBS settings rule, holding MCOs and other payers accountable.

The TEP identified two gap areas lacking any potential measures – equity and consumer leadership. Although difficult to measure, these areas are important. Consumer leadership remains a valuable asset to programs.

A TEP member noted state interest in understanding how best to measure parity. The TEP recommended that measures proposed should have equal applicability across all populations. The TEP also encourage consideration of how to measure equity in light of consumer choice and cultural preferences related to services and types of services that people choose.

Measure #5: Long-Term Services and Supports (LTSS) Comprehensive Assessment and Update (MLTSS-1)

This measure would be a re-specification of a process measure currently used in the MLTSS program, which assesses the approach to assessment, planning, and coordination of services and supports

focused on individuals' goals, needs, preferences, and values. Re-specification of MLTSS-1 would prepare it for use by fee-for-service (FFS) LTSS providers.

Summary of TEP Discussion and Recommendations

The TEP noted the very clear differences between FFS and MLTSS models. The TEP indicated that under FFS, a third party contractor would likely administer the assessment, rather than a care coordinator. As a result, the re-specification would need to address who conducts the assessment. With proper re-specification, this process measure could lead to a more organized FFS structure, which is greatly needed.

A TEP member noted that person-centeredness can be interpreted very differently by those working in the field. This issue can be addressed during alpha and beta testing.

The TEP also noted that care plans may be developed quickly with little depth or personalization. As a process measure, this would not determine how person-centered the plan actually is to meet an individual's needs. The TEP encourage considering going beyond measuring whether an individual has a plan and determine whether progress in person centeredness is being made.

The TEP noted that the significant differences across the different HCBS populations will require different wording and processes. If we pursue this measure, Lewin will confirm that re-specification is applicable to all HCBS populations.

There was support for the inclusion in the proposed measure of "representatives chosen by the individual." However, the TEP also urged Lewin to be cautious of proxy responses and potentially count them differently from individual responses because the individual responses and proxy responses do not always align.

The TEP raised concerns regarding inconsistencies between the CMS MLTSS specifications and NCQA Healthcare Effectiveness Data and Information Set (HEDIS) specifications. Lewin, NCQA, and CMS will work closely together to align the re-specification efforts of NCQA in this area with CMS' specifications. There was agreement that this is needed so the measure can be used in various programs.

Lewin confirmed that the MLTSS version of this measure is within the scope for maintenance. Any feedback on the MLTSS measure will also be considered.

Measure #6: LTSS Comprehensive Care Plan and Update (MLTSS-2)

This measure would be a re-specification of a process measure currently used in the MLTSS program which assesses the approach to assessment, planning, and coordination of services and supports that are focused on individuals' goals, needs, preferences, and values. Respecification of MLTSS-2 would prepare it for use by FFS LTSS providers. MLTSS-2 supplements data collected by MLTSS-1.

Summary of TEP Discussion and Recommendation

The TEP expressed a much greater need to focus on outcomes measures, particularly in FFS. While more feasible than outcomes measures, a process measure will not evaluate the quality of the care plan. The care plan must align with the individual's needs and how they want their needs addressed. The TEP prefers Lewin to consider measuring the number of individuals who believe their care plan meets their needs or who consider themselves the decision-maker in their plan. Asking the person directly through experience of care surveys helps assess person-centeredness.

Additionally, the TEP wants Lewin to consider who will respond to the assessment. Care coordinators will respond to this question very differently than the individual because they are not able to know every need or want and objectivity will be difficult.

The TEP wants Lewin to take cultural sensitivity and deep-rooted health disparities into account. While difficult to measure, but measuring language and background has been feasible. The TEP also noted that systems across the country collect cultural or SDOH data very differently.

While this measure does not give you the outcome of person centeredness, it does give you the framework and the structure that many areas and organizations do not have yet. By having a structure in place, it helps you check that you are not missing areas that are important to and for the person's life. Once the process is in place, we can move towards measuring the person-centeredness.

Concept #7: Performance and Accountability - Percentage of People Who Receive What is Authorized in their Service Plan

This de novo concept focuses on process, estimating the percentage of Medicaid beneficiaries utilizing HCBS that receive authorized services from their person-centered service plan (PCSP).

Summary of TEP Discussion and Recommendation

The TEP reinforced the importance of service plans, but also emphasized the importance they be constructed from a person-centered standpoint. Services authorized in a service plan do not always provide an individual what they need or want. HCBS participants do not use all of their authorized services for many reasons, not all of which are bad. The TEP thought this measure may be appropriate for certain areas of HCBS, such as personal care services and network adequacy.

The TEP also indicated that measuring the amount of service does not necessarily equate to quality. Additionally, the fluid nature of service plans in order to react quickly to the needs of the individual can make accurate measurement difficult.

In support of this concept, the TEP considers it a fundamental and feasible area to measure which is currently lacking. If someone does not receive needed services they need, that is a fundamental process failure.

Concept #8: Direct Service Workers (DSW) per 100 People Age 18 and Older with an Activity of Daily Living (ADL) Disability

This de novo concept focuses on structure, assessing the number of full-time equivalent (FTE) direct service professionals, home health aides, and personal care aides who support Medicaid beneficiaries over the age of 18, who are recipients of Medicaid HCBS.

Summary of TEP Discussion and Recommendation

The TEP suggested inclusion of paid family members or personal contacts as direct service workers (DSW) when specifying this concept.

The TEP considered this measure a starting point for measuring aspects of quality associated with DSWs in HCBS upon which CMS could build greater, more informative measures in the future. The TEP noted that counts differ from quality of the workforce and knowledge, there is greater value in measuring quality. It would be feasible to pull the count of workers from the Electronic Health Record.

The TEP expressed concern regarding the difficulty in connecting the number of DSWs with quality without understanding the underlying reasoning. A strict count does not always take acuity into account. Rather than focusing strictly on the number, the TEP recommended Lewin consider turnover or retention rates, especially at the time of separation. Some TEP members also felt that there is already a significant number of resources related to this topic, such that the addition of this measure would not be meaningful.

General Discussion of Measures and Concepts

Lewin asked the TEP to share their final thoughts after reviewing all of the measures and concepts. The TEP commented that additional proposed measures should speak to setting, choice and control, and community inclusion. Measures should also focus on outcomes measures in HCBS. However, creating a portfolio of measures that take into account a number of sources and inputs that will help CMS make the final decisions in this area remains the top priority. The TEP wants to include a mix of measure type, de novo versus re-specification. Lewin also noted that other contractors are currently addressing choice and control and community inclusion.

The TEP should not discuss all the measures in a vacuum when COVID-19 has such an impact. As it takes about two years to develop a measure, the team would not use the pandemic specifically as a reason to push a measure forward or take one back due to the timeline, but it exacerbates existing issues that will be discussed.

Lewin shared more information on the selection of eight measures from the narrowed list of thirteen measures/concepts and shared the five measures that were not included in the discussion. The TEP agreed to consider adding a self-direction measure in the list of measures/concepts. The HCBS field expresses interest for this topic and opportunities for improvement since HCBS includes self-direction.

The TEP recommended a few additional considerations.

- Survey administrators should handle proxies carefully so that individual perspectives are included.
- Assessing inclusion, desired activities, and happiness are complex, but important to capture.
- Our health care system is siloed, which is a barrier to measurement. Behavioral health and other key health services are not integrated into HCBS because of an inability to effectively communicate among the siloes.

Lewin reviewed upcoming activities and next steps before closing the meeting. Next steps include sharing a TEP meeting summary from this meeting, narrowing the candidate list to no more than four measures and concepts, conducting an ES/LR for the candidate measures and concepts, engaging individuals, caregivers, states, and other stakeholders to discuss the candidate measures and concepts, and preparing the findings from these activities for the next TEP meeting.

Appendix A. TEP Members and Project Team

Exhibit 1. TEP Members

Name and Title	Organization
Mary Lou Bourne, MS , Chief Quality and Innovation Officer	National Association of State Directors of Developmental Disabilities Services – Virginia
Daniel Brown, MBA , Executive Director	Racker – New York
Joseph Caldwell, PhD, MS , Director of the Community Living Center	Brandeis University – Massachusetts
Dana Cyra, MA , Caregiver and Executive Director	Inclusa – Wisconsin
Raina Josberger, MS , Deputy Director	Division of Quality Measurement, New York State Department of Health – New York
Cathy Lerza , Clinical Services and Quality Improvement Branch Manager	Kentucky Division of Developmental and Intellectual Disabilities – Kentucky
Kentrell Liddell, MD , Vice President of Quality Management and Infection Control	Mid-Delta Health Systems – Mississippi
Coretta Mallery, PhD, MA , Principal Researcher	American Institutes for Research – Virginia
Jill Morrow-Gorton, MD, MBA , Senior Medical Director	University of Pittsburgh Medical Center Health Plan – Pennsylvania
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Exhibit 2. Project Team Members

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