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November 17, 2020

Melissa Harris
Acting Director, Disabled and Elderly Health Programs Group
Centers for Medicare & Medicaid
7500 Security Boulevard
Baltimore, MD 21244

Dear Melissa:

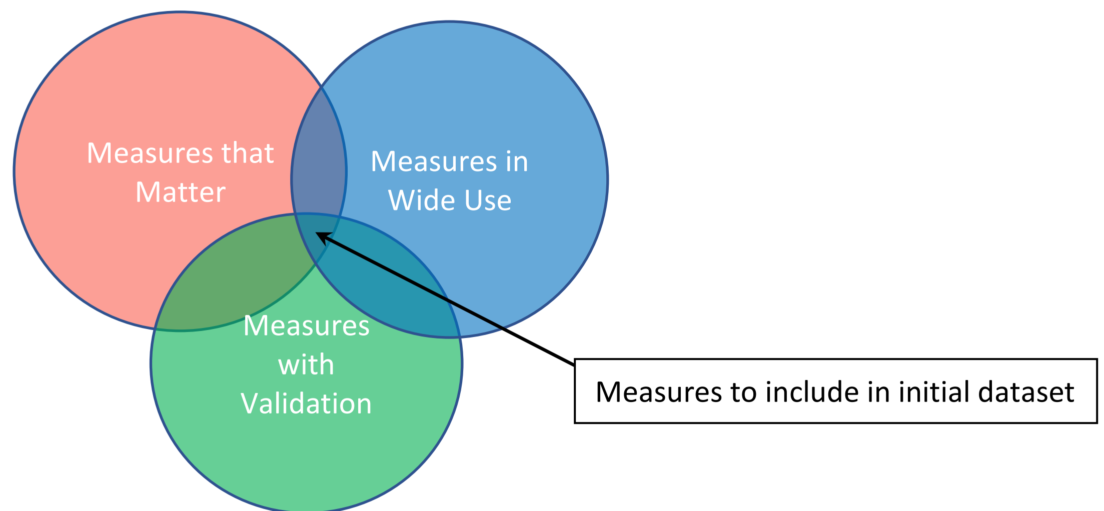
On behalf of ADvancing States, an association representing the nation's 56 state and territorial agencies on aging and disabilities and long-term services and supports directors, and the measure steward for the National Core Indicators – Aging and Disabilities (NCI-AD™) project, please accept the following comments in response to the CMS *Request for Information: Recommended Measure Set for Medicaid-Funded Home and Community-Based Services.* ADvancing States supports visionary leadership, the advancement of systems innovation, and the articulation of national policies that support long-term services and supports for older adults and people with disabilities. We are grateful to have participated in the CMS-lead Quality Measurement and Reporting workgroup since its inception over a year ago and are also grateful to the handful of our state members that participate. We appreciate CMS's efforts to establish a consistent method of comparing HCBS programs across states but also believe this endeavor must include careful consideration of sometimes subtle yet complex differences in state quality practices.

ADvancing States is the primary measure steward for the National Core Indicators-Aging & Disabilities© (NCI-AD™) survey project. The NCI-AD™ project utilizes a valid and reliable adult consumer survey for older adults and people with disabilities receiving publicly funded long-term services and supports, including programs administered in home and community-based settings. The survey was created out of a desire from our member states to utilize a tool that measured outcomes for older adults and physical disabilities populations. Modeled off the successful National Core Indicators© survey focused on individuals with intellectual or developmental disabilities, the NCI-AD™ survey went through rigorous revision and edits with input from a steering committee comprised of state aging and disability leaders from across the country. For this reason, we like to say the NCI-AD™ survey is a measure tool "by states, for states". The survey project officially kicked off in 2015 and states have responded with great interest. In five short years, almost 25 states have joined the project.

The NCI-AD™ project team, including staff from ADvancing States and the Human Services Research Institute (HSRI), provide technical assistance to member states in every facet of the project, including designing a statistically sound survey sample, providing standardized training for surveyors, programming a state-specific online data entry system for survey data, analyzing collected data, providing state-specific and national reports, and assisting with data utilization. By providing in-depth technical assistance, ADvancing States and HSRI help to mitigate any barriers states may face while participating in the project. The NCI-AD™ project team and NCI-AD™ member states work hard to maintain the NCI-AD™ project and ensure its relevancy for states invested in tracking their HCBS outcomes.

While we are incredibly proud of the NCI-AD™ project and believe in its ability to shape HCBS policy and programs and improve quality outcomes, we also recognize there are states who opt to use other tools, such as the HCBS CAHPS survey or even homegrown measures. In order to fairly represent our members, we have taken this into account and included this perspective in our feedback.

ADvancing States and our state members believe the initial measure set should include validated, meaningful measures that are in wide use. By doing so, the measure set will promote comparability between states utilizing measures that go beyond process with the potential to have meaningful impacts and improved outcomes for people served in HCBS programs.



Specific responses to many of the questions found in the RFI can be found below. Some general themes include:

- Prioritization of state flexibility should be a consideration in the development of the recommended measure set. ADvancing States strongly suggests that each measure in the base set have a similar measure in all three of the most commonly used survey tools: NCI, NCI-AD™, and HCBS CAHPS.
- The recommended measure set should serve multiple purposes for states. For example, the data collected for the measure set should also meet requirements for 1915(c) waiver assurances and sub-assurances.

- The recommended measure set should focus on collecting outcomes-level data that is actionable and meaningful to states and consumers. Unlike process measures, outcomes measures provide a more comprehensive picture of how individuals are experiencing their services and if the services they are getting are helping them to live the life they want to live.

  Our response will now address specific questions posed by CMS. We also offer some technical comments and corrections to language included in track changes in the attachment.

III. About the Draft Recommended Measure Set

A. Purpose

What is the value in 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?

- ADvancing States agrees having a standard set of measures is useful for states and other entities involved in the administration of HCBS programs. Reviewing HCBS outcomes in relation to similar states and national benchmarks is a valuable practice that helps states to determine policy and program priorities, among other things. In fact, our members, comprised of state aging and disability leaders, felt so strongly about this issue that we developed a measurement tool specifically for this purpose. The NCI-AD™ survey tool has grown exponentially over the last six years and up until the 19-20 year, almost half of states were utilizing NCI-AD™. We also recognize many of our member states are using different tools, such as HCBS CAHPS, to track quality and outcomes of HCBS programs. These survey tools require exponential amounts of time and effort for state staff in preparing for the survey, administering the survey, analyzing data collected, and utilizing and tracking data in quality initiatives. For this reason, and to ensure state autonomy and flexibility in deciding the best quality approach, we strongly believe the recommended quality measure set should remain voluntary. States are not all concurrently using the same measurement tool. States that have been administering a consistent approach to HCBS quality, no matter the approach or tool, should fully be able to utilize the information and data derived from that approach.

- There is value in having consistent measures to enable comparisons across states – the NCI-AD™ survey provides just that to participating states – allowing each state to benchmark themselves against other states with similar program structures. However, states should be able to pick which specific measures they believe are best suited to their program.

What benefits or challenges would result from the public release of a recommended set of quality measures?

- There are some complex considerations that must be thought through before the public release of the recommended set. Part of the challenge in releasing the measure set comes from the reverence that states give to the entity releasing the set – CMS. In general, states give more weight and consideration to recommendations coming from their federal partners. We recognize the potential for confusion among states reviewing a recommended set of measures

that includes multiple survey tools and strongly suggest clear instruction and technical assistance on use of the measure set when it is released.

- We also understand guidance issued by CMS has historically become requisite, either de facto or explicitly. The public release of the set should clearly indicate the intended use of the set and again, remain voluntary to provide maximum flexibility to states - some of which have used and deeply imbedded data from the same measurement tool in their quality initiatives year after year.

C. *Organization*

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

- ADvancing States believes asking states to adopt any measure set in full as a base set is going to pose many difficult and potentially costly challenges for states. We suggest simply including all the measures under each domain as potential measures. At the same time, we strongly suggest removing the requirement that the “starter” set be adopted in its entirety, as it creates inherent challenges for states. It is unclear to our states how requirements for adoption of specific measures in their entirety are consistent with “recommended” measures. This reads more similarly to a required measure set.
- If the recommended measure set is going to be presented as a base and extended set in its final form, we believe the base should be a concise set of measures that can be administered using a variety of tools to provide states as much flexibility as possible. In other words, if a specific measure is included from one tool, a reasonably similar measure should be offered in the others as well. Careful consideration should be given to the quality of the measures included in the base set as opposed to the quantity.

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

- Yes. The NQF framework was developed after rigorous discussion and negotiation. The purpose, intent and organization of the measures under the NQF domains is complex and adding another category of sorting does not appear to add to the value of the recommended set.

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

- This is not appropriate for us to comment on and should be left up to states to decide; however, we find that measures from NCI-AD™ in the following domains are most often used by states to identify areas for quality improvement: service coordination, care coordination, access to the community, person-centered planning, work, and access to needed equipment.
- We also recognize not all states prioritize measures the same way or agree which measures are the most important. Priorities differ by state and by administration and can change frequently depending on any number of factors.

D. *Measure Selection Criteria*

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

We have ranked the proposed measure selection criteria below in the order of importance (first being most important):

1. ***Importance to Measure and Report***: Extent to which the specific measure focus is important to making significant gains in quality and improving outcomes for a specific high-impact aspect of care where there is variation in or overall poor performance.
2. ***Scientific Acceptability of the Measure Properties:*** Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results, including across HCBS populations, when implemented.
3. ***Usability and Use:*** Extent to which states, HCBS programs, MLTSS plans, or other entities are using or could use performance results for both accountability and performance improvement. For example, whether a measure can be used to support the existing reporting requirements associated with the section 1915(c) assurances and sub- assurances or other CMS requirements will be considered as part of this criterion.
4. ***Feasibility:*** Extent to which the specifications (including measure logic) require data that are readily available or that could be captured without undue burden and can be implemented for performance measurement. This criterion also includes whether measure specifications and any instruments needed to collect data are publicly available at no cost.
5. ***Level at Which Measure Can Be Applied:*** Whether the measure can be applied at the statewide, delivery system, and/or population levels.
6. ***Type of Measure***: Whether the measure is a structural, process, or outcome measure.
7. ***Related and Competing Measures***: Extent to which there are related measures (i.e., measures that address either the same topic or the same population) and/or competing measures (i.e., measures that address both the same topic and the same population) in the measure set. NOTE: This is last based on our belief that for survey-based tools, similar measures from different tools should be available for states.

Should the base and extended measure sets only include measures that have undergone testing and validation?

- It is important to include measures that are scientifically sound in order to retain the integrity of quality improvement initiatives using valid and reliable data. We strongly suggest the introduction to the recommended measure concepts describe the flexibility for a state to select an instrument that has been validated and tested for reliability with the populations to be served, and the determination of meaningful measures and priorities be left up to the states.

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?

- Because the entities currently endorsing quality measures have little experience and appreciation for the unique importance of person-reported measures in HCBS programs, we do not believe that endorsement is a necessity or even a recommended approach for measures in the base or extended set. For example, the MLTSS measures in the base set represent very important process measures for managed care plans; however, the National Quality Forum declined to endorse them because the endorsement committee ‘did not see a need for them’. Far more important is the wide use and public reporting of quality measures.

Should CMS prioritize, for inclusion in the measure set, measures that have been endorsed by any particular entity?

- Endorsement should not be prioritized. We again stress the flexibility states need to continue using the measure tool of their choice that they feel best meets their needs, including some state-specific “homegrown” measures that will likely never be endorsed by an entity if for no other reason than the time and effort it requires of already busy state staff to submit measures for endorsement. We recognize states use and find value in a variety of measures, whether endorsed or not.

Should there be differences in how the measure selection criteria described above are applied to measures that are important to measure and/or are in wide use by states and/or managed care organizations?

- Yes. Priority should be given to measures that are in wide use by states and which reflect core outcomes for HCBS measures.

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)?

- We also note that for dually eligible individuals, the data to calculate some measures may not be readily available. CMS should keep that in mind when recommending measures for the base and extended set.

Should the base set and/or the extended set only include measures that are in the public domain and are available at no charge?

- We strongly disagree that the recommended measure set include only publicly available measures. Of far greater importance is selecting measures that are in wide use in states and which have publicly available data.

Is it important to offer publicly available measures that are free of charge as alternatives to any proprietary measures included in the base set?

- As noted earlier, we believe if a measure is included from one tool, a reasonably similar measure should be offered in the other two. The recommended measure set is not going to be useful if measures are not adopted and applied by states to improve their programs. Minimizing disruption to states’ HCBS quality programs should be a key consideration for CMS.

How important is it to include experience of care survey measures in the measure set?

- States are becoming more and more invested in tracking outcomes of HCBS programs, as evidenced by the rapid growth of the NCI-AD™ survey. Experience of care survey measures provide key information for states to understand how well HCBS programs are serving populations. Process measures may be easier to obtain but won’t provide the same insight or meaningful measurement data.

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)?

- Since the base set is proposed to be few, we believe it is important for base measures to be applicable across delivery systems. It can be helpful to look at differences in outcomes from different delivery systems. The opportunity for states to learn from one another is greater if the base set measures are applicable across delivery systems.

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?

- Yes. Compliance does not lead to ongoing improvements in HCBS quality. The compliance focus of the current 1915(c) waiver assurances and sub-assurances takes critical attention away from quality and outcomes measurement.

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?

- We believe that this is an absolute requirement of this effort. States are already stretched thin ensuring compliance with the waiver assurances and sub-assurances. Not ensuring that the RMS can do 'double duty' – moving quality improvement forward AND providing documentation of good HCBS service provision – is a real missed opportunity. Moreover, it could result in fewer states taking up the RMS (see comment above about the effort required by states to meet the compliance requirements currently in place). Our state agencies strongly urge this set of recommended measures be meaningful, useful, and of high priority to people with disabilities and their family members, and that it does not undermine sizable state-level investments and commitments made to date. We believe the RMS would benefit from multiple cross-division reviews at CMS to identify other areas of overlap. In fact, ADvancing States request that CMS publicly commit to working collaboratively with its state partners to re-examine the current approach to waiver quality, including a frank assessment of the aspects of HCBS program delivery that lead to the best quality outcomes for participants.

IV. *Limitations*

How often should the base set and/or the extended set be updated?

- We believe the base set should be reviewed no more often than once every five years. States must be given a chance to incorporate data into their quality initiatives, and that takes time. Being able to identify trends and patterns over time is incredibly helpful for states and changing measures too often will have a negative impact on their ability to do so.

VI. *Draft Recommended Measure Set, by NQF Domain*

How many measures is ideal for inclusion in the base set?

- ADvancing States does not have a specific number for inclusion but does stress that the quality of the measure should take precedent over the quantity. We will reiterate here that the draft measures should also overlap with other concurrent quality tracking requirements.

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How many measures is ideal for inclusion in the extended set?

- Since states can pick and choose which measures to include in the extended set, we do not see the use in limiting the number of measures.

Are there measures that have been misclassified by NQF domain?

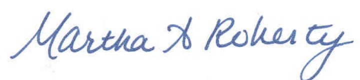
- We believe two of the NCI-AD™ measures are misclassified:
    - ❖ NCI-AD™ -27: Percentage of people whose support staff treat them with respect. This is not a workforce measure. It is focused on the person and as such is more appropriately categorized in the Human and Legal Rights domain.
    - ❖ NCI-AD™ -23: Percentage of people who have transportation to get to medical appointments when they need to. This is not a community inclusion measure as it focuses on access to needed medical services; it is more accurately categorized as a Service Delivery and Effectiveness domain measure.

Are there any measures you would recommend for use in the Medicaid and CHIP Scorecard, the Adult and Child Core Sets, or other CMS initiatives, such as the future Medicaid and CHIP Quality Rating System? Please be specific both in terms of measure(s) recommended and the CMS initiative for which you are recommending them.

- In keeping with our focus on ensuring the RMS have broad utility for states, we believe that all of the recommended measures should be included in the Medicaid scorecard as well as the Adult Core Set at some point in the future when it is appropriate and feasible to do so.

Thank you for the opportunity to share the perspective of our members with you. We urge you to review our comments considering our members' state-specific comments as well.

Sincerely,



Martha Roherty
Executive Director
ADvancing States