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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Spring 2024 Cycle Endorsement and Maintenance (E&M) Meeting Discussion Guide

ADVANCED ILLNESS AND POST-ACUTE CARE COMMITTEE

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Overview of Spring 2024 Measures for Review

For this measure review cycle, six measures were submitted to the Advanced Illness and Post-Acute Care committee for endorsement consideration (Table 1). The measures focused on improvements in ambulation, bathing, bed transferring, and management of oral medication in home health settings; eliciting feedback from Medicaid beneficiaries receiving home and community-based services (HCBS); and continuity of care after treatment for substance abuse disorder (Figure 1).

Table 1. Overview of Measures Under Endorsement Review

CBE Number	Measure Title	New/Maintenance	Developer/Steward
#0167	Improvement in Ambulation/Locomotion	Maintenance	Abt Associates/Centers for Medicare & Medicaid Services (CMS)
#0174	Improvement in Bathing	Maintenance	Abt Associates/CMS
#0175	Improvement in Bed Transferring	Maintenance	Abt Associates/CMS
#0176	Improvement in Management of Oral Medications	Maintenance	Abt Associates/CMS
#2967	Home and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Measure	Maintenance	The Lewin Group/CMS
#3453	Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder	Maintenance	The Lewin Group/CMS

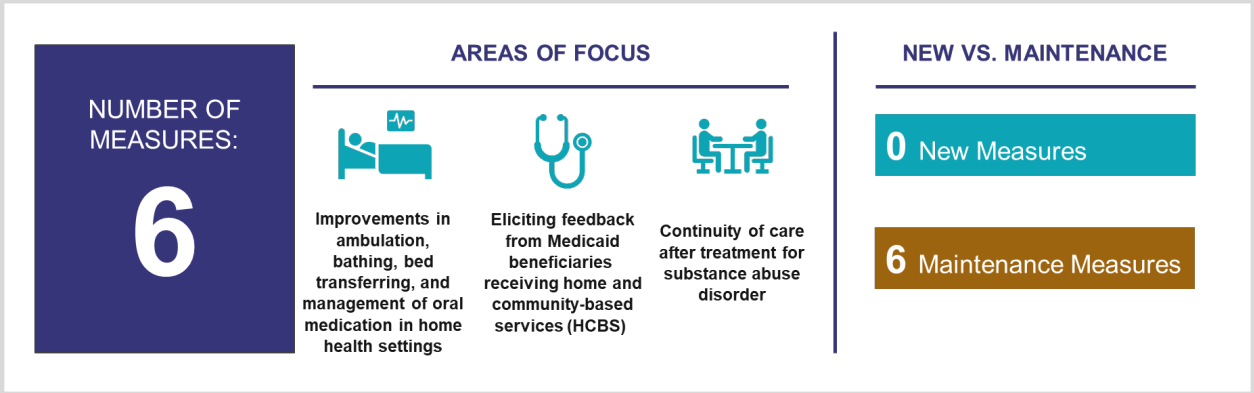

Figure 1. Spring 2024 Measures for Committee Review

Public Comment

Battelle accepts comments on measures under endorsement review through the Partnership for Quality Measurement (PQM) website and Public Comment Listening Sessions. For this evaluation cycle, the public comment period opened on May 16, 2024, and closed on June 14, 2024, and the Public Comment Listening Session was held on May 29, 2024.

Battelle received 19 public comments prior to the endorsement meeting. Of these 19 comments, 14 were supportive, zero were non-supportive, and five did not express either support or non-support. CBE #0167, #0174, #0175, and 0176 each received the same three supportive comments, emphasizing the importance and impact of the measures from both an organizational and patient perspective. CBE #0176 received one additional supportive comment expressing access to medications and consistent safe management are key to patient health. CBE #3453 received one supportive comment noting the important role follow-up care plays in patient support. The remaining comments for CBE #0167, #0174, #0175, and #0176 did not express support or non-support; rather, they emphasized the importance of maintenance measures being improved over time as more data are collected. One final comment for CBE #2967 outlined suggestions for the developer regarding the survey instrument used for this measure.

After the public comment period closed, developers/stewards had the opportunity to submit written responses to the public comments received. Summaries of the public comments and developer/steward responses are provided within the respective measure evaluation summaries of this discussion guide below.

Advisory Group Feedback

The Advisory Group was convened on June 5, 2024. Eleven of 20 (55%) active Advisory Group members were in attendance to share feedback and ask questions regarding the measures under endorsement review. Developers/stewards of the respective measures were also in attendance and provided responses to the Advisory Group discussions. After the meeting, developers/stewards had the opportunity to submit additional written responses to Advisory Group member feedback and questions.

Summaries of the Advisory Group member discussions and developer/steward responses are provided below, within the respective measure evaluation summaries of this discussion guide.

To support the review of the public comments and Advisory Group summaries, the number of comments or individuals that shared similar comments, feedback, and/or questions is represented as “a few” (2-3 individuals), “several” (4-6 individuals), and “many” (more than 6 individuals).

Measures Under Endorsement Review

CBE #0167: Improvement in Ambulation/Locomotion [Abt Associates/CMS]

Measure Description:

Percentage of home health episodes of care during which the patient improved in ability to ambulate.

Measure Status	
New or Maintenance: Maintenance	**Used in An Accountability Application?** Yes • Public Reporting • Payment Program • Quality Improvement with Benchmarking (external benchmarking to multiple organizations) • Quality Improvement (Internal to the specific organization)
CBE Endorsement Status: Endorsed **Last Endorsement Review Cycle:** Fall 2018	**Proposed/Planned Use:** Public Reporting & Home Health Star Ratings; CMS

Measure Characteristics

Measure Type	Target Population(s)	Level of Analysis	Care Setting(s)
Outcome	Elderly Individuals with Chronic Conditions	Facility	Home Care

Measure Overview
Rationale: Many patients who receive home health care are recovering from an injury or illness and may have difficulty walking or moving around safely. They may need help from a person or special equipment (like a walker or cane) to accomplish this activity. Home health care staff can encourage patients to be as independent as possible and can evaluate patients' needs for, and teach them how to use, special devices or equipment to help increase their ability to perform some activities without the assistance of another person. Safe ambulation and mobility are critical to being able to remain at home. Improving functional status such as a patient's ability to perform ambulation/locomotion, contributes to quality of life and allows them to live safely and as long as possible in their own environment. Getting better at walking or moving around may be a sign that they are meeting the goals of their care plan or that their health status is improving. Recovering independence in walking or moving around with assistive devices is often a rehabilitative goal for home health patients, making it a reasonable evaluation indicator of effective and high-value home health care.
Numerator:

Measure Overview
Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in ambulation locomotion at discharge than at start (or resumption) of care.
Denominator: Number of home health episodes of care ending with a discharge from the agency during the reporting period, other than those covered by generic or measure-specific exclusions.
Exclusions: All home health episodes for which the patient, at start/resumption of care, was able to ambulate/locomote independently (M1860[1] = 00), or the patient was nonresponsive (M1700[1] = 04 or M1710[1] = NA or M1720[1] = NA), or the episode is covered by the generic exclusions (see following section).
Measure is Risk-Adjusted and/or Stratified: Statistical Risk Model with Risk Factors Improvement in Ambulation/Locomotion (#0167) attempts to measure a home health agency's ability to improve patient ambulation/locomotion while the patient is in its care; however, because certain factors are outside of its control, the measure developer risk-adjusted the measure. Risk adjustment is used to promote incentives for home health agencies to provide the same care to patients regardless of patient characteristics at SOC/ROC. The risk factors that can be fully addressed should not be included in the risk adjustment model because the home health agency is expected to be responsible for addressing that risk factor. For instance, if all other risk factors are identical, a home health agency is expected to provide two patients with identical quality care regardless of race or ethnicity.

Logic Model
Summary: Improvement in Ambulation/Locomotion (#0167) measures whether the patient's ambulation/locomotion status at end of care (EOC) improves relative to the patient's ambulation/locomotion status at start or resumption of care (SOC/ROC). To improve, patients will receive support from three primary sources: their home health agency, caregivers, and themselves. For Improvement in Ambulation/Locomotion (#0167), the measure developers are concerned with attributing the improvement to the home health agency's care. Thus, the developer risk-adjusted the observed improvement to account for differences in patient characteristics at SOC/ROC.

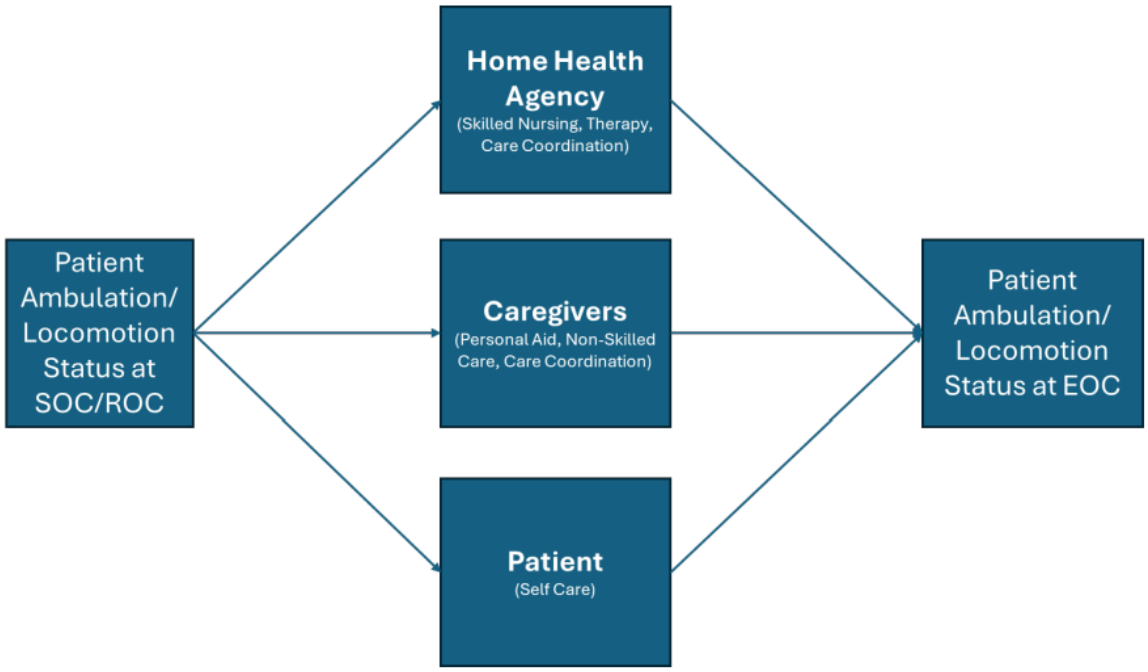

Figure 2. CBE #0167 Logic Model

Measure Evaluation Summary: CBE #0167

Importance
Staff Preliminary Rating: Met
• **Importance**: There is a business case for the measure along with supporting evidence for the importance of the measured outcomes with demonstrated gap in performance.

Feasibility
Staff Preliminary Rating: Met
• **Feasibility:** There are no feasibility challenges, fees, or proprietary components to this measure.

Reliability	
Staff Preliminary Rating: Met	
Testing Level:	Person or -Encounter Level and Accountable Entity Level
Testing Method:	The developer conducted reliability testing using **a split-half reliability test,** and results reported show statistics **exceed 0.80**, even within the decile with the smallest home health agencies, suggesting strong reliability and acceptability for drawing inferences about home health agencies. Based on the weighted kappa statistics the inter-rater reliability indicated **moderate agreement at SOC/ROC (0.43) and moderate agreement at discharge (0.67).**
• **Reliability:** The measure is well-defined. Reliability was assessed at both the patient and entity levels. Reliability statistics are above the established thresholds for most, if not all, entities.	

Validity	
Staff Preliminary Rating: Met	
Testing Level:	Person or Encounter Level and Accountable Entity Level
Testing Conducted:	The developer conducted validity testing using **the Spearman rank correlation,** and results reported show a **statistically significant positive correlation** with a publicly reported measure that similarly assesses patient functioning and *Discharge to Community (#3477)*, which lends evidence to the measure's validity. The item was also reviewed for the most recent Outcome and Assessment Information Set (OASIS) data set revision, which allowed for two national comment periods (60 days and 30 days) wherein the face validity of the item was supported by the comments received.

Validity
• **Validity:** The developer assessed measure validity using accountable entity-level empirical validity and data element-level validity. The interpretation of the empirical results supports an inference of validity.

Equity	
Staff Preliminary Rating: Met	
Equity Considered:	Yes
• **Equity:** The developer evaluated disparities in performance by subgroups for urbanicity/rurality, size, and share of quality episodes with non-white patients.	

Use & Usability	
Staff Preliminary Rating: Met	
Current or Planned Use:	Measure is currently used in Public Reporting & Home Health Star Ratings.
• **Use & Usability**: The developer provides data demonstrating overall improvement in the measure. The developer acknowledges the existence of performance gaps and anticipates further improvement with the nationwide expansion of home health value-based purchasing programs (HHVBP).	

Public Comment[1]

Number of Comments Received: 4

Full text of developer/steward responses can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
Three comments expressed support for this measure and emphasized the importance of the measure's purpose, specifically from a patient perspective.	Supportive	Thank you for your comment and support of this measure.

[1] Comments, as submitted, can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
One comment questions whether improvements and changes have been made to the measure since its initial endorsement.	N/A	Measure data are shared with home health agencies (HHAs) so they may take action to improve performance on this measure.

Advisory Group Feedback

Full text of developer/steward responses can be found on the PQM website.

Feedback/Questions	Summary of Developer Response
Risk Adjustment: A committee member asked for an overview of the risk adjustment. They also asked if specific risk adjusters go into predicting likelihood of improvement.	The developer said this measure is connected to the OASIS tool that is mandatory for clinicians to use in home health care. They said they use a standardized risk adjustment approach across these four improvement outcome measures (CBE 0167, 0174, 0175, and 0176), and that the primary rationale on why they might make an adjustment is to reflect the risk adjusters available in the current OASIS tool. In relation to specific risk adjusters predicting likelihood, the developer said all risk adjusters are taken from OASIS. They consider age, sex, payment source, admission source, risk of hospitalization, availability of assistance, the presence of pressure ulcers, living arrangements, and primary diagnoses. From there, they determine which factors are statistically significant; those factors are not taken out of the model. After that, the measure developer determines the final risk-adjustment coefficients that are then applied to the measure calculation to generate risk-adjusted measures. *Summary Response Received after the Advisory Group Meeting*: OASIS-based home health outcome measures are risk adjusted annually. CMS gives detailed information about risk adjustment of the Home Health Quality Reporting Program measures.
Improving Versus Maintaining: A committee member asked if the measure developer has considered the importance of patient maintaining (versus improving) in home health care. Another committee member asked if there is a way to capture more information about the potential for each patient to improve or maintain and measure changes within that set of expectations.	The developer said they acknowledge the importance of maintaining versus improving and have started to incorporate this into new measures, including a cross-setting [inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), long-term acute care hospital (LTACH), and home health] discharge function measure that was finalized in last year's home health final rule. *Summary Response Received after the Advisory Group Meeting*:

Feedback/Questions	Summary of Developer Response
	We continuously monitor these measures, the HHAs' performance, and seek input on improvements either to this measure and other measures relevant to home health patients for whom improvement is not expected. We use a robust risk-adjustment model that incorporates, among other factors, patient factors indicating less-likely improvement.
Palliative Care: A few committee members discussed how hospice is now an exclusion; they asked if the developer had considered patients receiving palliative care, as the patient populations are similar.	The developer responded by saying, for this specific measure, to go beyond discharge to hospice would require additional data sources. The discharge function measure (mentioned above) may be a more plausible scenario for some of these considerations. *Summary Response Received after the Advisory Group Meeting*: Thank you for your suggestion. This suggestion will be taken under consideration. We continuously monitor these measures, the HHAs' performance, and seek input on improvements to this measure and other measures.
General Support and Retesting Data: A committee member provided a general supportive comment for the measure and noted that the 2022 retesting data was helpful in terms of reliability and validity.	The developer did not respond to this feedback during the meeting. *Summary Response Received after the Advisory Group Meeting*: Thank you for the comment. We appreciate the support.
Literature Review: A committee member commented that they expected the literature review to have been stronger and to include a systematic review.	The developer said they have been consistently performing environmental scans and background research in the home health space, but the research is limited, especially when narrowed to the United States. The developer said, to that end, they have been trying to contribute and present more information. *Summary Response Received after the Advisory Group Meeting*: Thank you for the comment. We regularly update the literature for these measures through environmental scans. The research in home health continues to be limited in the United States. We are taking an active role to disseminate home health findings at conferences.
Performance Gap: A committee member commented on how the improvement in the performance gap has been narrowing. They asked if there was a point when the measure had done as much as it can.	The developer responded that they do not believe the measure is at risk of topping off soon. They said they consistently receive feedback, particularly from the provider community, on the value of these measures (CBE 0167, 0174, 0175, and 0176) and recently heard at a public comment meeting that this measure is useful. Additionally, the developer noted that as they introduce the discharge function measure (which will provide a sense of what the patient is doing in totality), there is also value in looking at specific domain function.

Feedback/Questions	Summary of Developer Response
	Summary Response Received after the Advisory Group Meeting: Thank you for the question. Overall, mean performance has been trending upward, with a low of 0.760 in calendar year (CY) 2019 and a high of 0.798 in CY 2022. The lower and upper bounds of the interquartile range have also increased with each year. Despite the steady increases year over year, there remains a performance gap for Improvement in Ambulation/Locomotion (#0167).
Similar Feedback to #0174: A committee member expressed the same questions pertaining to public feedback and composite vs. individual measures as noted with CBE #0174.	Please refer to the developer's responses for CBE #0174.
Similar Feedback to #0175: A few committee members expressed the same questions surrounding equity as noted with CBE #0175.	Please refer to the developer's responses for CBE #0175.

Key Discussion Points:

- **Improving vs. Maintaining:** There is importance in maintaining versus improving with respect to home health care.
    - The developer acknowledged this importance and has started to incorporate this into new measures, including a cross-setting [inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), long-term acute care hospital (LTACH), and home health] discharge function measure that was finalized in last year's home health final rule.
- **Palliative Care:** Hospice is now an exclusion; is there a consideration of palliative care?
    - Developer noted that to go beyond discharge to hospice would require additional data sources. The discharge function measure (mentioned above) may be a more plausible scenario for some of these considerations.
- **Performance Gap:** The gap is narrowing; at what point has the measure done as much as it can?
    - Developer noted the continued support from providers and recent public comment regarding the importance of this measure and the other three measures (CBE #0174, #0175, and #0176). Despite the steady increases year-over-year (mean performance of 0.760 in CY 2019 and a high of 0.798 in CY 2022), there remains a performance gap.
- **Consideration of a Composite:** Is there any consideration for having these measures (CBE #0167, #0174, #0175, and #0176) be a composite?
    - The developer noted that each measure is valuable in and of itself, allowing providers to see different aspects of function, which may be particularly beneficial when focusing on one or two aspects for a certain patient. They said they have also heard from home health providers that they support these as individual measures.
- **Public Feedback:** Is there feedback from the public on what is most important in terms of functional improvement and whether one aspect should be emphasized over another?
    - The developer noted that across care settings and particularly home health, there are a range of different patients, and each component of function gathers a slightly different aspect that contributes to the whole picture.

- **Equity:** The developer gained feedback from the Advisory Group on which critical issues they should be targeting for all three functional measures (CBE #0167, #0174, #0175, and #0176). One of the main areas they have made strides in is generating confidential feedback reports for home health providers to help them understand some of the broader social determinant issues. In addition, they compared each of the four function measures CY 2022 performance by subgroups for urbanicity/rurality, size, and share of quality episodes with non-white patients. The results for each measure indicate a performance gap across home health agencies by subgroup.

CBE #0174: Improvement in Bathing [Abt Associates/CMS]

Measure Description:

Percentage of home health episodes of care during which the patient got better at bathing self.

Measure Status	
New or Maintenance: Maintenance Measure	**Used in An Accountability Application?** Yes • Public Reporting • Payment Program • Quality Improvement with Benchmarking (external benchmarking to multiple organizations) • Quality Improvement (Internal to the specific organization)
CBE Endorsement Status: Endorsed **Last Endorsement Review Cycle:** Fall 2018	**Proposed/Planned Use:** MNHealthScores, MN Community Measurement Community Reports, HealthPartners Partners in Quality

Measure Characteristics

Measure Type	Target Population(s)	Level of Analysis	Care Setting(s)
Outcome	Elderly Individuals with Chronic Conditions	Facility	Home Care

Measure Overview
Rationale: Patients need certain physical abilities to bathe themselves in the bath or shower. Many patients who receive home health care are recovering from an injury or illness and may have difficulty performing the tasks of bathing and/or may need help from another person or special equipment to accomplish this activity. The required physical abilities for bathing can be developed or improved by patient teaching or through rehabilitative services. Home health care staff can encourage patients to be as independent as possible, can evaluate patients' needs for, and can teach them how to use, special devices or equipment and increase their ability to perform some activities without the assistance of another person. Improving patients' ability to bathe themselves contributes to patient comfort, hygiene, skin integrity, and quality of life and can allow them to live as long as possible in their own environment. Getting better at bathing may be a sign that patients are meeting the goals of their care plan and/or that their health status is improving. Recovering independence in bathing is often a rehabilitative goal for home health patients, making it a reasonable evaluation indicator of effective and high-value home health care.
Numerator: Number of home health episodes of care when the value recorded on the discharge assessment indicates less impairment in bathing at discharge than at start (or resumption) of care.
Denominator: Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.

Measure Overview
Exclusions: All home health episodes for which the patient, at start/resumption of care, was able to bathe independently (M1830[1] = 00), or the patient was nonresponsive (M1700[1] = 04 or M1710[1] = NA or M1720[1] = NA), or the episode is covered by the generic exclusions (see following section).
Measure is Risk-Adjusted and/or Stratified: Statistical risk model with risk factors Improvement in Bathing (#0174) attempts to measure a home health agency's ability to improve patient bathing while the patient is in its care; however, because certain factors are outside of its control, the measure developer risk-adjusts the measure. Risk adjustment is used to promote incentives for home health agencies to provide the same care to patients regardless of patient characteristics at SOC/ROC. The risk factors that can be fully addressed should not be included in the risk adjustment model because the home health agency is expected to be responsible for addressing those risk factors. For instance, if all other risk factors are identical, a home health agency is expected to provide two patients with identical quality care regardless of race or ethnicity.

Logic Model
Summary: Improvement in Bathing (#0174) measures whether the patient's ability to bathe at end of care (EOC) improves relative to the patient's ability to bathe at start or resumption of care (SOC/ROC). To improve, patients will receive support from three primary sources: the home health agency that provides skilled care, caregivers, and themselves. For Improvement in Bathing (#0174) we are concerned with attributing the improvement to the home health agency care, and as a result, we risk-adjust the observed improvement to account for differences in patient characteristics at SOC/ROC.

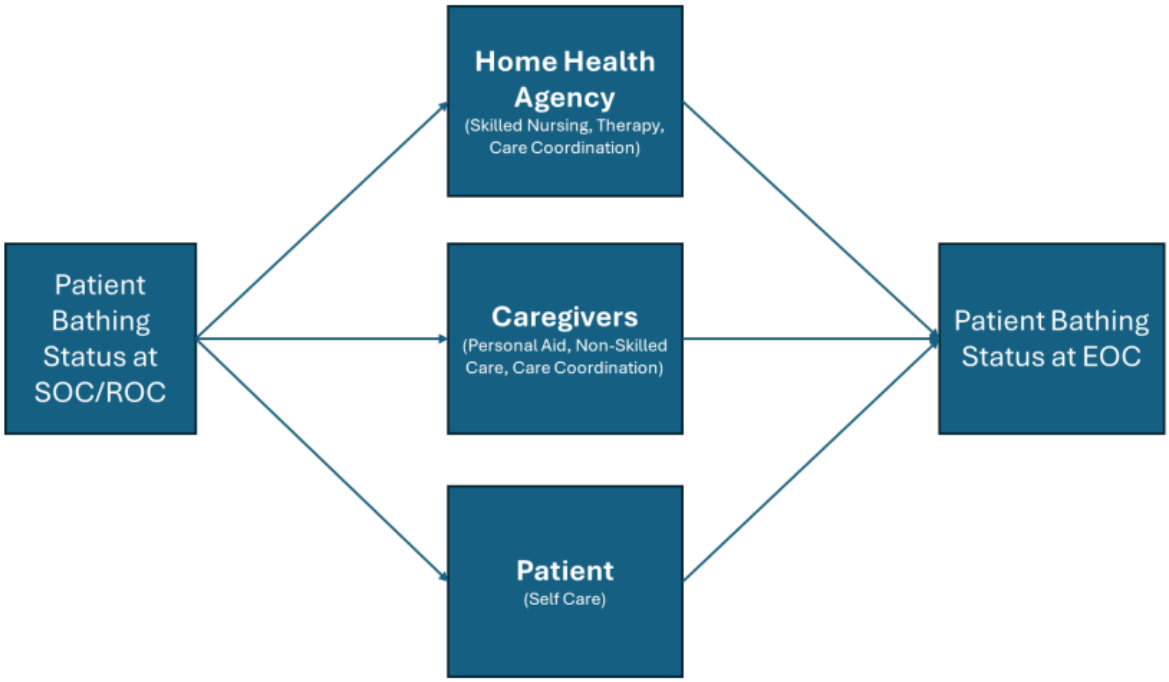

Figure 3. CBE #0174 Logic Model

Measure Evaluation Summary: CBE #0174

Importance
Staff Preliminary Rating: Met
• **Importance**: There is a business case for the measure along with supporting evidence for the importance of the measured outcomes with demonstrated gap in performance.

Feasibility
Staff Preliminary Rating: Met
• **Feasibility:** There are no feasibility challenges, fees, or proprietary components to this measure.

Reliability	
Staff Preliminary Rating: Met	
Testing Level:	Person or Encounter Level and Accountable Entity Level
Testing Method:	The developer conducted reliability testing using **a split-half reliability test,** and results reported show statistics **exceed 0.80**, even within the decile with the smallest home health agencies. Based on the weighted kappa statistics the inter-rater reliability indicated **moderate agreement at SOC/ROC (0.51) and moderate agreement at discharge (0.43).**
• **Reliability:** The measure is well-defined. Reliability was assessed at both the patient and entity level. Reliability statistics are above the established thresholds for most, if not all, entities.	

Validity	
Staff Preliminary Rating: Met	
Testing Level:	Person or Encounter Level and Accountable Entity Level
Testing Conducted:	Yes. Validity testing was conducted using **the Spearman rank correlation,** and results reported show a **statistically significant positive correlation** with a publicly reported measure that similarly assesses patient functioning and *Discharge to Community (#3477)*, which lends evidence to the measure's validity. The item was also reviewed as part of the OMB/PRA review process for the most recent OASIS data set revision, which allowed for two national comment periods (60 days and 30 days) wherein the face validity of the item was supported by the comments received.

Validity
• **Validity:** The developer assessed measure validity using accountable entity-level empirical validity and data element-level validity. The interpretation of the empirical results supports an inference of validity.

Equity	
Staff Preliminary Rating: Met	
Equity considered:	Yes
• **Equity:** The developer evaluated disparities in performance by subgroups for urbanicity/rurality, size, and share of quality episodes with non-white patients.	

Use & Usability	
Staff Preliminary Rating: Met	
Current or Planned Use:	Measure is currently used in Public Reporting and Home Health Star Ratings.
• **Use & Usability**: The developer provides data demonstrating overall improvement in the measure. The developer acknowledges the existence of performance gaps and anticipates further improvement with the nationwide expansion of HHVBP.	

Public Comment[2]

Number of Comments Received: 4

Full text of developer/steward responses can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
Three comments expressed support for this measure and emphasized the importance of the measure's purpose, specifically from a patient perspective.	Supportive	Thank you for your comment and support of this measure.
One comment questions whether improvements and changes have been made to the measure since its initial endorsement.	N/A	Measure data are shared with HHAs so they may take action to improve performance on this measure.

[2] Comments, as submitted, can be found on the PQM website.

Advisory Group Feedback

Full text of developer/steward responses can be found on the PQM website.

Feedback/Questions	Summary of Developer Response
Public Feedback: A committee member asked if the developer has any feedback from the public about what is most important in terms of functional improvement and whether one aspect should be emphasized over another?	The developer emphasized that they have many vehicles for public feedback, including a help desk and a regular technical expert panel (TEP). They said their recent analysis shows that across care settings and particularly home health, there are a range of different patients, and each component of function gathers a slightly different aspect that contributes to the whole picture. *Summary Response Received after the Advisory Group Meeting*: Thank you for the question. We have multiple ways to receive public feedback including a help desk and a regular TEP. We have not received any feedback specific to the question.
Composite Versus Individual Measures: A committee member asked if these measures might eventually be combined into a composite measure.	The developer said each measure is valuable in and of itself, allowing providers to see different aspects of function, which may be particularly beneficial when focusing on one or two aspects for a certain patient. They said they have also heard from home health providers that they support these as individual measures. A CMS representative echoed these sentiments. *Summary Response Received after the Advisory Group Meeting*: Thank you for the question. Each measure is valuable in and of itself, allowing providers to see different aspects of function, which may be particularly beneficial when focusing on one or two aspects for a certain patient. We have also heard from home health providers that they support these as individual measures.
Similar Feedback to #0175: A few committee members asked the same questions surrounding equity as noted with CBE #0175.	Please refer to the developer's responses for CBE #0175.

Key Discussion Points:

- **Consideration of a Composite:** Is there any consideration for having these measures (CBE #0167, #0174, #0175, and #0176) be a composite?
    - The developer noted that each measure is valuable in and of itself, allowing providers to see different aspects of function, which may be particularly beneficial when focusing on one or two aspects for a certain patient. They said they have also heard from home health providers that they support these as individual measures.

- **Public Feedback:** Is there feedback from the public on what is most important in terms of functional improvement and whether one aspect should be emphasized over another?
    - The developer noted that across care settings and particularly home health, there are a range of different patients, and each component of function gathers a slightly different aspect that contributes to the whole picture.
- **Equity:** The developer gained feedback from the Advisory Group on which critical issues they should be targeting for all three functional measures (CBE #0167, #0174, #0175, and #0176). One of the main areas they have made strides in is generating confidential feedback reports for home health providers to help them understand some of the broader social determinant issues. In addition, they compared each of the four function measures CY 2022 performance by subgroups for urbanicity/rurality, size, and share of quality episodes with non-white patients. The results for each measure indicate a performance gap across home health agencies by subgroup.

CBE #0175: Improvement in Bed Transferring [Abt Associates/CMS]

Measure Description:

Percentage of home health episodes of care during which the patient improved in ability to get in and out of bed.

Measure Status	
New or Maintenance: Maintenance	**Used in An Accountability Application?** Yes • Public Reporting • Payment Program • Quality Improvement with Benchmarking (external benchmarking to multiple organizations) • Quality Improvement (Internal to the specific organization)
CBE Endorsement Status: Endorsed **Last Endorsement Review Cycle:** Spring 2019	**Proposed/Planned Use:** Public Reporting and Home Health Star Ratings; CMS

Measure Characteristics

Measure Type	Target Population(s)	Level of Analysis	Care Setting(s)
Outcome	Elderly Individuals with Chronic Conditions	Facility	Home Care

Measure Overview
Rationale: Patients need certain physical abilities to transfer safely from bed to chair (and chair to bed), or to turn and position themselves in bed if bedfast. Many patients who receive home health care are recovering from an injury or illness and may have difficulty with bed transferring, and/or may need help from another person or special equipment to accomplish this activity. Safe transferring is critical in being able to remain at home. The required physical abilities for bed transferring can be developed or improved by managing patient symptoms and through rehabilitative services. Home health care staff can encourage patients to be as independent as possible, can evaluate patients´ needs for, and can teach them how to use, special devices or equipment and increase their ability to perform some activities without the assistance of another person. Improving functional status related to bed transferring contributes to quality of life and can allow patients to live as long as possible in their own environment. Recovering independence in bed transferring is often a rehabilitative goal for home health patients, making it a reasonable evaluation indicator of effective and high-value home health care.
Numerator: Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in bed transferring at discharge than at start (or resumption) of care.

Measure Overview
Denominator: Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Exclusions: All home health episodes of care for which the patient at start/resumption of care was able to transfer independently (M1850[1] = 00) or the patient was nonresponsive (M1700[1] = 04 or M1710[1] = NA or M1720[1] = NA) or the episode is covered by the generic exclusions (see following section).
Measure is Risk-Adjusted and/or Stratified: Statistical risk model with risk factors Improvement in Bed Transferring (#0175) attempts to measure a home health agency's ability to improve patient bed transferring while the patient is in its care; however, because certain factors are outside of its control, the measure developer risk-adjusts the measure. Risk adjustment is used to promote incentives for home health agencies to provide the same care to patients regardless of patient characteristics at SOC/ROC. The risk factors that can be fully addressed should not be included in the risk adjustment model because the home health agency is expected to be responsible for addressing that risk factor. For instance, if all other risk factors are identical, a home health agency is expected to provide two patients with identical quality care regardless of race or ethnicity.

Logic Model
Summary: Improvement in Bed Transferring (#0175) measures whether the patient's ability to get in and out of bed at end of care (EOC) improves relative to the patient's ability to get in and out of bed at start or resumption of care (SOC/ROC). To improve, patients will receive support from three primary sources: the home health agency that provides skilled care, caregivers, and themselves. For Improvement in Bed Transferring (#0175) we are concerned with attributing the improvement to the home health agency care, and as a result, we risk-adjust the observed improvement to account for differences in patient characteristics at SOC/ROC.

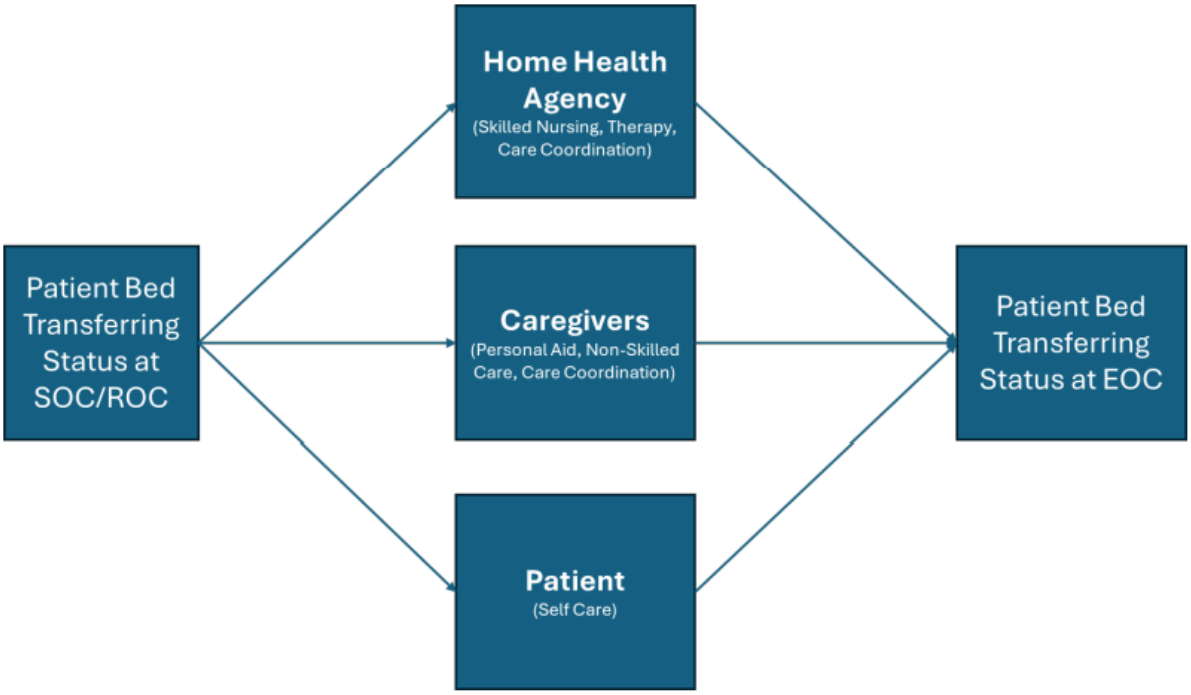

Figure 4. CBE #0175 Logic Model

Measure Evaluation Summary: CBE #0175

Importance
Staff Preliminary Rating: Met
• **Importance**: There is a business case for the measure along with supporting evidence for the importance of the measured outcomes with demonstrated gap in performance.

Feasibility
Staff Preliminary Rating: Met
Feasibility: There are no feasibility challenges, fees, or proprietary components to this measure.

Reliability	
Staff Preliminary Rating: Met	
Testing Level:	Person- or -Encounter-Level and Accountable Entity-Level
Testing Method:	Reliability testing was conducted using **a split-half reliability test** and results reported show statistics **exceed 0.80**, even within the decile with the smallest home health agencies, suggesting strong reliability and acceptability for drawing inferences about home health agencies. Based on the weighted kappa statistics the inter-rater reliability indicated **moderate agreement at SOC/ROC (0.42) and moderate agreement at discharge (0.45).**
• **Reliability:** The measure is well defined. Reliability was assessed at both the patient and entity level. Reliability statistics are above the established thresholds for most, if not all, entities.	

Validity	
Staff Preliminary Rating: Met	
Testing Level:	Person- or Encounter-Level and Accountable Entity-Level
Testing Conducted:	Validity testing was conducted using **the Spearman rank correlation** and results reported show a **statistically significant positive correlation** with a publicly reported measure that similarly assesses patient functioning and *Discharge to Community (#3477)*, which lends evidence to the measure's validity. The item was also reviewed as part of the OMB/PRA review process for the most recent OASIS data set revision which allowed for two national comment periods (60 days and 30 days) wherein the face validity of the item was supported by the comments received.

Validity
• **Validity:** The developer assessed measure validity using accountable entity-level empirical validity and data-element level validity. The interpretation of the empirical results supports an inference of validity.

Equity	
Staff Preliminary Rating: Met	
Equity considered:	Yes
• **Equity:** The developer evaluated disparities in performance by subgroups for urbanicity/rurality, size, and share of quality episodes with non-white patients.	

Use & Usability	
Staff Preliminary Rating: Met	
Current or Planned Use:	Measure is currently used in Public Reporting and Home Health Star Ratings.
• **Use & Usability**: While the rate of improvement has slowed down in recent years, the developer provides data demonstrating overall improvement in the measure. The developer acknowledges the existence of performance gaps and anticipates further improvement with the nationwide expansion of HHVBP.	

Public Comment[3]

Number of Comments Received: 4

Full text of developer/steward responses can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
Three comments expressed support for this measure and emphasized the importance of the measure's purpose, specifically from a patient perspective.	Supportive	Thank you for your comment and support of this measure.

[3] Comments, as submitted, can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
One comment questions whether improvements and changes have been made to the measure since its initial endorsement.	N/A	Measure data are shared with HHAs so they may take action to improve performance on this measure.

Advisory Group Feedback

Full text of developer/steward responses can be found on the PQM website.

Feedback/Questions	Summary of Developer Response
Equity: A few committee members asked if the developer could discuss equity issues for this measure as well as the other three functional measures.	The developer said they have dedicated time to this issue over the last few years. They said they had a TEP in 2022 on equity in home health and hospice health to gain guidance from experts on what they should be doing. They added that they have gained feedback on what critical issues they should be targeting from the rulemaking process. They highlighted that one of the main areas they have made strides in this domain is by generating confidential feedback reports for home health providers to help them understand some of the broader social determinant issues. The developer later added they sometimes consolidate data from these four measures to be able to identify trends across the country and various regions (such as urban versus rural areas, race) so that they can help inform providers and agencies. *Summary Response Received after the Advisory Group Meeting*: Across home health agencies, we compared each of the four function measures' CY 2022 performance by subgroups for urbanicity/rurality, size, and share of quality episodes with non-white patients. The results for each measure indicate a performance gap across home health agencies by subgroup. CMS is monitoring the persistence of these gaps and investigating next steps for addressing through reevaluated measure specifications or other policies (see https://www.cms.gov/medicare/quality/home-health-quality-reporting-program/home-health-qrp-health-equity for additional resources).
Similar Feedback to #0174: A committee member asked the same questions pertaining to public feedback and composite vs. individual measures as noted with CBE #0174.	Please refer to the developer's responses for CBE #0174.

Key Discussion Points:

- **Consideration of a Composite:** Is there any consideration for having these measures (CBE #0167, #0174, #0175, and #0176) be a composite?
    - The developer noted that each measure is valuable in and of itself, allowing providers to see different aspects of function, which may be particularly beneficial when focusing on one or two aspects for a certain patient. They said they have also heard from home health providers that they support these as individual measures.
- **Public Feedback:** Is there feedback from the public on what is most important in terms of functional improvement and whether one aspect should be emphasized over another?
    - The developer noted that across care settings and particularly home health, there are a range of different patients, and each component of function gathers a slightly different aspect that contributes to the whole picture.
- **Equity:** The developer gained feedback from the Advisory Group on which critical issues they should be targeting for all three functional measures (CBE #0167, #0174, #0175, and #0176). One of the main areas they have made strides in is generating confidential feedback reports for home health providers to help them understand some of the broader social determinant issues. In addition, they compared each of the four function measures CY 2022 performance by subgroups for urbanicity/rurality, size, and share of quality episodes with non-white patients. The results for each measure indicate a performance gap across home health agencies by subgroup.

CBE #0176: Improvement in Management of Oral Medications [Abt Associates/CMS]

Measure Description:

The percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.

Measure Status	
New or Maintenance: Maintenance Measure	**Used in An Accountability Application?** Yes • Public Reporting • Payment Program • Quality Improvement with Benchmarking (external benchmarking to multiple organizations) • Quality Improvement (Internal to the specific organization)
CBE Endorsement Status: Endorsed **Last Endorsement Review Cycle:** Fall 2018	**Proposed/Planned Use:** Public Reporting and Home Health Star Ratings

Measure Characteristics

Measure Type	Target Population(s)	Level of Analysis	Care Setting(s)
Outcome	Elderly Individuals with Chronic Conditions	Facility	Home Care

Measure Overview
Rationale: Many patients who receive home health care are recovering from an injury or illness and may have difficulty walking or moving around safely. They may need help from a person or special equipment (like a walker or cane) to accomplish this activity. Home health care staff can encourage patients to be as independent as possible and can evaluate patients' needs for, and teach them how to use, special devices or equipment to help increase their ability to perform some activities without the assistance of another person. Safe ambulation and mobility are critical to being able to remain at home. Improving functional status such as a patient's ability to perform ambulation/locomotion, contributes to quality of life and allows them to live safely and as long as possible in their own environment. Getting better at walking or moving around may be a sign that they are meeting the goals of their care plan or that their health status is improving. Recovering independence in walking or moving around with assistive devices is often a rehabilitative goal for home health patients, making it a reasonable evaluation indicator of effective and high-value home health care.
Numerator: The number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in taking oral medications at discharge than at start (or resumption) of care.

Measure Overview
Denominator: Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Exclusions: Home health quality episodes for which the patient, at start/resumption of care, was able to take oral medications correctly without assistance or supervision (M2020[1] = 00) or patient has no oral medications prescribed (M2020[1] = (NA,'^',') or M2020[2] = (NA)) or the patient was nonresponsive (M1700[1] = 04 or M1710[1] = NA or M1720[1] = NA) or the episode is covered by the generic exclusions (see following section).
Measure is Risk-Adjusted and/or Stratified: Yes, the measure is risk-adjusted using a statistical risk model with risk factors.

Logic Model
Summary: *Improvement in Management of Oral Medications (#0176)* measures whether the patient's ability to take the correct oral medications and proper dosage(s) at the correct times at end of care (EOC) improves relative to their ability to take the correct oral medications and proper dosage(s) at the correct times at start or resumption of care (SOC/ROC). To improve, patients will receive support from three primary sources: their home health agency, caregivers, and themselves. For *Improvement in Management of Oral Medications (#0176),* we are concerned with attributing the improvement to the home health agency's care. Thus, we risk-adjust the observed improvement to account for differences in patient characteristics at SOC/ROC.

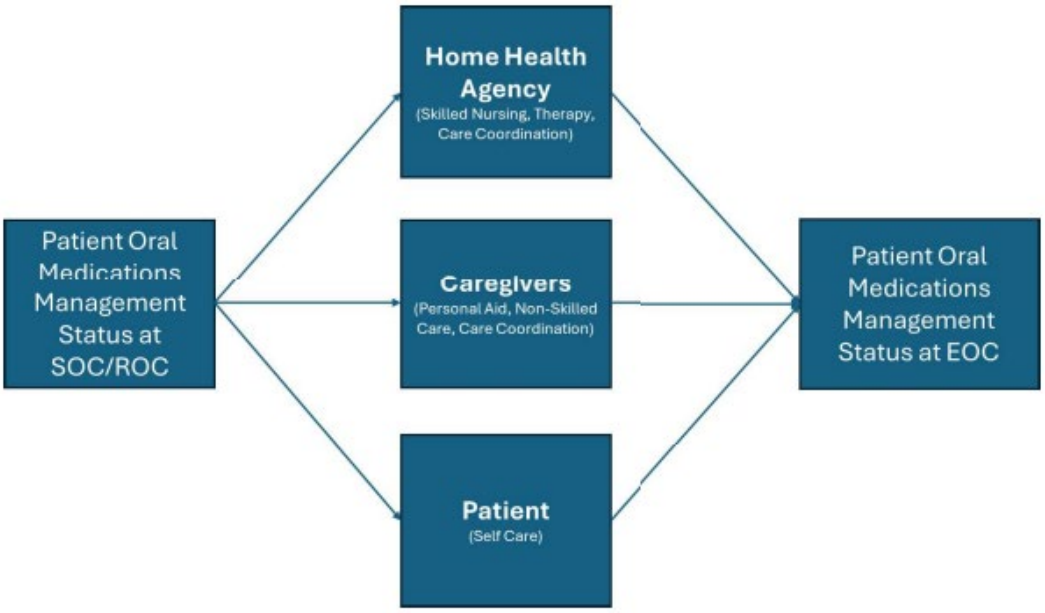

Figure 5. CBE #0176 Logic Model

Measure Evaluation Summary: CBE #0176

Importance
Staff Preliminary Rating: Met
• **Importance**: There is a business case for the measure along with supporting evidence for the importance of the measured outcomes with demonstrated gap in performance.

Feasibility
Staff Preliminary Rating: Met
• **Feasibility:** There are no feasibility challenges, fees, or proprietary components to this measure.

Reliability	
Staff Preliminary Rating: Met	
Testing Level:	Patient or Encounter Level; Accountable Entity Level
Testing Method:	Reliability testing was conducted using **a split-half reliability test** and results reported show statistics **exceed 0.80**, even within the decile with the smallest home health agencies, suggesting strong reliability and acceptability for drawing inferences about home health agencies. Based on the weighted kappa statistics the inter-rater reliability indicated **moderate agreement at SOC/ROC (1.00) and moderate agreement at discharge (0.65).**
• **Reliability:** The measure is well defined. Reliability was assessed at both the patient and entity level. Reliability statistics are above the established thresholds for most, if not all, entities.	

Validity	
Staff Preliminary Rating: Met	
Testing Level:	Patient or Encounter Level; Accountable Entity Level
Testing Conducted:	Validity testing was conducted using **the Spearman rank correlation** and results reported show a **statistically significant positive correlation** with a publicly reported measure that similarly assesses patient functioning and *Discharge to Community (#3477)*, which lends evidence to the measure's validity. The item was also reviewed as part of the OMB/PRA review process for the most recent OASIS data set revision which allowed for two national comment periods (60 days and 30 days) wherein the face validity of the item was supported by the comments received.

Validity
• **Validity:** The developer assessed measure validity using accountable entity-level empirical validity and data-element level validity. The interpretation of the empirical results supports an inference of validity.

Equity	
Staff Preliminary Rating: Met	
Equity considered:	Yes
• **Equity:** The developer evaluated disparities in performance by subgroups for urbanicity/rurality, size, and share of quality episodes with non-white patients.	

Use & Usability	
Staff Preliminary Rating: Met	
Current or Planned Use:	Measure is currently used in public reporting and Home Health Star Ratings.
• **Use & Usability**: While the rate of improvement has slowed down in recent years, the developer provides data demonstrating overall improvement in the measure. The developer acknowledges the existence of performance gaps and anticipates further improvement with the nationwide expansion of HHVBP.	

Public Comment[4]

Number of Comments Received: 5

Full text of developer/steward responses can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
Four comments shared support for the measure, from the patient and organizational perspectives. Commenters agreed that access to medications and consistent safe management is key to patient health.	Supportive	Thank you for your comment and support of this measure.

[4] Comments, as submitted, can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
One commenter emphasized the importance of ensuring that the data collected from the measure are resulting in improvements for patients, particularly since this is a maintenance measure that has been in use.	N/A	Measure data are shared with HHAs so they may take action to improve performance on this measure.

Advisory Group Feedback

Full text of developer/steward responses can be found on the PQM website.

Feedback/Questions	Summary of Developer Response
Improving Versus Interventions: A committee member commented that they thought this functional measure is slightly different than the other three as it feels more urgent and immediate. They said improvement may not be enough for this measure; they recommended that if individuals are at high risk of not managing their oral medications, interventions are needed.	The developer agreed that this measure is slightly different than the other three function measures and agreed that patients' ability to manage their medications is a great focus of concern. They noted another quality measure, the Drug Regimen Review, in the Home Health Quality Reporting Program, that seeks to identify significant issues with medications as identified by the assessing clinician during start of care and in management of care for oral medications. They said that guidance for this measure states the assessing clinical professional is responsible for identifying individuals who are high risk and interventions that will help them manage the risk. *Summary Response Received after the Advisory Group Meeting*: The Home Health Quality Reporting Program has multiple medication management measures to assess a patient's ability to manage their medications.
Similar Feedback to #0174: A committee member expressed the same questions pertaining to public feedback and composite vs. individual measures as noted with CBE #0174.	Please refer to the developer's responses for CBE #0174.
Similar Feedback to #0175: A few committee members expressed the same questions surrounding equity as noted with CBE #0175.	Please refer to the developer's responses for CBE #0175.

Key Discussion Points:

- **Consideration of a Composite:** Is there any consideration for having these measures (CBE #0167, #0174, #0175, and #0176) be a composite?

    - The developer noted that each measure is valuable in and of itself, allowing providers to see different aspects of function, which may be particularly beneficial when focusing on one or two aspects for a certain patient. They said they have also heard from home health providers that they support these as individual measures.
- **Public Feedback:** Is there feedback from the public on what is most important in terms of functional improvement and whether one aspect should be emphasized over another?
    - The developer noted that across care settings and particularly home health, there are a range of different patients, and each component of function gathers a slightly different aspect that contributes to the whole picture.
- **Equity:** The developer gained feedback from the Advisory Group on which critical issues they should be targeting for all three functional measures (CBE #0167, #0174, #0175, and #0176). One of the main areas they have made strides in is generating confidential feedback reports for home health providers to help them understand some of the broader social determinant issues. In addition, they compared each of the four function measures' CY 2022 performance by subgroups for urbanicity/rurality, size, and share of quality episodes with non-white patients. The results for each measure indicate a performance gap across home health agencies by subgroup.

CBE #2967: Home and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Measures [The Lewin Group/CMS]

Measure Description:

CAHPS Home- and Community-Based Services measures derive from a cross-disability survey to elicit feedback from adult Medicaid beneficiaries receiving home and community-based services (HCBS) about the quality of the long-term services and supports they receive in the community and delivered to them under the auspices of a state Medicaid HCBS program. The unit of analysis is the Medicaid HCBS program, and the accountable entity is the operating entity responsible for managing and overseeing a specific HCBS program within a given state.

Measure Status	
New or Maintenance: Maintenance Measure	**Used in An Accountability Application?** Yes – Quality Improvement
CBE Endorsement Status: Endorsed **Last Endorsement Review Cycle:** Fall 2016	**Proposed/Planned Use:** Home and Community-Based Services Measures

Measure Characteristics

Measure Type	Target Population(s)	Level of Analysis	Care Setting(s)
Patient-Reported Outcome-Based Performance Measure	Medicaid participants, 18 years and older, receiving long-term services and supports	Health Plan; Population or Geographic Area (State)	Home and community-based services

Measure Overview
Rationale: The information that is collected as part of the HCBS CAHPS Survey informs HCBS managed care plans and states about their performance on services that are highly valued by HCBS participants. The type of data that are collected when implementing the survey is not readily available through other measures and can be used to target areas of improvement where scores are lagging. As the measure becomes implemented, HCBS plans and states will have the ability to monitor performance over time and base care interventions, in part, on the trends they see in responses.
Numerator: The HCBS CAHPS Survey measures are created using top-box scoring. This refers to the percentage of respondents that give the most positive response. Details regarding the definition of the most positive response are noted below. HCBS service experience is measured in the following areas: *Scale Measures* 1. Staff are reliable and helpful—Average proportion of respondents that gave the most positive response on 6 survey items. 2. Staff listen and communicate well—Average proportion of respondents that gave the most positive response on 11 survey items.

Measure Overview
3. Case manager is helpful—Average proportion of respondents that gave the most positive response on 3 survey items. 4. Choosing the services that matter to you—Average proportion of respondents that gave the most positive response on 2 survey items. 5. Transportation to medical appointments—Average proportion of respondents that gave the most positive response on 3 survey items. 6. Personal safety and respect—Average proportion of respondents that gave the most positive response on 3 survey items. 7. Planning your time and activities—Average proportion of respondents that gave the most positive response on 6 survey items. *Global Rating Measures* 1. Global rating of personal assistance and behavioral health staff—Proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale. 2. Global rating of homemaker—Proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale. 3. Global rating of case manager—Proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale. *Recommendation Measures* 1. Would recommend personal assistance/behavioral health staff to family and friends—Proportion of respondents that gave the most positive response of Definitely Yes on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes). 2. Would recommend homemaker to family and friends—Proportion of respondents that gave the most positive response of Definitely Yes on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes). 3. Would recommend case manager to family and friends—Proportion of respondents that gave the most positive response of Definitely Yes on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes). *Unmet Needs Measures* 1. Unmet need in dressing/bathing due to lack of help—Top-box score on a Yes or No scale. 2. Unmet need in meal preparation/eating due to lack of help—Top-box score on a Yes or No scale. 3. Unmet need in medication administration due to lack of help—Top-box score on a Yes or No scale. 4. Unmet need in toileting due to lack of help—Top-box score on a Yes or No scale. 5. Unmet need with household tasks due to lack of help—Top-box score on a Yes or No scale. *Physical Safety Measure* 1. Hit or hurt by staff—Top-box score on a Yes or No scale.
Denominator: The denominator for all measures is the number of survey respondents. Individuals eligible for the HCBS CAHPS Survey include Medicaid participants who are age 18 and older in the sample period and have received HCBS services for 3 months or longer. Eligibility is further determined using three cognitive screening items, administered during the interview: 1. Does someone come into your home to help you? (Yes, No) 2. How do they help you? 3. What do you call them? Participants who are unable to answer these cognitive screening items are excluded. Some measures also have topic-specific screening items as well.

Measure Overview
Exclusions: No explicit exclusion criteria are specified; however, the denominator is limited to participants who are at least 18 years of age in the sample period and have received HCBS services for 3 months or longer, as well as their proxies. During survey administration, additional exclusions include individuals for whom a qualifying response was not received for the cognitive screening questions mentioned in the denominator statement below.
Measure is Risk-Adjusted and/or Stratified: The survey's data allow for stratified analyses on social risk factors (e.g., disability, race, ethnicity, gender, primary language, and education).

Logic Model
Summary: The structure of the HCBS plan, including the types of services and supports that are delivered through the plan, informs the processes that the plans can effectively incorporate into the care of their participants. This relationship influences outcomes that are highly valued by HCBS participants and their caregivers, including the services that they care about the most, meeting important needs, and satisfaction with the quality of services and supports they are receiving.

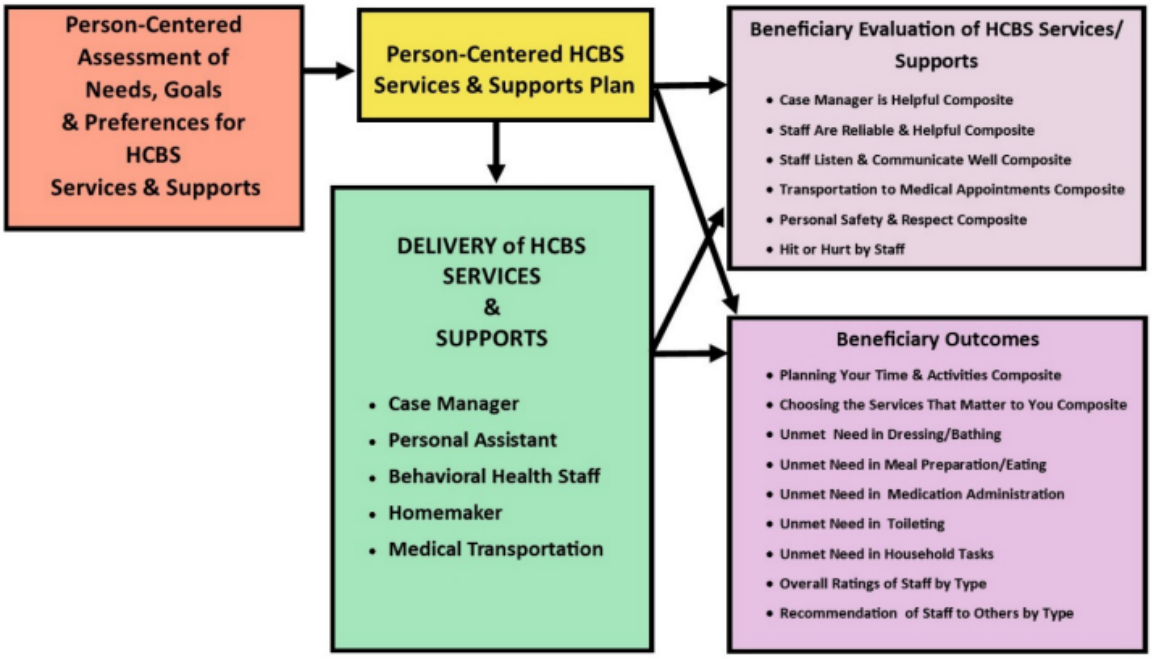

Figure 6. CBE #2967 Logic Model

Measure Evaluation Summary: CBE #2967

Importance
Staff Preliminary Rating: Met
• **Importance**: The developers cite the HCBS CAHPS itself as evidence of the measures' importance, because the PRO-PMs themselves are explicitly evaluative of HCBS services. The evidence review is narrow, focusing on the large size of the eligible population and the potentially sizable impact of the measures. The majority of the 19 PRO-PMs have substantial room for improvement and show significant variation by social risk factors such as age, gender, race, ethnicity, and education.

Feasibility
Staff Preliminary Rating: Not met but addressable
• **Feasibility:** The original feasibility assessment referenced in the submission identifies and discusses several substantial challenges to implementation, as well as steps that could be taken to mitigate some challenges. This assessment argues that response rates will rise over time as challenges are addressed, but updated response rates have not been reported. As this is a PRO-PM, the burden for collecting data falls on a survey vendor. There are no licensing requirements or fees, but entities will have to locate and contract with a suitable vendor, and there are also costs associated with this. Survey mode is not discussed in detail, but there does not appear to be a plan to collect survey responses electronically.

Reliability	
Staff Preliminary Rating: Not met but addressable	
Testing Level:	Accountable Entity Level
Testing Method:	The measure developer tested measure reliability using multiple methods that address different aspects of a measure's reliability (e.g., consistency, repeatability). The unit of analysis (i.e., the level of data) used to calculate the statistical measures of reliability varied based on the measure.
• **Reliability:** The measure is well-defined. Reliability was assessed for individual measures only, four of which have a reliability below 0.6 for more than 70% of the entities (three of the unmet needs measures and one of the scale measures). The developer may consider estimation of the reliability of case-mix adjusted the program-level scores with a method such as split-half reliability. Reliability could possibly be addressed by removing some of the low reliability measures.	

Validity

Staff Preliminary Rating: Not met but addressable	
Testing Level:	Accountable Entity Level
Testing Conducted:	The developer conducted validity testing using face validity, construct validity, convergent validity, and discriminant validity.

- **Validity:** Eligibility criteria appear appropriate and there are no exclusions for this measure. Face validity testing performed on six measures (five unmet needs and physical safety) using responses from 10 TEP members generally demonstrated moderate face validity. Risk factors explored for risk-adjustment models have strong, consistent associations with other CAHPS surveys (e.g., age, race, ethnicity, living alone, health status, language, proxy). Overall, the developer did not state a clear rationale for why some validity testing methods, including risk adjustment, were applied to only some measures and not others. Validity testing was not reported for the three recommendation measures.

Equity	
Staff Preliminary Rating: Met	
Equity Considered:	Yes

- **Equity:** Several potential social risk factors were examined for performance gaps, including age bands, gender, race, ethnicity, language spoken at home, education level, living arrangement, and health status. Most performance scores show significant variation by age, gender, race, ethnicity, and education, except for unmet needs, which had fewer responses overall and rarely showed significant differences.

Use & Usability	
Staff Preliminary Rating: Not met but addressable	
Current or Planned Use:	Measure is currently used for quality improvement internal to the specific organization.

- **Use & Usability**: This measure is currently in use in the HCBS program. Examples of how performance can be improved are drawn from program activities, such as using performance data to identify disparities in services or opportunities for quality improvement and developing corrective action plans. The developer described several events used to collect feedback, including meetings with state agencies and grantees, though no routine processes for collecting feedback were described. Performance on most measures has improved from 2022 to 2023; older data were not used in this analysis. The developer does not explain the lack of improvement in several measures or provide the number of programs and survey responses in earlier years of data.

Public Comment[5]

Number of Comments Received: 1

Full text of developer/steward responses can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
One comment suggested defining "completed survey," applying disposition reports to strengthen participation rate, and considering the use of virtual platforms to administer the survey.	N/A	*Summary Response Received after the Advisory Group Meeting*: • The Agency for Healthcare Research & Quality (AHRQ) and CMS provide guidance on how to determine if a survey is complete. More information is available here: https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbscahps-admin-ta-guide.pdf • Data on declinations are not available from states and managed care plans at this time. CMS will consider the feasibility of gathering these data in a future update to the HCBS CAHPS Survey instrument. • Administration of the HCBS CAHPS Survey via videoconference is allowed, as long as the participant has the ability to choose in-person or telephonic administration. Thank you for the feedback.

Advisory Group Feedback

Full text of developer/steward responses can be found on the PQM website.

Feedback/Questions	Summary of Developer Response
Use of Proxies: A few committee members commented that the data regarding proxy use were old. They asked if proxy responses look different from other responses.	The developer acknowledged the data on proxies are old. They said the proxy analysis was done when the measure was originally created and tested, and they have not done any feasibility assessments since then. *Summary Response Received after the Advisory Group Meeting*: • Substantial analysis of proxy responses was performed when developing the HCBS CAHPS Survey instrument. • At this time, rates of proxy responses are low (7.60% of the total participant eligible population) and likely represent populations for which use of proxies is both necessary and appropriate. Technical

[5] Comments, as submitted, can be found on the PQM website.

	assistance is available to states with populations for which a proxy must provide responses to the HCBS CAHPS Survey to ensure the data collected are accurate, reliable, and valid. Thank you for the feedback.
Response Rate: A few committee members asked if the developer had considered reducing the survey length or had considered different vehicles of distribution (such as email or use of artificial intelligence [AI]) to improve response rates.	The developer said they are working with states and plans to provide technical assistance on how to improve response rates. They are also gathering input from states and users to see what their recommendations are. They anticipate having more information to present at the next maintenance cycle. They added that while the survey is long, it includes four different provider types and only questions about the relevant provider types are asked. In terms of vehicles of distribution, the developer said the survey is designed to be interactive, such as adjusting and tailoring the terms. They did not feel that web and email were appropriate for their population. However, they have expanded to include video conferencing, so the data can be collected via video, telephone, or in person. They believe that some of the other tactics they outlined will help improve their response rates, although they may revisit this idea in the future. The developer said they have not explored artificial intelligence (AI) yet, and CMS may have some hesitancy surrounding the concept. *Summary Response Received after the Advisory Group Meeting*: • A breadth of technical-assistance options is available to states and managed care plans implementing HCBS CAHPS. As part of this effort, best practices to improve response rate are provided. • Use of artificial intelligence to improve data collection is not in use currently. Thank you for the feedback.
Bundling: A few committee members asked why “personal assistance” and “behavioral health” are combined.	The developer said they have received a lot of feedback on this topic and just held a listening session. They said they anticipate either providing a rationale or splitting the two for next cycle. *Summary Response Received after the Advisory Group Meeting*: • CMS is considering the feasibility of gathering data separately for personal care assistants and behavioral health staff. This change would appear in the next version of the HCBS CAHPS Survey

	and would feed into the HCBS CAHPS measures in a future endorsement review. Thank you for the feedback.
Terminology: A few committee members asked about whether certain titles (such as care manager) would be familiar to the people using the services.	The developer clarified that the delivery of the survey is intended to be dynamic. They said that within each state's Medicaid program, there are standardized types of providers, and those are likely the terms that will be used, with the individual provider having the option to select the most appropriate term (or name) as appropriate. They added that for HCBS, patients will likely have a consistent case manager. *Summary Response Received after the Advisory Group Meeting*: • Terms of Art for Provider Types: States and managed care plans are given the latitude to use alternative terms for providers (e.g., case managers) that are more common within the participant populations they serve. Providers may also be referred to by their name if the participant chooses to do so. Thank you for the feedback.
Multiple Touchpoints: One committee member raised a question about the timeliness of the survey, asking whether the developer had considered reaching out to the respondent multiple times over the course of their services, possibly allowing for a shorter survey and real-time feedback.	The developer said they would have to adjust how the survey is implemented to accomplish this, and they would take the suggestion back to their core group. They added that the survey looks at the 3 months preceding data collection. *Summary Response Received after the Advisory Group Meeting*: • CMS and the Lewin Group will consider collection of data longitudinally for future updates to the HCBS CAHPS Survey instrument. Thank you for the feedback.
Pediatric Population: A committee member asked whether the developer would consider including pediatric patients.	The developer said they have received substantial feedback around this topic, noting that a pediatric survey would result in a different measure. *Summary Response Received after the Advisory Group Meeting*: • CMS and the Lewin Group are working to specify a separate version of the HCBS CAHPS Survey for child, youth, and young-adult populations. • This instrument and its associated measures would be submitted as a separate measure to the consensus-based entity for evaluation in the future. Thank you for the feedback.

Key Discussion Points:

- **Improving Response Rates:** Consideration of reducing the survey size and creating different vehicles of distribution.
    - A breadth of technical-assistance options is available to states and managed-care plans implementing HCBS CAHPS. As part of this effort, best practices to improve response rate are provided. The developer also gathers input from states and users to see what they recommend to improve response rates.
    - The developer did not feel that web and email were appropriate for their population. However, they have expanded to include video conferencing, so the data can be collected via video, telephone, or in person. Use of artificial intelligence to improve data collection is not in use currently.
- **Proxy Data:** Proxy data are old.
    - The developer acknowledged the data on proxies are old. They said the proxy analysis was done when the measure was originally created and tested, and they have not done any feasibility assessments since then.
    - At this time, rates of proxy responses are low (7.60 percent of the total participant eligible population) and likely represent populations for which use of proxies is both necessary and appropriate. Technical assistance is available to states with populations for which a proxy must provide responses to the HCBS CAHPS Survey to ensure the data collected are accurate, reliable, and valid.
- **Bundling:** A few committee members asked why “personal assistance” and “behavioral health” are combined.
    - The developer noted that CMS is considering the feasibility of gathering data separately for personal care assistants and behavioral health staff. This change would appear in the next version of the HCBS CAHPS Survey and would feed into the HCBS CAHPS measures in a future endorsement review.
- **Feasibility:** Is there a near-term plan to support electronic data capture?
- **Reliability:** Four of the 19 measures have a reliability below 0.6 for more than 70% of the entities (3 of the unmet needs measures and 1 of the scale measures). Reliability could possibly be addressed by removing some of the low reliability measures.
- **Validity:** No clear rationale for why some validity testing methods, including risk adjustment, were applied to only some measures and not others. Validity testing was not reported for the 3 recommendation measures.
- **Use & Usability:** Performance on most measures has improved from 2022 to 2023; older data were not used in this analysis. The developer does not explain the lack of improvement in several measures or provide the number of programs and survey responses in earlier years of data.

CBE #3453: Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder [The Lewin Group/ CMS]

Measure Description:

Percentage of discharges from inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18–64, which were followed by a treatment service for SUD. SUD treatment services include having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being administered or dispensed a medication for SUD. (After an inpatient discharge only, residential treatment also counts as continuity of care.) Two rates are reported, continuity within 7 and 14 days after discharge.

Measure Status	
New or Maintenance: Maintenance Measure	**Used in An Accountability Application?** Yes • Quality Improvement with Benchmarking (external benchmarking to multiple organizations) • Quality Improvement (Internal to the specific organization)
CBE Endorsement Status: Endorsed **Last Endorsement Review Cycle:** Fall 2018	**Proposed/Planned Use:** Medicaid Innovation Accelerator Program (IAP)

Measure Characteristics

Measure Type	Target Population(s)	Level of Analysis	Care Setting(s)
Process	Patients ages 18-64 with SUD treatment	Population or Geographic Area (State)	Various

Measure Overview
Rationale: Continuity of care is related to improve health and life outcomes; therefore, a quality measure to target extra efforts to engage individuals less likely to have continuity of care is expected to yield better care for beneficiaries with SUD. Continuity after inpatient or residential treatment has been found to be generally low and the variation in continuity rates suggests that there is substantial opportunity for improvement. While other measures evaluate continuity of care after inpatient or residential substance use treatment, CBE #3453 varies in timing of continuity of care, diagnoses in the continuity of care visit, and the type of practitioners providing follow-up services. In addition, there are typically fewer quality measures for Medicaid and high rates of substance use for this population.
Numerator: Discharges from inpatient or residential treatment settings that were followed by: • An outpatient visit, intensive outpatient encounter, or partial hospitalization with a primary or secondary SUD diagnosis on the day after discharge through day 7 or 14;

- A telehealth encounter for SUD on the day after discharge through day 7 or 14;
- Pharmacotherapy (filling a prescription or being administered or dispensed a medication) on day of discharge through day 7 or 14; or
- Residential admissions on day 3 through day 7 or day 14 (for inpatient discharges only)

Denominator: Discharges from inpatient or residential treatment settings with a primary diagnosis of SUD by Medicaid or Medicare-Medicaid beneficiaries, aged 18 years and older, that occurred between January 1 and December 15 of the measurement year. Beneficiaries must be enrolled in Medicaid during the month of discharge from inpatient or residential treatment and the following month.

Exclusions: Denominator exclusions include discharges with hospice services during the measurement year and both the initial discharge and the admission/direct transfer discharge if the admission/direct transfer discharge occurs after December 15 of the measurement year. Discharges followed by admission or direct transfer to any inpatient (regardless of diagnosis) or SUD residential treatment setting within 7- or 14-day continuity of care period are also excluded. Transfer, hospitalization, or admission to inpatient or SUD residential treatment within 7 or 14 days after discharge may prevent a continuity of care visit from taking place. An exception is admission to residential treatment following discharge from inpatient treatment; these admissions are not excluded, because continuity into residential treatment after inpatient treatment is considered appropriate treatment.

Measure is Risk-Adjusted and/or Stratified:
No risk adjustment or stratification.

Logic Model

Summary: Continuity of care helps to sustain the gains attained in initial treatment and to prevent relapses.

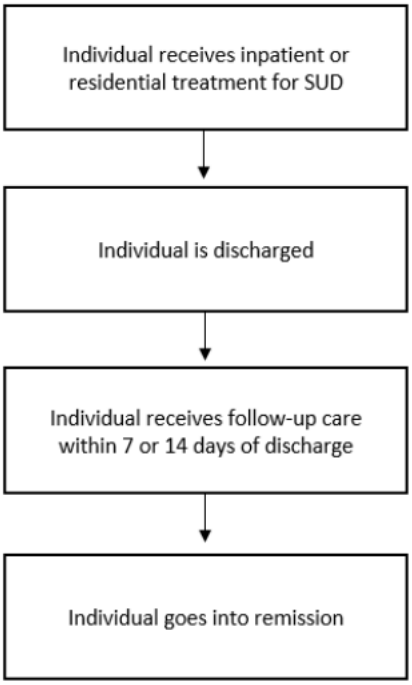

Figure 7. CBE #2967 Logic Model

Measure Evaluation Summary: CBE #3453

Importance
Staff Preliminary Rating: Met
• **Importance**: Overall, the process and data involved in the measure are straightforward and present an opportunity to enhance care for people who are treated for SUD.

Feasibility
Staff Preliminary Rating: Met
• **Feasibility:** Data are comprised of administrative claims or encounter data. Data collection does not involve sampling. The qualitative survey conducted indicated that there are minimal challenges for data collection and minimal burden to report.

Reliability	
Staff Preliminary Rating: Met	
Testing Level:	Accountable Entity Level
Testing Method:	The developer conducted a signal-to-noise analysis.
• **Reliability:** The measure is well-defined. Reliability is assessed at the state level. Reliability statistics are above the established thresholds.	

Validity	
Staff Preliminary Rating: Met	
Testing Level:	Accountable Entity Level
Testing Conducted:	The developer conducted validity testing using convergent validity and face validity.
• **Validity:** The developer employed the Transformed Medicaid Statistical Information System (T-MSIS) as the data source. In addition, the 7- and 14-day rates provide insight into duration and likelihood of remission.	

Equity	
Staff Preliminary Rating: Met	
Equity considered:	Yes
• **Equity:** The developer described meaningful differences in measure rates for patients of different ages, races, and dual eligibility status.	

Use & Usability	
Staff Preliminary Rating: Not met but addressable	
Current or Planned Use:	Measure is currently used in the Medicaid Innovator Accelerator Program (IAP).
• **Use & Usability**: The current use of the measure is documented; however, usability feedback was inconclusive and additional data are needed to understand barriers to use.	

Public Comment[6]

Number of Comments Received: 1

Full text of developer/steward responses can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
One comment shared support for the measure, noting the importance of follow-up care to keep patients supported.	Supportive	*Summary Response Received after the Advisory Group Meeting*: Thank you for the feedback.

[6] Comments, as submitted, can be found on the PQM website.

Advisory Group Feedback

Full text of developer/steward responses can be found on the PQM website.

Feedback/Questions	Summary of Developer Response
Measure Importance and Reliability Testing: A committee member emphasized the importance of continuity of care measures. They also added that the reliability estimates from the developer's 2021 data were excellent.	The developer did not respond to this feedback/question during the meeting. *Summary Response Received after the Advisory Group Meeting*: Thank you for the feedback.
Feasibility Feedback: A committee member asked if there was any feedback from the implementation and data collection of this measure, namely, if measure users are having any challenges with the measure. A committee member also asked if the developer had received feedback from the states on the use of the Transformed Medicaid Statistical Information System (T-MSIS) versus their own claims data.	The developer responded that the measure is calculated using administrative claims and that all the data elements are expressed in data fields available in both Medicaid and Medicare claims. The developer said this made the measure "inherently feasible." The developer said, at this point, they have not had any interaction with the states who are using the measure and comparing the results. They added their data are blinded, so it is not public data that could be compared. They said they would take the suggestion back and potentially reach out to a couple of states. *Summary Response Received after the Advisory Group Meeting*: • At this time, CMS and the Lewin Group have not received feedback—positive or negative—about the technical specifications for CBE #3453. Its calculation is inherently feasible because all data elements are available within administrative claims (either through the Transformed Medicaid Statistical Information System or within states' claims databases). Thank you for the feedback.
Target Population: A committee member asked if private payers and nonprofits are being captured in the measure.	The developer responded that their funding vehicle is Medicaid, so that is the population captured. They added that they did recently expand the population the measure covers to include older adults and dually enrolled individuals. In addition, they encourage other companies to pick up the measure for use. *Summary Response Received after the Advisory Group Meeting*: • CMS and the Lewin Group do not have access to administrative data from payers other than Medicare and Medicaid (e.g., commercial or non-profit data). The technical specifications for CBE #3453 are available to anyone who wishes to implement this

	measure within their claims environment. Thank you for the feedback.
Validity Testing: A committee member asked the developer to provide more information about the convergence validity testing.	The developer said that as part of the convergent testing, they looked at two measures: CBE #3400: Use of Pharmacotherapy for Opioid Use Disorder and CBE #0004: Healthcare Effectiveness Data and Information Set (HEDIS) Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment (IET). They hypothesized that when the measure score for CBE #3453 increased, the scores of the other two measures would as well. The developer confirmed that was the case, with strong p-values. The HEDIS measure has had its validity evaluated by the CBE and was demonstrated to be valid, while CBE #3400 is also currently undergoing endorsement review this cycle. *Summary Response Received after the Advisory Group Meeting*: • CMS and the Lewin Group evaluated CBE #3453 validity using CBE #3400 and the HEDIS IET measure, demonstrating strong quantitative validity results. CMS will continue to look for strong, valid measures to which CBE #3453 testing results could be compared (for future endorsement reviews). At this time, no other best-in-class measures exist, making CBE #3400 and HEDIS IET the strongest available. Thank you for the feedback.
Equity: A committee member asked for the developer to share any learnings about health equity issues with respect to this measure and what the next steps might be.	The developer shared that they examined performance scores in claims data. The developer observed gaps based on age and for individuals who are dually enrolled. They stated that the measure has improved care, and they hope to close those gaps. *Summary Response Received after the Advisory Group Meeting*: • Equity data presented in the Full Measure Submission form for CBE #3453 demonstrate a substantial gap in care for older adults and individuals who identify with a minority racial or ethnic category. Thank you for the feedback.

Key Discussion Points:

- **Use & Usability:** The current use of the measure is documented; however, usability feedback was inconclusive and additional data are needed to understand barriers to use.
    - Developer noted that they have not had any interaction with the states who are using the measure and comparing the results. They added their data are blinded, so it is not public data that could be compared. However, neither CMS or Lewin have received

any feedback, positive or negative, about feasiblity challenges with the specifications, adding that the measure is feasible since it uses claims data. They would consider potentially reaching out to a couple of states.