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Via email: HCBSMeasuresRFI@cms.hhs.gov

Re: Comments to CMS' Request for Information: Recommended Measure Set for Medicaid-Funded Home and Community-Based Services

Dear Ms. DeBoy and Ms. Bowdoin,

Thank you for the opportunity to provide comments on the Request for Information (RFI) on the Recommended Measure Set for Medicaid-Funded Home and Community-Based Services (HCBS). America's Health Insurance Plans, Blue Cross Blue Shield Association, Medicaid Health Plans of America, and the National MLTSS Health Plan Association collectively represent the significant majority of health plans providing coverage to Medicaid beneficiaries with long term services and supports (LTSS) needs.¹ We are dedicated to ensuring our beneficiaries have consistent access to high-quality services at the time and place of their choosing. As the national trade associations representing health insurance providers at the state and federal level who serve hundreds of millions of Americans every day, we applaud CMS for its leadership in seeking to measure and thus improve the HCBS and welcome the opportunity to respond to the questions posed in the RFI.

As noted in the RFI, comments are intended to inform the Centers for Medicare & Medicaid Services (CMS) initiatives including the Medicaid and CHIP Scorecard, the Adult and Child Core Sets, and the future Medicaid and CHIP Quality Rating System. Thus, while the discussion is currently around a voluntary system, it is possible that this will evolve into a mandatory accountability program. Given the importance and magnitude of the potential impact of this RFI on our organizations and our enrollees now and in the future, we have invested significant time and resources in the development of the attached comments. We hope that you find the responses constructive in advancing this critical work, and that this is the beginning of a fruitful partnership with the private sector in advancing HCBS measurement.

Given our collective experience with the creation and evolution of many measurement systems, we believe there are some overarching lessons learned that we wish to share here and that are infused within our responses. We want to emphasize the importance of adhering to a thorough measure development and quality measurement system implementation process by:

- specifying measures fully and making them publicly available,
- testing them in the field at the level to which they will be applied to assure scientific validity and feasibility,
- testing statistically any composites, domains, weighting, or summary statistics,
- testing via focus groups all layouts, display text, and graphics,
- sharing publicly results of all testing for stakeholder review,
- assessing them against selection criteria before inclusion in programs including the notion of being fit for purpose,

¹ www.ahip.org; www.bcbsa.com; www.medicaidplans.org, www.mltss.org

- ensuring there is always a reporting period of a year before integration into any accountability program,
- conducting dry run periods where reporting entities can seek corrections, and
- soliciting stakeholder feedback each step of the way before policy decisions are made.

We appreciate that the draft measures outlined in the RFI are an important first step to assessing HCBS quality, but such information is not yet ready to be incorporated in accountability programs such as public reporting or value-based purchasing. Below we outline several areas where we feel additional work is needed or clarifications are required before the information can be used to compare health insurance providers by consumers or governmental agencies.

Measure Specification and Testing

CMS is proposing to gather information and potentially compare the performance of health insurance providers on a complex population, increasing the importance of validated measures. The RFI proposes to use a combination of measurement tools that have not yet been converted to performance measures. We agree that it is important to test options for information gathering but emphasize the importance of using the results as the basis for further designing, testing, and validating performance measures. The tools suggested by CMS in the RFI are a good first step toward gathering information that can then inform the scientific process of measure development before integration into public reporting or value-based purchasing programs.

Heretofore, stakeholders have expressed concern over the survey instruments that would be used to gather data for the measurement system. Stakeholders wish to collect robust, beneficiary-reported data, but this can be burdensome to respondents and plans alike if not carefully crafted and administered. The RFI notes the intention to rely on measures developed from existing surveys, namely HCBS CAHPS and NCI/NCI-AD, all of which are proprietary surveys that add further expense to states and health plans. These tools were designed, tested, and validated as full surveys. Thus, additional development work and testing are needed to ensure the extracted items can be utilized as valid and reliable stand-alone performance measures or as a unified set. Raw rates, for example, would need to be further developed into measures and then tested at the level to which they would be applied. We encourage CMS to include only measures in the base set that are either available to the public via a survey instrument free of charge or have tested and validated to stand on their own.

CMS stated an intent to ultimately use the HCBS quality data to inform other measure initiatives, including the Adult and Child Core Sets and the future Medicaid and CHIP Quality Rating System. For this reason, it is essential that measures of HCBS quality undergo the same scientifically rigorous testing to ensure reliable results as the other measures in the aforementioned initiatives. Quality HCBS are essential to a happy and healthy life for millions of Medicaid beneficiaries. It would be a disservice to those beneficiaries to provide them with unreliable or misleading information on the quality of these services. All measures should be fully specified, and those specifications should be made publicly available. Additionally, those measures should be field tested at the level to which it is applied to ensure scientific validity and feasibility.

Measure Selection

We appreciate CMS's work to ensure measures selected for the HCBS core set meet the NQF endorsement criteria of importance to measure and report, scientific acceptability, feasibility, and usability and use. We agree that any performance measures selected must meet these criteria to ensure that it provides meaningful information and is possible for stakeholders to implement without undue burden. Based on our members' experience as well as the work of groups such as the Core Quality Measures Collaborative (CQMC), we suggest that CMS consider additional principles for measure selection that are detailed in the attached comments.

It is worth noting that the selection of measures may differ depending on the intended use. For example, some measures are sufficiently robust for internal quality improvement efforts based on trends over time. However, those same measures may not be suitable for rank order comparisons and thus consumer choice or payment differentiation. As an example, some measures are subject to volatility based on small sample sizes and thus unreliable for payment programs, but those same measures can be valuable as early warning signs by participating plans. Thus, it is very important to assess that a measure is fit for the particular purpose for which it will be used.

Aggregation

What makes disparate measures into a measurement system is how the measures are displayed, grouped and calculated into an overall score. While necessary, the testing and selection of the individual measures is not sufficient to create a robust measurement system. Statistical testing is required for any composites, domains, weighting, or summary statistics calculation. Moreover, focus group testing of all layouts, display text, and graphics are also critical. This ensures that consumers understand the information and find it easy to use.

Operations

Once the measures are successfully grouped into a measurement system, attention should be turned to the operational process. It is important to institute some checks and balances even within a voluntary system. For example, in the first year of reporting a measure, there can be hiccups that have nothing to do with actual performance but how the data is collected, aggregated, transmitted etc. Conducting dry run periods where reporting entities can seek corrections is a best practice. In addition, ensuring there is always a reporting period of at least a year where measures are publicly displayed before being integrated into any value-based purchasing program is key to a smoothly run program with continued stakeholder support.

Stakeholder Feedback

We very much appreciate CMS' solicitation of stakeholder input through this RFI. We believe that it is imperative that CMS continue to take the time to gather feedback as it proceeds with measure testing, selection, aggregation, and display. By working hand and glove with health insurance providers as policy decisions are made, we can build a powerful tool on which consumers, service providers, health insurers and CMS can relay.

We strongly support CMS' efforts to gather data to effectively measure HCBS and align the use of measures across the states. We encourage CMS to continue its thorough, thoughtful and transparent approach that is consistent with the CMS Meaningful Measures Initiative. We recognize the challenges inherent to creating robust measures in the HCBS space and ask that CMS continue to engage the stakeholder community. We thank you for the opportunity to comment on the RFI for the Recommended Measure Set for Medicaid-funded HCBS. We look forward to working with you on this worthy endeavor as CMS' work continues.

Sincerely,

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CMS RFI: Recommended Measure Set for Medicaid-Funded HCBS

Joint Comment Letter Response

11.18.20

PURPOSE

What is the value of having a standard set of recommended quality measures for voluntary use by states, managed care organizations, and other entities engaged in the administration and/or delivery of HCBS? What benefits or challenges would result from the release of a recommended set of quality measures?

There are several potential benefits to having a standard set of recommended quality measures for voluntary use by states. **A standard set of CMS recommended (Home and Community Based Services (HCBS) quality measures would ensure better consistency across payers (Managed Care Organizations (MCOs), Fee-for-Service (FFS), etc.) and states, and improve overall consumer choice, quality expectations, and policy advancement.** The release of a recommended set of quality measures would ensure greater consumer awareness and improve consumers' ability to make informed choices related to their HCBS if adopted by multiple states. It would also allow for cross-state comparisons that could advance important policy priorities (i.e., rebalancing) and provide a quality of care benchmark that all HCBS beneficiaries could expect to receive regardless of location. We want to stress broad availability of the measure specifications to allow those contracted to deliver HCBS to utilize the measures even if their state is slower to adopt them. This would also allow plans to validate measure results calculated by the states that do adopt the measures. Widespread use will support continuous quality improvement in HCBS, as comparative measures help entities identify opportunities for improvement.

One of the major challenges in a recommended measure set is the anticipated expense and cost-burden to states and health plans to alter existing assessment tools and processes. Depending on what the technical specifications for the measures in the RFI look like, both standardized assessment tools and non-standardized, state-mandated assessment tools may need adjustment. Data collection and reporting systems will also need revision at a significant cost to the state and payers. Plus, many states have significantly invested in lengthy, time-consuming surveys that yield small sample sizes. Small sample sizes are particularly concerning as the measures being recommended require a large sample to produce actionable results. Further, if the recommended measure set changes over time, additions that a state may want to include will result in additional costs and significantly impact benchmarking and trending capabilities year after year.

CONTENT & ORGANIZATION

Do you think that the measure set should be organized into a base set and an extended set? Why or why not?

Organizing the measures into base and extended sets ease implementation burdens on states, payers, and HCBS beneficiaries. Having an extended set also allows states to customize which measures they use

within the base or extended to their unique situation while simultaneously setting a common framework of recommended core measures.

We agree with having both a base and extended recommended measure set to allow for flexibility for plans and allowing core measures to be compared. This would allow plans that are new to the LTSS space the opportunity to start with a few measures and add more from the extended set as they grow over time. The same can also be said for states whose LTSS programs and their current ability to capture and synthesize quality measurement data vary nationally.

There should also be consistency between the base set of recommended measures and the NCQA LTSS HEDIS as well as NCQA LTSS distinction. There are some differences between the measures and specifications that would make the base set of measures CMS is proposing hard for states to implement. Clarity from CMS and NCQA that addresses these variations would be extremely valuable to states and plans alike, as these small changes have been disruptive in the ability of plans to consistently measure the same thing across the board over time in various parts of the country. For the organizational scheme of a base and extended set to achieve its goals of maximizing comparability while minimizing reporting burden, the measures and their full specifications must be aligned. Additionally, any consensus reached between CMS and NCQA should accommodate the tools used across states as it is a considerable undertaking for states to change the assessment tools they use. CMS should encourage states only use scientifically valid and reliable tools, as several states are doing this, but many still are not. The Association believes there is a strong rationale for prioritizing certain domains, there is an established breadth and depth of validated measures to draw upon (see additional recommendations below).

Do you agree with organizing the measures by NQF domain? If not, is there a different organizing framework that you would recommend?

While the eleven NQF domains represent important aspects of HCBS quality, there are concerns that dividing these concepts into so many domains may create measurement challenges. As noted in the RFI, several domains lack available measures, while others lack measures that are statistically robust and meet most of the selection criteria to be included in the recommended measure set. We caution CMS that if the focus on domains results in only one or two measures being identified in certain domains, the value of focusing on domains diminishes because such a small number of available measures will not help states get a true picture of what is going on in that domain. The Association, thus, suggests that domains be prioritized based upon the depth and number of base measures to effectively evaluate. CMS could collapse or combine domains with respect to the recommended set in the short term until more tested measures are available for each of the eleven NQF domains, and should solicit additional feedback on any proposed combination from various stakeholders (including advocates, health plans and states). In its 2017 recommendations on quality measurement, the MLTSS Association collapsed the existing domains into five categories. There could be some value in CMS and ACL, initially combining some of the domains, particularly to manage the number of measures. This approach would align with CMS's Meaningful Measure Initiative and would be similar to recent changes CMS made to the Hospital Star Ratings Program. Collapsing the NQF domains could allow for a simpler display to consumers and may allow for more robust reporting if CMS chooses to report summary scores by domain.

In addition to collapsing the NQF domains, there is an opportunity to reorganize the categorization of some measures. **For example, a case could be made that any measures related to “rebalancing and**

transitioning from institutionalization to HCBS” should be categorized as a separate domain given the significance of this issue in terms of establishing and monitoring rebalancing efforts within a state over time. There are several associated measures currently outlined in the recommended measure set for other domains that could be appropriately captured in a “rebalancing, transitioning, deinstitutionalization” domain, including but not limited to “system performance and accountability.” This category could also be extended over time to better measure efforts by states and plans that lead to a diversion in care transitions to institutions, another extremely important measure of rebalancing that is not currently captured well by states in LTSS systems.

Overall, the Association agrees with the idea of organizing the measures by domain, but suggests the measures could be temporarily combined/collapsed to allow for a more robust set of measures across a smaller number of domains that includes process, structure, and outcome measures (with an emphasis on inclusion of outcome measures in the recommended set). That way, states and plans have a better structure to prioritize certain measures (i.e., the outcome measures). That could also limit the total universe of measures, improving implementation feasibility and uptake by states.

Which domains in the NQF report are most important to address through the recommended measure set?

To ensure consistency, the recommended base set includes the three NCQA MLTSS-HEDIS measures contained under the “person-centered planning and coordination” NQF domain. As previously mentioned, if CMS does decide to prioritize certain domains over others or combine the 13 NQF domains in the short-term until more measures that meet a majority of the selection criteria are available, the MLTSS Association respectfully requests that CMS consider organizing them similarly to what was recommended in the [Model LTSS Performance Measurement and Network Adequacy Standards for States](#), with some slight adjustments/modifications. The following list is reflective of the Association’s most current recommendations for those domains that should be prioritized, and a suggested approach for organizing them and assuring key measures/areas are adequately covered:

- Integration Risk Factors
 - Equity
 - Social Risk Factors
 - Human and Legal Rights
- Person-Centered Planning & Coordination
 - Consumer Leadership in System Development
 - Choice and control
- Community Inclusion
 - Setting of Choice
 - System Performance & Accountability
- Quality of Life
 - Participant Satisfaction
 - Service Delivery and Effectiveness
 - Holistic Health and Functioning
- System Capacity
 - Caregiver Support
 - Workforce Capability

Please note that under the fifth suggested domain, “System Capacity”, there are two factors mentioned – workforce capability and caregiver support – that are extremely important to understanding the system's ability to effectively support individuals optimally their own homes and typical community settings. The Association notes some gaps in the draft recommended measure set in terms of prioritizing these areas, so has attempted also to capture these areas in its recommended list of domains/subdomains to focus on.

Measure Selection Criteria

Are there changes that CMS should make to the measure selection criteria?

Which of the criteria are most important and should be prioritized?

The Association believes the following three criteria are the most important to be considered and weighed in terms of prioritizing the inclusion of specific measures in both the base and recommended measure set:

- *Feasibility*: If MLTSS plans cannot implement and report on the measure within reasonable efforts to do so (for example, if a measure relates to a specific population that is not captured in the plan), then it should not be included in the base set until the data barriers are removed.
- *Use/Usability*: Plans must apply and use the measures to inform changes to service provision and internal priorities for spurring systems change.
- *Scientific Applicability*: Even if a measure has been widely adopted and is being applied consistently across the country if there is no assurance that the measure has been rigorously tested for validity and reliability, then the measure may not be effectively measuring what it is supposed to be and thus misleading both plans and states. While adopting valid and reliable measures is important, there are currently a limited number of scientifically acceptable measures available in the HCBS space. This process of implementing a recommended measure set should assist with building an evidence base so that more measures tested for validity and reliability can be available in the future.

Based on work with the Core Quality Measure Collaborative and our members’ experiences, we believe there are some additional measure selection criteria CMS could consider:

- *Alignment with Value-Based Payment Principles* – It is also recommended that the alignment of a measure to value-based purchasing principles be considered an additional selection criterion. The RFI states that “the HCBS recommended measure set is intended ... to create opportunities to have comparative quality data on HCBS programs and services, including for value-based purchasing and alternative payment models.” Certainly, some measures included in the base set that are more amenable to VBP and APM models, such as MLTSS-6 (LTSS Admission to an Institution from the Community). However, other measures in the base set would not be appropriate for VBP or APM models, such as the percentage of people in group settings whose visitors can come at any time (NCI-AD), particularly during the pandemic. Alternatively, suppose CMS cannot include alignment with value-based purchasing principles as a selection criterion. An important distinction should be made between measures that are appropriate for states that have implemented VBP or APM arrangements v. others that do not. Another way to frame the

issue would be for CMS to simply clarify to states that they should not include the entire base set in its current form into a VBP or APM arrangement.

- *“Beneficiary Check”*— to ensure that the measures CMS ultimately determines are necessary and selections for the base or extended set align with what HCBS beneficiaries themselves feel are important indicators of quality HCBS. The CQMC measure selection principles emphasize the need for measures that provide a person-centered, holistic view of quality. CMS could also consider the beneficiaries experience of care and if the measure(s) addresses social determinants of health.
- *Promoting Innovation*: The measure represents a meaningful balance between burden and innovation. Measures in the set should minimize data collection and reporting burden, be ambitious yet within the locus of control of the measured entity (i.e., the measured entity can meaningfully influence the outcome and the measure is implemented at the intended level of attribution) and are appropriately risk- adjusted and account for factors beyond the control of health insurance providers.
- *Unintended Consequences*: The measure is unlikely to promote unintended adverse consequences.

We would also recommend that CMS consider the composition of the measure set when selecting measures. An ideal measure set should include an appropriate mix of measures while emphasizing outcome measures and measures that address cross-cutting aspects of quality. The measure set should provide meaningful information to all stakeholders while using the most efficient and parsimonious number of measures. We would emphasize that the measure set should be person-centered and conceptually important to HCBS beneficiaries, including addressing their experiences and promoting health equity by addressing social determinants of health and reducing healthcare disparities.

Should the base and extended measure sets only include measures that have undergone testing and validation? How important is it for measures in the base set and/or extended set to be endorsed by a consensus-based entity, an accreditation body, or other independent entity? Should CMS prioritize, for inclusion in the measure set, measures that have been endorsed by any particular entity?

Arguably, there is tremendous value in ensuring that any measures included within the measure set have completed rigorous testing and validation, particularly in the base set. Measures used for accountability purposes (such as public reporting or value-based payment) should be proven to be valid and reliable prior to implementation. The Association would caution that some of the draft measures in the base and extended set may require further development and testing before implementation for accountability purposes.

We recognize the importance of gathering beneficiary reported information to ensure measurement efforts address the aspects of care most important to the people receiving these services. We appreciate the widespread use of the NCI and NCI-AD and the efforts states have put into implementation and the psychometric soundness of the instruments. However, we would recommend that CMS look to the

National Quality Forum’s 2012 report on Patient-Reported Outcomes in Performance Measurement and use the pathway outlined in that work develop and test the indicators as patient-reported outcome-based performance measures (PRO-PMs) before implementing them in accountability applications. NQF notes that PRO-PMs are based on PRO data aggregated for an entity deemed as accountable for the quality of care or services delivered. The Association would encourage CMS to specify how PRO-PMs from the NCI and NCI-AD will be constructed (e.g., an average change, a percentage improvement, or the percentage of respondents meeting a specific benchmark value) and to fully specify the measures including target populations, exclusion criteria, and any necessary risk adjustment. Finally, we would recommend that CMS fully test these PRO-PMs for reliability and validity at the health plan and MCO levels of analysis and not report raw or unadjusted rates.

Endorsement by a consensus-based entity, accreditation body, or other independent entity should not be required, but can provide affirmative evidence of the robust nature of a measure. We believe measures without such endorsement should be considered for inclusion given these bodies generally do not have significant experience with the nuances and non-medical nature of HCBS. Instead, all measures that have been rigorously tested and in wide use should be reviewed and evaluated for their suitability in the recommended measure set based upon a consistent application of the selection criteria.

We do not believe that CMS should require that entity particular entity endorse measures at this time. However, we recommend prioritizing the existing NCQA LTSS-HEDIS measures since most MLTSS plans are already collecting data on those measures and could report on them relatively quickly.

Should there be differences in how the measure selection criteria described above are applied to measures that are important to measure and/or are widely used by states and/or managed care organizations? Should the base and extended measure sets cross all HCBS populations? If no, what special populations should be addressed in the extended set? What types of measures, if any, would apply only to a suggested population(s)?

Many states have implemented measures that get to the heart of whether person-centered care planning is occurring, as well as measuring the number of people transitioning from institutional care to HCBS settings. Even though these measures may not currently meet the “scientific acceptability” selection criteria, they yield valuable information that could immediately inform health plan and state action. As such, we strongly encourage CMS to rigorously apply the usability and use selection criteria. The rationale for not doing so in the RFI is the “lack of publicly available information on the extent to which the measures are currently in use.” However, several organizations, such as the Community Living Policy Center at Brandeis University, have very thorough databases of HCBS measures in wide use by states and MLTSS plans. In the future, it would be extremely useful if federally-funded efforts focused on HCBS measure development and testing published the level of “scientific acceptability” of various measures so that states and plans alike could access this data to help inform whether to include specific measures in HCBS quality efforts in the future (as well as to determine whether to invest in further testing or validation of a measure that may not yet be deemed “scientifically acceptable” but which has demonstrated some initial promise for becoming a rigorous measure). However, measures without sufficient testing should be considered for collection and calculation of results to build the evidence base or internal quality improvement, not for public reporting or within a payment programs until such evidence is generated. Additionally, further consideration should be taken with respect to what the

requirements will be around publicly reporting data, particularly when sufficient sample sizes are not possible to assure generalization of the stratified results.

The MLTSS Association recommends implementing base measures across all HCBS populations with stratification based on demographic characteristics (e.g., race, age, sex, gender, disability type, dual eligibility status, etc.) and level/types of need. There are instances where stratification is particularly important in getting a truer picture of why there may be substantial data disparities. The challenge to stratification is ensuring that data can be captured on a large enough sample size to make any assertions on specific populations without losing statistical significance or validity.

Should the base set and/or the extended set only include measures that are in the public domain and are available at no charge? Is it important to offer publicly available measures that are free of charge as alternatives to any proprietary measures included in the base set? Should publicly available measures be offered as alternatives to any proprietary measures included in the extended set? How important is it to include experience of care survey measures in the measure set?

Experience of care survey measures are essential in assessing performance in meeting several important outcome-related goals and benchmarks. For example, it would be hard to determine compliance with a measure such as “percentage of people whose service plan reflects their preferences and choices,” without an experience of care survey measure. There is an important balance to strike in terms of avoiding “survey fatigue” among HCBS program participants and getting a clear sense of the experience of individuals in terms of getting the services they need based on their preferences and whether such services resulted in desired outcomes linked back to goals outlined in the person-centered plan.

To our knowledge, there are no member experience of care measures relative to HCBS provision that are currently publicly available free of charge to states or health plans. Member experience of care measures used to date are in surveys that States (and plans) must pay for. States must pay to use NCI and NCI-AD, and MLTSS health plans must pay for administration of HCBS-CAHPS where it is contractually required by states. If measures extrapolated from these surveys are included in the HCBS recommended measure set, then it is important that CMS and ACL push for these national surveys to become more affordable (and ideally, free) to all states and health plans, or not include any measures from these tools until they are tested and validated to stand on their own outside of the survey tool. All of these surveys were developed and/or implemented with the support of federal investment, and thus should be publicly available without enormous expense to states and plans.

Measures that are publicly available and free of charge offers greater parity in the HCBS quality measurement process by allowing all states access to such measures. CMS might see more significant usage of consumer experience surveys (both HCBS-CAHPS and NCI, NCI-AD) if they were available free of charge to states and health plans. Until then, the field is hungry for modularized measures that can be used independently of an extensive survey and still get at this critically important area.

These survey-based measures should not be the basis of value-based purchasing or other alternative payment models, at least not until they are better validated and more widely implemented. Measuring care experience would be extremely valuable to comparing state and plan performance in the future, but available measures do not track or provide actionable information. A few limitations of experience of care

survey measures, however, that need to be addressed before widespread usage are: surveyor training and bias (implicit and explicit); limited sample sizes; significant lag in results (for example, some plans are just now in 2020 getting survey results from 2018). Given these constraints, some existing measures would require the state to be the reporting entity instead of plans.

Are there any measurement domains or areas for which it is important to have population-specific measures? How important is it for measures included in the base set to be applicable across delivery system types (e.g., fee for service, managed care, self-direction)?

All measures in the base set should apply across HCBS populations; however, as previously stated, they should also be able to yield a large enough sample to allow for stratification by demographic characteristics (e.g., race, age, sex, gender, disability type, dual eligibility status, etc.) as well as across eligible HCBS waiver/state plan subpopulations (physical disability, intellectual/developmental disability, serious mental illness, older/aging individuals, etc.). Further, defining LTSS populations consistently is critically important to yielding accurate findings relative to quality measurement.

There are some instances in which there may be important questions specific to one or more subpopulations that should be considered population-specific within the extended set. One suggested approach is applying the basic set to the full population and stratifying the extended measure set. Additionally, targeting questions to specific populations may be less burdensome than asking everyone the complete set of questions.

Regarding delivery system, the Association also believes that the measures in the recommended set are applicable across delivery system types as well (which include FFS and managed care), and, at a minimum, should be a requirement of all measures in the base set. Otherwise, it will be overly complicated, confusing, challenging, and misleading to compare HCBS quality across systems if measures cannot be consistently applied across FFS and MLTSS system types. Please note that the Association does **not** consider self-direction to be a delivery-system type comparable to FFS or managed care. It is a form of consumer-directed services available in both FFS and managed care. It would be valuable to compare beneficiary experience and satisfaction with self-direction in both delivery systems (FFS and managed care) to assess if there are any meaningful differences and learn from any variations.

Of course, certain measures that are applicable for managed LTSS are not transferrable into some fee-for-service population (e.g., care plans). Additionally, there are distinctions in language that should be factored into the discussion (for example, some states use the terms service coordination and case management synonymously, while others do not). Such exceptions would need to be factored into this strategy as well. And yet, it is also important to note that some FFS models include strong service coordination, PCP process, and in some cases a managed manner of approval or authorization of plans. For example, one Medicaid FFS model ensures that the member gets individually assessed for each service with no coordination, but some FFS models describe a waiver model. These synergies but slight distinctions in payer models are also important to factor into either using the same measure across plans or similar measures that may be phrased slightly differently but are focused on measuring the same phenomena.

Another area of concern that the Association would like to emphasize is the use of a measure across different facets of LTSS provision (for example, measuring and comparing the quality measure across

institutional v. HCBS populations). For example, a major source of confusion in the current HEDIS LTSS Measure set is including the nursing home population in measures that seem to be focused on HCBS services. There should be a distinction between quality measures for people living in the community and quality measures for people residing in a nursing home. The current rates for the LTSS measure set provide an inconsistent picture of quality or compliance in a program when the participant's assessment, care plan, and service model are entirely different in the 2+ settings, but the results are not stratified by setting.

Some stakeholders have indicated a preference for decreasing reliance on process measures and the focus on compliance in HCBS quality measurement programs, instead putting an increased focus on quality improvement and the use of outcome measures. Would greater focus on quality and outcomes facilitate the provision of Medicaid-funded HCBS? If so, how? What specific existing process or structural measures generate the most valuable information for measuring and improving quality or outcomes? Are there specific measures that your organization is using for compliance purposes that you would recommend for inclusion in the recommended measure set? Please be specific both about the measures suggested and how they are being used by your organization. CMS intends to include information in the recommended measure set on how each measure can be used to support reporting requirements associated with the section 1915(c) assurances and sub-assurances or other CMS requirements. How can CMS further reduce measurement and reporting burden through this recommended measure set?

The MLTSS Association concurs with other stakeholders that focusing on outcome measures would be most valuable for moving the field forward in the provision of high-quality, results-oriented LTSS. It should be noted, however, that collecting data on certain process measures is critical in getting to important outcomes. For example, although "flu vaccination" is a process measure, this year, it is related to a critical life-or-death outcome (in terms of decreasing HCBS beneficiaries' COVID-19 infection and mortality rates).

Below is a representative list of processes or structural measures that can generate valuable information for measuring and improving quality or outcomes. It is important to note that the following measures are in state operational reports, performance measures, or HEDIS measures, and would also be useful process measures to include as structural or process measures in the recommended extended set.

Integration Risk Factors

- All-Cause Readmission
- All transition and rebalancing measures (MLTSS-6, MLTSS-7, MLTSS-8, Percentage of LTSS beneficiaries receiving HCBS)
- Flu Vaccination
- Falls with or without injury
- Critical incidents and abuse reports per 1,000 members
- Restrictive Intervention & Restraint Utilization Rates
- Percentage of beneficiaries who feel safe and know who to talk to if not

Person-Centered Planning, Consumer Engagement & Self-Determination

- Consumer representation/involvement in governance structure and planning related to quality assurance and improvement
- Level to which HCBS consumers, on their own or with support, are provided sufficient, understandable information to make decisions
- Processes to monitor the quality of care management to ensure comprehensive, person-centered assessment and care planning processes.
- Percentage of beneficiaries reporting care plan includes things important to them
- Self-direction of services and supports among Medicaid beneficiaries receiving LTSS

Community Inclusion

- Proportion of people who had a goal related to getting a job in their service plan, and % of those individuals who have acquired or maintained competitive integrated employment (and thus achieved their goal)
- Percentage of people who can see or talk to their friends and family when they want to

Quality of Life

- Percent of respondents who indicate being engaged in meaningful activities as they desire

System Capacity

- Caregiver assessment conducted
- Payment/Prior Approval/Appeal Rates (% of payments made correctly and consistently; % of prior approval denials; % of appeals processed within a specified time frame)

With respect to specific measures that are being used by health plans for compliance purposes, this varies across plans and also based on any guidance from state Medicaid agencies as part of contractual agreements, but a representative sample is laid out below:

- **Network Adequacy by SPC:** Measures the number of members currently utilizing the service and projects future enrollments. This measure helps the MLTSS plan assess HCBS provider network adequacy.

With respect to reducing measurement and reporting burden for both states and health plans via the recommended measure set, the following areas would be of great benefit in terms of streamlining data and maximizing efficiencies in the quality measurement process:

- Provide consistent guidance in measure specifications across CMS & NCQA measures (however, it is also important not to change the specifications too quickly just to make sure that they can be measured over time and be used for improvement purposes, so there is a careful striking of the two priorities with regards to developing specifications and allowing them to be used and assessed for feasibility over time).
- Provide all Medicare data (eligibility, claims, and clinical) for an MLTSS plan's HCBS members who are dually eligible and unaligned.

- Require that all facilities provide MLTSS plans with free and timely access to MDS data in a manner that the plans can ingest into their data systems.
- Allow MLTSS plans to incorporate some of the member experience measures (that would not pose a conflict of interest) into our existing assessment process.
- Redirect CMS' previous focus and state Medicaid investments on assurances/sub-assurances and focus heavily on advancing outcome-related (with some structural/process) measures looking specifically at quality.

LIMITATIONS

How often should the measure set be reviewed for potential retirement of included measures and/or addition of new measures? How often should the base set and/or the extended set be updated?

The association recommends CMS follow a similar review process that is currently used for the Medicaid and CHIP Child and Adult Core Sets, which is designed to identify gaps and suggest updates to strengthen and improve the set. The process includes:

- A. **Annual Core Set Review Workgroup:** The workgroup is comprised of Medicaid and CHIP stakeholders and measurement experts who develop a set of recommendations for changes to the Core Sets. Any annual care set review workgroup created for the purposes of revisiting the core/extended measure sets for HCBS quality should also include representation among other payer segments that may be implicated, like special needs plans (SNPs), for example.
- B. **Meeting:** The Workgroup convenes each year to provide input into the annual revisions to the Medicaid and CHIP Child and Adult Core Sets measures. This meeting is open to the public, and meeting transcripts are posted.
- C. **Draft Report:** A report summarizing the Workgroup's review process and recommendations is made available in draft format.
- D. **Public Comment:** The Draft Report is posted for public comment.
- E. **Final Report:** The Final Report summarizes the Workgroup's review process and recommendations. It also includes the public comments submitted on the draft report.
- F. **State Outreach:** The recommendations in the Final Report are discussed with state partners to obtain their feedback.
- G. **Internal Stakeholder Outreach and Federal Review Process:** Given the importance of measure alignment, the recommendations in the Final Report, along with feedback from state partners, are also discussed internally in CMS and with key Federal partners before updates to the Core Sets are reviewed with Center for Medicaid & CHIP Services (CMCS) leadership.
- H. **The Annual Core Set Update is published** in a Center Informational Bulletin (CIB) by December 31st.

Based on the experience of health plans from the Adult Core Set, it is important that CMS balance between making sure measures are still actionable and meaningful and not changing measures too quickly. If the measures are continuously changed, they cannot be measured over time and used or

assessed for improvement. Thus, it is recommended that the core set be assessed annually but not necessarily changed unless as follows:

- There is a significant breakthrough in one or more of the measures currently in the extended set (for example, the measure(s) have been scientifically tested and found to be valid and reliable, or a measure that was initially included as part of a national survey not available publicly or free-of-charge was later made available publicly and for free), thus warranting the measure to become part of the core set; or
- There is a need to retire some of the measures (though this should only be considered every 3-5 years). The Association suggests following the same process as established for Medicaid QRS at a macro-level for measure review. However, at the micro-level, CMS/HEDIS measures need to be aligned exactly, so changes do not have to be continuously made at the plan level. Additionally, any process developed should include a mechanism for immediately requesting a measure be put on hold or the information/data collected around the measure suppressed when it is discovered/reported that the measure is causing an intended consequence or harm.

Are there other components of measure specifications (beyond those described above) that should be included in the measure set? Is there other information about the measures that CMS should include in the measure set? Does your organization experience any barriers with collecting data for quality measurement purposes? Does your organization experience any barriers with accessing data systems for quality measurement purposes? How many measures is ideal for inclusion in the base set?

Are there other measures that should be included in the base set or the extended set? In particular, CMS would be interested in feedback on measures that can address gaps related to specific NQF domains, including recommendations for measures that assess access to HCBS, such as measures of potential access (e.g., provider supply and participation in Medicaid), realized access (e.g., % of people who receive what is authorized in their service plan), and perceived access (e.g., beneficiary experience). CMS would also be interested in recommendations for HCBS measures that are relevant for people with behavioral health conditions. Are there measures you think would be most useful to a beneficiary when choosing a managed care plan, a provider, or a self-directed service delivery model?

Concerning additional components of measure specifications that should be included in the measure set, the Association would like to see the following:

- *Alignment with existing LTSS measure set specification:* As previously mentioned, the Association believes it is imperative that the specifications for the proposed base and extended set of HCBS measures fully align with the technical requirements for the NCQA LTSS HEDIS measures, the NCQA LTSS distinction requirements, and with the Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual issued in May 2019. Today, significant confusion exists in individual states about specific aspects of the specifications that may not be fully aligned, such as eligibility for inclusion in the measure count and exceptions for face-to-face assessments in the member's home. Without precise and

consistent technical specifications, states will interpret the expectations from CMS and NCQA differently, significantly limiting comparison purposes (and thus jeopardize one of CMS' highest priority goals for the recommended measure set). The Association cannot stress the importance of alignment between CMS' recommended measure set and NCQA LTSS requirements enough.

- *Access to full, timely, and free Medicare claims and chart data for unaligned dually-eligible HCBS members:* If the proposed HCBS measure specifications call for the use of administrative claims and/or clinical/chart data, MLTSS plans will have a difficult time collecting and reporting that data. For example, when a dual eligible member receives both their Medicaid and Medicare services from the same managed care plan (what CMS calls "aligned enrollment"), reporting the data is fairly straightforward. But when the member receives their Medicaid from one health plan and their Medicare from a different health plan (MA or DSNP) or through FFS, it is extremely difficult for the Medicaid MLTSS health plan to report these measures because we do not have *full, timely, and free* access to the claims and clinical/chart data for these unaligned duals. The only way for a Medicaid MLTSS plan serving an unaligned dual to receive that member's Medicare clinical/chart data (or claims data in the case of an unaligned MA or DSNP) is to specifically request it from the other plan or FFS entity using an external vendor at significant expense to the Medicaid MLTSS plan. The vendor's success in getting that data from the other health plan or FFS entity promptly varies, with significant delays being the norm.

The Association wishes to highlight the following barriers with respect to accessing data systems for quality measurement purposes:

Current regulations require that states transmit information on six demographic factors to MCOs at the time of enrollment. Although one of those factors is "disability status," all MCOs get information on "whether the individual qualified for Medicaid based on disability," not what specific type of disability the member has. Thus, it would be challenging to stratify and compare data across providers, plans, or states by disability subpopulation. Additionally, federal definitions of disability types differ from state variations, so this is another area where consistent terms and definitions/scopes of what is included for each disability type would help move the field forward in looking at quality in LTSS provision stratified by disability subpopulation.

Stratification of the proposed HCBS base and extended set based on specific disability types would help uncover population-specific differences in key outcome areas. To accomplish this, the Association recommends that CMS guide states on how to amend their state Medicaid applications to best capture disability-related data accurately and consistently. One valid and reliable way for states to do this is to ask Medicaid applicants during the eligibility process about disability status using the six questions on the American Community Survey (ACS), which are also on the Survey of Income and Program Participation (SIPP), and the Current Population Survey (CPS). All three surveys ask about six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent living difficulty. Respondents who report any one of the six disability types are considered to have a disability.

Health plans can access a significant amount of data for quality improvement efforts, including accessing state and federal data. The barriers for using the data involve the lag time in the state and federal data (often 6 months or more), which impacts real-time member-facing interventions because of analyzing this

old data. While pharmacy and medical divisions can study a population with the data, member outreach efforts require access to real-time data or data only a few days old.

Regarding member experience data, the Association reaffirms its position that the reporting entity for some member experience survey data needs to be the state, not the MLTSS plan. MLTSS plans would have significant difficulty reporting state-generated member experience data (such as for NCI and NCI-AD).

The Association also notes that there are some barriers to using data to improve quality. Data received in state Medicaid eligibility files that health plans receive is rarely accurate. To update that information, LTSS beneficiaries must change their information with the Social Security Administration, a complex process that takes a lot of time and effort on the member's part. Even if MLTSS plans update eligibility and demographic data in our internal care management systems, automatic data override each month when we receive a new state Medicaid eligibility file.

For MLTSS plans serving unaligned, dually-eligible beneficiaries, except for one state (Ohio), plans also do not get information that acknowledges whether a member is fee-for-service Medicare or Medicare Advantage, only that the individuals are dually eligible. Quality for dually-eligible HCBS members could be significantly improved if state Medicaid agencies sent MLTSS health plans more detailed information on what type of Medicare coverage our HCBS members have.

Although some plans have access to Coordination of Benefits Agreement (COBA) data in most states for dually eligible HCBS beneficiaries, continual limitations related to this specific population include:

- *Long delays in claims data:* The provider submits to Medicare, and once CMS has processed the claim, it then crosses over to us. We never know how long it will take CMS to process.
- *Differential in Timeframe of Claims and Data Analysis:* When plans can pull data based on COBA claims, there is an assumption that the member has had a claim in that time period – i.e., if we pull claims for the last six months, we run the risk of a member not having a claim during that period. It requires the utilization, which is not an accurate measure for pulling membership.
- *Administration Burden to Process Claims under COBA:* When a plan goes live with COBA, the process is initiated by the state, and a COBA agreement is filled out between the MCO and CMS that details what claim types will be shared. The state gets final sign-off on this document, and often claims Medicaid will not pay that are not included in the data-sharing agreement. There is an administrative burden to process these claims, and if we know that Medicaid will not be covering them, it is generally assumed it is not necessary to pass them along.

Regarding ideal number of measures to be incorporated in the recommended measure set, the Medicare STAR Rating measure list includes 34 measures, so it would be in line with other well-established base measure sets for government-sponsored products if it aligns within 30-40 measures. However, the quantity of measures should not drive what gets included, but rather, the number of selection criteria a measure meets.

Regarding the inclusion of other measures:

If CMS wishes to proactively drive state and MLTSS health plan response to the DSNP Integration Requirements, we recommend the inclusion of the following measures in the base set—

- “Data sharing agreements in place for unaligned plans providing services to dual-eligible beneficiaries enrolled in multiple plans;” and
- “Percentage of dual-eligible beneficiaries in integrated care arrangements or aligned arrangements.”

Also, as previously mentioned, the Association recommends CMS include the following measure in the base or extended set, which will address some of the gaps in NQF domains noted above:

- Timeliness of start of services by service type. Measures the amount of time between when an HCBS service is authorized and implemented in the member’s home. This measure helps MLTSS plans assess HCBS provider network adequacy. Could assist with measuring provider supply/participation and realized access.
- “Percent responding yes to: Do the services you receive meet your needs and goals?” from NCI-AD could also address the realized access gap.

Additionally, the Association urges that at least one caregiver assessment measure be included in the base set:

- Either “Caregiver assessment conducted,” and/or
- “Caregiver Access to Resources”

The Association does not believe there are any measures in the draft recommended measure set that are misclassified by the NQF domain. However, per our earlier suggestion, should CMS considered combining or reducing the number of domains in the short term, it will be important to revisit this topic with stakeholders before formally publishing the first recommended measure set.

For additional measures from the Medicaid and CHIP Scorecard, the Adult and Child Core Set, and in future Medicaid Quality Rating Systems that should be added to the recommended measure set, the Association suggests that, as a minimum, MLTSS 1 and MLTSS 2 (Comprehensive Assessment and Care Plan) be incorporated. Additionally, the inclusion of Rating of Health Plan and Customer Service Questions in the Adult Core Set CAHPS would be greatly beneficial and assist members in choosing a health plan.

Should critical incidence measures be used, they should be carefully worded so as not to deter proper reporting. If the measure focused on substantiated cases of abuse/neglect/restraint usage and whether the MCO and provider fully addressed the issues discovered, the measure would be a more realistic view of quality than alarming people with incident reporting rates. Also, the categories of critical incidents vary from program to program and state to state, so the list of categories would have to be defined for the measure and rate, or it would not be meaningful or consistent.

Finally, concerning measures that would be most useful to a beneficiary when choosing a managed care plan, a provider, or a self-directed service delivery model, the Association recommends at a minimum the following:

- Percentage of time services were provided on time as requested
- Percentage of beneficiaries reporting care plan includes things important to them
- Percentage of people who can see or talk to their friends and family when they want to
- Percent of respondents who indicate being engaged in meaningful activities as they desire
- Consumer satisfaction measures (Would you recommend to friend/family member?)
- % of consumers living in their individual, private home or apartment not managed by a service provider/agency, and where they are listed as the tenant/owner or co-tenant/owner on the lease, or live with a relative that is not considered a paid service provider
- % of working-age consumers engaged in competitive integrated employment
- % of consumers using technology to minimize the need for staff support to live independently
- Number or percentage of consumers on Governing Board, Member Advisory Committee, and other Organizational Committee of the Health Plan