NATIONAL QUALITY FORUM
Driving measurable health improvements together

Patient Experience and Function, Fall 2020 Cycle: CDP Report

TECHNICAL REPORT
SEPTEMBER 20, 2021

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https://www.qualityforum.org

Contents

Executive Summary

Patient Experience and Function (PEF) is a National Quality Forum (NQF) measure topic area encompassing patient functional status, satisfaction, and experience of care, as well as issues related to care coordination. Central to the concepts associated with patient experience with their overall care is the patient's health-related quality of life (HRQoL) and the many factors that influence it, including communication, care coordination, transitions of care, and use of health information technology (IT).

The NQF PEF Standing Committee was established to evaluate measures within this topic area for NQF endorsement. NQF has 49 endorsed measures in the PEF portfolio that address patient assessments of care, mobility and self-care, shared decision making, patient activation, and care coordination. Most of the measures within this portfolio are patient-reported outcome performance measures (PRO-PMs), including measures of patient experience, patient satisfaction, and functional status.

The Standing Committee addressed measures from a single topical area during the fall 2020 cycle, consisting of an appropriate needs and priorities assessment within service planning for individuals receiving home and community-based services (HCBS). The measures reviewed are associated with a survey instrument for Medicaid HCBS recipients called the Functional Assessment Standardized Items (FASI) tool.

For this project, the Standing Committee evaluated two newly submitted measures against NQF's standard evaluation criteria. The Standing Committee endorsed the following measure:

> **NQF #3593** Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs (The Lewin Group/Centers for Medicare & Medicaid Services [CMS])

The developer withdrew the following measure after the Standing Committee did not pass the measure on the evidence criterion:

> **NQF #3594** Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs (The Lewin Group/CMS)

The Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendations. Brief summaries of the measures currently under review are included in the body of the report; detailed summaries of the Standing Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

PEF is a measurement domain focused on the quality of patient satisfaction and experience of care, patient-reported outcome measures (PROMs), and care coordination. The United States (U.S.) healthcare system has increasingly embraced the idea that patient experience of care delivery is not simply important because of its association with positive clinical outcomes, but also because it is a desirable endpoint unto itself.[1,2] Ensuring that each person and family is engaged within a care partnership is critical to achieving better patient outcomes.[3] Care coordination measures also represent a fundamental component of the success of this integrated approach, providing a multidimensional framework that spans the continuum of care and promotes quality care delivery, better patient experiences, and more meaningful outcomes.[4-6] Well-coordinated care encompasses effective communication among all patient and provider inputs of the care spectrum.[7,8] It also ensures that accountable structures and processes are in place for the integration of comprehensive plans of care across providers and settings.[9]

Quality Measures in HCBS Settings

Appropriate service planning is a critical process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in the community.[10] Medicaid will cover HCBS, provided that a person-centered service plan is in place that addresses the beneficiary's long-term care needs as an alternative to institutional living.[11] Measuring the quality of such plans and the extent to which individuals' needs and priorities are addressed is a key priority.

In 2019, NQF convened the CMS-funded Person-Centered Planning and Practice Committee to develop a framework for quality measurement related to person-centered planning (PCP), especially for those in HCBS settings. This Committee's June 2020 Final Report outlines a series of quality measure recommendations associated with appropriate planning for individuals receiving long-term services and supports (LTSS). The report specifically recognizes the FASI tool as one of the few measurements available, and it calls for quality measures that ensure individuals' needs and priorities are appropriately assessed and documented within the individuals' service plan.

NQF Portfolio of Performance Measures for Patient Experience and Function Conditions

The PEF Standing Committee (Appendix C) oversees NQF's portfolio of PEF measures (Appendix B), which includes measures of functional status, communication, shared decision making, care coordination, patient experience, and LTSS. This portfolio contains 50 measures: four process measures, one composite measure, and 45 outcome measures, of which 27 are PRO-PMs (see table below).

Table 1. NQF Patient Experience and Function Portfolio of Measures

Measure Summary	Process	Outcome/Resource Use	Composite
Functional status change and assessment	2	23	0
Shared decision making	0	3	0
Care coordination	2	5	0

Measure Summary	Process	Outcome/Resource Use	Composite
Patient experience	0	10	1
Long-term services and supports	0	4	0
Total	4	45	1

Additional measures have been assigned to other portfolios. These include healthcare-associated infection measures (Patient Safety), care coordination measures (Geriatrics and Palliative Care), imaging efficiency measures (Cost and Efficiency), and a variety of condition- or procedure-specific outcome measures (Cardiovascular, Cancer, Renal, etc.).

Patient Experience and Function Measure Evaluation

On February 9 and 12, 2021, the PEF Standing Committee evaluated two new measures undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 2. Patient Experience and Function Measure Evaluation Summary

Status	Maintenance	New	Total
Measures under review	0	2	2
Measures endorsed	0	1	1
Measures withdrawn from consideration	0	1	1

Comments Received Prior to Standing Committee Evaluation

NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on December 17, 2020 and closed on April 28, 2021. No comments were submitted to be shared with the Standing Committee prior to the measure evaluation meeting (Appendix F).

Comments Received After Standing Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on April 28, 2021. Following the Standing Committee's evaluation of the measures under review, NQF did not receive any comments from organizations (including member organizations) or individuals pertaining to the draft report and to the measures under review.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Standing Committee's recommendations. No NQF members provided feedback.

Overarching Issues

During the Standing Committee's discussion of the measures, an overarching issue emerged that was factored into the Standing Committee's ratings and recommendations for both measures and is not repeated in detail with each individual measure.

Representation of Individual's Voice in Measurement

During the review of the two measures, the Standing Committee expressed concerns related to the extent to which the voices of individuals receiving HCBS are appropriately captured by the measures. Some Standing Committee members suggested that the measures are not directly capturing the patients' priorities and may be subjecting those priorities to provider interpretation when documented within the service plan. They also expressed that ensuring the individuals' priorities are articulated without provider interpretation is a key element to person-centered measurement.

Summary of Measure Evaluation

The following brief summary of the measure evaluation highlights the major issues that the Standing Committee considered. Details of the Standing Committee's discussion and ratings of the criteria for the measure are included in Appendix A. Quorum is a requirement for voting to occur for NQF Standing Committees and is defined as greater than 60 percent of active Standing Committee members present during a given meeting. The PEF Standing Committee has 24 members with two recusals this measurement cycle, meaning that 16 members must be present to conduct the vote. Quorum was reached and maintained throughout the measure evaluation.

NQF #3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs (Centers for Medicare & Medicaid Services (CMS)/The Lewin Group): Recommended

Description: This measure reports the percentage of home and community-based services (HCBS) recipients ages 18 years or older who have identified at least as many total personal priorities (up to three) as needs in the areas of self-care, mobility, or instrumental activities of daily living (IADL) combined as determined by the most recent FASI assessment. **Measure Type**: Process; **Level of Analysis**: Other; **Setting of Care**: Home Care, Other; **Data Source**: Electronic Health Records, Instrument-Based Data, Paper Medical Records

The Standing Committee noted that patient preferences surrounding care needs are critical; however, there are challenges associated with ensuring that such needs are frequently updated given that they may change and are honored by providers. The Standing Committee also noted the conditional nature of the FASI instrument: Those who do not complete the FASI are not included in the denominator. The Standing Committee acknowledged that the measure captures the extent to which patient priorities are included when they have a documented need. The developer noted the limitations in the FASI instrument's deployment, with two states having currently adopted the FASI in their HCBS programs. The Standing Committee reviewed the rationale behind this measure being considered a process measure despite drawing on the FASI as a data source. NQF staff clarified that the measure does not directly report FASI needs; rather, it simply enumerates them but not in a patient-reported outcome (PRO). One Standing Committee member expressed concern that the measure is not agnostic to how functional needs are identified; rather, it relies explicitly on the FASI instrument. This Standing

Committee member encouraged the measure developer to potentially explore other options as data sources.

The Standing Committee reflected on the specific interpretation of the performance gap for this measure, noting that a gap would indicate that an HCBS provider is not ensuring that individuals who identify needs are also identifying accompanying priorities. The Standing Committee noted the demographic stratification included in the sample and that some disparities were reflected in the analysis. The Standing Committee's vote reflected the consensus that the developer's submission demonstrated that a gap exists in performance. During the discussion on reliability, the Standing Committee reviewed the developer's approach to testing the measure, noting the agreement amongst abstractors according to the kappa statistics and the limits of agreement analysis. During the discussion on validity, the Standing Committee expressed concern that the measure may exclude individuals who are not able to complete an FASI but still reached consensus that the validity testing was appropriate. During the feasibility discussion, the Standing Committee noted that the measure requires abstraction from the FASI and that it may be challenging to incorporate FASI data into electronic health records (EHRs). It was also noted that feasibility is affected by varying needs for intensive training for abstractors. The Standing Committee did not reach consensus on feasibility, which is not a must-pass criterion. The Standing Committee expressed no concerns regarding use but noted that this is a reflection on the implementation of the measure and not the FASI. During the discussion on usability, the Standing Committee expressed concern that the measure is not usable by patients and that it is an interpretation of the voice of the patient rather than a direct reflection of it. The Standing Committee did not reach consensus on usability—which is not a must-pass criterion—nor did they reach consensus on overall suitability for endorsement.

The Standing Committee reconvened during the post-comment meeting to discuss the measure and conduct a final vote on overall suitability for endorsement. Since feasibility and usability are not must-pass criteria, the Standing Committee did not re-vote on those sub-criteria. The Standing Committee passed the measure on overall suitability for endorsement and recommended the measure for endorsement during the post-comment meeting. The CSAC upheld the Standing Committee's recommendation and endorsed the measure.

Measures Withdrawn From Consideration

NQF #3594 was withdrawn from consideration by the developer on June 1, 2021. The developer plans to resubmit this measure in a future cycle after addressing the Standing Committee's feedback on the measure.

References

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10. Person Centered Planning | ACL Administration for Community Living. https://acl.gov/programs/consumer-control/person-centered-planning. Last accessed March 2021.
11. Key Message and Tips for Providers: Person-Centered Service Plans. August 2015. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/key-messages-Person-Centered-Service-Plans-%5BSeptember-2015%5D.pdf. Last accessed March 2021.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Vote totals may differ between measure criteria and between measures, as Standing Committee members often have to join calls late or leave calls early. NQF ensures that quorum is maintained for all live voting. All voting outcomes are calculated using the number of Standing Committee members present for that vote as the denominator. Quorum for this meeting was established to be 15 Standing Committee members present.

Endorsed Measures

NQF #3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Measure Worksheet | Specifications

Description: This measure reports the percentage of home and community-based services (HCBS) recipients ages 18 years or older who have identified at least as many total personal priorities (up to three) as needs in the areas of self-care, mobility, or instrumental activities of daily living (IADL) combined as determined by the most recent FASI assessment.

For the purposes of this measure application, the term *home and community-based services* will also refer to community-based long-term services and supports (CB-LTSS). The definition of HCBS in the September 2016 National Quality Forum (NQF) report titled *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement* is consistent with the way the Centers for Medicare & Medicaid Services (CMS) uses CB-LTSS.

Numerator Statement: The number of HCBS recipients ages 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment and who have identified at least as many total personal priorities (up to three) as functional needs in the areas of self-care, mobility, or IADL combined on the same FASI assessment.

Denominator Statement: The number of HCBS recipients ages 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment.

Exclusions: Exclusions inherent in the denominator definition include individuals younger than 18 years of age, individuals who have not had an FASI assessment within the chosen time period, and individuals who have had an FASI assessment but no functional needs were identified in the areas of self-care, mobility, or IADLs.

Adjustment/Stratification: None

Level of Analysis: Other

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Electronic Health Records, Instrument-Based Data, Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING: February 9, 2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H- 0; M-12; L-4; I-2 /18 Votes**; 1b. Performance Gap **H-2; M-14; L-2; I-1/ 19 Votes**; Evidence Exception: **N/A**

Rationale:

The Standing Committee noted that the evidence provided was reflective of a relatively new area in healthcare research.

The summary of the evidence provided suggests person-centered approaches to patient care lead to improvement in overall satisfaction and quality of life (QOL) as well as physical outcomes.

The developer cited studies that review processes involving the documentation of personal preferences/priorities as consistent with efforts to provide person-centered services in HCBS programs.

The developer provided a performance gap assessment by program type from data in a sample of 675 HCBS individuals served by 10 organizations from five states. Populations served by the organizations

Include the following:

Older adults
Individuals with physical disabilities,
Individuals with intellectual/ developmental disabilities (IDD)
Individuals with an acquired brain injury
Individuals with mental health or substance use disorders (MH or SUDs)

The Standing Committee noted that the performance score range suggests an opportunity for improvement (range: 33 – 51%).

The Standing Committee agreed that the data suggest performance disparities based on race for the measure.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **H-0; M-13; L-2; I-2/ 17 Votes**; 2b. Validity: **H-0; M-11; L-6; I-0/ 17 Votes**
Rationale:

The Standing Committee reviewed the reliability submission for the measure:

- The developer assessed the documented need (100% agreement).
- The developer used Bland-Altman limits of agreement (LOA) to evaluate rater consistency in determining the number of needs. The percentage of records that fell within the LOA by HBCS program type ranged from 90.6% to 95.3%.
- The developer used kappa statistics to determine agreement upon whether there were as many personal priorities as there were needs ($\kappa = 0.9723$, $p < 0.001$).

The Standing Committed noted that the developer assessed the face validity of the data elements and the measure score.

The Standing Committee acknowledged that the developer's approach to both reliability and validity was appropriate and fell within acceptable limits.

3. Feasibility: H-0; M-10; L-7; I-0/ 17 Votes
(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)
Rationale:

During the feasibility discussion, the Standing Committee noted that the measure requires abstraction from the FASI and that it may be challenging to incorporate FASI data into EHRs.

It was also noted that feasibility is affected by varying needs for intensive training for abstractors.

The Standing Committee did not reach consensus on feasibility, which is not a must-pass criterion for new measures. Since feasibility is not a must-pass criterion, the Standing Committee did not re-vote on feasibility during the post-comment meeting.

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-11; No Pass-6/ 17 Votes**; 4b. Usability **H-0; M-9; L-7; I-2/ 18 Votes**

Rationale:

The Standing Committee expressed no concerns regarding use but noted that this is a reflection on the implementation of the measure and not the FASI. It was also noted that the FASI is currently only used in two state Medicaid programs.

During the discussion on usability, the Standing Committee expressed concern that the measure is not usable by patients and that it is an interpretation of the voice of the patient rather than a direct reflection of it.

The Standing Committee did not reach consensus on usability, which is not a must-pass criterion for new measures. Since usability is not a must-pass criterion, the Standing Committee did not re-vote on usability during the post-comment meeting.

5. Related and Competing Measures

No related and competing measures were noted.

6. Standing Committee Recommendation for Endorsement: Original Vote: **CNR Yes-8; No-9 / 17 Votes**; Post Comment Vote: **Yes-14; No-2 / 16 Votes**

Rationale:

The Standing Committee did not reach consensus on the overall suitability for endorsement during the original measure evaluation meeting on February 9, 2021.

The Standing Committee reconvened on June 1, 2021, to discuss this measure during the post-comment meeting and to conduct a final vote on suitability for endorsement.

The Standing Committee elaborated on concerns mentioned during the evaluation meeting during the post-comment call, voted via survey after the meeting by June 9, 2021, and passed the measure on overall suitability for endorsement.

7. Public and Member Comment

No public or member comments were received.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-12; No-0 (June 29, 2021: Approved for Endorsement)

The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals

No appeals were received.

Appendix B: Patient Experience and Function Portfolio—Use in Federal Programs[a]

NQF #	Title	Federal Programs: Finalized or Implemented as of June 30, 2021
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child	Merit-Based Incentive Payment System (MIPS) Program (Implemented) Medicare Shared Savings Program (Shared Savings Program) (Implemented)
0006	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)	Marketplace Quality Rating System (QRS) (Implemented)
0166	HCAHPS	Hospital Inpatient Quality Reporting (IQR) (Implemented) Hospital Value-Based Purchasing (HVBP) (Implemented) Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) (Implemented)
0258	CAHPS In-Center Hemodialysis Survey	End-Stage Renal Disease Quality Incentive Program (ESRD QIP) (Implemented)
0291	Emergency Transfer Communication Measure	None
0422	Functional Status Change for Patients With Knee Impairments	MIPS Program (Implemented)
0423	Functional Status Change for Patients With Hip Impairments	MIPS Program (Implemented)
0424	Functional Status Change for Patients With Foot and Ankle Impairments	MIPS Program (Implemented)
0425	Functional Status Change for Patients With Lumbar Impairments	MIPS Program (Implemented)
0426	Functional Status Change for Patients With Shoulder Impairments	MIPS Program (Implemented)
0427	Functional Status Change for Patients With Elbow, Wrist, and Hand Impairments	MIPS Program (Implemented)

[a] Per CMS Measures Inventory Tool as of 09/09/2021

NQF #	Title	Federal Programs: Finalized or Implemented as of June 30, 2021
0428	Functional Status Change for Patients With General Orthopedic Impairments	None
0517	CAHPS® Home Health Care Survey (experience with care)	Home Health Quality Reporting Program (HH QRP) (Implemented)
1741	Patient Experience With Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	None
2286	Functional Change: Change in Self-Care Score	None
2287	Functional Change: Change in Motor Score	None
2321	Functional Change: Change in Mobility Score	None
2483	Gains in Patient Activation (PAM) Scores at 12 Months	None
2548	Child Hospital CAHPS (HCAHPS)	None
2612	CARE: Improvement in Mobility	None
2613	CARE: Improvement in Self-Care	None
2614	CoreQ: Short-Stay Discharge Measure	None
2615	CoreQ: Long-Stay Resident Measure	None
2616	CoreQ: Long-Stay Family Measure	None
2631	Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Long-Term Care Hospital Quality Reporting (LTCH QRP) (Implemented)

NQF #	Title	Federal Programs: Finalized or Implemented as of June 30, 2021
2632	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support	LTCH QRP (Implemented)
2633	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	Inpatient Rehabilitation Facility Quality Reporting (IRF QRP) (Implemented)
2634	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	IRF QRP (Implemented)
2635	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	IRF QRP (Implemented)
2636	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	IRF QRP (Implemented)
2643	Average Change in Functional Status Following Lumbar Spine Fusion Surgery	MIPS Program (Implemented)
2653	Average Change in Functional Status Following Total Knee Replacement Surgery	MIPS Program (Implemented)
2769	Functional Change: Change in Self-Care Score for Skilled Nursing Facilities	None
2774	Functional Change: Change in Mobility Score for Skilled Nursing Facilities	None
2775	Functional Change: Change in Motor Score for Skilled Nursing Facilities	None
2776	Functional Change: Change in Motor Score in Long-Term Acute Care Facilities	None

NQF #	Title	Federal Programs: Finalized or Implemented as of June 30, 2021
2777	Functional Change: Change in Self Care Score for Long-Term Acute Care Facilities	None
2778	Functional Change: Change in Mobility Score for Long-Term Acute Care Facilities	None
2958	Informed, Patient-Centered (IPC) Hip and Knee Replacement Surgery	None
2962	Shared Decision Making Process	None
2967	CAHPS® Home and Community-Based Services Measures	Medicaid (Implemented)
3227	CollaboRATE Shared Decision Making Score	None
3420	CoreQ: AL Resident Satisfaction Measure	None
3422	CoreQ: AL Family Satisfaction Measure	None
3455	Timely Follow-Up After Acute Exacerbations of Chronic Conditions	None
3461	Functional Status Change for Patients With Neck Impairments	MIPS Program (Finalized)
3477	Discharge to Community – Post-Acute Care Measure for Home Health Agencies	HH QRP (Implemented)
3479	Discharge to Community – Post-Acute Care Measure for Inpatient Rehabilitation Facilities	IRF QRP (Implemented)
3480	Discharge to Community – Post-Acute Care Measure for Long-Term Care Hospitals	LTCH QRP (Implemented)
3481	Discharge to Community – Post-Acute Care Measure for Skilled Nursing Facilities	Skilled Nursing Facility Quality Reporting (SNF QRP) (Implemented)

NQF #	Title	Federal Programs: Finalized or Implemented as of June 30, 2021
3559	Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA) ((CMS)/Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE))	None
3593	Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs	Medicaid (Implemented 2018)

Appendix C: Patient Experience and Function Standing Committee and NQF Staff

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Appendix D: Measure Specifications

NQF #3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

STEWARD

Centers for Medicare & Medicaid Services

DESCRIPTION

The percentage of home and community-based services (HCBS) recipients aged 18 years or older who have identified at least as many total personal priorities (up to three) as needs in the areas of self-care, mobility, or instrumental activities of daily living (IADL) combined as determined by the most recent FASI assessment.

For the purposes of this measure application, the term “home and community-based services” also will refer to community-based long-term services and supports (CB-LTSS). The definition of HCBS in the September 2016 National Quality Forum (NQF) report titled Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement is consistent with the way the Centers for Medicare & Medicaid Services (CMS) uses CB-LTSS.

TYPE

Process

DATA SOURCE

Electronic Health Records, Instrument-Based Data, Paper Medical Records

1. FASI set. CMS developed the FASI, as part of the Testing Experience and Functional Assessment Tools (TEFT) demonstration, to assess the status of individuals receiving HCBS. HCBS program staff or assessors at agencies under contract to state HCBS programs use the FASI set to assess HCBS recipients’ functional ability and need for assistance. A FASI assessment commonly is performed during an in-person visit, and it can be performed in any community-based setting where HCBS recipients reside. The assessor can use various sources of information to complete a FASI assessment including an interview with the person, an interview with a helper, written records, and naturally occurring observation of performance. Fields for the FASI set are available within CMS’s Data Element Library (DEL) and are attached in Section S.2b.
2. Data abstraction. Each program will apply methods of their choice for abstracting FASI data. These methods are likely to be similar to those used by the state to generate existing quality measures that are derived from the same data sources. One method could be to make use of a data abstraction form. The Appendix contains a sample form that is based on the form used during measure testing. This form could be adapted by programs implementing the measure.

LEVEL

Other

SETTING

Home Care, Other Medicaid HCBS Program

NUMERATOR STATEMENT

The number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment and who have identified at least as many total personal priorities (up to three) as functional needs in the areas of self-care, mobility, or IADL combined on the same FASI assessment.

NUMERATOR DETAILS

The numerator is a portion (i.e., a potential subset) of HCBS recipients in the denominator. This portion is determined by the presence of personal priorities in two text boxes provided for each functional area in Section B of the FASI form, Functional Abilities and Goals. The FASI form instructs the assessor to ask the person to describe at least one or two personal priorities in the area for the next 6 months. The FASI form also instructs the assessor to note when the person does not express any personal priorities in the area.

The frequency of data aggregation will be at the discretion of state users because CMS has determined that states will use the standardized items (i.e., FASI) from which the measure is derived on a voluntary basis. It is anticipated that states would calculate the measure at least annually per HCBS program. Some states may choose to calculate the measure more frequently than annually (e.g., every 3 or 6 months).

DENOMINATOR STATEMENT

The number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment.

DENOMINATOR DETAILS

The proposed measure focuses on the assessment of functional needs that are common among adult HCBS recipients and derived from use of FASI. These are functional needs in the areas of self-care, mobility, and IADLs. The denominator is determined by items in Section B of the FASI form, Functional Abilities and Goals.

Self-care needs are identified in the following items on the FASI form: 6a (eating), 6b (oral hygiene), 6c (toileting hygiene), 6d (wash upper body), 6e (shower/bathe self), 6f (upper body dressing), 6g (lower body dressing), and 6h (putting on/taking off footwear).

Bed mobility and transfer needs are identified in the following items on the FASI form: 7a (roll left and right), 7b (sit to lying), 7c (lying to sitting on side of bed), 7d (sit to stand), 7e (chair/bed-to-chair transfer), 7f (toilet transfer), and 7g (car transfer).

If the response to item 8 on the FASI form indicates that the person walks, ambulation needs are identified in the following items on the FASI form: 8a (walks 10 feet), 8b (walks 50 feet with two turns), 8c (walks 150 feet), 8d (walks 10 feet on uneven surfaces), 8e (1 step (curb)), 8f (4 steps), 8g (12 steps), 8h (walks indoors), 8i (carries something in both hands), 8j (picking up object), 8k (walks for 15 minutes), and 8l (walks across a street).

If the response to item 9 on the FASI form indicates that the person uses a manual wheelchair, wheelchair mobility needs are identified in the following items on the FASI form: 9a (wheels 50 feet with two turns), 9b (wheels 150 feet), 9c (wheels for 15 minutes) and 9d (wheels across a street).

If the response to item 10 on the FASI form indicates that the person uses a motorized wheelchair/scooter, wheelchair/scooter mobility needs are identified in the following items on the FASI form: 10a (wheels 50 feet with two turns), 10b (wheels 150 feet), 10c (wheels for 15 minutes) and 10d (wheels across a street).

IADLs are identified in the following items on the FASI form: 11a (makes a light cold meal), 11b (makes a light hot meal), 11c (light daily housework), 11d (heavier periodic housework), 11e (light shopping), 11f (telephone-answering call), 11g (telephone-placing call), 11h (medication management-oral medications), 11i (medication management-inhalant/mist medications), 11j (medication management-injectable medications), 11k (simple financial management), and 11l (complex financial management).

EXCLUSIONS

Exclusions inherent in the denominator definition include individuals younger than 18 years, individuals who have not had a FASI assessment within the chosen time period, and individuals who have had a FASI assessment but no functional needs were identified in the areas of self-care, mobility, or IADLs.

EXCLUSION DETAILS

See S.7. denominator details for information required to identify functional needs.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

The primary unit of analysis is the Medicaid HCBS program type. Programs can provide a combination of standard medical services and non-medical services. Standard services include, but are not limited to, case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. For more information click here.

These programs are designed to provide an array of services to a certain target population; as a result, each state typically operates more than one HCBS program. Five HCBS program types were used for the testing of this measure. Their labels reflect the predominant population eligible for services under each HCBS program. However, the group of individuals served within a single HCBS program type may be heterogeneous by design (e.g., the intentional combination of individuals with mental health and substance use disorders) or because of the presence of comorbidities.

1. HCBS programs serving individuals who are older adults
2. HCBS programs serving individuals with a physical disability
3. HCBS programs serving individuals with an intellectual or developmental disability
4. HCBS programs serving individuals with an acquired brain injury
5. HCBS programs serving individuals with mental health or substance use disorders.

Medicaid agencies in the states have administrative authority over these HCBS programs and determine which services and supports to offer beneficiaries who are deemed eligible for a given HCBS program. Although Medicaid HCBS programs are administered by state Medicaid agencies under various Medicaid legal authorities, they are frequently operated by other entities including non-Medicaid state agencies (e.g., department of aging, etc.), non-state governmental entities (e.g., county, etc.), or managed care organizations. The operating entities then contract with direct service/support providers.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

The following steps are used to create the score for this measure:

1. Restrict HCBS sample to individuals aged 18 years or older who have had a FASI assessment within the chosen time period.
2. Count the number of sampled individuals with at least one FASI-documented functional need in self-care, mobility, or IADLs. Documented functional needs are based on receiving either a “05” or below (04, 03, 02, or 01), or “88” on any item in the Self-Care, Mobility, or IADL sections of a FASI. See S.2b. (data dictionary, code table, or value sets) for value labels and S.7 (denominator details) for the list of specific items on the FASI form comprising the Self-Care, Mobility, and IADL sections.
3. For each individual with at least one FASI-documented functional need, count the number of FASI-documented functional needs in the three areas combined and count the number of personal priorities for the three areas combined. Personal priorities can include any number from each of the three sections (Self-Care, Mobility, and IADL).
4. Count the number of sampled individuals for whom the number of personal priorities from step 3 is at least as many as the number of functional needs (up to three) in step 2.
5. Calculate the percentage by dividing the resulting number in step 4 by the resulting number in step 2. 113612

Appendix E: Related and Competing Measures

Comparison of NQF #3593 and NQF #2967

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs
#2967 CAHPS® Home and Community-Based Services Measures

Steward

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Centers for Medicare & Medicaid Services

#2967 CAHPS® Home and Community-Based Services Measures

Centers for Medicare & Medicaid Services

Description

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The percentage of home and community-based services (HCBS) recipients aged 18 years or older who have identified at least as many total personal priorities (up to three) as needs in the areas of self-care, mobility, or instrumental activities of daily living (IADL) combined as determined by the most recent FASI assessment.

For the purposes of this measure application, the term "home and community-based services" also will refer to community-based long-term services and supports (CB-LTSS). The definition of HCBS in the September 2016 National Quality Forum (NQF) report titled Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement is consistent with the way the Centers for Medicare & Medicaid Services (CMS) uses CB-LTSS.

#2967 CAHPS® Home and Community-Based Services Measures

The 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 that are delivered to them under the auspices of a state Medicaid HCBS program. The unit of analysis for NQF 2967 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.

The measures consist of 7 scale measures, 6 global rating and recommendation measures, and 6 individual measures:

Scale Measures

1. Staff are reliable and helpful—Top-box score composed of 6 survey items
2. Staff listen and communicate well—Top-box score composed of 11 survey items
3. Case manager is helpful—Top-box score composed of 3 survey items
4. Choosing the services that matter to you—Top-box score composed of 2 survey items
5. Transportation to medical appointments—Top-box score composed of 3 survey items
6. Personal safety and respect—Top-box score composed of 3 survey items
7. Planning your time and activities—Top-box score composed of 6 survey items

Global Ratings Measures

8. Global rating of personal assistance and behavioral health staff—Top-box score on a 0–10 scale
9. Global rating of homemaker—Top-box score on a 0–10 scale
10. Global rating of case manager—Top-box score on a 0–10 scale

Recommendations Measures

11. Would recommend personal assistance/behavioral health staff to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)
12. Would recommend homemaker to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)
13. Would recommend case manager to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)

Unmet Needs Measures

14. Unmet need in dressing/bathing due to lack of help—Top-box score on a Yes or No scale
15. Unmet need in meal preparation/eating due to lack of help—Top-box score on a Yes or No scale
16. Unmet need in medication administration due to lack of help—Top-box score on a Yes or No scale
17. Unmet need in toileting due to lack of help—Top-box score on a Yes or No scale
18. Unmet need with household tasks due to lack of help—Top-box score on a Yes or No scale

Physical Safety Measure

19. Hit or hurt by staff—Top-box score on a Yes or No scale

Type

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Process

#2967 CAHPS® Home and Community-Based Services Measures

Outcome: PRO-PM

Data Source

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Electronic Health Records, Instrument-Based Data, Paper Medical Records

1. FASI set. CMS developed the FASI, as part of the Testing Experience and Functional Assessment Tools (TEFT) demonstration, to assess the status of individuals receiving HCBS. HCBS program staff or assessors at agencies under contract to state HCBS programs use the FASI set to assess HCBS recipients' functional ability and need for assistance. A FASI assessment commonly is performed during an in-person visit, and it can be performed in any community-based setting where HCBS recipients reside. The assessor can use various sources of information to complete a FASI assessment including an interview with the person, an interview with a helper, written records, and naturally occurring observation of performance. Fields for the FASI set are available within CMS's Data Element Library (DEL) and are attached in Section S.2b.
2. Data abstraction. Each program will apply methods of their choice for abstracting FASI data. These methods are likely to be similar to those used by the state to generate existing quality measures that are derived from the same data sources. One method could be to make use of a data abstraction form. The Appendix contains a sample form that is based on the form used during measure testing. This form could be adapted by programs implementing the measure.

   Available at measure-specific web page URL identified in S.1 Attachment

#2967 CAHPS® Home and Community-Based Services Measures

Instrument-Based Data CAHPS Home- and Community-Based Services Survey

In-person and phone

English and Spanish

Available in attached appendix at A.1 No data dictionary

Level

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Other

#2967 CAHPS® Home and Community-Based Services Measures

Other

Setting

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Home Care, Other Medicaid HCBS Program

#2967 CAHPS® Home and Community-Based Services Measures

Other Home and Community-Based Services Program

Numerator Statement

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment and who have identified at least as many total personal priorities (up to three) as functional needs in the areas of self-care, mobility, or IADL combined on the same FASI assessment.

#2967 CAHPS® Home and Community-Based Services Measures

The CAHPS Home- and Community-Based Services 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
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
8. Global Rating Measures
9. Global rating of personal assistance and behavioral health staff—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale
10. Global rating of homemaker—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale
11. Global rating of case manager—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale
12. Recommendation Measures
13. Would recommend personal assistance/behavioral health staff to family and friends—Average 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)
14. Would recommend homemaker to family and friends—Average 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)
15. Would recommend case manager to family and friends—Average 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)
16. Unmet Needs Measures
17. Unmet need in dressing/bathing due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)
18. Unmet need in meal preparation/eating due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)
19. Unmet need in medication administration due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)
20. Unmet need in toileting due to lack of help—Average proportion of respondents that gave the most positive response of Yes on a 1–2 scale (Yes or No)
21. Unmet need with household tasks due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)
22. Physical Safety Measure
23. Hit or hurt by staff—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)

Numerator Details

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The numerator is a portion (i.e., a potential subset) of HCBS recipients in the denominator. This portion is determined by the presence of personal priorities in two text boxes provided for each functional area in Section B of the FASI form, Functional Abilities and Goals. The FASI form instructs the assessor to ask the person to describe at least one or two personal priorities in the area for the next 6 months. The FASI form also instructs the assessor to note when the person does not express any personal priorities in the area.

The frequency of data aggregation will be at the discretion of state users because CMS has determined that states will use the standardized items (i.e., FASI) from which the measure is derived on a voluntary basis. It is anticipated that states would calculate the measure at least annually per HCBS program. Some states may choose to calculate the measure more frequently than annually (e.g., every 3 or 6 months).

#2967 CAHPS® Home and Community-Based Services Measures

To calculate the program-level scores:

Score each item using the top box method; calculate a mode adjusted score for each respondent; calculate case mix adjusted scores for each program; and calculate means for the scale measures.

Scale Measures:

For each survey item, the top-box numerator is the number of respondents who selected the most positive response category.

Staff are reliable and helpful—Survey items 13, 14, 15, 19, 37, and 38

13: In the last 3 months, how often did {personal assistance/behavioral health staff} come to work on time?

14: In the last 3 months, how often did {personal assistance/behavioral health staff} work as long as they were supposed to?

15: In the last 3 months, when staff could not come to work on a day that they were scheduled, did someone let you know that {personal assistance/behavioral health staff} could not come that day?

19: In the last 3 months, how often did {personal assistance/behavioral health staff} make sure you had enough personal privacy when you dressed, took a shower, or bathed?

37: In the last 3 months, how often did {homemakers} come to work on time?

38: In the last 3 months, how often did {homemakers} work as long as they were supposed to?

Staff listen and communicate well—Survey items 28, 29, 30, 31, 32, 33, 41, 42, 43, 44, and 45

28: In the last 3 months, how often did {personal assistance/behavioral health staff} treat you with courtesy and respect?

29: In the last 3 months, how often were the explanations {personal assistance/behavioral health staff} gave you hard to understand because of an accent or the way {personal assistance/behavioral health staff} spoke English?

30: In the last 3 months, how often did {personal assistance/behavioral health staff} treat you the way you wanted them to?

31: In the last 3 months, how often did {personal assistance/behavioral health staff} explain things in a way that was easy to understand?

32: In the last 3 months, how often did {personal assistance/behavioral health staff} listen carefully to you?

33: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what kind of help you needed with everyday activities, like getting ready in the morning, getting groceries, or going places in your community?

41: In the last 3 months, how often did {homemakers} treat you with courtesy and respect?

42: In the last 3 months, how often were the explanations {homemakers} gave you hard to understand because of an accent or the way the {homemakers} spoke English?

43: In the last 3 months, how often did {homemakers} treat you the way you wanted them to?

44: In the last 3 months, how often did {homemakers} listen carefully to you?

45: In the last 3 months, did you feel {homemakers} knew what kind of help you needed?

Case manager is helpful—Survey items 49, 51, and 53

49: In the last 3 months, could you contact this {case manager} when you needed to?

51: In the last 3 months, did this {case manager} work with you when you asked for help with getting or fixing equipment?

53: In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?

Choosing the services that matter to you—Survey items 56 and 57

56: In the last 3 months, did your [program-specific term for "service plan"] include . . .

57: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what's on your [program-specific term for "service plan"], including the things that are important to you?

Transportation to medical appointments—Survey items 59, 61, and 62

59: Medical appointments include seeing a doctor, a dentist, a therapist, or someone else who takes care of your health. In the last 3 months, how often did you have a way to get to your medical appointments?

61: In the last 3 months, were you able to get in and out of this ride easily?

62: In the last 3 months, how often did this ride arrive on time to pick you up?

Personal safety and respect—Survey items 64, 65, and 68

64: In the last 3 months, was there a person you could talk to if someone hurt you or did something to you that you didn't like?

65: In the last 3 months, did any {personal assistance/behavioral health staff, homemakers, or your case managers} take your money or your things without asking you first?

68: In the last 3 months, did any {staff} yell, swear, or curse at you?"

Planning your time and activities—Survey items 75, 77, 78, 79, 80, and 81

75: In the last 3 months, when you wanted to, how often could you get together with these family members who live nearby?"

77: In the last 3 months, when you wanted to, how often could you get together with these friends who live nearby? "

78: In the last 3 months, when you wanted to, how often could you do things in the community that you like?

79: In the last 3 months, did you need more help than you get from {personal assistance/behavioral health staff} to do things in your community?

80: In the last 3 months, did you take part in deciding what you do with your time each day?

81: In the last 3 months, did you take part in deciding when you do things each day—for example, deciding when you get up, eat, or go to bed?

Global Ratings Measures:

The numerator for each global measure includes the number of respondents who answered 9 or 10 for the item (on a scale of 0 to 10).

Global rating of personal assistance and behavioral health staff—Survey item 35

35: Using any number from 0 to 10, where 0 is the worst help from {personal assistance/behavioral health staff} possible and 10 is the best help from {personal assistance/behavioral health staff}

possible, what number would you use to rate the help you get from {personal assistance/behavioral health staff}?

Global rating of homemaker—Survey item 46

46: Using any number from 0 to 10, where 0 is the worst help from {homemakers} possible and 10 is the best help from {homemakers} possible, what number would you use to rate the help you get from {homemakers}?

Global rating of case manager—Survey item 54

54: Using any number from 0 to 10, where 0 is the worst help from {case manager} possible and 10 is the best help from {case manager} possible, what number would you use to rate the help you get from {case manager}?

Recommendation Measures:

The numerator for each recommendation measure includes the number of respondents who answered Definitely Yes for the item (on a scale of Definitely No, Probably No, Probably Yes, or Definitely Yes). Item numbers and item text are listed below.

Would recommend personal assistance/behavioral health staff to family and friends—Survey item 36

36: Would you recommend the {personal assistance/behavioral health staff} who help you to your family and friends if they needed help with everyday activities? Would you say you recommend the {personal assistance/behavioral health staff}?

Would recommend homemaker to family and friends—Survey item 47

47: Would you recommend the {homemakers} who help you to your family and friends if they needed {program-specific term for homemaker services}? Would you say you recommend the {homemakers}?

Would recommend case manager to family and friends—Survey item 55

55: Would you recommend the {case manager} who helps you to your family and friends if they needed {program-specific term for case-management services}? Would you say you recommend the {case manager}?

Unmet Needs Measures:

The numerator for each unmet needs measure includes the number of respondents who answered No for that item (these items are then reverse coded so that higher scores reflect a better experience). Item numbers and item text are listed below.

Unmet need in dressing/bathing due to lack of help—Survey item 18

18: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in meal preparation/eating due to lack of help—Survey item 22

22: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in medication administration due to lack of help—Survey item 25

25: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in toileting due to lack of help—Survey item 27

27: In the last 3 months, did you get all the help you needed with toileting from {personal assistance/behavioral health staff} when you needed it? (not reverse coded).

Unmet need with household tasks due to lack of help—Survey item 40

40: In the last 3 months, was this because there were no {homemakers} to help you?

Physical Safety Measure:

The numerator for the following physical safety measure includes the number of respondents who answered No for this item (this item is then reverse coded so that higher scores reflect a better experience). The item number and item text is listed below.

Hit or hurt by staff—Survey item 71

71: In the last 3 months, did any {staff} hit you or hurt you?

Denominator Statement

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment.

#2967 CAHPS® Home and Community-Based Services Measures

The denominator for all measures is the number of survey respondents. Individuals eligible for the CAHPS Home- and Community-Based Services survey include Medicaid beneficiaries who are at least 18 years of age in the sample period, and have received HCBS services for three months or longer and their proxies. 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?

Individuals who are unable to answer these cognitive screening items are excluded. Some measures also have topic-specific screening items as well. Additional detail is provided in S.9.

Individuals who are more likely to be good proxy respondents during the CAHPS Home- and Community-Based Services survey data collection are: (a) those who are willing to respond on behalf of the beneficiary; (b) unpaid caregivers, family members, friends, and neighbors; and (c) those who know the beneficiary well enough that he or she is familiar with the services and supports they are receiving, having regular, ongoing contact with them. Examples of circumstances that increase the likelihood that someone has knowledge about the beneficiary and their care situation include living with the beneficiary, managing the beneficiary's in-home care for a majority of the day, having regular conversations with the beneficiary about the services they receive, in-person visits with the beneficiary, and being present when services/supports are delivered. Individuals who are less likely to be good proxy respondents are: (a) those with paid responsibilities for providing services/supports to the beneficiary, including family members and friends who are paid to help the beneficiary ; and (b) guardians or conservators whose only responsibility is to oversee the beneficiary's finances. Due to the nature of data being collected through CAHPS, individuals who formally or informally deliver HCBS services are discouraged from acting as a proxy.

Denominator Details

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The proposed measure focuses on the assessment of functional needs that are common among adult HCBS recipients and derived from use of FASI. These are functional needs in the areas of self-

care, mobility, and IADLs. The denominator is determined by items in Section B of the FASI form, Functional Abilities and Goals.

Self-care needs are identified in the following items on the FASI form: 6a (eating), 6b (oral hygiene), 6c (toileting hygiene), 6d (wash upper body), 6e (shower/bathe self), 6f (upper body dressing), 6g (lower body dressing), and 6h (putting on/taking off footwear).

Bed mobility and transfer needs are identified in the following items on the FASI form: 7a (roll left and right), 7b (sit to lying), 7c (lying to sitting on side of bed), 7d (sit to stand), 7e (chair/bed-to-chair transfer), 7f (toilet transfer), and 7g (car transfer).

If the response to item 8 on the FASI form indicates that the person walks, ambulation needs are identified in the following items on the FASI form: 8a (walks 10 feet), 8b (walks 50 feet with two turns), 8c (walks 150 feet), 8d (walks 10 feet on uneven surfaces), 8e (1 step (curb)), 8f (4 steps), 8g (12 steps), 8h (walks indoors), 8i (carries something in both hands), 8j (picking up object), 8k (walks for 15 minutes), and 8l (walks across a street).

If the response to item 9 on the FASI form indicates that the person uses a manual wheelchair, wheelchair mobility needs are identified in the following items on the FASI form: 9a (wheels 50 feet with two turns), 9b (wheels 150 feet), 9c (wheels for 15 minutes) and 9d (wheels across a street).

If the response to item 10 on the FASI form indicates that the person uses a motorized wheelchair/scooter, wheelchair/scooter mobility needs are identified in the following items on the FASI form: 10a (wheels 50 feet with two turns), 10b (wheels 150 feet), 10c (wheels for 15 minutes) and 10d (wheels across a street).

IADLs are identified in the following items on the FASI form: 11a (makes a light cold meal), 11b (makes a light hot meal), 11c (light daily housework), 11d (heavier periodic housework), 11e (light shopping), 11f (telephone-answering call), 11g (telephone-placing call), 11h (medication management-oral medications), 11i (medication management-inhalant/mist medications), 11j (medication management-injectable medications), 11k (simple financial management), and 11l (complex financial management).

#2967 CAHPS® Home and Community-Based Services Measures

While there are myriad home and community-based services and supports (HCBS) that Medicaid programs provide (at their discretion) to beneficiaries with long-term care needs, the proposed provider-related measures in this submission focus on the most common provider types for adults receiving Medicaid HCBS. These include personal assistance providers, behavioral health staff, homemakers, and case managers.

While Medicare-certified home health agencies may provide similar services to Medicare beneficiaries, the Medicare benefit is a post-acute care benefit and typically limited to episodes following hospitalization. Medicaid home and community-based services are a long-term care benefit and support persons with long-term care needs over lengthier durations. Personal assistance services, help in the home by behavioral health staff, and homemaker services typically involve assistance with activities of daily living (bathing, dressing, grooming, toileting, eating; mobility) and instrumental activities of daily living (meal preparation, housework, laundry, food shopping). Case management is an integral component of Medicaid HCBS programs; the role of the case manager includes working with the beneficiary to assesses his/her need for services/supports and to develop a person-centered care/service plan, monitoring service delivery, and responding to the individual's changing needs and circumstances.

Not all HCBS beneficiaries receive all services. Questions 4, 6, 8, and 11 assess which services the beneficiary receives. Beneficiaries are then eligible for different survey questions based on these responses.

These questions are:

4: In the last 3 months, did you get {program specific term for personal assistance} at home?

6: In the last 3 months, did you get {program specific term for behavioral health specialist services} at home?

8: In the last 3 months, did you get {program specific term for homemaker services} at home?

11: In the last 3 months, did you get help from {program specific term for case manager services} to help make sure that you had all the services you needed?

Scale Measure 1: Staff are reliable and helpful

13: The number of surveys completed by all those who responded Yes to screener 4 or 6

14: The number of surveys completed by all those who responded Yes to screener 4 or 6

15: The number of surveys completed by all those who responded Yes to screener 4 or 6

19: The number of surveys completed by all those who responded Yes to screener 4 or 6

37: The number of surveys completed by all those who responded Yes to screener 8

38: The number of surveys completed by all those who responded Yes to screener 8

Scale Measure 2: Staff listen and communicate well

28: The number of surveys completed by all those who responded Yes to screener 4 or 6

29: The number of surveys completed by all those who responded Yes to screener 4 or 6

30: The number of surveys completed by all those who responded Yes to screener 4 or 6

31: The number of surveys completed by all those who responded Yes to screener 4 or 6

32: The number of surveys completed by all those who responded Yes to screener 4 or 6

33: The number of surveys completed by all those who responded Yes to screener 4 or 6

41: The number of surveys completed by all those who responded Yes to screener 8

42: The number of surveys completed by all those who responded Yes to screener 8

43: The number of surveys completed by all those who responded Yes to screener 8

44: The number of surveys completed by all those who responded Yes to screener 8

45: The number of surveys completed by all those who responded Yes to screener 8

Scale Measure 3: Case manager is helpful

49: The number of surveys completed by all those who responded Yes to screener 11

51: The number of surveys completed by all those who responded Yes to screener 11

53: The number of surveys completed by all those who responded Yes to screener 11

Scale Measure 4: Choosing the services that matter to you

56: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11

57: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11

Scale Measure 5: Transportation to medical appointments

59: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11

61: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11

62: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11

Scale Measure 6: Personal safety and respect
64: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
65: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
68: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Scale Measure 7: Planning your time and activities
75: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
77: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
78: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
79: The number of surveys completed by all those who responded Yes to screener 4 or 6
80: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
81: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11

Global Rating Measures:

Global rating of personal assistance and behavioral health staff
35: The number of surveys completed by all those who responded Yes to screener 4 or 6
Global rating of homemaker
46: The number of surveys completed by all those who responded Yes to screener 8

Global rating of case manager

54: The number of surveys completed by all those who responded Yes to screener 11

Recommendation Measures:

Recommendation of personal assistance and behavioral health staff to family/friends
36: The number of surveys completed by all those who responded Yes to screener 4 or 6
Recommendation of homemaker to family/friends
47: The number of surveys completed by all those who responded Yes to screener 8
Recommendation of case manager to family/friends
55: The number of surveys completed by all those who responded Yes to screener 11

Unmet Needs Measures:

Unmet need in dressing/bathing due to lack of help
18: The number of surveys completed by all those who responded Yes to 16 and No to 17
Unmet need in meal preparation/eating due to lack of help
22: The number of surveys completed by all those who responded Yes to 20 and No to 21
Unmet need in medication administration due to lack of help
25: The number of surveys completed by all those who responded Yes to 23 and No to 24
Unmet need in toileting due to lack of help
27: The number of surveys completed by all those who responded Yes to 26
Unmet need with household tasks due to lack of help
40: The number of surveys completed by all those who responded No to 39

Personal Safety Measures:

Hit or hurt by staff
71: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11

Exclusions

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Exclusions inherent in the denominator definition include individuals younger than 18 years, individuals who have not had a FASI assessment within the chosen time period, and individuals who have had a FASI assessment but no functional needs were identified in the areas of self-care, mobility, or IADLs.

#2967 CAHPS® Home and Community-Based Services Measures

Individuals less than 18 years of age and individuals that have not received HCBS services for at least 3 months should be excluded. During survey administration, additional exclusions include individuals that failed any of the cognitive screening items mentioned in the denominator statement below.

Exclusion Details

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

See S.7. denominator details for information required to identify functional needs.

#2967 CAHPS® Home and Community-Based Services Measures

Individuals who are unable to answer one or more of the following cognitive screening items should be excluded. If the respondent is not able to answer (e.g., provides an invalid/nonsensical response, does not respond, or indicates "I don't know"), the interviewer should end the interview.

1. Does someone come into your home to help you? (Yes or No)
2. How do they help you? Open-Ended Response

   Examples of correct responses include:

   "Helps me get ready every day"

   "Cleans my home"

   "Works with me at my job"

   "Helps me to do things"

   "Drives me around"
3. What do you call them? Open-Ended Response

   Examples of sufficient responses include:

   "My worker"

   "My assistant"

   Names of staff ("Jo", "Dawn", etc.)

Risk Adjustment

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

No risk adjustment or risk stratification

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#2967 CAHPS® Home and Community-Based Services Measures

Statistical risk model

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142229| 113612

Stratification

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The primary unit of analysis is the Medicaid HCBS program type. Programs can provide a combination of standard medical services and non-medical services. Standard services include, but are not limited to, case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. For more information, click here.

These programs are designed to provide an array of services to a certain target population; as a result, each state typically operates more than one HCBS program. Five HCBS program types were used for the testing of this measure. Their labels reflect the predominant population eligible for services under each HCBS program. However, the group of individuals served within a single HCBS program type may be heterogeneous by design (e.g., the intentional combination of individuals with mental health and substance use disorders) or because of the presence of comorbidities.

4.

Medicaid agencies in the states have administrative authority over these HCBS programs and determine which services and supports to offer beneficiaries who are deemed eligible for a given HCBS program. Although Medicaid HCBS programs are administered by state Medicaid agencies under various Medicaid legal authorities, they are frequently operated by other entities including non-Medicaid state agencies (e.g., department of aging, etc.), non-state governmental entities (e.g., county, etc.), or managed care organizations. The operating entities then contract with direct service/support providers.

#2967 CAHPS® Home and Community-Based Services Measures

The intended primary unit of analysis is the Medicaid HCBS program. However, states may wish to stratify by sub-state agencies such as counties or regional entities with program operational and budgetary authority. In some instances, a state may wish to stratify by case-management agency as well, given they are typically viewed as having substantial responsibility for developing beneficiary service and support plans as well as monitoring whether the service/support plan addresses the person's needs and meet their goals.

States are increasingly moving users of Medicaid long-term services and supports, including HCBS, into managed care arrangements (typically referred to as Managed Long-Term Services and Supports or MLTSS) where the managed care organization (MCO) is the primary accountable entity for ensuring HCBS beneficiary, health, welfare and quality of life. As such, we also anticipate some states may want to stratify based on (MCO).

Type Score

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Rate/proportion better quality = higher score

#2967 CAHPS® Home and Community-Based Services Measures

Other (specify): Case-mix adjusted top box score better quality = higher score

Algorithm

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The following steps are used to create the score for this measure:

1. Restrict HCBS sample to individuals aged 18 years or older who have had a FASI assessment within the chosen time period.
2. Count the number of sampled individuals with at least one FASI-documented functional need in self-care, mobility, or IADLs. Documented functional needs are based on receiving either a "05" or below (04, 03, 02, or 01), or "88" on any item in the Self-Care, Mobility, or IADL sections of a FASI. See S.2b. (data dictionary, code table, or value sets) for value labels and S.7 (denominator details) for the list of specific items on the FASI form comprising the Self-Care, Mobility, and IADL sections.
3. For each individual with at least one FASI-documented functional need, count the number of FASI-documented functional needs in the three areas combined and count the number of personal priorities for the three areas combined. Personal priorities can include any number from each of the three sections (Self-Care, Mobility, and IADL).
4. Count the number of sampled individuals for whom the number of personal priorities from step 3 is at least as many as the number of functional needs (up to three) in step 2.
5. Calculate the percentage by dividing the resulting number in step 4 by the resulting number in step 2. 113612

#2967 CAHPS® Home and Community-Based Services Measures

Scoring specifications for the measures will follow the same general scoring approach as used by other CAHPS surveys that use the CAHPS analysis program. The measures are based on case-mix adjusted top box scores. The research team suggests general health rating, mental health rating, age, education, gender, whether respondent lives alone, and response option as case- mix adjusters for these measures. We also recommend including survey mode as an additional adjustment variable and proxy status if proxy responses are permitted. More information about case-mix adjustment is available in Instructions for Analyzing Data from CAHPS Surveys (available from the downloadable zip file).

To create scores for each scale measure:

1. Calculate the score for each item using the top box method.
2. Calculate a mode adjusted score for each item.
3. Calculate case-mix adjusted scores for each program.
4. Calculate means for the scale measures weighting each item equally.

The steps for user-defined calculations of risk-adjusted scores can be found in Instructions for Analyzing Data from CAHPS Surveys: Using the CAHPS Analysis Program Version 4.1 available from the downloadable zip file.

To create scores for each global rating and individual item measure, follow steps 1-3 above. 142229| 113612

Submission Items

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

5.1 Identified measures: 2967 : CAHPS® Home- and Community-Based Services Measures

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: There is one related measure. At a high level, NQF#2967 CAHPS Home and Community-Based Services Measures is related in terms of the target population because it applies to individuals aged 18 years and older who receive HCBS. It also includes a composite measure of the individual's experience "choosing the services that matter to you," which reflects the participant's goals and priorities. Although they both apply to the same general target population and concept, the proposed measure contributes actionable information about the concept from a different perspective. NQF#2967 is a set of patient- (participant-) reported outcome measures, and the proposed measure is a process measure describing the functional assessment and its contents as created by the accountable entity. Being able to measure whether assessments are capturing personal priorities associated with functional needs adds value to efforts to deliver person-centered services and supports by providing essential upstream information about provider processes. Both measures are instrument-based and make use of instruments developed under CMS's TEFT demonstration.

5b.1 If competing, why superior or rationale for additive value:

#2967 CAHPS® Home and Community-Based Services Measures

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

#2967 CAHPS® Home and Community-Based Services Measures

#2967 CAHPS® Home and Community-Based Services Measures

Steward

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Centers for Medicare & Medicaid Services

#2967 CAHPS® Home and Community-Based Services Measures

Centers for Medicare & Medicaid Services

Description

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The percentage of home and community-based services (HCBS) recipients aged 18 years or older who have identified at least as many total personal priorities (up to three) as needs in the areas of self-care, mobility, or instrumental activities of daily living (IADL) combined as determined by the most recent FASI assessment.

For the purposes of this measure application, the term "home and community-based services" also will refer to community-based long-term services and supports (CB-LTSS). The definition of HCBS in the September 2016 National Quality Forum (NQF) report titled Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement is consistent with the way the Centers for Medicare & Medicaid Services (CMS) uses CB-LTSS.

#2967 CAHPS® Home and Community-Based Services Measures

The 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 that are delivered to them under the auspices of a state Medicaid HCBS program. The unit of analysis for NQF 2967 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.

The measures consist of 7 scale measures, 6 global rating and recommendation measures, and 6 individual measures:

Scale Measures

1. Staff are reliable and helpful—Top-box score composed of 6 survey items
2. Staff listen and communicate well—Top-box score composed of 11 survey items
3. Case manager is helpful—Top-box score composed of 3 survey items
4. Choosing the services that matter to you—Top-box score composed of 2 survey items
5. Transportation to medical appointments—Top-box score composed of 3 survey items
6. Personal safety and respect—Top-box score composed of 3 survey items
7. Planning your time and activities—Top-box score composed of 6 survey items

Global Ratings Measures

8. Global rating of personal assistance and behavioral health staff—Top-box score on a 0–10 scale
9. Global rating of homemaker—Top-box score on a 0–10 scale
10. Global rating of case manager—Top-box score on a 0–10 scale

Recommendations Measures

11. Would recommend personal assistance/behavioral health staff to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)
12. Would recommend homemaker to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)
13. Would recommend case manager to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)

Unmet Needs Measures

14. Unmet need in dressing/bathing due to lack of help—Top-box score on a Yes or No scale
15. Unmet need in meal preparation/eating due to lack of help—Top-box score on a Yes or No scale
16. Unmet need in medication administration due to lack of help—Top-box score on a Yes or No scale
17. Unmet need in toileting due to lack of help—Top-box score on a Yes or No scale
18. Unmet need with household tasks due to lack of help—Top-box score on a Yes or No scale

Physical Safety Measure

19. Hit or hurt by staff—Top-box score on a Yes or No scale

Type

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Process

#2967 CAHPS® Home and Community-Based Services Measures

Outcome: PRO-PM

Data Source

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Electronic Health Records, Instrument-Based Data, Paper Medical Records

1. FASI set. CMS developed the FASI, as part of the Testing Experience and Functional Assessment Tools (TEFT) demonstration, to assess the status of individuals receiving HCBS. HCBS program staff or assessors at agencies under contract to state HCBS programs use the FASI set to assess HCBS recipients' functional ability and need for assistance. A FASI assessment commonly is performed during an in-person visit, and it can be performed in any community-based setting where HCBS recipients reside. The assessor can use various sources of information to complete a FASI assessment including an interview with the person, an interview with a helper, written records, and naturally occurring observation of performance. Fields for the FASI set are available within CMS's Data Element Library (DEL) and are attached in Section S.2b.
2. Data abstraction. Each program will apply methods of their choice for abstracting FASI data. These methods are likely to be similar to those used by the state to generate existing quality measures that are derived from the same data sources. One method could be to make use of a data abstraction form. The Appendix contains a sample form that is based on the form used during measure testing. This form could be adapted by programs implementing the measure.

   Available at measure-specific web page URL identified in S.1 Attachment

#2967 CAHPS® Home and Community-Based Services Measures

Instrument-Based Data CAHPS Home- and Community-Based Services Survey

In-person and phone

English and Spanish

Available in attached appendix at A.1 No data dictionary

Level

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Other

#2967 CAHPS® Home and Community-Based Services Measures

Other

Setting

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Home Care, Other Medicaid HCBS Program

#2967 CAHPS® Home and Community-Based Services Measures

Other Home and Community-Based Services Program

Numerator Statement

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment and who have identified

at least as many total personal priorities (up to three) as functional needs in the areas of self-care, mobility, or IADL combined on the same FASI assessment.

#2967 CAHPS® Home and Community-Based Services Measures

The CAHPS Home- and Community-Based Services 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
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

8. Global rating of personal assistance and behavioral health staff—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale
9. Global rating of homemaker—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale
10. Global rating of case manager—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale

Recommendation Measures

11. Would recommend personal assistance/behavioral health staff to family and friends—Average 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)
12. Would recommend homemaker to family and friends—Average 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)
13. Would recommend case manager to family and friends—Average 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

14. Unmet need in dressing/bathing due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)

15. Unmet need in meal preparation/eating due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)
16. Unmet need in medication administration due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)
17. Unmet need in toileting due to lack of help—Average proportion of respondents that gave the most positive response of Yes on a 1–2 scale (Yes or No)
18. Unmet need with household tasks due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)

    Physical Safety Measure
19. Hit or hurt by staff—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)

Numerator Details

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The numerator is a portion (i.e., a potential subset) of HCBS recipients in the denominator. This portion is determined by the presence of personal priorities in two text boxes provided for each functional area in Section B of the FASI form, Functional Abilities and Goals. The FASI form instructs the assessor to ask the person to describe at least one or two personal priorities in the area for the next 6 months. The FASI form also instructs the assessor to note when the person does not express any personal priorities in the area.

The frequency of data aggregation will be at the discretion of state users because CMS has determined that states will use the standardized items (i.e., FASI) from which the measure is derived on a voluntary basis. It is anticipated that states would calculate the measure at least annually per HCBS program. Some states may choose to calculate the measure more frequently than annually (e.g., every 3 or 6 months).

#2967 CAHPS® Home and Community-Based Services Measures

To calculate the program-level scores:

Score each item using the top box method; calculate a mode adjusted score for each respondent; calculate case mix adjusted scores for each program; and calculate means for the scale measures.

Scale Measures:

For each survey item, the top-box numerator is the number of respondents who selected the most positive response category.

Staff are reliable and helpful—Survey items 13, 14, 15, 19, 37, and 38

13: In the last 3 months, how often did {personal assistance/behavioral health staff} come to work on time?

14: In the last 3 months, how often did {personal assistance/behavioral health staff} work as long as they were supposed to?

15: In the last 3 months, when staff could not come to work on a day that they were scheduled, did someone let you know that {personal assistance/behavioral health staff} could not come that day?

19: In the last 3 months, how often did {personal assistance/behavioral health staff} make sure you had enough personal privacy when you dressed, took a shower, or bathed?

37: In the last 3 months, how often did {homemakers} come to work on time?

38: In the last 3 months, how often did {homemakers} work as long as they were supposed to?

Staff listen and communicate well—Survey items 28, 29, 30, 31, 32, 33, 41, 42, 43, 44, and 45

28: In the last 3 months, how often did {personal assistance/behavioral health staff} treat you with courtesy and respect?

29: In the last 3 months, how often were the explanations {personal assistance/behavioral health staff} gave you hard to understand because of an accent or the way {personal assistance/behavioral health staff} spoke English?

30: In the last 3 months, how often did {personal assistance/behavioral health staff} treat you the way you wanted them to?

31: In the last 3 months, how often did {personal assistance/behavioral health staff} explain things in a way that was easy to understand?

32: In the last 3 months, how often did {personal assistance/behavioral health staff} listen carefully to you?

33: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what kind of help you needed with everyday activities, like getting ready in the morning, getting groceries, or going places in your community?

41: In the last 3 months, how often did {homemakers} treat you with courtesy and respect?

42: In the last 3 months, how often were the explanations {homemakers} gave you hard to understand because of an accent or the way the {homemakers} spoke English?

43: In the last 3 months, how often did {homemakers} treat you the way you wanted them to?

44: In the last 3 months, how often did {homemakers} listen carefully to you?

45: In the last 3 months, did you feel {homemakers} knew what kind of help you needed?

Case manager is helpful—Survey items 49, 51, and 53

49: In the last 3 months, could you contact this {case manager} when you needed to?

51: In the last 3 months, did this {case manager} work with you when you asked for help with getting or fixing equipment?

53: In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?

Choosing the services that matter to you—Survey items 56 and 57

56: In the last 3 months, did your [program-specific term for “service plan”] include . . .

57: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what’s on your [program-specific term for “service plan”], including the things that are important to you?

Transportation to medical appointments—Survey items 59, 61, and 62

59: Medical appointments include seeing a doctor, a dentist, a therapist, or someone else who takes care of your health. In the last 3 months, how often did you have a way to get to your medical appointments?

61: In the last 3 months, were you able to get in and out of this ride easily?

62: In the last 3 months, how often did this ride arrive on time to pick you up?

Personal safety and respect—Survey items 64, 65, and 68

64: In the last 3 months, was there a person you could talk to if someone hurt you or did something to you that you didn’t like?

65: In the last 3 months, did any {personal assistance/behavioral health staff, homemakers, or your case managers} take your money or your things without asking you first?

68: In the last 3 months, did any {staff} yell, swear, or curse at you?"

Planning your time and activities—Survey items 75, 77, 78, 79, 80, and 81

75: In the last 3 months, when you wanted to, how often could you get together with these family members who live nearby?"

77: In the last 3 months, when you wanted to, how often could you get together with these friends who live nearby? "

78: In the last 3 months, when you wanted to, how often could you do things in the community that you like?

79: In the last 3 months, did you need more help than you get from {personal assistance/behavioral health staff} to do things in your community?

80: In the last 3 months, did you take part in deciding what you do with your time each day?

81: In the last 3 months, did you take part in deciding when you do things each day—for example, deciding when you get up, eat, or go to bed?

Global Ratings Measures:

The numerator for each global measure includes the number of respondents who answered 9 or 10 for the item (on a scale of 0 to 10).

Global rating of personal assistance and behavioral health staff—Survey item 35

35: Using any number from 0 to 10, where 0 is the worst help from {personal assistance/behavioral health staff} possible and 10 is the best help from {personal assistance/behavioral health staff} possible, what number would you use to rate the help you get from {personal assistance/behavioral health staff}?

Global rating of homemaker—Survey item 46

46: Using any number from 0 to 10, where 0 is the worst help from {homemakers} possible and 10 is the best help from {homemakers} possible, what number would you use to rate the help you get from {homemakers}?

Global rating of case manager—Survey item 54

54: Using any number from 0 to 10, where 0 is the worst help from {case manager} possible and 10 is the best help from {case manager} possible, what number would you use to rate the help you get from {case manager}?

Recommendation Measures:

The numerator for each recommendation measure includes the number of respondents who answered Definitely Yes for the item (on a scale of Definitely No, Probably No, Probably Yes, or Definitely Yes). Item numbers and item text are listed below.

Would recommend personal assistance/behavioral health staff to family and friends—Survey item 36

36: Would you recommend the {personal assistance/behavioral health staff} who help you to your family and friends if they needed help with everyday activities? Would you say you recommend the {personal assistance/behavioral health staff}?

Would recommend homemaker to family and friends—Survey item 47

47: Would you recommend the {homemakers} who help you to your family and friends if they needed {program-specific term for homemaker services}? Would you say you recommend the {homemakers}?

Would recommend case manager to family and friends—Survey item 55

55: Would you recommend the {case manager} who helps you to your family and friends if they needed {program-specific term for case-management services}? Would you say you recommend the {case manager}?

Unmet Needs Measures:

The numerator for each unmet needs measure includes the number of respondents who answered No for that item (these items are then reverse coded so that higher scores reflect a better experience). Item numbers and item text are listed below.

Unmet need in dressing/bathing due to lack of help—Survey item 18

18: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in meal preparation/eating due to lack of help—Survey item 22

22: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in medication administration due to lack of help—Survey item 25

25: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in toileting due to lack of help—Survey item 27

27: In the last 3 months, did you get all the help you needed with toileting from {personal assistance/behavioral health staff} when you needed it? (not reverse coded).

Unmet need with household tasks due to lack of help—Survey item 40

40: In the last 3 months, was this because there were no {homemakers} to help you?

Physical Safety Measure:

The numerator for the following physical safety measure includes the number of respondents who answered No for this item (this item is then reverse coded so that higher scores reflect a better experience). The item number and item text is listed below.

Hit or hurt by staff—Survey item 71

71: In the last 3 months, did any {staff} hit you or hurt you?

Denominator Statement

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment.

#2967 CAHPS® Home and Community-Based Services Measures

The denominator for all measures is the number of survey respondents. Individuals eligible for the CAHPS Home- and Community-Based Services survey include Medicaid beneficiaries who are at least 18 years of age in the sample period, and have received HCBS services for three months or longer and their proxies. 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?

Individuals who are unable to answer these cognitive screening items are excluded. Some measures also have topic-specific screening items as well. Additional detail is provided in S.9.

Individuals who are more likely to be good proxy respondents during the CAHPS Home- and Community-Based Services survey data collection are: (a) those who are willing to respond on behalf of the beneficiary; (b) unpaid caregivers, family members, friends, and neighbors; and (c) those who know the beneficiary well enough that he or she is familiar with the services and supports they are receiving, having regular, ongoing contact with them. Examples of circumstances that increase the likelihood that someone has knowledge about the beneficiary and their care situation include living with the beneficiary, managing the beneficiary's in-home care for a majority of the day, having regular conversations with the beneficiary about the services they receive, in-person visits with the beneficiary, and being present when services/supports are delivered. Individuals who are less likely to be good proxy respondents are: (a) those with paid responsibilities for providing services/supports to the beneficiary, including family members and friends who are paid to help the beneficiary ; and (b) guardians or conservators whose only responsibility is to oversee the beneficiary's finances. Due to the nature of data being collected through CAHPS, individuals who formally or informally deliver HCBS services are discouraged from acting as a proxy.

Denominator Details

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The proposed measure focuses on the assessment of functional needs that are common among adult HCBS recipients and derived from use of FASI. These are functional needs in the areas of self-care, mobility, and IADLs. The denominator is determined by items in Section B of the FASI form, Functional Abilities and Goals.

Self-care needs are identified in the following items on the FASI form: 6a (eating), 6b (oral hygiene), 6c (toileting hygiene), 6d (wash upper body), 6e (shower/bathe self), 6f (upper body dressing), 6g (lower body dressing), and 6h (putting on/taking off footwear).

Bed mobility and transfer needs are identified in the following items on the FASI form: 7a (roll left and right), 7b (sit to lying), 7c (lying to sitting on side of bed), 7d (sit to stand), 7e (chair/bed-to-chair transfer), 7f (toilet transfer), and 7g (car transfer).

If the response to item 8 on the FASI form indicates that the person walks, ambulation needs are identified in the following items on the FASI form: 8a (walks 10 feet), 8b (walks 50 feet with two turns), 8c (walks 150 feet), 8d (walks 10 feet on uneven surfaces), 8e (1 step (curb)), 8f (4 steps), 8g (12 steps), 8h (walks indoors), 8i (carries something in both hands), 8j (picking up object), 8k (walks for 15 minutes), and 8l (walks across a street).

If the response to item 9 on the FASI form indicates that the person uses a manual wheelchair, wheelchair mobility needs are identified in the following items on the FASI form: 9a (wheels 50 feet with two turns), 9b (wheels 150 feet), 9c (wheels for 15 minutes) and 9d (wheels across a street).

If the response to item 10 on the FASI form indicates that the person uses a motorized wheelchair/scooter, wheelchair/scooter mobility needs are identified in the following items on the FASI form: 10a (wheels 50 feet with two turns), 10b (wheels 150 feet), 10c (wheels for 15 minutes) and 10d (wheels across a street).

IADLs are identified in the following items on the FASI form: 11a (makes a light cold meal), 11b (makes a light hot meal), 11c (light daily housework), 11d (heavier periodic housework), 11e (light shopping), 11f (telephone-answering call), 11g (telephone-placing call), 11h (medication

management-oral medications), 11i (medication management-inhalant/mist medications), 11j (medication management-injectable medications), 11k (simple financial management), and 11l (complex financial management).

#2967 CAHPS® Home and Community-Based Services Measures

While there are myriad home and community-based services and supports (HCBS) that Medicaid programs provide (at their discretion) to beneficiaries with long-term care needs, the proposed provider-related measures in this submission focus on the most common provider types for adults receiving Medicaid HCBS. These include personal assistance providers, behavioral health staff, homemakers, and case managers.

While Medicare-certified home health agencies may provide similar services to Medicare beneficiaries, the Medicare benefit is a post-acute care benefit and typically limited to episodes following hospitalization. Medicaid home and community-based services are a long-term care benefit and support persons with long-term care needs over lengthier durations. Personal assistance services, help in the home by behavioral health staff, and homemaker services typically involve assistance with activities of daily living (bathing, dressing, grooming, toileting, eating; mobility) and instrumental activities of daily living (meal preparation, housework, laundry, food shopping). Case management is an integral component of Medicaid HCBS programs; the role of the case manager includes working with the beneficiary to assesses his/her need for services/supports and to develop a person-centered care/service plan, monitoring service delivery, and responding to the individual's changing needs and circumstances.

Not all HCBS beneficiaries receive all services. Questions 4, 6, 8, and 11 assess which services the beneficiary receives. Beneficiaries are then eligible for different survey questions based on these responses.

These questions are:

4: In the last 3 months, did you get {program specific term for personal assistance} at home?

6: In the last 3 months, did you get {program specific term for behavioral health specialist services} at home?

8: In the last 3 months, did you get {program specific term for homemaker services} at home?

11: In the last 3 months, did you get help from {program specific term for case manager services} to help make sure that you had all the services you needed?

Scale Measure 1: Staff are reliable and helpful

13: The number of surveys completed by all those who responded Yes to screener 4 or 6

14: The number of surveys completed by all those who responded Yes to screener 4 or 6

15: The number of surveys completed by all those who responded Yes to screener 4 or 6

19: The number of surveys completed by all those who responded Yes to screener 4 or 6

37: The number of surveys completed by all those who responded Yes to screener 8

38: The number of surveys completed by all those who responded Yes to screener 8

Scale Measure 2: Staff listen and communicate well

28: The number of surveys completed by all those who responded Yes to screener 4 or 6

29: The number of surveys completed by all those who responded Yes to screener 4 or 6

30: The number of surveys completed by all those who responded Yes to screener 4 or 6

31: The number of surveys completed by all those who responded Yes to screener 4 or 6

32: The number of surveys completed by all those who responded Yes to screener 4 or 6

33: The number of surveys completed by all those who responded Yes to screener 4 or 6
41: The number of surveys completed by all those who responded Yes to screener 8
42: The number of surveys completed by all those who responded Yes to screener 8
43: The number of surveys completed by all those who responded Yes to screener 8
44: The number of surveys completed by all those who responded Yes to screener 8
45: The number of surveys completed by all those who responded Yes to screener 8
Scale Measure 3: Case manager is helpful
49: The number of surveys completed by all those who responded Yes to screener 11
51: The number of surveys completed by all those who responded Yes to screener 11
53: The number of surveys completed by all those who responded Yes to screener 11
Scale Measure 4: Choosing the services that matter to you
56: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
57: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Scale Measure 5: Transportation to medical appointments
59: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
61: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
62: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Scale Measure 6: Personal safety and respect
64: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
65: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
68: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Scale Measure 7: Planning your time and activities
75: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
77: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
78: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
79: The number of surveys completed by all those who responded Yes to screener 4 or 6
80: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
81: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Global Rating Measures:
Global rating of personal assistance and behavioral health staff
35: The number of surveys completed by all those who responded Yes to screener 4 or 6
Global rating of homemaker
46: The number of surveys completed by all those who responded Yes to screener 8
Global rating of case manager
54: The number of surveys completed by all those who responded Yes to screener 11
Recommendation Measures:
Recommendation of personal assistance and behavioral health staff to family/friends
36: The number of surveys completed by all those who responded Yes to screener 4 or 6
Recommendation of homemaker to family/friends

47: The number of surveys completed by all those who responded Yes to screener 8

Recommendation of case manager to family/friends

55: The number of surveys completed by all those who responded Yes to screener 11

Unmet Needs Measures:

Unmet need in dressing/bathing due to lack of help

18: The number of surveys completed by all those who responded Yes to 16 and No to 17

Unmet need in meal preparation/eating due to lack of help

22: The number of surveys completed by all those who responded Yes to 20 and No to 21

Unmet need in medication administration due to lack of help

25: The number of surveys completed by all those who responded Yes to 23 and No to 24

Unmet need in toileting due to lack of help

27: The number of surveys completed by all those who responded Yes to 26

Unmet need with household tasks due to lack of help

40: The number of surveys completed by all those who responded No to 39

Personal Safety Measures:

Hit or hurt by staff

71: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11

Exclusions

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Exclusions inherent in the denominator definition include individuals younger than 18 years, individuals who have not had a FASI assessment within the chosen time period, and individuals who have had a FASI assessment but no functional needs were identified in the areas of self-care, mobility, or IADLs.

#2967 CAHPS® Home and Community-Based Services Measures

Individuals less than 18 years of age and individuals that have not received HCBS services for at least 3 months should be excluded. During survey administration, additional exclusions include individuals that failed any of the cognitive screening items mentioned in the denominator statement below.

Exclusion Details

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

See S.7. denominator details for information required to identify functional needs.

#2967 CAHPS® Home and Community-Based Services Measures

Individuals who are unable to answer one or more of the following cognitive screening items should be excluded. If the respondent is not able to answer (e.g., provides an invalid/nonsensical response, does not respond, or indicates “I don’t know”), the interviewer should end the interview.

1. Does someone come into your home to help you? (Yes or No)
2. How do they help you? Open-Ended Response

   Examples of correct responses include:

   “Helps me get ready every day”

"Cleans my home"

"Works with me at my job"

"Helps me to do things"

"Drives me around"

3. What do you call them? Open-Ended Response

Examples of sufficient responses include:

"My worker"

"My assistant"

Names of staff ("Jo", "Dawn", etc.)

Risk Adjustment

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

No risk adjustment or risk stratification

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#2967 CAHPS® Home and Community-Based Services Measures

Statistical risk model

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Stratification

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The primary unit of analysis is the Medicaid HCBS program type. Programs can provide a combination of standard medical services and non-medical services. Standard services include, but are not limited to, case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. For more information, click here.

These programs are designed to provide an array of services to a certain target population; as a result, each state typically operates more than one HCBS program. Five HCBS program types were used for the testing of this measure. Their labels reflect the predominant population eligible for services under each HCBS program. However, the group of individuals served within a single HCBS program type may be heterogeneous by design (e.g., the intentional combination of individuals with mental health and substance use disorders) or because of the presence of comorbidities.

1. HCBS programs serving individuals who are older adults
2. HCBS programs serving individuals with a physical disability
3. HCBS programs serving individuals with an intellectual or developmental disability
4. HCBS programs serving individuals with an acquired brain injury
5. HCBS programs serving individuals with mental health or substance use disorders.

Medicaid agencies in the states have administrative authority over these HCBS programs and determine which services and supports to offer beneficiaries who are deemed eligible for a given

HCBS program. Although Medicaid HCBS programs are administered by state Medicaid agencies under various Medicaid legal authorities, they are frequently operated by other entities including non-Medicaid state agencies (e.g., department of aging, etc.), non-state governmental entities (e.g., county, etc.), or managed care organizations. The operating entities then contract with direct service/support providers.

#2967 CAHPS® Home and Community-Based Services Measures

The intended primary unit of analysis is the Medicaid HCBS program. However, states may wish to stratify by sub-state agencies such as counties or regional entities with program operational and budgetary authority. In some instances, a state may wish to stratify by case-management agency as well, given they are typically viewed as having substantial responsibility for developing beneficiary service and support plans as well as monitoring whether the service/support plan addresses the person's needs and meet their goals.

States are increasingly moving users of Medicaid long-term services and supports, including HCBS, into managed care arrangements (typically referred to as Managed Long-Term Services and Supports or MLTSS) where the managed care organization (MCO) is the primary accountable entity for ensuring HCBS beneficiary, health, welfare and quality of life. As such, we also anticipate some states may want to stratify based on (MCO).

Type Score

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Rate/proportion better quality = higher score

#2967 CAHPS® Home and Community-Based Services Measures

Other (specify): Case-mix adjusted top box score better quality = higher score

Algorithm

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

The following steps are used to create the score for this measure:

1. Restrict HCBS sample to individuals aged 18 years or older who have had a FASI assessment within the chosen time period.
2. Count the number of sampled individuals with at least one FASI-documented functional need in self-care, mobility, or IADLs. Documented functional needs are based on receiving either a "05" or below (04, 03, 02, or 01), or "88" on any item in the Self-Care, Mobility, or IADL sections of a FASI. See S.2b. (data dictionary, code table, or value sets) for value labels and S.7 (denominator details) for the list of specific items on the FASI form comprising the Self-Care, Mobility, and IADL sections.
3. For each individual with at least one FASI-documented functional need, count the number of FASI-documented functional needs in the three areas combined and count the number of personal priorities for the three areas combined. Personal priorities can include any number from each of the three sections (Self-Care, Mobility, and IADL).
4. Count the number of sampled individuals for whom the number of personal priorities from step 3 is at least as many as the number of functional needs (up to three) in step 2.
5. Calculate the percentage by dividing the resulting number in step 4 by the resulting number in step 2. 113612

#2967 CAHPS® Home and Community-Based Services Measures

Scoring specifications for the measures will follow the same general scoring approach as used by other CAHPS surveys that use the CAHPS analysis program. The measures are based on case-mix adjusted top box scores. The research team suggests general health rating, mental health rating, age, education, gender, whether respondent lives alone, and response option as case- mix adjusters for these measures. We also recommend including survey mode as an additional adjustment variable and proxy status if proxy responses are permitted. More information about case-mix adjustment is available in Instructions for Analyzing Data from CAHPS Surveys (available from the downloadable zip file).

To create scores for each scale measure:

1. Calculate the score for each item using the top box method.
2. Calculate a mode adjusted score for each item.
3. Calculate case-mix adjusted scores for each program.
4. Calculate means for the scale measures weighting each item equally.

The steps for user-defined calculations of risk-adjusted scores can be found in Instructions for Analyzing Data from CAHPS Surveys: Using the CAHPS Analysis Program Version 4.1 available from the downloadable zip file.

To create scores for each global rating and individual item measure, follow steps 1-3 above.
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Submission Items

#3593 Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

5.1 Identified measures: 2967 : CAHPS® Home- and Community-Based Services Measures

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: There is one related measure. At a high level, NQF#2967 CAHPS Home and Community-Based Services Measures is related in terms of the target population because it applies to individuals aged 18 years and older who receive HCBS. It also includes a composite measure of the individual's experience "choosing the services that matter to you," which reflects the participant's goals and priorities. Although they both apply to the same general target population and concept, the proposed measure contributes actionable information about the concept from a different perspective. NQF#2967 is a set of patient- (participant-) reported outcome measures, and the proposed measure is a process measure describing the functional assessment and its contents as created by the accountable entity. Being able to measure whether assessments are capturing personal priorities associated with functional needs adds value to efforts to deliver person-centered services and supports by providing essential upstream information about provider processes. Both measures are instrument-based and make use of instruments developed under CMS's TEFT demonstration.

5b.1 If competing, why superior or rationale for additive value:

#2967 CAHPS® Home and Community-Based Services Measures

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

Comparison of NQF #3594, NQF #2967, NQF #2624, and NQF #2631

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs
#2967 CAHPS® Home and Community-Based Services Measures
#2624 Functional Outcome Assessment
#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Steward

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Centers for Medicare & Medicaid Services

#2967 CAHPS® Home and Community-Based Services Measures

Centers for Medicare & Medicaid Services

#2624 Functional Outcome Assessment

Centers for Medicare & Medicaid Services

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Centers for Medicare & Medicaid Services

Description

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The percentage of home and community-based services (HCBS) recipients aged 18 years or older whose PCSP documentation addresses needs in the areas of self-care, mobility, and instrumental activities of daily living (IADL) as determined by the most recent FASI assessment.

For the purposes of this measure application, the term “home and community-based services” also will refer to community-based long-term services and supports (CB-LTSS). The definition of HCBS in the September 2016 National Quality Forum (NQF) report titled Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement is consistent with the way the Centers for Medicare & Medicaid Services (CMS) uses CB-LTSS.

#2967 CAHPS® Home and Community-Based Services Measures

The 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 that are delivered to them under the auspices of a state Medicaid HCBS program. The unit of analysis for NQF 2967 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.

The measures consist of 7 scale measures, 6 global rating and recommendation measures, and 6 individual measures:

Scale Measures

1. Staff are reliable and helpful—Top-box score composed of 6 survey items
2. Staff listen and communicate well—Top-box score composed of 11 survey items
3. Case manager is helpful—Top-box score composed of 3 survey items
4. Choosing the services that matter to you—Top-box score composed of 2 survey items
5. Transportation to medical appointments—Top-box score composed of 3 survey items
6. Personal safety and respect—Top-box score composed of 3 survey items
7. Planning your time and activities—Top-box score composed of 6 survey items

Global Ratings Measures

8. Global rating of personal assistance and behavioral health staff—Top-box score on a 0–10 scale
9. Global rating of homemaker—Top-box score on a 0–10 scale
10. Global rating of case manager—Top-box score on a 0–10 scale

Recommendations Measures

11. Would recommend personal assistance/behavioral health staff to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)
12. Would recommend homemaker to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)
13. Would recommend case manager to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)

Unmet Needs Measures

14. Unmet need in dressing/bathing due to lack of help—Top-box score on a Yes or No scale
15. Unmet need in meal preparation/eating due to lack of help—Top-box score on a Yes or No scale
16. Unmet need in medication administration due to lack of help—Top-box score on a Yes or No scale
17. Unmet need in toileting due to lack of help—Top-box score on a Yes or No scale
18. Unmet need with household tasks due to lack of help—Top-box score on a Yes or No scale

Physical Safety Measure

19. Hit or hurt by staff—Top-box score on a Yes or No scale

#2624 Functional Outcome Assessment

Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

This quality measure reports the percentage of all Long-Term Care Hospital (LTCH) patients with an admission and discharge functional assessment and a care plan that addresses function.

Type

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Process

#2967 CAHPS® Home and Community-Based Services Measures

Outcome: PRO-PM

#2624 Functional Outcome Assessment

Process

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Process

Data Source

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Electronic Health Records, Instrument-Based Data, Paper Medical Records

1. FASI set. CMS developed the FASI as part of the Testing Experience and Functional Assessment Tools (TEFT) demonstration to assess the status of individuals receiving HCBS. HCBS program staff or assessors at agencies under contract to state HCBS programs use the FASI set to assess HCBS recipients' functional ability and need for assistance. A FASI assessment commonly is performed during an in-person visit, and it can be performed in any community-based setting where HCBS recipients reside. The assessor can use various sources of information to complete a FASI assessment including an interview with the person, an interview with a helper, written records, and naturally occurring observation of performance. Fields for the FASI set are available within CMS's Data Element Library (DEL) and are attached in Section S.2b.
2. PCSP documentation. A PCSP typically is developed by the case manager following a state-established process that considers unmet needs and informal support systems and then fills in gaps with Medicaid or other services. A PCSP is put in place after the assessment is conducted. It can be created in all community-based settings, depending on the recipient's need. The format of a PCSP can vary across and within programs.
3. Data abstraction. Each program will apply methods of their choice for abstracting FASI data. These methods are likely to be similar to those used by the state to generate existing quality measures that are derived from the same data sources. One method could be to make use of a data abstraction form. The Appendix contains a sample form that is based on the form used during measure testing. This form could be adapted by programs implementing the measure.

   Available at measure-specific web page URL identified in S.1 Attachment

#2967 CAHPS® Home and Community-Based Services Measures

Instrument-Based Data CAHPS Home- and Community-Based Services Survey

In-person and phone

English and Spanish

Available in attached appendix at A.1 No data dictionary

#2624 Functional Outcome Assessment

Claims, Paper Medical Records, Registry Data The source is the medical record, which provides patient information for the encounter. Medicare Part B claims data is provided for test purposes.

No data collection instrument provided Attachment

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Other The Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set Version 3.00 (LTCH CARE Data Set v3.00)

No data collection instrument provided No data dictionary

Level

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Other

#2967 CAHPS® Home and Community-Based Services Measures

Other

#2624 Functional Outcome Assessment

Clinician : Group/Practice, Clinician : Individual

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Facility

Setting

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Home Care, Other Medicaid HCBS Program

#2967 CAHPS® Home and Community-Based Services Measures

Other Home and Community-Based Services Program

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#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Post-Acute Care

Numerator Statement

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment within the previous 12 months and with documentation that the subsequent PCSP addresses the FASI-identified functional needs in self-care, mobility, and IADLs.

#2967 CAHPS® Home and Community-Based Services Measures

The CAHPS Home- and Community-Based Services 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
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

8. Global rating of personal assistance and behavioral health staff—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale
9. Global rating of homemaker—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale
10. Global rating of case manager—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale

Recommendation Measures

11. Would recommend personal assistance/behavioral health staff to family and friends—Average 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)
12. Would recommend homemaker to family and friends—Average 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)
13. Would recommend case manager to family and friends—Average 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

14. Unmet need in dressing/bathing due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)
15. Unmet need in meal preparation/eating due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)

16. Unmet need in medication administration due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)
17. Unmet need in toileting due to lack of help—Average proportion of respondents that gave the most positive response of Yes on a 1–2 scale (Yes or No)
18. Unmet need with household tasks due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)

    Physical Safety Measure

19. Hit or hurt by staff—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)

#2624 Functional Outcome Assessment

Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

The numerator for this quality measure is the number of Long-Term Care Hospital (LTCH) patients with complete functional assessment data and at least one self-care or mobility goal.

For patients with a complete stay, all three of the following are required for the patient to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment; and (3) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the discharge assessment.

For patients who have an incomplete stay, discharge data are not required. It can be challenging to gather accurate discharge functional assessment data for patients who experience incomplete stays. The following are required for the patients who have an incomplete stay to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; and (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment.

Patients who have incomplete stays are defined as those patients (1) with incomplete stays due to a medical emergency, including LTCH length of stay less than 3 days, (2) who leave the LTCH against medical advice, or (3) who die while in the LTCH. Discharge functional status data are not required for these patients because these data may be difficult to collect at the time of the medical emergency, if the patient dies or if the patient leaves against medical advice.

Numerator Details

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The numerator is a portion (i.e., a potential subset) of HCBS recipients in the denominator. This portion is the result of a review of PCSP documentation in conjunction with the FASI to determine whether the PCSP addresses each functional need. For the PCSP to be counted as addressing the identified functional needs in self-care, mobility, or IADLs, a service (paid or unpaid) or a plan in

progress must be associated with each need. Documentation of a PCSP is identified through a HCBS recipient's case record.

The frequency of data aggregation will be at the discretion of state users because CMS has determined that states will use the standardized items (i.e., FASI) from which the measure is derived on a voluntary basis. It is anticipated that states would calculate the measure at least annually per HCBS program. Some states may choose to calculate the measure more frequently than annually (e.g., every 3 or 6 months).

#2967 CAHPS® Home and Community-Based Services Measures

To calculate the program-level scores:

Score each item using the top box method; calculate a mode adjusted score for each respondent; calculate case mix adjusted scores for each program; and calculate means for the scale measures.

Scale Measures:

For each survey item, the top-box numerator is the number of respondents who selected the most positive response category.

Staff are reliable and helpful—Survey items 13, 14, 15, 19, 37, and 38

13: In the last 3 months, how often did {personal assistance/behavioral health staff} come to work on time?

14: In the last 3 months, how often did {personal assistance/behavioral health staff} work as long as they were supposed to?

15: In the last 3 months, when staff could not come to work on a day that they were scheduled, did someone let you know that {personal assistance/behavioral health staff} could not come that day?

19: In the last 3 months, how often did {personal assistance/behavioral health staff} make sure you had enough personal privacy when you dressed, took a shower, or bathed?

37: In the last 3 months, how often did {homemakers} come to work on time?

38: In the last 3 months, how often did {homemakers} work as long as they were supposed to?

Staff listen and communicate well—Survey items 28, 29, 30, 31, 32, 33, 41, 42, 43, 44, and 45

28: In the last 3 months, how often did {personal assistance/behavioral health staff} treat you with courtesy and respect?

29: In the last 3 months, how often were the explanations {personal assistance/behavioral health staff} gave you hard to understand because of an accent or the way {personal assistance/behavioral health staff} spoke English?

30: In the last 3 months, how often did {personal assistance/behavioral health staff} treat you the way you wanted them to?

31: In the last 3 months, how often did {personal assistance/behavioral health staff} explain things in a way that was easy to understand?

32: In the last 3 months, how often did {personal assistance/behavioral health staff} listen carefully to you?

33: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what kind of help you needed with everyday activities, like getting ready in the morning, getting groceries, or going places in your community?

41: In the last 3 months, how often did {homemakers} treat you with courtesy and respect?

42: In the last 3 months, how often were the explanations {homemakers} gave you hard to understand because of an accent or the way the {homemakers} spoke English?

43: In the last 3 months, how often did {homemakers} treat you the way you wanted them to?

44: In the last 3 months, how often did {homemakers} listen carefully to you?

45: In the last 3 months, did you feel {homemakers} knew what kind of help you needed?

Case manager is helpful—Survey items 49, 51, and 53

49: In the last 3 months, could you contact this {case manager} when you needed to?

51: In the last 3 months, did this {case manager} work with you when you asked for help with getting or fixing equipment?

53: In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?

Choosing the services that matter to you—Survey items 56 and 57

56: In the last 3 months, did your [program-specific term for "service plan"] include . . .

57: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what's on your [program-specific term for "service plan"], including the things that are important to you?

Transportation to medical appointments—Survey items 59, 61, and 62

59: Medical appointments include seeing a doctor, a dentist, a therapist, or someone else who takes care of your health. In the last 3 months, how often did you have a way to get to your medical appointments?

61: In the last 3 months, were you able to get in and out of this ride easily?

62: In the last 3 months, how often did this ride arrive on time to pick you up?

Personal safety and respect—Survey items 64, 65, and 68

64: In the last 3 months, was there a person you could talk to if someone hurt you or did something to you that you didn't like?

65: In the last 3 months, did any {personal assistance/behavioral health staff, homemakers, or your case managers} take your money or your things without asking you first?

68: In the last 3 months, did any {staff} yell, swear, or curse at you?"

Planning your time and activities—Survey items 75, 77, 78, 79, 80, and 81

75: In the last 3 months, when you wanted to, how often could you get together with these family members who live nearby?"

77: In the last 3 months, when you wanted to, how often could you get together with these friends who live nearby? "

78: In the last 3 months, when you wanted to, how often could you do things in the community that you like?

79: In the last 3 months, did you need more help than you get from {personal assistance/behavioral health staff} to do things in your community?

80: In the last 3 months, did you take part in deciding what you do with your time each day?

81: In the last 3 months, did you take part in deciding when you do things each day—for example, deciding when you get up, eat, or go to bed?

Global Ratings Measures:

The numerator for each global measure includes the number of respondents who answered 9 or 10 for the item (on a scale of 0 to 10).

Global rating of personal assistance and behavioral health staff—Survey item 35

35: Using any number from 0 to 10, where 0 is the worst help from {personal assistance/behavioral health staff} possible and 10 is the best help from {personal assistance/behavioral health staff} possible, what number would you use to rate the help you get from {personal assistance/behavioral health staff}?

Global rating of homemaker—Survey item 46

46: Using any number from 0 to 10, where 0 is the worst help from {homemakers} possible and 10 is the best help from {homemakers} possible, what number would you use to rate the help you get from {homemakers}?

Global rating of case manager—Survey item 54

54: Using any number from 0 to 10, where 0 is the worst help from {case manager} possible and 10 is the best help from {case manager} possible, what number would you use to rate the help you get from {case manager}?

Recommendation Measures:

The numerator for each recommendation measure includes the number of respondents who answered Definitely Yes for the item (on a scale of Definitely No, Probably No, Probably Yes, or Definitely Yes). Item numbers and item text are listed below.

Would recommend personal assistance/behavioral health staff to family and friends—Survey item 36

36: Would you recommend the {personal assistance/behavioral health staff} who help you to your family and friends if they needed help with everyday activities? Would you say you recommend the {personal assistance/behavioral health staff}?

Would recommend homemaker to family and friends—Survey item 47

47: Would you recommend the {homemakers} who help you to your family and friends if they needed {program-specific term for homemaker services}? Would you say you recommend the {homemakers}?

Would recommend case manager to family and friends—Survey item 55

55: Would you recommend the {case manager} who helps you to your family and friends if they needed {program-specific term for case-management services}? Would you say you recommend the {case manager}?

Unmet Needs Measures:

The numerator for each unmet needs measure includes the number of respondents who answered No for that item (these items are then reverse coded so that higher scores reflect a better experience). Item numbers and item text are listed below.

Unmet need in dressing/bathing due to lack of help—Survey item 18

18: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in meal preparation/eating due to lack of help—Survey item 22

22: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in medication administration due to lack of help—Survey item 25

25: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in toileting due to lack of help—Survey item 27

27: In the last 3 months, did you get all the help you needed with toileting from {personal assistance/behavioral health staff} when you needed it? (not reverse coded).

Unmet need with household tasks due to lack of help—Survey item 40

40: In the last 3 months, was this because there were no {homemakers} to help you?

Physical Safety Measure:

The numerator for the following physical safety measure includes the number of respondents who answered No for this item (this item is then reverse coded so that higher scores reflect a better experience). The item number and item text is listed below.

Hit or hurt by staff—Survey item 71

71: In the last 3 months, did any {staff} hit you or hurt you?

#2624 Functional Outcome Assessment

Numerator Instructions: Documentation of a current functional outcome assessment must include identification of the standardized tool used.

Definitions:

Standardized Tool – A tool that has been normed and validated. Examples of tools for functional outcome assessment include, but are not limited to: Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), Patient-Reported Outcomes Measurement Information System (PROMIS), Disabilities of the Arm, Shoulder and Hand (DASH), and Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL).

Note: A functional outcome assessment is multi-dimensional and quantifies pain and musculoskeletal/neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does not meet the criteria of a functional outcome assessment standardized tool.

Functional Outcome Assessment – Patient completed questionnaires designed to measure a patient's physical limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.

Current (Functional Outcome Assessment) – A patient having a documented functional outcome assessment utilizing a standardized tool and a care plan if indicated within the previous 30 days.

Functional Outcome Deficiencies – Impairment or loss of physical function related to musculoskeletal/neuromusculoskeletal capacity, may include but are not limited to: restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.

Care Plan – A care plan is an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. These may include observations, goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused on one or more of the patient’s health care problems. Care plans may also be known as a treatment plan.

Not Eligible (Denominator Exception) – A patient is not eligible if one or more of the following reason(s) is documented at the time of the encounter:

Patient refuses to participate

Patient unable to complete questionnaire

Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status

NUMERATOR NOTE: The intent of this measure is for a functional outcome assessment tool to be utilized at a minimum of every 30 days but submission is required at each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the numerator quality-data code G8942 should be used for submission purposes.

Numerator Quality-Data Coding Options:

Functional Outcome Assessment Documented as Positive AND Care Plan Documented

Performance Met: G8539: Functional outcome assessment documented as positive using a standardized tool AND a care plan based, on identified deficiencies on the date of the functional outcome assessment, is documented

OR

Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan not Required Performance Met: G8542: Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required

OR

Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated, Within the Previous 30 Days Performance Met: G8942: Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented

OR

Functional Outcome Assessment not Documented, Patient not Eligible

Denominator Exception: G8540: Functional outcome assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter

OR

Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible

Denominator Exception: G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter

OR

Functional Outcome Assessment not Documented, Reason not Given Performance Not Met: G8541: Functional outcome assessment using a standardized tool not documented, reason not given

OR

Functional Outcome Assessment Documented as Positive, Care Plan not Documented, Reason not Given Performance Not Met: G8543: Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented, reason not given

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

For patients with a complete stay, each functional assessment item listed below must have a valid score or code at admission and discharge and at least one of the self-care or mobility items must have a valid numeric code as a discharge goal. Providers use the 6-point rating scale when coding discharge goals.

For patients with an incomplete stay, each functional assessment item listed below must have a valid score or code at admission and at least one of the self-care or mobility items must have a valid numeric code as a discharge goal. No discharge data are required for patients with incomplete stays.

The self-care functional assessment items are:

GG0130A. Eating

GG0130B. Oral hygiene

GG0130C. Toileting hygiene

GG0130D. Wash upper body

Valid scores/codes for the self-care functional assessment items are:

06 - Independent

05 - Setup or clean-up assistance

04 - Supervision or touching assistance

03 - Partial/moderate assistance

02 - Substantial/maximal assistance

01 - Dependent

07 - Patient refused

09 - Not applicable

88 - Not attempted due to medical condition or safety concerns

The mobility functional assessment items are:

GG0170A. Roll left and right

GG0170B. Sit to lying

GG0170C. Lying to sitting on side of bed

GG0170D. Sit to stand

GG0170E. Chair/bed-to-chair transfer

GG0170F. Toilet transfer

For patients who are walking:

GG0170I. Walk 10 feet

GG0170J. Walk 50 feet with two turns

GG0170K. Walk 150 feet

For patients who use a wheelchair, complete the following items:

GG0170R. Wheel 50 feet with two turns

GG0170RR1. Indicate the type of wheelchair/scooter used

GG0170S. Wheel 150 feet

GG0170SS1. Indicate the type of wheelchair/scooter used

Valid scores/codes for the mobility functional assessment items are:

06 - Independent

05 - Setup or clean-up assistance

04 - Supervision or touching assistance

03 - Partial/moderate assistance

02 - Substantial/maximal assistance
01 - Dependent
07 - Patient refused
09 - Not applicable
88 - Not attempted due to medical condition or safety concerns
Valid scores/codes for the self-care and mobility discharge goal items are:
06 - Independent
05 - Setup or clean-up assistance
04 - Supervision or touching assistance
03 - Partial/moderate assistance
02 - Substantial/maximal assistance
01 – Dependent
Cognitive Function
C1610A-E2. Signs and Symptoms of Delirium (CAM © [Confusion Assessment Method]):
C1610A. and C1610B. Acute Onset and Fluctuating Course
C1610C. Inattention
C1610D. Disorganized Thinking
C1610E1 and C160E2. Altered Level of Consciousness
Valid codes for C1610-Signs and Symptoms of Delirium are:
1 - Yes
0 - No
Communication: Understanding and Expression
BB0700. Expression of Ideas and Wants
Valid codes are:
4 - Expresses without difficulty
3 - Expresses with some difficulty
2 - Frequently exhibits difficulty with expressing needs and ideas
1 - Rarely/Never expresses self or speech is very difficult to understand
BB0800. Understanding Verbal Content:
Valid codes are:
4 - Understands
3 - Usually understands
2 - Sometimes understands
1 - Rarely/Never understands

Bladder Continence
H0350. Bladder Continence
Valid codes are:
0 - Always continent

1 - Stress incontinence only

2 - Incontinent less than daily

3 - Incontinent daily

4 - Always incontinent

5 - No urine output

9 - Not applicable

For patients with incomplete stays, admission data and at least one goal are required for the patient to be counted in the numerator. No discharge data are required. Patients with incomplete stays are identified based on the following data elements:

1) Patients with incomplete stays due to a medical emergency. These patients are excluded if:

- **a)** Item A0250. Reason for Assessment is coded 11 = Unplanned discharge OR
- **b)** The length of stay is less than 3 days based on item A0220. Admission Date and A0270: Discharge Date OR
- **c)** Item A2110. Discharge Location is coded 04 = Hospital emergency department OR 05 = Short-stay acute care hospital OR 06 = Long-term care hospital OR 08 = Psychiatric hospital or unit.

2) Patients who leave the LTCH against medical advice. These patients are identified based on the reason for the assessment:

- **a)** Item A0250. Reason for Assessment is coded as 11 = Unplanned discharge OR
- **b)** Item A2110. Discharge Location is coded 12 = Discharged Against Medical Advice.

3) No discharge functional status data are required if a patient dies while in the LTCH.

These patients are identified based on the reason for the assessment:

- **a)** Item A0250. Reason for Assessment is coded 12 = Expired.

Denominator Statement

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment within the previous 12 months.

#2967 CAHPS® Home and Community-Based Services Measures

The denominator for all measures is the number of survey respondents. Individuals eligible for the CAHPS Home- and Community-Based Services survey include Medicaid beneficiaries who are at least 18 years of age in the sample period, and have received HCBS services for three months or longer and their proxies. 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?

Individuals who are unable to answer these cognitive screening items are excluded. Some measures also have topic-specific screening items as well. Additional detail is provided in S.9.

Individuals who are more likely to be good proxy respondents during the CAHPS Home- and Community-Based Services survey data collection are: (a) those who are willing to respond on

behalf of the beneficiary; (b) unpaid caregivers, family members, friends, and neighbors; and (c) those who know the beneficiary well enough that he or she is familiar with the services and supports they are receiving, having regular, ongoing contact with them. Examples of circumstances that increase the likelihood that someone has knowledge about the beneficiary and their care situation include living with the beneficiary, managing the beneficiary's in-home care for a majority of the day, having regular conversations with the beneficiary about the services they receive, in-person visits with the beneficiary, and being present when services/supports are delivered. Individuals who are less likely to be good proxy respondents are: (a) those with paid responsibilities for providing services/supports to the beneficiary, including family members and friends who are paid to help the beneficiary ; and (b) guardians or conservators whose only responsibility is to oversee the beneficiary's finances. Due to the nature of data being collected through CAHPS, individuals who formally or informally deliver HCBS services are discouraged from acting as a proxy.

#2624 Functional Outcome Assessment

All visits for patients aged 18 years and older

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

The denominator is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period.

Denominator Details

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The proposed measure focuses on the assessment of functional needs that are common among adult HCBS recipients and derived from use of FASI. These are functional needs in the areas of self-care, mobility, and IADLs. The denominator is determined by items in Section B of the FASI form, Functional Abilities and Goals.

Self-care needs are identified in the following items on the FASI form: 6a (eating), 6b (oral hygiene), 6c (toileting hygiene), 6d (wash upper body), 6e (shower/bathe self), 6f (upper body dressing), 6g (lower body dressing), and 6h (putting on/taking off footwear).

Bed mobility and transfer needs are identified in the following items on the FASI form: 7a (roll left and right), 7b (sit to lying), 7c (lying to sitting on side of bed), 7d (sit to stand), 7e (chair/bed-to-chair transfer), 7f (toilet transfer), and 7g (car transfer).

If the response to item 8 on the FASI form indicates that the person walks, ambulation needs are identified in the following items on the FASI form: 8a (walks 10 feet), 8b (walks 50 feet with two turns), 8c (walks 150 feet), 8d (walks 10 feet on uneven surfaces), 8e (1 step (curb)), 8f (4 steps), 8g (12 steps), 8h (walks indoors), 8i (carries something in both hands), 8j (picking up object), 8k (walks for 15 minutes), and 8l (walks across a street).

If the response to item 9 on the FASI form indicates that the person uses a manual wheelchair, wheelchair mobility needs are identified in the following items on the FASI form: 9a (wheels 50 feet with two turns), 9b (wheels 150 feet), 9c (wheels for 15 minutes) and 9d (wheels across a street).

If the response to item 10 on the FASI form indicates that the person uses a motorized wheelchair/scooter, wheelchair/scooter mobility needs are identified in the following items on the

FASI form: 10a (wheels 50 feet with two turns), 10b (wheels 150 feet), 10c (wheels for 15 minutes) and 10d (wheels across a street).

IADLs are identified in the following items on the FASI form: 11a (makes a light cold meal), 11b (makes a light hot meal), 11c (light daily housework), 11d (heavier periodic housework), 11e (light shopping), 11f (telephone-answering call), 11g (telephone-placing call), 11h (medication management-oral medications), 11i (medication management-inhalant/mist medications), 11j (medication management-injectable medications), 11k (simple financial management), and 11l (complex financial management.

#2967 CAHPS® Home and Community-Based Services Measures

While there are myriad home and community-based services and supports (HCBS) that Medicaid programs provide (at their discretion) to beneficiaries with long-term care needs, the proposed provider-related measures in this submission focus on the most common provider types for adults receiving Medicaid HCBS. These include personal assistance providers, behavioral health staff, homemakers, and case managers.

While Medicare-certified home health agencies may provide similar services to Medicare beneficiaries, the Medicare benefit is a post-acute care benefit and typically limited to episodes following hospitalization. Medicaid home and community-based services are a long-term care benefit and support persons with long-term care needs over lengthier durations. Personal assistance services, help in the home by behavioral health staff, and homemaker services typically involve assistance with activities of daily living (bathing, dressing, grooming, toileting, eating; mobility) and instrumental activities of daily living (meal preparation, housework, laundry, food shopping). Case management is an integral component of Medicaid HCBS programs; the role of the case manager includes working with the beneficiary to assesses his/her need for services/supports and to develop a person-centered care/service plan, monitoring service delivery, and responding to the individual's changing needs and circumstances.

Not all HCBS beneficiaries receive all services. Questions 4, 6, 8, and 11 assess which services the beneficiary receives. Beneficiaries are then eligible for different survey questions based on these responses.

These questions are:

4: In the last 3 months, did you get {program specific term for personal assistance} at home?

6: In the last 3 months, did you get {program specific term for behavioral health specialist services} at home?

8: In the last 3 months, did you get {program specific term for homemaker services} at home?

11: In the last 3 months, did you get help from {program specific term for case manager services} to help make sure that you had all the services you needed?

Scale Measure 1: Staff are reliable and helpful

13: The number of surveys completed by all those who responded Yes to screener 4 or 6

14: The number of surveys completed by all those who responded Yes to screener 4 or 6

15: The number of surveys completed by all those who responded Yes to screener 4 or 6

19: The number of surveys completed by all those who responded Yes to screener 4 or 6

37: The number of surveys completed by all those who responded Yes to screener 8

38: The number of surveys completed by all those who responded Yes to screener 8

Scale Measure 2: Staff listen and communicate well

28: The number of surveys completed by all those who responded Yes to screener 4 or 6
29: The number of surveys completed by all those who responded Yes to screener 4 or 6
30: The number of surveys completed by all those who responded Yes to screener 4 or 6
31: The number of surveys completed by all those who responded Yes to screener 4 or 6
32: The number of surveys completed by all those who responded Yes to screener 4 or 6
33: The number of surveys completed by all those who responded Yes to screener 4 or 6
41: The number of surveys completed by all those who responded Yes to screener 8
42: The number of surveys completed by all those who responded Yes to screener 8
43: The number of surveys completed by all those who responded Yes to screener 8
44: The number of surveys completed by all those who responded Yes to screener 8
45: The number of surveys completed by all those who responded Yes to screener 8
Scale Measure 3: Case manager is helpful
49: The number of surveys completed by all those who responded Yes to screener 11
51: The number of surveys completed by all those who responded Yes to screener 11
53: The number of surveys completed by all those who responded Yes to screener 11
Scale Measure 4: Choosing the services that matter to you
56: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
57: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Scale Measure 5: Transportation to medical appointments
59: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
61: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
62: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Scale Measure 6: Personal safety and respect
64: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
65: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
68: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Scale Measure 7: Planning your time and activities
75: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
77: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
78: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
79: The number of surveys completed by all those who responded Yes to screener 4 or 6
80: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
81: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Global Rating Measures:
Global rating of personal assistance and behavioral health staff
35: The number of surveys completed by all those who responded Yes to screener 4 or 6
Global rating of homemaker
46: The number of surveys completed by all those who responded Yes to screener 8
Global rating of case manager

54: The number of surveys completed by all those who responded Yes to screener 11

Recommendation Measures:

Recommendation of personal assistance and behavioral health staff to family/friends

36: The number of surveys completed by all those who responded Yes to screener 4 or 6

Recommendation of homemaker to family/friends

47: The number of surveys completed by all those who responded Yes to screener 8

Recommendation of case manager to family/friends

55: The number of surveys completed by all those who responded Yes to screener 11

Unmet Needs Measures:

Unmet need in dressing/bathing due to lack of help

18: The number of surveys completed by all those who responded Yes to 16 and No to 17

Unmet need in meal preparation/eating due to lack of help

22: The number of surveys completed by all those who responded Yes to 20 and No to 21

Unmet need in medication administration due to lack of help

25: The number of surveys completed by all those who responded Yes to 23 and No to 24

Unmet need in toileting due to lack of help

27: The number of surveys completed by all those who responded Yes to 26

Unmet need with household tasks due to lack of help

40: The number of surveys completed by all those who responded No to 39

Personal Safety Measures:

Hit or hurt by staff

71: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11

#2624 Functional Outcome Assessment

The following information is provided in the specification in order to identify and calculate the numerator criteria:

Denominator Criteria (Eligible Cases):

Patients aged = 18 years on date of encounter

AND

Patient encounter during the performance period (CPT): 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

The denominator includes all LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period, including patients of all ages and patients with all payer sources. Patients are selected based on submitted LTCH CARE Data Set Admission and Discharge forms.

Exclusions

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Exclusions inherent in the denominator definition include individuals younger than 18 years, individuals who have not had a FASI assessment within the previous 12 months, and individuals who have had a FASI assessment, but no functional needs were identified in the areas of self-care, mobility, or IADLs. In addition, individuals without 3 months of continuous HCBS enrollment are excluded.

#2967 CAHPS® Home and Community-Based Services Measures

Individuals less than 18 years of age and individuals that have not received HCBS services for at least 3 months should be excluded. During survey administration, additional exclusions include individuals that failed any of the cognitive screening items mentioned in the denominator statement below.

#2624 Functional Outcome Assessment

A patient is not eligible or can be considered a denominator exception and excluded from the measure if one or more of the following reason(s) is documented at the time of the encounter:

Patient refuses to participate

Patient unable to complete questionnaire

Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

There are no denominator exclusions for this measure.

Exclusion Details

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

See S.7, Denominator Details, for information required to identify functional needs.

#2967 CAHPS® Home and Community-Based Services Measures

Individuals who are unable to answer one or more of the following cognitive screening items should be excluded. If the respondent is not able to answer (e.g., provides an invalid/nonsensical response, does not respond, or indicates "I don't know"), the interviewer should end the interview.

1. Does someone come into your home to help you? (Yes or No)
2. How do they help you? Open-Ended Response

   Examples of correct responses include:

   "Helps me get ready every day"

   "Cleans my home"

   "Works with me at my job"

   "Helps me to do things"

   "Drives me around"

3. What do you call them? Open-Ended Response

   Examples of sufficient responses include:

   "My worker"

   "My assistant"

   Names of staff ("Jo", "Dawn", etc.)

#2624 Functional Outcome Assessment

The information required to identify and calculate the measure exceptions follows:

Functional Outcome Assessment not Documented, Patient not Eligible G8540: Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter

OR

Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

There are no denominator exclusions for this measure.

Risk Adjustment

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

No risk adjustment or risk stratification

113612

113612

#2967 CAHPS® Home and Community-Based Services Measures

Statistical risk model

142229| 113612

142229| 113612

#2624 Functional Outcome Assessment

No risk adjustment or risk stratification

141015| 147517

141015| 147517

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

No risk adjustment or risk stratification

138203| 141592

138203| 141592

Stratification

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The primary unit of analysis is the Medicaid HCBS program type. Programs can provide a combination of standard medical services and nonmedical services. Standard services include but are not limited to case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States also can propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. (Source: Home & Community-Based Services 1915(c))

These programs are designed to provide an array of services to a certain target population; as a result, each state typically operates more than one HCBS program. Five HCBS program types were used to test this measure. Their labels reflect the predominant population eligible for services under each HCBS program. However, the group of individuals served within a single HCBS program may be heterogeneous by design (e.g., the intentional combination of individuals with mental health or substance use disorders) or because of the presence of comorbidities. These are the program types:

1. HCBS programs serving individuals who are older adults
2. HCBS programs serving individuals with a physical disability
3. HCBS programs serving individuals with an intellectual or developmental disability
4. HCBS programs serving individuals with an acquired brain injury
5. HCBS programs serving individuals with mental health or substance use disorders.

Medicaid agencies in the states have administrative authority over these HCBS programs and determine which services and supports to offer beneficiaries who are deemed eligible for a given HCBS program. Although Medicaid HCBS programs are administered by state Medicaid agencies under various Medicaid legal authorities, they frequently are operated by other entities including non-Medicaid state agencies (e.g., department of aging), non-state governmental entities (e.g., county), or managed care organizations. The operating entities then contract with direct service and support providers.

#2967 CAHPS® Home and Community-Based Services Measures

The intended primary unit of analysis is the Medicaid HCBS program. However, states may wish to stratify by sub-state agencies such as counties or regional entities with program operational and budgetary authority. In some instances, a state may wish to stratify by case-management agency as well, given they are typically viewed as having substantial responsibility for developing beneficiary service and support plans as well as monitoring whether the service/support plan addresses the person's needs and meet their goals.

States are increasingly moving users of Medicaid long-term services and supports, including HCBS, into managed care arrangements (typically referred to as Managed Long-Term Services and Supports or MLTSS) where the managed care organization (MCO) is the primary accountable entity for ensuring HCBS beneficiary, health, welfare and quality of life. As such, we also anticipate some states may want to stratify based on (MCO).

#2624 Functional Outcome Assessment

No stratification.

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

This measure does not use stratification.

Type Score

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Rate/proportion better quality = higher score

#2967 CAHPS® Home and Community-Based Services Measures

Other (specify): Case-mix adjusted top box score better quality = higher score

#2624 Functional Outcome Assessment

Rate/proportion better quality = higher score

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Rate/proportion better quality = higher score

Algorithm

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The following steps are used to create the score for this measure:

1. Restrict the HCBS sample to individuals aged 18 years or older with continuous enrollment for at least 3 months and those who have had a FASI assessment within the previous 12 months.
2. Count the number of sampled individuals with at least one FASI-documented functional need in self-care, mobility, or IADLs. Documented functional needs are based on receiving either a “05” or below (04, 03, 02, or 01) or “88” on any item in the Self-Care, Mobility, or IADL sections of a FASI form. See S.2b. (data dictionary, code table, or value sets) for value labels and S.7 (denominator details) for the list of specific items on the FASI form that comprise the Self-Care, Mobility, and IADL sections.
3. For each individual with at least one FASI-documented functional need, determine whether the PCSP documentation indicates that there is either a paid service, unpaid help, or a plan in progress for addressing each FASI-identified functional need in self-care, mobility, and IADLs.
4. Count the number of sampled individuals for whom the PCSP addresses all FASI-identified functional needs in self-care, mobility, and IADLs.
5. Calculate the percentage by dividing the resulting number in step 4 by the resulting number in step 2. 113612

#2967 CAHPS® Home and Community-Based Services Measures

Scoring specifications for the measures will follow the same general scoring approach as used by other CAHPS surveys that use the CAHPS analysis program. The measures are based on case-mix adjusted top box scores. The research team suggests general health rating, mental health rating, age, education, gender, whether respondent lives alone, and response option as case- mix adjusters for these measures. We also recommend including survey mode as an additional adjustment variable and proxy status if proxy responses are permitted. More information about

case-mix adjustment is available in Instructions for Analyzing Data from CAHPS Surveys (available from the downloadable zip file).

To create scores for each scale measure:

1. Calculate the score for each item using the top box method.
2. Calculate a mode adjusted score for each item.
3. Calculate case-mix adjusted scores for each program.
4. Calculate means for the scale measures weighting each item equally.

The steps for user-defined calculations of risk-adjusted scores can be found in Instructions for Analyzing Data from CAHPS Surveys: Using the CAHPS Analysis Program Version 4.1 available from the downloadable zip file.

To create scores for each global rating and individual item measure, follow steps 1-3 above.
142229| 113612

#2624 Functional Outcome Assessment

To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD) and Denominator Exceptions (B).

Numerator (A): Number of patients meeting numerator criteria

Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion

Denominator Exceptions (B): Number of patients with valid exceptions

1) Identify the patients who meet the eligibility criteria for the denominator (PD), which includes patients who are 18 years and older with appropriate encounters as defined by encounter codes during the performance period.
2) Identify which of those patients meet the numerator criteria (A), which includes patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies.
3) For those patients who do not meet the numerator criteria, determine whether an appropriate exception applies (B) and subtract those patients from the denominator with the following calculation: Numerator (A)/ [Performance Denominator (PD) - Denominator Exceptions (B)].
141015| 147517

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

1) For each LTCH, the stay records of patients discharged during the 12 month target time period are identified and counted. This count is the denominator.
2) The records of patients with complete stays are identified and the number of these patient stays with complete admission functional assessment data AND at least one self-care or mobility discharge goal AND complete discharge functional assessment data is counted.
3) The records of patients with incomplete stays are identified, and the number of these patient records with complete admission functional status data AND at least one self-care or mobility discharge goal is counted.
4) The counts from step 2 (complete LTCH stays) and step 3 (incomplete LTCH stays) are summed. The sum is the numerator count.
5) The numerator count is divided by the denominator count to calculate this quality measure.

For the numerator, complete data are defined as:

1. a valid numeric score indicating the patient's status, or a valid code indicating the activity did not occur or could not be assessed, for each of the functional assessment items on the admission assessment; and
2. a valid numeric score for one or more of the self-care or mobility items that is a discharge goal;
3. a valid numeric score indicating the patient's status, or a valid code indicating the activity did not occur or could not be assessed, for each of the functional assessment items on the discharge assessment. (Note: Discharge data are not required for patients with incomplete LTCH stays.)

Denominator: The denominator for this quality measure is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period. 138203| 141592

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

5.1 Identified measures: 2624 : Functional Outcome Assessment

2631 : Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

2967 : CAHPS® Home- and Community-Based Services Measures

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: No further harmonization is possible. Both the proposed measure and NQF#2624 rely on a standardized functional assessment to specify the numerator, although the target populations differ. The proposed measure relies on the FASI assessment, which has been tested and validated specifically in HCBS populations, and NQF #2624 specifies use of any standardized assessment tool that has been normalized and validated (e.g., Oswestry Disability Index, Patient-Reported Outcomes Measurement Information System, Knee Outcome Survey Activities of Daily Living Scale). FASI meets the NQF #2624 specification requirement for a standardized assessment tool that has been normalized and validated. Like the proposed measure, NQF#2631 requires both a complete functional assessment (using the Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set Version 3.00) and a minimum level of alignment between the assessed needs/goals and the care services. NQF#2967 focuses specifically on individuals continuously enrolled in HCBS for 3 months or longer who pass a cognitive screen and their proxies. The proposed measure, while necessarily focusing on a subset of HCBS recipients who have documented functional needs as measured by the FASI, also excludes individuals who do not have 3 months of continuous HCBS enrollment.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures.

#2967 CAHPS® Home and Community-Based Services Measures

#2624 Functional Outcome Assessment

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

#2967 CAHPS® Home and Community-Based Services Measures

#2967 CAHPS® Home and Community-Based Services Measures

#2624 Functional Outcome Assessment

#2624 Functional Outcome Assessment

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Steward

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Centers for Medicare & Medicaid Services

#2967 CAHPS® Home and Community-Based Services Measures

Centers for Medicare & Medicaid Services

#2624 Functional Outcome Assessment

Centers for Medicare & Medicaid Services

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Centers for Medicare & Medicaid Services

Description

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The percentage of home and community-based services (HCBS) recipients aged 18 years or older whose PCSP documentation addresses needs in the areas of self-care, mobility, and instrumental activities of daily living (IADL) as determined by the most recent FASI assessment.

For the purposes of this measure application, the term “home and community-based services” also will refer to community-based long-term services and supports (CB-LTSS). The definition of HCBS in the September 2016 National Quality Forum (NQF) report titled Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement is consistent with the way the Centers for Medicare & Medicaid Services (CMS) uses CB-LTSS.

#2967 CAHPS® Home and Community-Based Services Measures

The 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 that are delivered to them under the auspices of a state Medicaid HCBS program. The unit of analysis for NQF 2967 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.

The measures consist of 7 scale measures, 6 global rating and recommendation measures, and 6 individual measures:

Scale Measures

1. Staff are reliable and helpful—Top-box score composed of 6 survey items
2. Staff listen and communicate well—Top-box score composed of 11 survey items
3. Case manager is helpful—Top-box score composed of 3 survey items
4. Choosing the services that matter to you—Top-box score composed of 2 survey items
5. Transportation to medical appointments—Top-box score composed of 3 survey items
6. Personal safety and respect—Top-box score composed of 3 survey items
7. Planning your time and activities—Top-box score composed of 6 survey items

Global Ratings Measures

8. Global rating of personal assistance and behavioral health staff—Top-box score on a 0–10 scale
9. Global rating of homemaker—Top-box score on a 0–10 scale
10. Global rating of case manager—Top-box score on a 0–10 scale

Recommendations Measures

11. Would recommend personal assistance/behavioral health staff to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)
12. Would recommend homemaker to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)
13. Would recommend case manager to family and friends—Top-box score on a 1–4 scale (Definitely No, Probably No, Probably Yes, or Definitely Yes)

Unmet Needs Measures

14. Unmet need in dressing/bathing due to lack of help—Top-box score on a Yes or No scale
15. Unmet need in meal preparation/eating due to lack of help—Top-box score on a Yes or No scale
16. Unmet need in medication administration due to lack of help—Top-box score on a Yes or No scale
17. Unmet need in toileting due to lack of help—Top-box score on a Yes or No scale
18. Unmet need with household tasks due to lack of help—Top-box score on a Yes or No scale

Physical Safety Measure

19. Hit or hurt by staff—Top-box score on a Yes or No scale

#2624 Functional Outcome Assessment

Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

This quality measure reports the percentage of all Long-Term Care Hospital (LTCH) patients with an admission and discharge functional assessment and a care plan that addresses function.

Type

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Process

#2967 CAHPS® Home and Community-Based Services Measures

Outcome: PRO-PM

#2624 Functional Outcome Assessment

Process

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Process

Data Source

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Electronic Health Records, Instrument-Based Data, Paper Medical Records

1. FASI set. CMS developed the FASI as part of the Testing Experience and Functional Assessment Tools (TEFT) demonstration to assess the status of individuals receiving HCBS. HCBS program staff or assessors at agencies under contract to state HCBS programs use the FASI set to assess HCBS recipients' functional ability and need for assistance. A FASI assessment commonly is performed during an in-person visit, and it can be performed in any community-based setting where HCBS recipients reside. The assessor can use various sources of information to complete a FASI assessment including an interview with the person, an interview with a helper, written records, and naturally occurring observation of performance. Fields for the FASI set are available within CMS's Data Element Library (DEL) and are attached in Section S.2b.
2. PCSP documentation. A PCSP typically is developed by the case manager following a state-established process that considers unmet needs and informal support systems and then fills in gaps with Medicaid or other services. A PCSP is put in place after the assessment is conducted. It can be created in all community-based settings, depending on the recipient's need. The format of a PCSP can vary across and within programs.
3. Data abstraction. Each program will apply methods of their choice for abstracting FASI data. These methods are likely to be similar to those used by the state to generate existing quality measures that are derived from the same data sources. One method could be to make use of a data abstraction form. The Appendix contains a sample form that is based on the form used during measure testing. This form could be adapted by programs implementing the measure.

   Available at measure-specific web page URL identified in S.1 Attachment

#2967 CAHPS® Home and Community-Based Services Measures

Instrument-Based Data CAHPS Home- and Community-Based Services Survey

In-person and phone

English and Spanish

Available in attached appendix at A.1 No data dictionary

#2624 Functional Outcome Assessment

Claims, Paper Medical Records, Registry Data The source is the medical record, which provides patient information for the encounter. Medicare Part B claims data is provided for test purposes.

No data collection instrument provided Attachment

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Other The Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set Version 3.00 (LTCH CARE Data Set v3.00)

No data collection instrument provided No data dictionary

Level

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Other

#2967 CAHPS® Home and Community-Based Services Measures

Other

#2624 Functional Outcome Assessment

Clinician : Group/Practice, Clinician : Individual

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Facility

Setting

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Home Care, Other Medicaid HCBS Program

#2967 CAHPS® Home and Community-Based Services Measures

Other Home and Community-Based Services Program

#2624 Functional Outcome Assessment

Outpatient Services

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Post-Acute Care

Numerator Statement

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment within the previous 12 months and with documentation that the subsequent PCSP addresses the FASI-identified functional needs in self-care, mobility, and IADLs.

#2967 CAHPS® Home and Community-Based Services Measures

The CAHPS Home- and Community-Based Services 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
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

8. Global rating of personal assistance and behavioral health staff—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale
9. Global rating of homemaker—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale
10. Global rating of case manager—Average proportion of respondents that gave the most positive response of 9 or 10 on a 0–10 scale

Recommendation Measures

11. Would recommend personal assistance/behavioral health staff to family and friends—Average 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)
12. Would recommend homemaker to family and friends—Average 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)
13. Would recommend case manager to family and friends—Average 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

14. Unmet need in dressing/bathing due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)
15. Unmet need in meal preparation/eating due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)

16. Unmet need in medication administration due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)
17. Unmet need in toileting due to lack of help—Average proportion of respondents that gave the most positive response of Yes on a 1–2 scale (Yes or No)
18. Unmet need with household tasks due to lack of help—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)

    Physical Safety Measure

19. Hit or hurt by staff—Average proportion of respondents that gave the most positive response of No on a 1–2 scale (Yes or No)

#2624 Functional Outcome Assessment

Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

The numerator for this quality measure is the number of Long-Term Care Hospital (LTCH) patients with complete functional assessment data and at least one self-care or mobility goal.

For patients with a complete stay, all three of the following are required for the patient to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment; and (3) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the discharge assessment.

For patients who have an incomplete stay, discharge data are not required. It can be challenging to gather accurate discharge functional assessment data for patients who experience incomplete stays. The following are required for the patients who have an incomplete stay to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; and (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment.

Patients who have incomplete stays are defined as those patients (1) with incomplete stays due to a medical emergency, including LTCH length of stay less than 3 days, (2) who leave the LTCH against medical advice, or (3) who die while in the LTCH. Discharge functional status data are not required for these patients because these data may be difficult to collect at the time of the medical emergency, if the patient dies or if the patient leaves against medical advice.

Numerator Details

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The numerator is a portion (i.e., a potential subset) of HCBS recipients in the denominator. This portion is the result of a review of PCSP documentation in conjunction with the FASI to determine whether the PCSP addresses each functional need. For the PCSP to be counted as addressing the identified functional needs in self-care, mobility, or IADLs, a service (paid or unpaid) or a plan in

progress must be associated with each need. Documentation of a PCSP is identified through a HCBS recipient's case record.

The frequency of data aggregation will be at the discretion of state users because CMS has determined that states will use the standardized items (i.e., FASI) from which the measure is derived on a voluntary basis. It is anticipated that states would calculate the measure at least annually per HCBS program. Some states may choose to calculate the measure more frequently than annually (e.g., every 3 or 6 months).

#2967 CAHPS® Home and Community-Based Services Measures

To calculate the program-level scores:

Score each item using the top box method; calculate a mode adjusted score for each respondent; calculate case mix adjusted scores for each program; and calculate means for the scale measures.

Scale Measures:

For each survey item, the top-box numerator is the number of respondents who selected the most positive response category.

Staff are reliable and helpful—Survey items 13, 14, 15, 19, 37, and 38

13: In the last 3 months, how often did {personal assistance/behavioral health staff} come to work on time?

14: In the last 3 months, how often did {personal assistance/behavioral health staff} work as long as they were supposed to?

15: In the last 3 months, when staff could not come to work on a day that they were scheduled, did someone let you know that {personal assistance/behavioral health staff} could not come that day?

19: In the last 3 months, how often did {personal assistance/behavioral health staff} make sure you had enough personal privacy when you dressed, took a shower, or bathed?

37: In the last 3 months, how often did {homemakers} come to work on time?

38: In the last 3 months, how often did {homemakers} work as long as they were supposed to?

Staff listen and communicate well—Survey items 28, 29, 30, 31, 32, 33, 41, 42, 43, 44, and 45

28: In the last 3 months, how often did {personal assistance/behavioral health staff} treat you with courtesy and respect?

29: In the last 3 months, how often were the explanations {personal assistance/behavioral health staff} gave you hard to understand because of an accent or the way {personal assistance/behavioral health staff} spoke English?

30: In the last 3 months, how often did {personal assistance/behavioral health staff} treat you the way you wanted them to?

31: In the last 3 months, how often did {personal assistance/behavioral health staff} explain things in a way that was easy to understand?

32: In the last 3 months, how often did {personal assistance/behavioral health staff} listen carefully to you?

33: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what kind of help you needed with everyday activities, like getting ready in the morning, getting groceries, or going places in your community?

41: In the last 3 months, how often did {homemakers} treat you with courtesy and respect?

42: In the last 3 months, how often were the explanations {homemakers} gave you hard to understand because of an accent or the way the {homemakers} spoke English?

43: In the last 3 months, how often did {homemakers} treat you the way you wanted them to?

44: In the last 3 months, how often did {homemakers} listen carefully to you?

45: In the last 3 months, did you feel {homemakers} knew what kind of help you needed?

Case manager is helpful—Survey items 49, 51, and 53

49: In the last 3 months, could you contact this {case manager} when you needed to?

51: In the last 3 months, did this {case manager} work with you when you asked for help with getting or fixing equipment?

53: In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?

Choosing the services that matter to you—Survey items 56 and 57

56: In the last 3 months, did your [program-specific term for "service plan"] include . . .

57: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what's on your [program-specific term for "service plan"], including the things that are important to you?

Transportation to medical appointments—Survey items 59, 61, and 62

59: Medical appointments include seeing a doctor, a dentist, a therapist, or someone else who takes care of your health. In the last 3 months, how often did you have a way to get to your medical appointments?

61: In the last 3 months, were you able to get in and out of this ride easily?

62: In the last 3 months, how often did this ride arrive on time to pick you up?

Personal safety and respect—Survey items 64, 65, and 68

64: In the last 3 months, was there a person you could talk to if someone hurt you or did something to you that you didn't like?

65: In the last 3 months, did any {personal assistance/behavioral health staff, homemakers, or your case managers} take your money or your things without asking you first?

68: In the last 3 months, did any {staff} yell, swear, or curse at you?"

Planning your time and activities—Survey items 75, 77, 78, 79, 80, and 81

75: In the last 3 months, when you wanted to, how often could you get together with these family members who live nearby?"

77: In the last 3 months, when you wanted to, how often could you get together with these friends who live nearby? "

78: In the last 3 months, when you wanted to, how often could you do things in the community that you like?

79: In the last 3 months, did you need more help than you get from {personal assistance/behavioral health staff} to do things in your community?

80: In the last 3 months, did you take part in deciding what you do with your time each day?

81: In the last 3 months, did you take part in deciding when you do things each day—for example, deciding when you get up, eat, or go to bed?

Global Ratings Measures:

The numerator for each global measure includes the number of respondents who answered 9 or 10 for the item (on a scale of 0 to 10).

Global rating of personal assistance and behavioral health staff—Survey item 35

35: Using any number from 0 to 10, where 0 is the worst help from {personal assistance/behavioral health staff} possible and 10 is the best help from {personal assistance/behavioral health staff} possible, what number would you use to rate the help you get from {personal assistance/behavioral health staff}?

Global rating of homemaker—Survey item 46

46: Using any number from 0 to 10, where 0 is the worst help from {homemakers} possible and 10 is the best help from {homemakers} possible, what number would you use to rate the help you get from {homemakers}?

Global rating of case manager—Survey item 54

54: Using any number from 0 to 10, where 0 is the worst help from {case manager} possible and 10 is the best help from {case manager} possible, what number would you use to rate the help you get from {case manager}?

Recommendation Measures:

The numerator for each recommendation measure includes the number of respondents who answered Definitely Yes for the item (on a scale of Definitely No, Probably No, Probably Yes, or Definitely Yes). Item numbers and item text are listed below.

Would recommend personal assistance/behavioral health staff to family and friends—Survey item 36

36: Would you recommend the {personal assistance/behavioral health staff} who help you to your family and friends if they needed help with everyday activities? Would you say you recommend the {personal assistance/behavioral health staff}?

Would recommend homemaker to family and friends—Survey item 47

47: Would you recommend the {homemakers} who help you to your family and friends if they needed {program-specific term for homemaker services}? Would you say you recommend the {homemakers}?

Would recommend case manager to family and friends—Survey item 55

55: Would you recommend the {case manager} who helps you to your family and friends if they needed {program-specific term for case-management services}? Would you say you recommend the {case manager}?

Unmet Needs Measures:

The numerator for each unmet needs measure includes the number of respondents who answered No for that item (these items are then reverse coded so that higher scores reflect a better experience). Item numbers and item text are listed below.

Unmet need in dressing/bathing due to lack of help—Survey item 18

18: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in meal preparation/eating due to lack of help—Survey item 22

22: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in medication administration due to lack of help—Survey item 25

25: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?

Unmet need in toileting due to lack of help—Survey item 27

27: In the last 3 months, did you get all the help you needed with toileting from {personal assistance/behavioral health staff} when you needed it? (not reverse coded).

Unmet need with household tasks due to lack of help—Survey item 40

40: In the last 3 months, was this because there were no {homemakers} to help you?

Physical Safety Measure:

The numerator for the following physical safety measure includes the number of respondents who answered No for this item (this item is then reverse coded so that higher scores reflect a better experience). The item number and item text is listed below.

Hit or hurt by staff—Survey item 71

71: In the last 3 months, did any {staff} hit you or hurt you?

#2624 Functional Outcome Assessment

Numerator Instructions: Documentation of a current functional outcome assessment must include identification of the standardized tool used.

Definitions:

Standardized Tool – A tool that has been normed and validated. Examples of tools for functional outcome assessment include, but are not limited to: Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), Patient-Reported Outcomes Measurement Information System (PROMIS), Disabilities of the Arm, Shoulder and Hand (DASH), and Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL).

Note: A functional outcome assessment is multi-dimensional and quantifies pain and musculoskeletal/neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does not meet the criteria of a functional outcome assessment standardized tool.

Functional Outcome Assessment – Patient completed questionnaires designed to measure a patient's physical limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.

Current (Functional Outcome Assessment) – A patient having a documented functional outcome assessment utilizing a standardized tool and a care plan if indicated within the previous 30 days.

Functional Outcome Deficiencies – Impairment or loss of physical function related to musculoskeletal/neuromusculoskeletal capacity, may include but are not limited to: restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.

Care Plan – A care plan is an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. These may include observations, goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused on one or more of the patient’s health care problems. Care plans may also be known as a treatment plan.

Not Eligible (Denominator Exception) – A patient is not eligible if one or more of the following reason(s) is documented at the time of the encounter:

Patient refuses to participate

Patient unable to complete questionnaire

Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status

NUMERATOR NOTE: The intent of this measure is for a functional outcome assessment tool to be utilized at a minimum of every 30 days but submission is required at each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the numerator quality-data code G8942 should be used for submission purposes.

Numerator Quality-Data Coding Options:

Functional Outcome Assessment Documented as Positive AND Care Plan Documented

Performance Met: G8539: Functional outcome assessment documented as positive using a standardized tool AND a care plan based, on identified deficiencies on the date of the functional outcome assessment, is documented

OR

Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan not Required Performance Met: G8542: Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required

OR

Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated, Within the Previous 30 Days Performance Met: G8942: Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented

OR

Functional Outcome Assessment not Documented, Patient not Eligible

Denominator Exception: G8540: Functional outcome assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter

OR

Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible

Denominator Exception: G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter

OR

Functional Outcome Assessment not Documented, Reason not Given Performance Not Met: G8541: Functional outcome assessment using a standardized tool not documented, reason not given

OR

Functional Outcome Assessment Documented as Positive, Care Plan not Documented, Reason not Given Performance Not Met: G8543: Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented, reason not given

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

For patients with a complete stay, each functional assessment item listed below must have a valid score or code at admission and discharge and at least one of the self-care or mobility items must have a valid numeric code as a discharge goal. Providers use the 6-point rating scale when coding discharge goals.

For patients with an incomplete stay, each functional assessment item listed below must have a valid score or code at admission and at least one of the self-care or mobility items must have a valid numeric code as a discharge goal. No discharge data are required for patients with incomplete stays.

The self-care functional assessment items are:

GG0130A. Eating

GG0130B. Oral hygiene

GG0130C. Toileting hygiene

GG0130D. Wash upper body

Valid scores/codes for the self-care functional assessment items are:

06 - Independent

05 - Setup or clean-up assistance

04 - Supervision or touching assistance

03 - Partial/moderate assistance

02 - Substantial/maximal assistance

01 - Dependent

07 - Patient refused

09 - Not applicable

88 - Not attempted due to medical condition or safety concerns

The mobility functional assessment items are:

GG0170A. Roll left and right

GG0170B. Sit to lying

GG0170C. Lying to sitting on side of bed

GG0170D. Sit to stand

GG0170E. Chair/bed-to-chair transfer

GG0170F. Toilet transfer

For patients who are walking:

GG0170I. Walk 10 feet

GG0170J. Walk 50 feet with two turns

GG0170K. Walk 150 feet

For patients who use a wheelchair, complete the following items:

GG0170R. Wheel 50 feet with two turns

GG0170RR1. Indicate the type of wheelchair/scooter used

GG0170S. Wheel 150 feet

GG0170SS1. Indicate the type of wheelchair/scooter used

Valid scores/codes for the mobility functional assessment items are:

06 - Independent

05 - Setup or clean-up assistance

04 - Supervision or touching assistance

03 - Partial/moderate assistance

02 - Substantial/maximal assistance
01 - Dependent
07 - Patient refused
09 - Not applicable
88 - Not attempted due to medical condition or safety concerns
Valid scores/codes for the self-care and mobility discharge goal items are:
06 - Independent
05 - Setup or clean-up assistance
04 - Supervision or touching assistance
03 - Partial/moderate assistance
02 - Substantial/maximal assistance
01 – Dependent
Cognitive Function
C1610A-E2. Signs and Symptoms of Delirium (CAM © [Confusion Assessment Method]):
C1610A. and C1610B. Acute Onset and Fluctuating Course
C1610C. Inattention
C1610D. Disorganized Thinking
C1610E1 and C160E2. Altered Level of Consciousness
Valid codes for C1610-Signs and Symptoms of Delirium are:
1 - Yes
0 - No
Communication: Understanding and Expression
BB0700. Expression of Ideas and Wants
Valid codes are:
4 - Expresses without difficulty
3 - Expresses with some difficulty
2 - Frequently exhibits difficulty with expressing needs and ideas
1 - Rarely/Never expresses self or speech is very difficult to understand
BB0800. Understanding Verbal Content:
Valid codes are:
4 - Understands
3 - Usually understands
2 - Sometimes understands
1 - Rarely/Never understands

Bladder Continence
H0350. Bladder Continence
Valid codes are:
0 - Always continent

1 - Stress incontinence only

2 - Incontinent less than daily

3 - Incontinent daily

4 - Always incontinent

5 - No urine output

9 - Not applicable

For patients with incomplete stays, admission data and at least one goal are required for the patient to be counted in the numerator. No discharge data are required. Patients with incomplete stays are identified based on the following data elements:

1) Patients with incomplete stays due to a medical emergency. These patients are excluded if:

- **a)** Item A0250. Reason for Assessment is coded 11 = Unplanned discharge OR
- **b)** The length of stay is less than 3 days based on item A0220. Admission Date and A0270: Discharge Date OR
- **c)** Item A2110. Discharge Location is coded 04 = Hospital emergency department OR 05 = Short-stay acute care hospital OR 06 = Long-term care hospital OR 08 = Psychiatric hospital or unit.

2) Patients who leave the LTCH against medical advice. These patients are identified based on the reason for the assessment:

- **a.** Item A0250. Reason for Assessment is coded as 11 = Unplanned discharge OR
- **b.** Item A2110. Discharge Location is coded 12 = Discharged Against Medical Advice.

3) No discharge functional status data are required if a patient dies while in the LTCH.

These patients are identified based on the reason for the assessment:

- **a)** Item A0250. Reason for Assessment is coded 12 = Expired.

Denominator Statement

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL as determined by the most recent FASI assessment within the previous 12 months.

#2967 CAHPS® Home and Community-Based Services Measures

The denominator for all measures is the number of survey respondents. Individuals eligible for the CAHPS Home- and Community-Based Services survey include Medicaid beneficiaries who are at least 18 years of age in the sample period, and have received HCBS services for three months or longer and their proxies. 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?

Individuals who are unable to answer these cognitive screening items are excluded. Some measures also have topic-specific screening items as well. Additional detail is provided in S.9.

Individuals who are more likely to be good proxy respondents during the CAHPS Home- and Community-Based Services survey data collection are: (a) those who are willing to respond on

behalf of the beneficiary; (b) unpaid caregivers, family members, friends, and neighbors; and (c) those who know the beneficiary well enough that he or she is familiar with the services and supports they are receiving, having regular, ongoing contact with them. Examples of circumstances that increase the likelihood that someone has knowledge about the beneficiary and their care situation include living with the beneficiary, managing the beneficiary's in-home care for a majority of the day, having regular conversations with the beneficiary about the services they receive, in-person visits with the beneficiary, and being present when services/supports are delivered. Individuals who are less likely to be good proxy respondents are: (a) those with paid responsibilities for providing services/supports to the beneficiary, including family members and friends who are paid to help the beneficiary ; and (b) guardians or conservators whose only responsibility is to oversee the beneficiary's finances. Due to the nature of data being collected through CAHPS, individuals who formally or informally deliver HCBS services are discouraged from acting as a proxy.

#2624 Functional Outcome Assessment

All visits for patients aged 18 years and older

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

The denominator is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period.

Denominator Details

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The proposed measure focuses on the assessment of functional needs that are common among adult HCBS recipients and derived from use of FASI. These are functional needs in the areas of self-care, mobility, and IADLs. The denominator is determined by items in Section B of the FASI form, Functional Abilities and Goals.

Self-care needs are identified in the following items on the FASI form: 6a (eating), 6b (oral hygiene), 6c (toileting hygiene), 6d (wash upper body), 6e (shower/bathe self), 6f (upper body dressing), 6g (lower body dressing), and 6h (putting on/taking off footwear).

Bed mobility and transfer needs are identified in the following items on the FASI form: 7a (roll left and right), 7b (sit to lying), 7c (lying to sitting on side of bed), 7d (sit to stand), 7e (chair/bed-to-chair transfer), 7f (toilet transfer), and 7g (car transfer).

If the response to item 8 on the FASI form indicates that the person walks, ambulation needs are identified in the following items on the FASI form: 8a (walks 10 feet), 8b (walks 50 feet with two turns), 8c (walks 150 feet), 8d (walks 10 feet on uneven surfaces), 8e (1 step (curb)), 8f (4 steps), 8g (12 steps), 8h (walks indoors), 8i (carries something in both hands), 8j (picking up object), 8k (walks for 15 minutes), and 8l (walks across a street).

If the response to item 9 on the FASI form indicates that the person uses a manual wheelchair, wheelchair mobility needs are identified in the following items on the FASI form: 9a (wheels 50 feet with two turns), 9b (wheels 150 feet), 9c (wheels for 15 minutes) and 9d (wheels across a street).

If the response to item 10 on the FASI form indicates that the person uses a motorized wheelchair/scooter, wheelchair/scooter mobility needs are identified in the following items on the

FASI form: 10a (wheels 50 feet with two turns), 10b (wheels 150 feet), 10c (wheels for 15 minutes) and 10d (wheels across a street).

IADLs are identified in the following items on the FASI form: 11a (makes a light cold meal), 11b (makes a light hot meal), 11c (light daily housework), 11d (heavier periodic housework), 11e (light shopping), 11f (telephone-answering call), 11g (telephone-placing call), 11h (medication management-oral medications), 11i (medication management-inhalant/mist medications), 11j (medication management-injectable medications), 11k (simple financial management), and 11l (complex financial management.

#2967 CAHPS® Home and Community-Based Services Measures

While there are myriad home and community-based services and supports (HCBS) that Medicaid programs provide (at their discretion) to beneficiaries with long-term care needs, the proposed provider-related measures in this submission focus on the most common provider types for adults receiving Medicaid HCBS. These include personal assistance providers, behavioral health staff, homemakers, and case managers.

While Medicare-certified home health agencies may provide similar services to Medicare beneficiaries, the Medicare benefit is a post-acute care benefit and typically limited to episodes following hospitalization. Medicaid home and community-based services are a long-term care benefit and support persons with long-term care needs over lengthier durations. Personal assistance services, help in the home by behavioral health staff, and homemaker services typically involve assistance with activities of daily living (bathing, dressing, grooming, toileting, eating; mobility) and instrumental activities of daily living (meal preparation, housework, laundry, food shopping). Case management is an integral component of Medicaid HCBS programs; the role of the case manager includes working with the beneficiary to assesses his/her need for services/supports and to develop a person-centered care/service plan, monitoring service delivery, and responding to the individual's changing needs and circumstances.

Not all HCBS beneficiaries receive all services. Questions 4, 6, 8, and 11 assess which services the beneficiary receives. Beneficiaries are then eligible for different survey questions based on these responses.

These questions are:

4: In the last 3 months, did you get {program specific term for personal assistance} at home?

6: In the last 3 months, did you get {program specific term for behavioral health specialist services} at home?

8: In the last 3 months, did you get {program specific term for homemaker services} at home?

11: In the last 3 months, did you get help from {program specific term for case manager services} to help make sure that you had all the services you needed?

Scale Measure 1: Staff are reliable and helpful

13: The number of surveys completed by all those who responded Yes to screener 4 or 6

14: The number of surveys completed by all those who responded Yes to screener 4 or 6

15: The number of surveys completed by all those who responded Yes to screener 4 or 6

19: The number of surveys completed by all those who responded Yes to screener 4 or 6

37: The number of surveys completed by all those who responded Yes to screener 8

38: The number of surveys completed by all those who responded Yes to screener 8

Scale Measure 2: Staff listen and communicate well

28: The number of surveys completed by all those who responded Yes to screener 4 or 6
29: The number of surveys completed by all those who responded Yes to screener 4 or 6
30: The number of surveys completed by all those who responded Yes to screener 4 or 6
31: The number of surveys completed by all those who responded Yes to screener 4 or 6
32: The number of surveys completed by all those who responded Yes to screener 4 or 6
33: The number of surveys completed by all those who responded Yes to screener 4 or 6
41: The number of surveys completed by all those who responded Yes to screener 8
42: The number of surveys completed by all those who responded Yes to screener 8
43: The number of surveys completed by all those who responded Yes to screener 8
44: The number of surveys completed by all those who responded Yes to screener 8
45: The number of surveys completed by all those who responded Yes to screener 8
Scale Measure 3: Case manager is helpful
49: The number of surveys completed by all those who responded Yes to screener 11
51: The number of surveys completed by all those who responded Yes to screener 11
53: The number of surveys completed by all those who responded Yes to screener 11
Scale Measure 4: Choosing the services that matter to you
56: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
57: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Scale Measure 5: Transportation to medical appointments
59: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
61: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
62: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Scale Measure 6: Personal safety and respect
64: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
65: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
68: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Scale Measure 7: Planning your time and activities
75: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
77: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
78: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
79: The number of surveys completed by all those who responded Yes to screener 4 or 6
80: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
81: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11
Global Rating Measures:
Global rating of personal assistance and behavioral health staff
35: The number of surveys completed by all those who responded Yes to screener 4 or 6
Global rating of homemaker
46: The number of surveys completed by all those who responded Yes to screener 8
Global rating of case manager

54: The number of surveys completed by all those who responded Yes to screener 11

Recommendation Measures:

Recommendation of personal assistance and behavioral health staff to family/friends

36: The number of surveys completed by all those who responded Yes to screener 4 or 6

Recommendation of homemaker to family/friends

47: The number of surveys completed by all those who responded Yes to screener 8

Recommendation of case manager to family/friends

55: The number of surveys completed by all those who responded Yes to screener 11

Unmet Needs Measures:

Unmet need in dressing/bathing due to lack of help

18: The number of surveys completed by all those who responded Yes to 16 and No to 17

Unmet need in meal preparation/eating due to lack of help

22: The number of surveys completed by all those who responded Yes to 20 and No to 21

Unmet need in medication administration due to lack of help

25: The number of surveys completed by all those who responded Yes to 23 and No to 24

Unmet need in toileting due to lack of help

27: The number of surveys completed by all those who responded Yes to 26

Unmet need with household tasks due to lack of help

40: The number of surveys completed by all those who responded No to 39

Personal Safety Measures:

Hit or hurt by staff

71: The number of surveys completed by all those who responded Yes to screener 4, 6, 8, or 11

#2624 Functional Outcome Assessment

The following information is provided in the specification in order to identify and calculate the numerator criteria:

Denominator Criteria (Eligible Cases):

Patients aged = 18 years on date of encounter

AND

Patient encounter during the performance period (CPT): 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

The denominator includes all LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period, including patients of all ages and patients with all payer sources. Patients are selected based on submitted LTCH CARE Data Set Admission and Discharge forms.

Exclusions

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Exclusions inherent in the denominator definition include individuals younger than 18 years, individuals who have not had a FASI assessment within the previous 12 months, and individuals who have had a FASI assessment, but no functional needs were identified in the areas of self-care, mobility, or IADLs. In addition, individuals without 3 months of continuous HCBS enrollment are excluded.

#2967 CAHPS® Home and Community-Based Services Measures

Individuals less than 18 years of age and individuals that have not received HCBS services for at least 3 months should be excluded. During survey administration, additional exclusions include individuals that failed any of the cognitive screening items mentioned in the denominator statement below.

#2624 Functional Outcome Assessment

A patient is not eligible or can be considered a denominator exception and excluded from the measure if one or more of the following reason(s) is documented at the time of the encounter:

Patient refuses to participate

Patient unable to complete questionnaire

Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

There are no denominator exclusions for this measure.

Exclusion Details

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

See S.7, Denominator Details, for information required to identify functional needs.

#2967 CAHPS® Home and Community-Based Services Measures

Individuals who are unable to answer one or more of the following cognitive screening items should be excluded. If the respondent is not able to answer (e.g., provides an invalid/nonsensical response, does not respond, or indicates "I don't know"), the interviewer should end the interview.

1. Does someone come into your home to help you? (Yes or No)
2. How do they help you? Open-Ended Response

Examples of correct responses include:

"Helps me get ready every day"

"Cleans my home"

"Works with me at my job"

"Helps me to do things"

"Drives me around"

3. What do you call them? Open-Ended Response

   Examples of sufficient responses include:

   "My worker"

   "My assistant"

   Names of staff ("Jo", "Dawn", etc.)

#2624 Functional Outcome Assessment

The information required to identify and calculate the measure exceptions follows:

Functional Outcome Assessment not Documented, Patient not Eligible G8540: Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter

OR

Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

There are no denominator exclusions for this measure.

Risk Adjustment

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

No risk adjustment or risk stratification

113612

113612

#2967 CAHPS® Home and Community-Based Services Measures

Statistical risk model

142229| 113612

142229| 113612

#2624 Functional Outcome Assessment

No risk adjustment or risk stratification

141015| 147517

141015| 147517

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

No risk adjustment or risk stratification

138203| 141592

138203| 141592

Stratification

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The primary unit of analysis is the Medicaid HCBS program type. Programs can provide a combination of standard medical services and nonmedical services. Standard services include but are not limited to case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States also can propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. (Source: Home & Community-Based Services 1915(c))

These programs are designed to provide an array of services to a certain target population; as a result, each state typically operates more than one HCBS program. Five HCBS program types were used to test this measure. Their labels reflect the predominant population eligible for services under each HCBS program. However, the group of individuals served within a single HCBS program may be heterogeneous by design (e.g., the intentional combination of individuals with mental health or substance use disorders) or because of the presence of comorbidities. These are the program types:

1. HCBS programs serving individuals who are older adults
2. HCBS programs serving individuals with a physical disability
3. HCBS programs serving individuals with an intellectual or developmental disability
4. HCBS programs serving individuals with an acquired brain injury
5. HCBS programs serving individuals with mental health or substance use disorders.

Medicaid agencies in the states have administrative authority over these HCBS programs and determine which services and supports to offer beneficiaries who are deemed eligible for a given HCBS program. Although Medicaid HCBS programs are administered by state Medicaid agencies under various Medicaid legal authorities, they frequently are operated by other entities including non-Medicaid state agencies (e.g., department of aging), non-state governmental entities (e.g., county), or managed care organizations. The operating entities then contract with direct service and support providers.

#2967 CAHPS® Home and Community-Based Services Measures

The intended primary unit of analysis is the Medicaid HCBS program. However, states may wish to stratify by sub-state agencies such as counties or regional entities with program operational and budgetary authority. In some instances, a state may wish to stratify by case-management agency as well, given they are typically viewed as having substantial responsibility for developing beneficiary service and support plans as well as monitoring whether the service/support plan addresses the person's needs and meet their goals.

States are increasingly moving users of Medicaid long-term services and supports, including HCBS, into managed care arrangements (typically referred to as Managed Long-Term Services and Supports or MLTSS) where the managed care organization (MCO) is the primary accountable entity for ensuring HCBS beneficiary, health, welfare and quality of life. As such, we also anticipate some states may want to stratify based on (MCO).

#2624 Functional Outcome Assessment

No stratification.

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

This measure does not use stratification.

Type Score

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

Rate/proportion better quality = higher score

#2967 CAHPS® Home and Community-Based Services Measures

Other (specify): Case-mix adjusted top box score better quality = higher score

#2624 Functional Outcome Assessment

Rate/proportion better quality = higher score

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Rate/proportion better quality = higher score

Algorithm

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

The following steps are used to create the score for this measure:

1. Restrict the HCBS sample to individuals aged 18 years or older with continuous enrollment for at least 3 months and those who have had a FASI assessment within the previous 12 months.
2. Count the number of sampled individuals with at least one FASI-documented functional need in self-care, mobility, or IADLs. Documented functional needs are based on receiving either a “05” or below (04, 03, 02, or 01) or “88” on any item in the Self-Care, Mobility, or IADL sections of a FASI form. See S.2b. (data dictionary, code table, or value sets) for value labels and S.7 (denominator details) for the list of specific items on the FASI form that comprise the Self-Care, Mobility, and IADL sections.
3. For each individual with at least one FASI-documented functional need, determine whether the PCSP documentation indicates that there is either a paid service, unpaid help, or a plan in progress for addressing each FASI-identified functional need in self-care, mobility, and IADLs.
4. Count the number of sampled individuals for whom the PCSP addresses all FASI-identified functional needs in self-care, mobility, and IADLs.
5. Calculate the percentage by dividing the resulting number in step 4 by the resulting number in step 2. 113612

#2967 CAHPS® Home and Community-Based Services Measures

Scoring specifications for the measures will follow the same general scoring approach as used by other CAHPS surveys that use the CAHPS analysis program. The measures are based on case-mix adjusted top box scores. The research team suggests general health rating, mental health rating, age, education, gender, whether respondent lives alone, and response option as case- mix adjusters for these measures. We also recommend including survey mode as an additional adjustment variable and proxy status if proxy responses are permitted. More information about

case-mix adjustment is available in Instructions for Analyzing Data from CAHPS Surveys (available from the downloadable zip file).

To create scores for each scale measure:

1. Calculate the score for each item using the top box method.
2. Calculate a mode adjusted score for each item.
3. Calculate case-mix adjusted scores for each program.
4. Calculate means for the scale measures weighting each item equally.

The steps for user-defined calculations of risk-adjusted scores can be found in Instructions for Analyzing Data from CAHPS Surveys: Using the CAHPS Analysis Program Version 4.1 available from the downloadable zip file.

To create scores for each global rating and individual item measure, follow steps 1-3 above.
142229| 113612

#2624 Functional Outcome Assessment

To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD) and Denominator Exceptions (B).

Numerator (A): Number of patients meeting numerator criteria

Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion

Denominator Exceptions (B): Number of patients with valid exceptions

1) Identify the patients who meet the eligibility criteria for the denominator (PD), which includes patients who are 18 years and older with appropriate encounters as defined by encounter codes during the performance period.
2) Identify which of those patients meet the numerator criteria (A), which includes patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies.
3) For those patients who do not meet the numerator criteria, determine whether an appropriate exception applies (B) and subtract those patients from the denominator with the following calculation: Numerator (A)/ [Performance Denominator (PD) - Denominator Exceptions (B)].
141015| 147517

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

1) For each LTCH, the stay records of patients discharged during the 12 month target time period are identified and counted. This count is the denominator.
2) The records of patients with complete stays are identified and the number of these patient stays with complete admission functional assessment data AND at least one self-care or mobility discharge goal AND complete discharge functional assessment data is counted.
3) The records of patients with incomplete stays are identified, and the number of these patient records with complete admission functional status data AND at least one self-care or mobility discharge goal is counted.
4) The counts from step 2 (complete LTCH stays) and step 3 (incomplete LTCH stays) are summed. The sum is the numerator count.
5) The numerator count is divided by the denominator count to calculate this quality measure.

For the numerator, complete data are defined as:

1. a valid numeric score indicating the patient's status, or a valid code indicating the activity did not occur or could not be assessed, for each of the functional assessment items on the admission assessment; and
2. a valid numeric score for one or more of the self-care or mobility items that is a discharge goal;
3. a valid numeric score indicating the patient's status, or a valid code indicating the activity did not occur or could not be assessed, for each of the functional assessment items on the discharge assessment. (Note: Discharge data are not required for patients with incomplete LTCH stays.)

Denominator: The denominator for this quality measure is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period. 138203| 141592

#3594 Alignment of Person-Centered Service Plan (PCSP) With Functional Assessment Standardized Items (FASI) Needs

5.1 Identified measures: 2624 : Functional Outcome Assessment

2631 : Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

2967 : CAHPS® Home- and Community-Based Services Measures

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: No further harmonization is possible. Both the proposed measure and NQF#2624 rely on a standardized functional assessment to specify the numerator, although the target populations differ. The proposed measure relies on the FASI assessment, which has been tested and validated specifically in HCBS populations, and NQF #2624 specifies use of any standardized assessment tool that has been normalized and validated (e.g., Oswestry Disability Index, Patient-Reported Outcomes Measurement Information System, Knee Outcome Survey Activities of Daily Living Scale). FASI meets the NQF #2624 specification requirement for a standardized assessment tool that has been normalized and validated. Like the proposed measure, NQF#2631 requires both a complete functional assessment (using the Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set Version 3.00) and a minimum level of alignment between the assessed needs/goals and the care services. NQF#2967 focuses specifically on individuals continuously enrolled in HCBS for 3 months or longer who pass a cognitive screen and their proxies. The proposed measure, while necessarily focusing on a subset of HCBS recipients who have documented functional needs as measured by the FASI, also excludes individuals who do not have 3 months of continuous HCBS enrollment.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures.

#2967 CAHPS® Home and Community-Based Services Measures

#2624 Functional Outcome Assessment

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Appendix F: Pre-Evaluation Comments

As of January 21, 2021, no comments were received.

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