Home and Community-Based Services (HCBS) Measures Technical Expert Panel Meeting #4 Summary Report: October 24, 2022

Background

Technical Expert Panel Purpose

The Centers for Medicare & Medicaid Services (CMS) contracted with The Lewin Group (Lewin), and its partners National Committee for Quality Assurance, George Washington University, Marymount University, American Institutes for Research, Qlarant, and Facilis Solutions to develop and maintain a standard set of home and community-based services (HCBS) measures through project number HHSM-500-2014-00033I, task number 75FCMC19F0004, entitled HCBS Measure Development, Endorsement, Maintenance, and Alignment Contract.

As part of its measure development process, CMS asks measure developers to gather groups of stakeholders and experts who contribute direction and thoughtful input during measure development and maintenance. The HCBS Measures technical expert panel was established and held its first meeting in April 2020. Subsequent meetings took place in June 2020, October 2021, and October 2022.

Meeting Objectives

During the meeting on October 24, 2022, feedback from the technical expert panel was gathered on environmental scan and literature review findings for the Medicaid managed long-term services and supports (LTSS) measures, ambulatory care sensitive conditions for Medicaid HCBS participants, and direct care worker measures. Testing results were reviewed for LTSS Minimizing Facility Length of Stay (LTSS-7) and LTSS Successful Transition After Long-Term Facility Stay (LTSS-8) with the members and then introduced the HCBS Quality Measure Set. The technical expert panel was also provided updates on the current measure work status for the caregiver support measure and a review of consensus-based entity (CBE) updates for the Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services (HCBS CAHPS®) Survey and Functional Assessment Standardized Items performance measure 2. Four measures were not discussed with the technical expert panel because measure maintenance activities were not underway at the time. These measures are Screening, Risk Assessment, and Plan of Care to Prevent Future Falls (LTSS-5), Long-Term Services and Supports Admission to a Facility from the Community (LTSS-6), Admission to an Institution from the Community Among Medicaid Fee-for-Service HCBS Users (HCBS-1), and Self-Direction of Services and Supports among People Receiving Long-Term Services and Supports through Managed Care Organizations (HCBS-10).

Discussion Summary

Throughout this summary, the term *meeting* refers to the HCBS technical expert panel meeting #4.

Welcome and Recap of Meeting #3

The October 2021 meeting included a review of technical expert panel member feedback on the environmental scan and literature review results for each of the measures or measure sets, including Medicaid LTSS, Functional Assessment Standardized Items, HCBS CAHPS, ambulatory care sensitive conditions for Medicaid HCBS participants, caregiver support, and direct care worker.

Medicaid LTSS Measures: Managed Care and Fee-for-Service Delivery System Updates

Exhibit I includes the full names of the LTSS measures and their corresponding shorthand names used throughout this summary.

Exhibit I. Medicaid LTSS Measures Terminology

Medicaid LTSS Measure Full Names	Medicaid LTSS Measure Shorthand Names
LTSS Comprehensive Assessment and Update (LTSS-1)	LTSS Comprehensive Assessment
LTSS Comprehensive Care Plan and Update (LTSS-2)	LTSS Comprehensive Care Plan
LTSS Shared Care Plan with Primary Care Provider (LTSS-3)	LTSS Shared Care Plan
LTSS Reassessment/Care Plan Update After Inpatient Discharge (LTSS-4)	LTSS Reassessment Care Plan after Discharge
LTSS Screening, Risk Assessment, and Plan of Care to Prevent Future Falls (LTSS-5)	LTSS Fall Prevention
LTSS Admission to a Facility from the Community (LTSS-6)	LTSS Facility Admission from Community
LTSS Minimizing Facility Length of Stay (LTSS-7)	LTSS Minimizing Facility Length of Stay
LTSS Successful Transition After Long-Term Facility Stay (LTSS-8)	LTSS Successful Transition after Long-Term Facility Stay

Environmental scan and literature review findings were shared along with the themes from articles relevant to current measure specifications. Face validity and feasibility findings from the June 2022 LTSS focus group were also presented. The technical expert panel received an update on testing of LTSS-1 Comprehensive Assessment, LTSS-2 Comprehensive Care Plan, LTSS-3 Shared Care Plan, and LTSS-4 Reassessment Care Plan after Discharge, along with beta testing updates for LTSS-7 Minimizing Facility Length of Stay and LTSS-8 Successful

Transition after Long-Term Facility Stay. Testing results and upcoming milestones were also presented.

Environmental Scan and Literature Review Findings

The environmental scan and literature review update performed in the last year focused on gray literature review topics around Medicaid managed LTSS and resonance to Medicaid fee-for-service LTSS.

Literature review highlights include 1) the need for more complete data across the different LTSS delivery systems, including fee-for-service; 2) the importance of the managed LTSS measures to improve care coordination for dually eligible beneficiaries given data information sharing challenges; and 3) the need to improve data to support a comparable set of measures and outcomes across states, which might help advance knowledge on effects of managed LTSS relative to fee-for-service. In addition, the literature supports the inclusion of caregiver assessment and documentation of caregiver needs in the managed LTSS-1 Comprehensive Assessment, managed LTSS-2 Comprehensive Care Plan, and managed LTSS-4 Reassessment Care Plan after Discharge measures; telehealth options for LTSS comprehensive assessments; and the importance of person-centered care.

Summary of TEP Discussion for Caregiver Needs and Support

The technical expert panel was informed that the environmental scan and literature review themes from articles relevant to current specifications support inclusion of caregiver assessment and documentation of caregiver needs to better support LTSS participants.

Members were asked whether an assessment of caregivers and their needs should be added as an assessment element. Four members agreed that a data element documenting evidence that a caregiver assessment was completed should be added to the specifications; one member specifically described the value of a caregiver assessment being added to the LTSS measures, noting that it could address caregiver burnout and the use of respite services. One member raised a concern that caregiver changes might not align with an annual assessment schedule but was unopposed to its inclusion in the measure specifications.

Multiple members saw benefit to including a caregiver assessment component in LTSS-1 Comprehensive Assessment, LTSS-2 Comprehensive Care Plan, and LTSS-4 Reassessment Care Plan after Discharge, if consideration is given to the number and variety of caregivers a participants may use.

Summary of TEP Discussion for Virtual Assessments and Care Planning (Telehealth)

Three members agreed with continuing to allow for telehealth, which one member indicated is an option that LTSS consumers want based on survey work the member's organization conducted. Multiple members proposed taking a hybrid approach where some portions of the assessment are conducted virtually and others face-to-face. When considering a hybrid approach, virtual visits, it was suggested, could be as effective as face-to-face visits if the participant had been receiving the same services for years. A technical expert panel member added that virtual visits could help mitigate the length of time needed to perform the assessment.

Three members did not support continuing to allow virtual assessments and care planning once the COVID-19 public health emergency ended. One of these members indicated, “when you enter a home, you enter a life,” and asserted that face-to-face assessments shed light on issues that would be unobserved via a virtual visit. Another raised concerns that the data on the quality of virtual assessments and care planning are insufficient to make a determination at this time.

Summary of TEP Discussion for Person-Centered Services

The technical expert panel was asked whether LTSS measures should use the most person-centered language and approach to assessment and care planning for LTSS participants. Multiple members commented that person-centeredness should be ensured in the assessment and care planning process. A member said that pursuing person-centeredness is an effective means to advancing health equity.

Summary of TEP Discussion for Respecifying the Managed LTSS Measures and Developing Equivalent Medicaid Fee-for-Service LTSS Measures

The technical expert panel was asked for its perspective on respecifying the managed LTSS measures and developing equivalent fee-for-service LTSS measures. Members were also asked whether they think the states would implement the fee-for-service LTSS measures effectively. Members commented that creating fee-for-service measures that align with existing managed-care measures would be ideal and potentially feasible; however, it was noted that program design might vary by state and delivery system. Many members agreed that fee-for-service measures would be useful in improving services and incorporating opportunities for improvement into quality initiatives for participants receiving fee-for-service LTSS.

Technical expert panel members shared that they see challenges for states in implementing the measures effectively in the fee-for-service environment. Several members noted that acquiring the data necessary from the fee-for-service environment might be difficult in certain states. It was noted that managed care plans are required to report data necessary to assess quality, and that states with fee-for-service delivery systems do not go by the same requirements nor receive financial incentives for quality reporting. One member explained that states with delivery of LTSS through managed care could have small fee-for-service populations, which could make data collection and performance measurement challenging for the fee-for-service LTSS delivery system.

Summary of TEP Discussion on Importance of CBE Endorsement

Technical expert panel members were asked whether LTSS measure use would depend on whether the measures had CBE endorsement and were also asked whether CBE endorsement would be considered an important factor contributing to measure use. Most members believed that discussions around measure use at the state level do not include a focus on CBE endorsement. One technical expert panel member said that CBE endorsement can serve as a check and balance to ensure measure fundamentals are sound. A member shared the opinion that CBE endorsement is a positive step yet unnecessary to begin aligning managed LTSS and fee-for-service LTSS measures.

Findings from the Medicaid LTSS Focus Group

Regarding LTSS-7 Minimizing Facility Length of Stay and LTSS-8 Successful Transition after Long-Term Facility Stay face validity, focus group members generally agreed with most of the specifications including timeframes for completing assessments, care plans, and post-discharge. Agreement also occurred around the considerations of including caregiver needs, completing an assessment in person, and identifying exclusions for the eligible population for these measures as well as the risk adjustment component to these measures.

Recommendations were made to align with the HCBS setting definitions of community settings that are residences and institutional facilities. There was agreement for expanding the definition of facility to include psychiatric and specialty hospitals. However, concerns arose about excluding the medical benefit because of feasibility of removing this component and potential negative impacts. There was also disagreement among focus group participants about stratification by dually eligible participants.

Regarding feasibility, focus group participants identified challenges with tracking hospital admissions and discharges and long-term care stays, even when connected to provider reporting systems. These challenges still exist because of difficulties in alignment among care management, claims, and hospital reporting systems. Further, tracking discharges for participants dually eligible for Medicare and Medicaid is especially difficult.

Summary of TEP Discussion on Focus Group Findings

The technical expert panel discussion focused on the challenges present in accessing hospital discharge data. Members generally agreed that incomplete data and lack of data access are challenges to effective tracking of participant transitions across settings.

The technical expert panel members were asked whether they agree with the feedback shared by the focus group regarding measure face validity for the LTSS measures. Their comments focused on the feasibility of measurement rather than on the measures' face validity. Specifically, their comments focused on the challenges in identifying hospital discharges, particularly for dually eligible participants.

One member believed that the timely exchange of admission, discharge, and transfer data will make capturing participant changes in disposition easier for payers. Another member stated that admission, discharge, and transfer data are imperfect and that identifying hospital discharges is difficult even with a robust reporting system. The same member added that data feeds often are accessible to only the primary payer and that regardless of payer status, hospitals can opt out of data sharing agreements, which leads to incomplete data. A third member concurred with the discussion that tracking dually eligible discharges is difficult, especially for participants in a nonintegrated dual-eligible health plan.

Medicaid LTSS-1 Comprehensive Assessment, LTSS-2 Comprehensive Care Plan, LTSS-3 Shared Care Plan, and LTSS-4 Reassessment Care Plan after Discharge Testing Updates

Qualitative and quantitative data inform both testing analyses and results. Qualitative input is being collected through discussions with the technical expert panel and through a series of

measure surveys. Public comment regarding measure face validity, feasibility, and usability will be collected following testing.

Quantitative data collection activities are in progress. Data abstracted from managed LTSS plan participants and fee-for-service LTSS participants' electronic health records within participating states will be used. Abstracted data will include all data elements required to assess the measure's importance, reliability, and validity.

Uncertainty exists about the feasibility of the Medicaid LTSS-3 Shared Care Plan measure for both managed care and fee-for-service delivery systems because medical specialists, not primary care providers, often coordinate care for LTSS participants. Further, different states might have different policies or expectations around the distribution of care plans to medical providers.

The recruitment of states for data collection focused on states with either a fee-for-service delivery system or states with a hybrid arrangement with both fee-for-service and managed care delivery systems. Selected states had a large enough LTSS participant population with a sufficient number of HCBS participants, including participants who had a facility discharge. Recruitment also involved selecting states with electronic records with web-based platforms for remote access or a capability to share data through alternative means along with sufficient state staff support.

Summary of TEP Discussion on Testing Updates

Technical expert panel members were asked for suggestions for how to address the feasibility issues within the Medicaid LTSS-3 Shared Care Plan measure specifications. Members were also asked what the typical workflow looks like for sharing care plans for LTSS participants in fee-for-service versus managed care.

One member explained that "primary care provider" could be changed to "principal care provider" to redefine who would be in that role but was unsure whether claims data can be used to identify the principal care provider in fee-for-service. Two members said allowing participants to identify their primary care provider would be important. A member also recommended looking at frequency (i.e., the provider who has seen the participant most often). Another argued that primary care should be the provider who delivers routine well care in addition to some common types of specialty chronic care, regardless of how it is paid for. In addition, two members agreed that claims data could be challenging to look at in fee-for-service. One member shared that in New York, more than 90 percent of participants with disabilities are in fee-for-service and that the LTSS care plan is rarely given to health providers because of time and resource limitations.

Data Element Overview for Medicaid LTSS Measures

The technical expert panel was asked how to potentially simplify by consolidating or removing certain data elements from the Medicaid LTSS-1 Comprehensive Assessment, Medicaid LTSS-2 Comprehensive Care Plan, Medicaid LTSS-3 Shared Care Plan, and Medicaid LTSS-4 Reassessment Care Plan after Discharge measures. Examples of how the process could be streamlined (e.g., consolidating related data elements, such as activities of daily living and instrumental activities of daily living, into a single data element, removing the core versus supplemental data element distinction) were presented.

Summary of TEP Discussion on Data Elements for Medicaid LTSS Measures

The technical expert panel was asked three questions: 1) What data element variations should be explored in beta testing? 2) Should data elements with very low or very high prevalence be removed from the list? 3) Which elements are most critical to capture from the list?

Two technical expert panel members explained that answering these three questions fully without seeing the data is difficult. One member said an element with low prevalence could be explained because of issues with data capture.

One member agreed that combining activities of daily living and instrumental activities of daily living as well as removing the distinction between core and supplemental elements might be appropriate because many LTSS components are in the supplemental elements.

A member explained that streamlining would be helpful, but an allowance should be made for more critical elements, especially elements most used in assessments, which should be kept. This person stated that core and supplemental elements should be looked at in terms of threshold, delineating between elements for everyone and then extra elements that show higher quality care. Another member offered keeping elements that demonstrate good care planning.

The technical expert panel provided no response when asked whether certain data elements should be kept from the list.

Medicaid LTSS-7 Minimizing Facility Length of Stay and LTSS-8 Successful Transition after Long-Term Facility Stay Beta Testing Updates

Beta testing for the Medicaid LTSS-7 Minimizing Facility Length of Stay and Medicaid LTSS-8 Successful Transition after Long-Term Facility Stay measures occurred from July to November 2022, with key findings identified for the measures' reliability, face validity, feasibility, and usability.

Quantitative data were obtained from the Transformed Medicaid Statistical Information System Analytical Files, with preliminary rates calculated using these data for calendar years 2018 and 2019. Qualitative data were collected via input from the technical expert panel as well as via a review of publicly available documents. Following testing completion, survey input and public comment for the measures' face validity, feasibility, and usability will also be collected.

Next presented were the preliminary data and performance rates from 2019 data for the Medicaid LTSS-7 Minimizing Facility Length of Stay and Medicaid LTSS-8 Successful Transition after Long-Term Facility Stay measures overall and by selected participant characteristics: age, gender, racial or ethnic identification or both, and dual-eligibility status.

Data on the scientific acceptability of the measure (both reliability and validity) were displayed. The signal-to-noise ratio (reliability) reveals that the preliminary performance measure results are highly reliable. The convergent validity results reveal that statistically significant correlations exist between the managed care results and the fee-for-service results but that the correlation between the similar managed care and fee-for-service measures are less conclusive. There is a positive correlation between the managed care LTSS-7 Minimizing Facility Length of Stay and the fee-for-service LTSS-7 Minimizing Facility Length of Stay measures, but a similar result

does not occur for the managed care LTSS-8 Successful Transition after Long-Term Facility Stay and fee-for-service LTSS-8 Successful Transition after Long-Term Facility Stay measures.

Presented last was the risk adjustment model and risk adjustment characteristics required per the specifications for these same measures.

Summary of TEP Discussion on Beta Testing Updates

One technical expert panel member asked for the measure team's perspective on the variation between managed care and fee-for-service performance rates. The Lewin team stated that the results displayed are preliminary and not risk adjusted. It was also explained that the underlying policy and program design for participants receiving LTSS is different in a managed care delivery system than in a fee-for-service delivery system. Different criteria apply for eligibility or different programs engaged in managed care LTSS programs compared with fee-for-service, which means the populations in these different programs likely have different characteristics that might influence measure performance. One member responded that nearly all populations in New York are in managed care LTSS, except for persons with disabilities, which would drive differences in performance in that state.

One member explained that more resources exist for planning and transition out of the facility in managed care than in fee-for-service delivery systems, and some fee-for-service programs might not have case management, which would help support facility transitions. The same member stated that the results and age differences are unsurprising because some populations are more or less likely to use facilities. Another member concurred with these statements.

One member stated that if successful discharge or transition means community residence for 60 or more days, then validating the measures might prove challenging. The member explained that home health agencies struggle with a similar measure (OASIS, M2420 - Discharge Disposition) because the agencies are unable to track participant status in the community following discharge from their care.

One member stated that some data gaps could exist between Medicare managed care and Medicare fee-for-service groups. Another member asked whether the purpose of the measures is to compare performance across states or to trend performance over time within one state. The technical expert panel members were informed that both purposes (cross-sectional comparisons and internal evaluations over time) are valid uses of the LTSS measures.

One member expressed that these measures are important concepts because having people live in the community with HCBS services is the goal of the waivers and managed LTSS programs. Another member agreed and emphasized the importance of exploring data gaps.

Members were also asked to reflect on the list of risk adjustment variables and whether other population characteristics should be considered. A member noted that behaviors for people with dementia, such as wandering and aggression, are difficult to manage in the community and might be important characteristics to include in the risk adjustment model.

The technical expert panel was asked whether the performance in managed care and fee-for-service can be directly compared because differences in the population characteristics exist between the two. No feedback was received.

HCBS Quality Measure Set

CMS is developing a standard measure set for use in HCBS in response to the 2016 National Quality Forum report "Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement." CMS published a request for information in 2020 that sought public input on a draft set of quality measures for Medicaid-funded HCBS and engaged a broad range of stakeholders to receive additional feedback on the draft measure set and to identify opportunities to support states in using the measure set.

As a result of these stakeholder engagement activities, CMS is releasing the first of two planned guidance documents to promote the common and consistent use of nationally standardized quality measures in HCBS programs and to support states in improving HCBS quality and outcomes. The quality measure set is designed to promote more common and consistent use of nationally standardized quality measures in HCBS programs both within and across states and to create opportunities for CMS and states to have consistent comparable data on quality for HCBS.

CMS plans to incorporate the use of the measure set into reporting requirements for specific authorities, including the Money Follows the Person demonstration and potentially future Section 1115 demonstrations that include HCBS in the measure set.

HCBS CAHPS Measures

CBE Updates

The HCBS CAHPS Survey is currently used in Arizona, Connecticut, Florida, Kansas, Pennsylvania, and West Virginia. Testing was recently completed for the 19 measures comprising the package. Nearly 6,000 survey responses were received from 17 different entities, which include state programs and managed care plans. Most of the data within the analytic file represents individuals from aged and disabled populations. Responses were also received from participants with acquired brain injuries and intellectual developmental disabilities. The HCBS CAHPS measures gained endorsement in October 2016 as CBE #2967.

Summary of TEP Discussion on HCBS CAHPS CBE Updates

A technical expert panel member raised concerns that the survey responses might fail to capture an accurate reflection of the population. It was shared that no definitive answer exists on how the sample affects the reporting of data and that knowing whether the sampling data accurately represents the population is difficult.

CBE Functional Assessment Standardized Items Performance Measures Updates

The meeting included updates on Functional Assessment Standardized Items Performance Measure 1, which focuses on identifying personal priorities, and Functional Assessment Standardized Items Performance Measure 2, which assesses the patient-centered service plan.

Performance measure 1 gained endorsement in July 2021 as CBE #3593. For performance measure 2, the CBE waived submissions of new and maintenance measures in fall 2021 and spring 2022 to future cycles because of the COVID-19 public health emergency. CMS and

Lewin will bring performance measure 2 to the Patient Experience and Function Project's Standing Committee in fall 2022 as a new measure.

The Functional Assessment Standardized Items set was tested in nine organizations across four states: Colorado, Connecticut, Georgia, and Kentucky. Reliability was assessed at the data-element level, which produced sufficiently strong results. Face validity was evaluated using information from Functional Assessment Standardized Items reviewers and technical expert panel members, with results showing moderate to high support for the measure's critical data elements and validity at the measure-score level.

Ambulatory Care Sensitive Conditions for Medicaid HCBS Participants Updates

Evidence from the literature and findings from beta testing were discussed with the technical expert panel members.

Environmental Scan and Literature Review Findings

Findings from the ambulatory care sensitive conditions for Medicaid HCBS participants environmental scan and literature review were shared. The literature search included gray literature published from February 15, 2021, through March 25, 2022. Three emerging themes were identified: the need for comprehensive care for behavioral health conditions, the link between cardiovascular disease and mental health, and the impact of health equity disparities on access to treatment.

Summary of TEP Discussion on Comprehensive Care for Behavioral Health Conditions

Multiple technical expert panel members agreed that including select behavioral health conditions in the ambulatory care sensitive conditions for Medicaid HCBS participants measure would provide useful data for decision-makers and health systems. One member noted that current care models that integrate behavioral health and primary care have succeeded, so a measure that provides information on HCBS participants who require care in an ambulatory care setting would provide helpful information. However, another member pointed out that behavioral health care availability varies greatly and that this range in access could impact the measure. It was shared with the technical expert panel members that addressing rurality and urbanicity in the measure using claims data could serve as a proxy to help control for this factor.

Another member noted that the proposed stratification for behavioral health conditions could help clinicians and decision-makers more easily determine whether causes such as poor access to behavioral health services and inadequate use of primary care have led to higher rates of emergency department use. The member added that they thought segmenting out the results would provide a clearer image of how care access affects emergency department use.

Summary of TEP Discussion on Cardiovascular Disease–Mental Health Connection

A couple of the technical expert panel members echoed the importance of the link between cardiovascular disease and behavioral health conditions. However, two members also noted that this link is complicated. These technical expert panel members pointed out that the connection between poor behavioral health conditions and poor cardiovascular health can be confounded by multiple types of risk factors, such as smoking, obesity, side effects of

medications used to treat the behavioral health condition, and inadequate access to primary care. The technical expert panel recommended that this link be considered in further testing.

Summary of TEP Discussion on Health Equity Disparities in Access to Treatment

The technical expert panel determined that health disparities are another important consideration for the ambulatory care sensitive conditions for Medicaid HCBS participants measure. However, one member noted concern about ability to accurately capture disparities using claims data, remarking that Z codes could be useful because they can capture transportation needs, hearing and vision problems, and other such information. Nevertheless, these codes are not always used because they are not linked with payment. The usefulness of Z codes could be evaluated further during beta testing.

Alpha Testing Results

High-level results from the ambulatory care sensitive conditions for Medicaid HCBS participants alpha testing survey were shared. The technical expert panel was asked to provide feedback on the measure's face validity, feasibility, and usability. The results showed that the respondents strongly affirmed the measure's face validity and recommended maintaining most measure specifications from the DUALS-1 measure (e.g., age range, acute and chronic conditions, exclusion criteria, subpopulation strata). The respondents also thought that the measure was generally feasible to calculate using claims data; however, certain populations, such as dually eligible participants, might be more difficult to capture. The respondents also generally confirmed the usability of the measure and that the data collected from the measure could aid Medicaid agencies and other entities in decision-making.

Findings from the Ambulatory Care Sensitive Conditions for Medicaid HCBS Participants Focus Group

The technical expert panel was presented with takeaways from the ambulatory care sensitive conditions for Medicaid HCBS participants focus group. The focus group thought that the measure could help understand health equity among Medicaid and HCBS participant subpopulations as well as help assess system-wide performance.

For the measure's face validity, the focus group recommended reporting state performance using age bands, such as younger adults versus older adults, as well as stratification of results by urbanicity and rurality. The focus group also recommended inclusion of additional acute, chronic, and behavioral health conditions and consideration for separate measures to evaluate hospital admissions and readmissions.

Summary of TEP Discussion on Focus Group Findings

The technical expert panel generally agreed with the takeaways shared from the focus group. The members shared additional thoughts for consideration during further measure specification development and testing. When asked about how the inclusion of behavioral health diagnoses might affect the measure's usability, one member shared that this inclusion is important; however, data collection in some states with less comprehensive information on behavioral health might be difficult. The technical expert panel was also asked whether the measure should report separate rates for physical and mental health conditions. Three members noted their agreement.

Caregiver Support Measure

Status Update and Next Steps

For the caregiver support measure, the technical expert panel was provided with the key measure developments since the last meeting, the current measure status, and next steps. Based on feedback during the last meeting and from alpha testing results, the measure focus selected for further development was caregiver strain and use of supports to mitigate strain. The recommendation was also made that the term “caregiver burnout” should be replaced with “caregiver strain” to accommodate language both socially acceptable and accurately reflective of the concept.

However, the caregiver support measure has been indefinitely paused to prioritize the most feasible measures in the HCBS measure portfolio. From an assessment completed among the HCBS candidate measures, caregiver support lacks relevant, readily available data collection efforts. Additionally, similar measure development efforts by other stakeholders have been identified. Recognizing the long-term importance of this topic, Lewin together with CMS remains open to reconsidering this decision in the future option years as funding resources permit.

The immediate priority measure transition action item is to collect and submit caregiver strain measure materials developed and descriptions of next steps to facilitate smooth resumption of work should funding become available and caregiver strain and support take higher priority.

Summary of TEP Discussion on Caregiver Support Status Update and Next Steps

A technical expert panel member agreed that obtaining readily available data would be challenging, suggesting that the caregiver support measure concept could be more easily measured if included in a care planning and assessment measure.

Direct Care Worker Update

Over the last year work has continued on the direct care worker concept to refine the measure focus based on feedback received. It is also being explored how to identify direct care workforce stability by worker role and demographic information using currently available data.

specification continues.

Environmental Scan and Literature Review Findings

Findings from the direct care worker literature review identified 26 resources that pertain to direct care worker turnover and retention. The resources cover four major themes: the impact of the American Rescue Plan Act, the impact of the COVID-19 public health emergency, the impact of wages and career advancement opportunities, and the need for increased training.

Summary of TEP Discussion on Impact of American Rescue Plan Act

The American Rescue Plan Act provided states with additional federal funding for Medicare HCBS, and the technical expert panel considered how states have leveraged the Act to conduct direct service workforce stabilization. One member responded that funds distributed under the Act in most states were used as one-time funds, such as employee bonuses.

Summary of TEP Discussion on Impact of COVID-19 Public Health Emergency

The COVID-19 public health emergency is exacerbating existing direct care worker shortages, and technical expert panel members were asked whether they are aware of other interventions related to the impact of COVID-19. One member responded that COVID-19 was not the driver of workforce turnover because turnover had been a concern before the public health emergency.

Summary of TEP Discussion on Wages and Career Advancement Opportunities

The technical expert panel discussed the potential impact of increasing wages and creating career advancement opportunities on workforce stabilization and how these strategies could be leveraged for intervention. A technical expert panel member expressed that wages are the main issue behind turnover and that increasing wages 26 percent decreased vacancies in one organization from 28 percent to 11 percent in six months. Members provided additional suggestions beyond increasing wages for workforce stabilization, including supporting work-life balance and providing health benefits.

One member suggested that both wage per hour and annual wage should be considered because direct care workers' income stream might be unpredictable from week to week. The technical expert panel then considered whether the measure should be assessed quarterly or should use a different period. One member suggested quarterly measurement because the first 30 to 60 days of work is pivotal for turnover and retention. Another member suggested that, in addition to annual wage, annual disposable income be considered because workers might receive subsidies from states based on income.

Summary of TEP Discussion on Need for Increased Training

The technical expert panel was asked for additional insight regarding how increased training could affect direct service workforce turnover. One member noted that no federal minimum training requirements exist for direct care workers. Two members suggested that effective supervision of workers could also improve retention. Sharing current work with the state of Indiana to run a direct care work advisory board, a member indicated that wage, training, and support from agencies were important for worker retention. However, members agreed that training without wage increases or health benefits might be ineffective for direct care worker retention.

Summary of TEP Discussion on Stress and Turnover, Burnout and Retention

Noting that turnover leads to vacancies, which could cause overwork or missed shifts, members suggested that vacancy rates be considered in addition to turnover. A member noted that most providers use employment agencies to fill positions, and another technical expert panel member added that agencies already measure vacancies. Next steps for the direct care worker concept will include plans to link to the measure the ratio of workers to participants and to determine how this link could affect quality.

Alpha Testing Results

The direct care worker alpha testing results were shared. The survey assessed the face validity, feasibility, and usability of the direct care worker measure concept. Additionally, survey respondents were asked to rank the proposed measure concepts (Turnover/Retention, Supply,

Job Satisfaction, Injury and Abuse) for prioritization during measure development. The alpha testing results found that respondents agreed all proposed concepts had face validity and usability, but they had concerns related to the impact of data availability on feasibility. Specifically, respondents indicated that primary data collection would burden respondents. It was also recommended that the direct care worker population be measured as defined by CMS.[1] The technical expert panel gave the proposed measure concepts similar rankings. Based on these results, the Lewin team weighted the concepts, and the turnover and retention concept was selected.

Summary of TEP Discussion on Measure Specifications

Asked to provide feedback on the draft measure specifications and recommendations for potential data sources, the technical expert panel did not respond. The Lewin team will continue to analyze the landscape of publicly available data and will determine how these data can be applied to the direct care worker turnover measure concept.

Feedback from the technical expert panel on the measure population inclusions and exclusions was received, which will inform measure beta testing. The Lewin team intends to use the CMS definition of direct care workers to define the measure population, but additional recommendations for inclusions and exclusions will be considered during measure development. Members disagreed on whether to include or exclude self-directing direct care workers in the measure population, with two members indicating that including self-directing direct care workers lowers vacancy rates. Additionally, one member suggested excluding workers paid in the measurement period but not currently working.

The technical expert panel discussed the measure's cadence but came to no consensus. One member, noting that turnover is highest within the first 30 days, asked whether this rate would be captured in the measure. A member suggested that, if the purpose of the measure is to analyze services quality, measuring turnover annually would be sufficient because turnover would impact overall quality regardless of measurement period and would also be more cost effective. Some CMS measures use rolling quarters, which could also be considered for the direct care worker measure.

The technical expert panel discussed other potential avenues for measurement. One member proposed looking at the number of missed shifts resulting from worker vacancies. Members also shared potential resources and surveys that could be used for the measure, which will be reviewed as measure development continues.

[1] Direct care workers include workers who provide nursing services, assist with activities of daily living (such as mobility, personal hygiene, eating), or provide support with instrumental activities of daily living (such as cooking, grocery shopping, managing finances). Specifically, they include nurses (registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists), licensed nursing assistants, direct support professionals, personal care attendants, home health aides, and other individuals who are paid to directly provide services to Medicaid beneficiaries receiving HCBS to address activities of daily living or instrumental activities of daily living.

Appendix A: Technical Expert Panel Members and Project Team

Exhibit I. Technical Expert Panel Members

Name and Title	Organization
Mary Lou Bourne, MS, Chief Executive Officer	Management Support Solutions – Maryland
Daniel Brown, MBA, Executive Director	Racker – New York
Joseph Caldwell, PhD, MS, Director of the Community Living Center	Brandeis University – Massachusetts
Dana Cyra, MA, Caregiver and Executive Director	Inclusa – Wisconsin
Raina Josberger, MS, Deputy Director of the Division of Quality Measurement	New York State Department of Health – New York
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Exhibit II. Project Team

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